

Submitted to: Centers for Medicare & Medicaid Services (CMS)
Sponsoring Agency, June 2011

2011 ANNUAL REPORT

**ESRD NETWORK OF NEW ENGLAND
NETWORK # 1
CONTRACT # HHSM-500-2010-NW001C**

30 Hazel Terrace, Woodbridge, Connecticut 06525
Phone: (203) 387-9332 Fax: (203) 389-9902 Email: info@nw1.esrd.net
Website: <http://www.networkofnewengland.org>

I. PREFACE

MESSAGE FROM THE CHAIR

Throughout 2011, Network 1, The Network of New England, vigorously pursued its mission “to facilitate the improvement of health care and quality of life for individuals who have chronic kidney disease and those treated with dialysis and transplantation”. Numerous projects, presentations, and collaborations have successfully implemented our mission.

As in previous years, our principal Quality Improvement project was Fistula First. The Medical Review Board (MRB) and Network Staff continued to emphasize that **all** providers must improve their prevalent AVF rates and, hence, each provider was assigned a specific AVF change goal. In addition, intense focus and interaction occurred with those facilities “stuck” at AVF rates < 50%. Progress occurred (detailed review in this Annual Report) and Network 1 reached a CMS dashboard AVF rate of 63.4% in December of 2011; the Network goal assigned by CMS for March 2012 had been set at 62.9%. Every New England state had a > 60% AVF rate, with New Hampshire > 73%. Catheter Reduction Strategies led to a > 90 day catheter rate of 9% by December 2011.

The Network anticipated the financial impact of the 2012 Quality Incentive Program on facilities throughout New England. Network Staff utilized performance score reports for 2011 (containing 2010 data) to notify providers with “at risk” data for URR < 65% or Hgb >12. Focused interventions were identified for each of these providers.

The Network Specific Quality Improvement Project expanded our previous work on flu vaccinations from a concentration on Large Dialysis Organization (LDO) facilities to the inclusion of independent and hospital based facilities. Substantial improvement occurred in most categories with an overall seasonal immunization vaccination rate of 85% for 2011/2012.

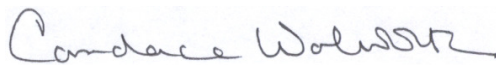
Since 2008, Networks 1 and 5 have developed and supported the 5 Diamond Patient Safety Program, a web based program for dialysis staff and patient training. In 2011, three new modules were added and our emphasis was on increasing facility enrollment and participation. By December 2011, of the 163 facilities in Network 1 eligible to participate, 60 (37%) enrolled and of these 46 (77%) had achieved diamond status.

The Board of Directors (BOD) and the staff of the Network reinvigorated our attention to complaints and grievances by developing new documentation methodology and enacting a more structural process of nurse/physician review of particular clinical cases. While the total number of complaints and grievances brought to the Network remains low, each is extensively evaluated by the Patient Services Coordinator (PSC), Quality Manager Nurses and the Grievance Chair, if necessary.

The strong educational commitment of Network 1 continued throughout 2011. The Annual meeting for the Network Council occurred in October 2011. More than 700 patients, providers and members of industry attended and presentations included Health Care Associated Infections (HAI), Transplantation, Vascular Access, and Professionalism. The Annual Network Dialysis Technician Educational Meetings took place in April 2011 in Sturbridge, Massachusetts and Portsmouth, New Hampshire and 200 technicians attended each of the 2 meetings. Speakers emphasized the vital role of dialysis technicians in HAI, vascular access assessment and preservation, and transplant education.

The Network has been awarded several non-CMS contracts in the area of HAI. These endeavors, as well as the numerous other projects, presentations, and day-to-day interactions with patients, providers and collaborators, could not occur without the extraordinarily dedicated staff of Network 1. These accomplishments also reflect the work of the committed, all volunteer patients and professionals who serve as members of the MRB and BOD.

Network 1 looks to increase collaboration with sister Networks, Quality Improvement Organizations (QIOs), State Survey Agencies and National Coalitions throughout 2012 to achieve quality care for the ESRD/CKD community. Challenges will continue to include the impact of the Quality Incentive Program on the access to care and the quality of care for ESRD patients throughout New England. Network 1 will continue to address its mission and the future challenges with expertise, energy and innovation.



Candace Walworth, MD
Network Chair

**Network of New England
Mission Statement**

The mission of the Network of New England is to facilitate the improvement of health care and quality of life for individuals who have chronic kidney disease and those treated with dialysis or transplantation

2011 ANNUAL REPORT – TABLE OF CONTENTS

I.	PREFACE	
	1. MESSAGE FROM THE CHAIR	
	2. TABLE OF CONTENTS	
II.	INTRODUCTION	1
	A. NETWORK DESCRIPTION	3
	B. NETWORK STRUCTURE	8
	1. NETWORK STAFF	8
	2. COMMITTEE FUNCTION & ACTIVITY	9
	➤ Network Council: Facility Constituents	9
	➤ Board of Directors	10
	➤ Medical Review Board	11
	➤ Finance Committee	12
	➤ Grievance Committee	12
	➤ Network Advisory Committee	12
	➤ Nominating Committee	13
	➤ Ad Hoc Committees	13
	➤ Ad Hoc: 2011 Annual Meeting and Technician Meeting Committees	13
	➤ Patient Advisory Committee (PAC)	13
III.	CMS NATIONAL GOALS AND NETWORK ACTIVITIES	15
	A. IMPROVE THE QUALITY AND SAFETY OF DIALYSIS RELATED SERVICES PROVIDED FOR INDIVIDUALS WITH ESRD	15
	➤ Quality Improvement Work Plan	15
	➤ National Fistula First Vascular Access Improvement Initiative (Task 1a)	15
	➤ Clinical Performance Measures (Task 1b)	21
	– National CMS Clinical Performance Measures Project	21
	➤ Network Specific Improvement Project (Task 1c)	24
	– Immunization Project	24
	➤ Facility Level Quality Assessment (Task 1d)	26
	– 5 Diamond Safety Project	26
	<i>Other Quality Improvement Activities in 2011</i>	27
	➤ Healthcare Associated Infections (HAI)	27
	➤ FFBI Committee Work	28
	➤ Clinical Technical Assistance	28
	➤ ELab	29
	➤ Acute Dialysis Programs	29

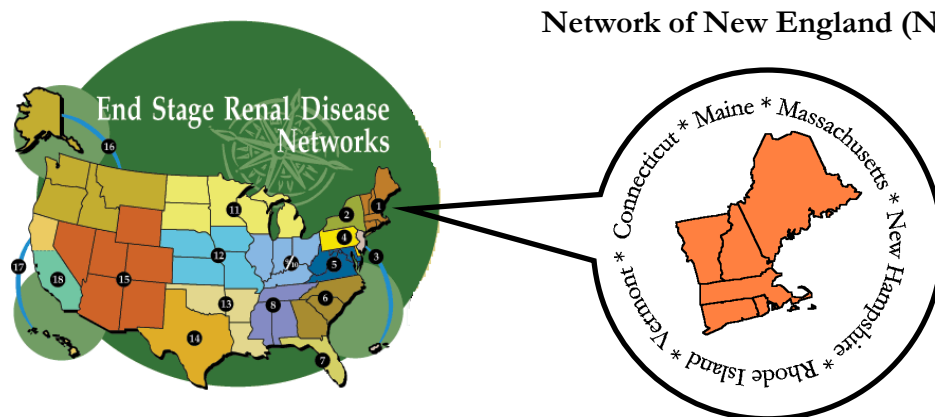
➤	Assisting Facilities with Continuous Quality Improvement Activities	29
➤	Achieving Network #1 Goals in Quality of Care & Safety	29
B.	IMPROVE THE INDEPENDENCE, QUALITY OF LIFE, AND REHABILITATION (TO THE EXTENT POSSIBLE) OF INDIVIDUALS WITH ESRD THROUGH TRANSPLANTATION, USE OF SELF-CARE MODALITIES (E.G., PERITONEAL DIALYSIS, HOME HEMODIALYSIS), IN-CENTER SELF-CARE, AS MEDICALLY APPROPRIATE, THROUGH THE END OF LIFE	31
➤	Withdrawal from Dialysis Trends	31
➤	Profile Analysis of ESRD Incidence Population	32
➤	Prevalence Population and Employment Status	35
➤	Incidence Population and Employment Status	35
➤	Vocational Rehabilitation	37
➤	Network #1 Staff Provide Community Educational Materials	38
➤	Achieving Network #1 Goals in Quality of Life for ESRD Patients	38
C.	IMPROVE PATIENT PERCEPTION OF CARE AND EXPERIENCE OF CARE, AND RESOLVE PATIENT’S COMPLAINTS AND GRIEVANCES	39
➤	Complaints, Grievances and Contact Report for 2011	39
➤	Network Notes Published in 2011	41
➤	Kidney Chronicles Published in 2011	42
➤	The Patient Advisory Committee (PAC) Remains Active in 2011	42
➤	“Need Help Finding Your Way”	43
➤	Solomon four Group Design Project	43
➤	Decreasing Patient Provider Conflict Toolkit	44
➤	CMS Dialysis Facility Compare	44
➤	Achieving Network #1 Goals to Address Patient Grievances and Experience of Care	45
➤	End of Life Coalition (EOL)	45
➤	Network 1 Collaborative with Donated Dental Services	45
➤	Explore Transplant Workshop	46
➤	Achieving Network 1 Goals in collaboration with Other Organizations	46
D.	IMPROVE COLLABORATION WITH PROVIDERS TO ENSURE ACHIEVEMENT OF THE GOALS THROUGH THE MOST EFFICIENT AND EFFECTIVE MEANS POSSIBLE, WITH RECOGNITION OF THE DIFFERENCES AMONG PROVIDERS (E.G., INDEPENDENT, HOSPITAL-BASED, MEMBER OF A GROUP, AFFILIATE OF AN ORGANIZATION) AND THE ASSOCIATED POSSIBILITIES/CAPABILITIES	47
➤	23 rd Annual Network of New England Educational Meeting	47
➤	Network of New England Technician Educational Meetings	48
➤	Emergency Preparedness	50

➤ Donate Life Connecticut	51
➤ Donor Designation Collaborative	52
➤ Forum of ESRD Networks	52
➤ State Survey Agencies	52
➤ Quality Improvement Organizations	52
➤ National Kidney Foundation Affiliates	52
➤ Network of New England Website	53
➤ Network Publication	53
➤ Network #1 Collaborative with Donated Dental Services	53
➤ Achieving Network #1 Goals in Collaboration with Other Organizations	54
E. IMPROVE THE COLLECTION, RELIABILITY, TIMELINESS, AND USE OF DATA TO MEASURE PROCESSES OF CARE AND OUTCOMES; MAINTAIN PATIENT REGISTRY; AND TO SUPPORT THE ESRD NETWORK PROGRAM	55
➤ Information Management	55
- System Architecture	55
➤ Network Role in Maintaining ESRD Data	56
- Patient Registry	56
- Updating Status of Medicare ESRD Beneficiaries	56
- Verification of Patient Data	56
- Provider and Personnel Database	57
➤ Quality Assurance of Patient Data	57
- VISION Generated 2728 Forms Validation	58
- DATA Systems	58
- VISION	58
- SIMS	58
- Central-SIMS	59
- REMIS	59
- QualityNet Exchange	59
- REMEDY	60
- National Help Desk for ESRD CROWN System	60
- Electronic Laboratory Data Collection Project	60
- Fistula First initiative	60
- United States Renal Data System (USRDS)	60
- Dialysis Facility Specific Reports	60
- Dialysis Facility Compare	61
- United Network for Organ Sharing (UNOS)	61
➤ Information Management Support for Quality Management Reports	61
➤ Information Management Support for Administrative Reports	61

➤ Information Management Support for Patient Services	62
➤ Information Management Support for Provider Education	62
- Statistical Summary Booklet	62
- Facility Directory	62
- Information for New Facility / Data Packet / QI Packet	62
- Information for New Patient Packets	62
- Technical Assistance	63
- Data Requests	63
- Disaster Preparedness and Business Continuity and Contingency Plan (BCCP)	63
- Development and Testing of ESRD Network Data and Data Systems	63
- Task Groups and Committees	63
➤ CROWNWeb	64
➤ Achieving Network #1 Goals in Data Management	65
IV. SANCTION RECOMMENDATIONS	66
V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES	67
VI. DATA TABLES	69
Table 1: ESRD Incidence	70
Table 2: ESRD Dialysis Prevalence	72
Table 3: Dialysis Modality by Self-Care Settings - Home	74
Table 4: Dialysis Modality by In-Center Settings	82
Table 5: Renal Transplants by State	90
Table 6: Renal Transplants by Transplant Type, Age, Race, Gender and Primary Diagnosis	91
Table 7: Dialysis Deaths	93
Table 8: Vocational Rehabilitation	95

II. INTRODUCTION

The Network of New England, Inc., is one of 18 End Stage Renal Disease (ESRD) Network Organizations in the country to participate in the ESRD Network Organization Program as a contractor to the Centers for Medicare & Medicaid Services (CMS). The current Network Organization contract is from September 2010 to June 2012. This non-profit organization has been awarded Network Organization contracts since 1978. The Network of New England (Network 1) serves the New England region, consisting of six states, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.



The ESRD Network Program was established under the ESRD Amendments to the Social Security Act of 1972 for individuals with end stage renal disease (ESRD). The Network of New England facilitates the improvement of health care and quality of life for individuals who have chronic renal insufficiency, and those treated with dialysis or transplantation. The current CMS strategic goals for the Network Program are:

- * Improve the quality and safety of dialysis related services provided for individuals with ESRD.
- * Improve the independence, quality of life, and rehabilitation (to the extent possible) of individuals with ESRD through transplantation, use of self-care modalities (e.g., peritoneal dialysis, home hemodialysis), in-center self-care, as medically appropriate, through the end of life.
- * Improve patient perception of care and experience of care, and resolve patients' complaints and grievances.
- * Improve collaboration with providers to ensure achievement of all Program goals through the most efficient means possible, with recognition of the differences among providers (e.g., independent, hospital-based, member of a group, affiliate of an organization) and the associated possibilities/capabilities.
- * Maintain a patient registry; improve the collection, reliability, timeliness, and use of data to measure processes of care and outcomes and to support the ESRD Network Program.

With respect to the above strategic goals, CMS uses the Institute of Medicine's (IOM) definition of quality, which is: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." These strategic goals also fall under the Mission of the Health Care Quality Improvement Program (HCQIP) by helping to assure the IOM aims of patient centered, effective, safe, efficient, equitable, and timely care.

Emerging Issues in ESRD Program

Several new regulations were passed by CMS in 2010 that effect the care provided to ESRD patients. These come under Section 153(b) and section 153(c) of the Medicare Improvements for Patients and Providers Act (MIPPA).

End-Stage Renal Disease Prospective Payment System: Section 153(b) of MIPPA requires implementation of the bundled ESRD PPS effective for Medicare outpatient maintenance dialysis services furnished on or after January 1, 2011. This payment system combines payments for the composite rate and separately billable services into a single base rate (also called bundled payment).

Quality Incentive Program (QIP): Section 153(c) of MIPPA requires implementation of a QIP for Medicare outpatient end-stage renal disease (ESRD) dialysis providers and facilities with payment consequences beginning January 1, 2012. The ESRD QIP is the first Medicare program that links any provider or facility payments to performance based on outcomes as assessed through specific quality measures. ESRD QIP would reduce ESRD payments by up to 2.0 percent for dialysis providers and facilities that fail to meet or exceed a total performance score for performance standards established with respect to certain specified measures.

Performance Score Certificates: Performance Score Certificate is a document intended to inform patients and their families how a dialysis facility performed in the ESRD QIP. PSC must be publicly posted by dialysis facilities in an area easily visible to patients and their families. CMS compares each facility's performance in the performance period to a performance standard to calculate scores for each measure. The performance scores are then weighted and combined to derive the facility's Total Performance Score. For more information, please visit <http://www.dialysisreports.org/>

CROWNWeb: According to conditions for coverage of ESRD facilities, dialysis facility must furnish ESRD data and information to CMS for Program Administration. CMS is working with several contractors and the Network Organizations to build the CROWNWeb, which will facilitate the collection and maintenance of information directly from ESRD facilities using a web based system. CROWNWeb will also require facilities to enter clinical data on all dialysis patients and report administrative information on facility personnel and dialysis services. CROWNWeb system is shared by CMS, the Networks, and facility users, with role-based access. CROWNWeb national roll out is set for 2012. For more information, please visit <http://www.projectcrownweb.org/crown/index.php>

Healthcare Associated Infections: In 2008, the U.S. Department of Health and Human Services (HHS) established a senior-level Steering Committee for the Prevention of Healthcare-Associated Infections. Through late 2008 and 2009, the Steering Committee, along with scientists and program officials across HHS, developed the HHS Action Plan to Prevent Healthcare-Associated Infections

(http://www.hhs.gov/ash/initiatives/hai/actionplan/hhs_hai_action_plan_final_06222009.pdf), providing a roadmap for HAI prevention in acute care hospitals. In late 2009, the Steering Committee approved Phase II of the *Action Plan* to include outpatient dialysis facilities.

State Healthcare-Associated Infection Prevention Plans: The 2009 Omnibus Bill required states receiving Preventive Health and Health Services (PHHS) Block Grant funds to certify that they will submit a plan to reduce HAIs to the Secretary of Health and Human Services by January 2010. Several states in New England are in the process of developing such plans and some states, such as CT, included dialysis as a “setting” in their plans.

Fistula First Breakthrough Initiative: Hemodialysis patients with fistulas have better morbidity and mortality outcomes than patients with other types of vascular access. CMS has since 2003, made Fistula Breakthrough Initiative contract performance requirements for Network Organizations. Each organization receives a goal in July of each contract year. Networks are required to achieve that goal by March of the following year. Network of New England’s goal for the March of 2011 is 60.2% AVF in prevalent patients.

The Network of New England strives to accomplish the HCQIP program mission, CMS strategic program goals, as well as the objectives of CMS national breakthrough initiatives through the leadership of knowledgeable individuals serving on the Network Board of Directors, Medical Review Board, and various committees, and with the cooperation of the personnel of ESRD providers throughout New England. This Network is committed to a long-standing tradition of non-punitive collaboration among professionals and patients.

A. NETWORK DESCRIPTION

The Network of New England’s geographic area consists of six states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont. According to Census Bureau all six states have a combined population of approximately 14.49 million people according to 2011 estimates based on 2010 census (<http://factfinder2.census.gov>). The individual states in New England vary greatly in area, population, and incidence of ESRD. Some of the patient access to ESRD services challenges that the Network of New England faces in its oversight responsibilities can be attributed to the diverse distribution of patients in rural and urban areas.

Geographic Distribution

In general, the New England area is considered urban/metropolitan. Individual states vary widely in demographic features. The demographic features of the New England area have an influence on availability of ESRD services and treatment choices. There is variation in population density and land area of different states. Maine is the largest of the six New England states and has the lowest population density. Rhode Island is the smallest state with highest population density. The majority of the residents of Connecticut, Massachusetts, and Rhode Island live in metropolitan areas and the majority of the residents of Maine, New Hampshire, and Vermont live in rural areas.

Population Distribution

The population distribution for the year 2011 is based on Census Bureau population estimates for 2011 based on 2010 census (Table A). ESRD incidence data is from the Standard Information Management System (SIMS) database maintained by Network of New England. The Network tracks the racial distribution of the ESRD population to identify any patterns of interest or concern. As the table shows, the New England region has a smaller percentage of black residents than the national average. Approximately 19% of the New England population is over 60 years of age. But over 65% of ESRD population is over 60 years of age. The increasing number of elderly in the general population contributes to a rising number of CKD patients, and in turn ESRD patients.

Table A: 2011 Crude Incidence Rates (New ESRD Patients)

State	Population*	Percent African American	Percent White	Number of New ESRD Patients	Rate Per Million
Connecticut	3,580,709	10.1	77.57	931	6
Maine	1,328,188	1.18	95.23	268	201
Massachusetts	6,587,536	6.63	80.41	1,767	268
New Hampshire	1,318,194	1.14	93.89	255	193
Rhode Island	1,051,302	5.72	81.41	309	293
Vermont	626,431	1.00	95.29	108	172
Network	14,492,360	6.19	83.02	3662**	252
National	311,591,917	12.6	72.4	99,681	319

* US Census Bureau 2011 Census; <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>. ESRD incident data is based on the Network of New England Patient Registry and is based on the state of residence of the patient. ** This includes 146 patients with transplant therapy as an initial treatment and includes 24 patients who reside in neighboring states such as New York in Network total.

Incident ESRD Patient Population in New England States

There was a 1.8% decrease in the incident ESRD population from 2010 to 2011 in the New England states compared to US where there is also a decrease of 1.16%. Every state in the Network of New England area has a lower ESRD incidence rate per million than national rate. The average age of an incident ESRD patient in New England is 65. Please refer to Table 1 at the end of this report for a complete analysis of incident ESRD population by age, gender, race, and primary diagnosis.

Prevalent Dialysis Patient Population in New England States

The number of prevalent patients receiving dialysis services in New England continues to slowly increase each year (Table B and Figure 6). The prevalent ESRD population increased 2.2% from 2010 to 2011. This is less than the national increase of 3.2% from 2010 to 2011 (preliminary data). Apart from the described geographical and population factors, the availability of dialysis facilities in each state may impact the number of patients who are treated in each dialysis program. Maine, with approximately 33,000 sq miles of land area and a population of 1.3 million, has 18 dialysis facilities while Rhode Island, with approximately 1,000 square miles of land area and a population of 1.0 million, has 17 dialysis facilities. This diversity of state size reflects the range in dialysis census by state.

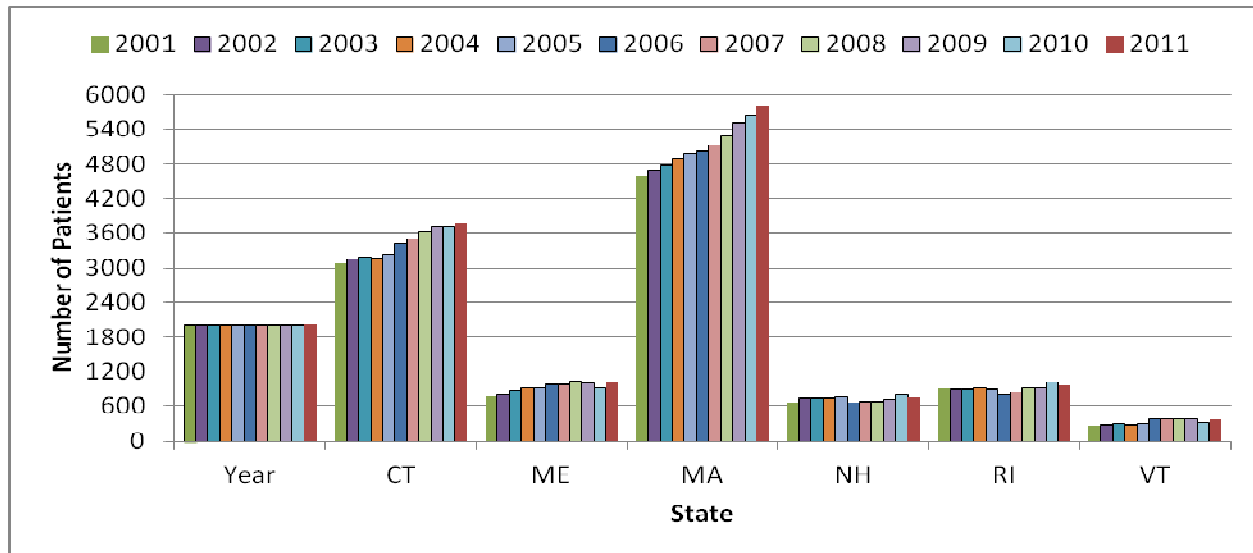
Table B: Prevalent Dialysis Patient Data by Year and by State of Dialysis Treatment*

Year	CT	ME	MA	NH	RI	VT	Network
2000	3,035	752	4,535	648	920	241	10,131
2001	3,083	767	4,601	682	910	266	10,309
2002	3,146	806	4,698	732	894	272	10,548
2003	3,196	870	4,783	751	903	288	10,791
2004	3,168	916	4,880	732	913	277	10,886
2005	3,237	927	4,981	758	908	289	11,100
2006	3,423	988	5,034	667	797	383	11,340
2007	3,497	975	5,123	690	838	380	11,558
2008	3,620	1,044	5,284	677	915	381	11,966
2009	3,724	1,003	5,522	712	922	388	12,323
2010	3,730	922	5,626	800	1,021	328	12,427
2011	3,765	1,001	5,796	749	973	368	12,698

Source: Network 1 SIMS Database - Includes CT Veterans Administration patients for 1988-1989 and all Veterans Administration patients for 2000 – 2011.

** This table cannot be compared to the CMS Facility Survey because the CMS Facility Survey is limited to only Medicare approved facilities.*

The prevalent dialysis population data is analyzed by gender, race, primary diagnosis, and age distribution (see Figures 2, 3, 4). The gender distribution indicates that 58% are male and diabetes continues to be the leading cause of renal disease. Patients identified as Black have a disproportionately higher rate of ESRD. Analysis of the age distribution indicates that the ESRD population is older than the general population (Figure 4). The average age of a prevalent dialysis patient in New England is 64. Refer to Table 2 at the end of the report for a complete analysis of the prevalent ESRD population by age, gender, race, and primary diagnosis.

Figure 1***Prevalence of ESRD Dialysis Patients by State of Provider 2001-2011***

Source: Network 1 SIMS database

ESRD Facilities in New England States

There are 174 dialysis facilities in the Network 1 area at the end of 2011. The total number of kidney transplant programs (15) remained the same. Hospital-based outpatient dialysis centers continue to be purchased by large dialysis corporations. Lack of hospital-based dialysis units can create challenges in treating patients with multiple co-morbid medical conditions. Several facilities have changed ownership from Small Dialysis Organizations (SDO) to Large Dialysis Organizations (LDO) and several SDO's are acquiring facilities from LDO's.

Treatment Options: Home Dialysis and In-Center Dialysis

ESRD patients have two dialysis options, hemodialysis and peritoneal dialysis. Dialysis treatment can be obtained in a facility or can be performed at home with a back-up facility for emergencies and periodic clinical assessment. Home dialysis allows for a flexible schedule, more control over the dialysis treatment, and relatively less travel for clinical management. In 2011, 90% of the ESRD patients in New England were receiving dialysis in outpatient dialysis clinics called ESRD providers. Ten percent of ESRD patients in New England were utilizing different forms of home dialysis (Table C). Of the 1,261 home dialysis patients in New England, only 12.3% are on hemodialysis, 63.3% are on Continuous Cycling Peritoneal Dialysis (CCPD), and 24.2% are on Continuous Ambulatory Peritoneal Dialysis (CAPD). In 2011 there is a slight decrease in the use of home hemodialysis compared to 2010. Several New England clinics are utilizing newer technologies of frequent and nocturnal dialysis, which may move patients toward more frequent hemodialysis and home dialysis in the coming years. The Network of New England distributes information to providers to educate patients about the various treatment options that are available to them including transplantation. For distribution and analysis of the use of the self-care setting and hemodialysis, please refer to data tables 3 and 4 at the end of the Annual Report.

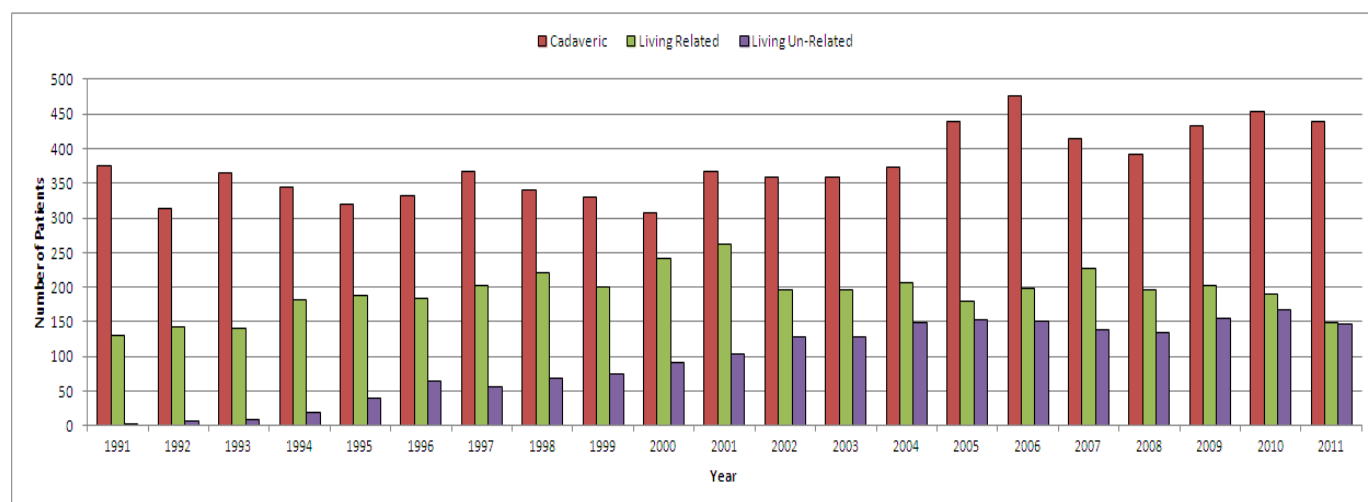
Table C: 2011 Dialysis Prevalence by Modality: By State of Provider Service

State	In-center	Home Hemodialysis	IPD	CAPD	CCPD	Total Home	Total Patients
CT	3,168	58	0	152	347	557	3,725
MA	5,314	56	0	107	360	523	5,837
ME	892	14	0	17	44	75	9,67
NH	723	17	0	15	29	61	784
RI	1,049	5	0	11	12	28	1,077
VT	289	5	0	4	7	17	306
Network 1	11,435	155	0	306	799	1,261	12,696

Source: CMS Facility Survey (includes Veteran Administration patients)

Kidney Transplantation

Kidney transplantation is the preferred treatment choice for kidney failure. The number of individuals on the kidney transplant waitlist as of December 31, 2011, in the New England states was 3,104 (CMS Facility Survey 2011). Forty percent of the total kidney transplants in 2011 were from living donors (147 living unrelated, 149 living related) (Figure 2). Comparing 2010 to 2011, there is an overall decrease of 9.3% in kidney transplantation in the Network area. This decrease may be due to recent changes by UNOS. Criteria for selecting suitable donors are now more restrictive. For analysis of the transplantation data, please refer to data tables 5 and 6 at the end of the Annual Report.

Figure 2**Renal Transplants by Donor Type - All Transplant Centers in New England**

Source: CMS Facility Survey (includes Veterans Administration patients)

NETWORK STRUCTURE

The Network of New England, Inc., is responsible for dialysis and kidney transplant providers in a geographic area that covers the six New England states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

1. NETWORK STAFF

The Network Executive Director supervises the administrative staff. The Executive Director is accountable to the Board of Directors (BOD) for the overall performance and activities of the Network staff. The office staff works within a team model. Each professional employee has a primary area of responsibility, which falls within one of four major themes – Administrative, Quality Management, Information Management, and Patient/Community Services. The employees as of December 31, 2011, were:

Network Personnel

– Administration

- Jenny Kitsen, BA, Executive Director
Administrator of CMS contract; supervises Network staff; reports to Network Board of Directors; directs conduct of special projects.
- Joan Kliger, MS, Financial Manager
Provides office management support; performs payroll and bookkeeping duties; assists Executive Director with corporate reporting activities.
- Cynthia Andrzejewski, BS, Administrative Assistant
Provides administrative support for Board of Directors, maintains corporate documents and assists with coordination of internal quality controls.

– Quality Improvement

- Cynthia Lambert, RN, BSN, Medical Quality Manager
- Martha Bean, RN, BS, Medical Quality Manager
Directs all quality improvement initiatives; reports to Medical Review Board; responds to all clinical inquiries and regulation related to nephrology nursing; provides consultation to professional community on ESRD clinical policies and procedures.

– **Community Outreach and Patient Grievances**

- Amber Borges, MSW, LCSW, Patient Services Coordinator

Provides and develops educational materials for patients and providers; handles patient grievances/complaints; manages activities of Patient Advisory Committee (PAC); supports ESRD community partnership activities; editor of Network newsletter.

- Danielle Daley, MBA, Community Development Coordinator

Responsible for coordinating the coalition activities of this Network; development of regional disaster plan; coordination of local ESRD provider-related emergencies; maintains Network website; assists in preparation of educational materials for patients and professionals.

– **Information Management**

- Jaya Bhargava, PhD, Information Systems Manager

Oversees the internal processing and tracking of data forms; promotes and supports VISION for independent providers; provides cross-departmental IT support; tests and promotes deployment of CROWNWeb.

- Karen DeGeorge, AS, Information Management Specialist

Assists in the maintenance of the Patient Registry; coordinates the year-end Facility Survey, resolves CMS Accretions and Notifications; responsible for registration of providers into Quality Net Identity Provisioning Systems (QIPS); evaluates provider data compliance.

– **Support Staff**

- Laurene Jones, Project Assistant

Processes Patient Monthly Activity Forms; maintains provider personnel files and provider reports; provides phone reception services.

- Terri Ross, Office Assistant

Information processing for clinical projects; responsible for patient packet returns; maintains registration materials for educational meetings.

2. COMMITTEE FUNCTION AND ACTIVITIES

Network Council: Facility Constituents

All ESRD providers in the New England area that have been issued an ESRD provider number by the Centers for Medicare & Medicaid Services (CMS) are facility constituents of the Network Council. One of the conditions of participation in Medicare's ESRD program requires every ESRD provider to be a member of the ESRD Network Council in its respective regions. The Network Patient Advisory Committee (PAC) serves as the patient representatives on the Council. An ESRD facility that has been issued a Department of Veterans Affairs Station Number is also eligible to participate in Network activities. Effective in 1990, all Veterans Administration Dialysis/Transplant Programs are required by the Veterans Administration to submit ESRD data in order to participate in Network activities.

As a facility constituent, an ESRD provider shall:

- Acknowledge its agreement to comply with CMS regulations;
- Acknowledge its agreement to comply with the ESRD Network goals and objectives;
- Designate to the ESRD Network in writing the names and telephone numbers of its key management personnel;
- Participate in the Network Annual Meeting; and
- Submit quality of care recommendations to the Network.

Board of Directors

The Board members govern the affairs of this Network Organization. The Board has all the powers and duties necessary and appropriate for the administration of the affairs of the Network and for compliance with the rules and regulations of Medicare’s ESRD program, contained in the Code of Federal Regulations. The Board has all such powers that state law, the Certificate of Incorporation, or the bylaws permit in accordance with regulations in Connecticut.

The number of Board members shall be no less than 25 or more than 40. As of December 2011, there were 31 members on the Board. The Board includes physicians and other professionals who work in the ESRD field as well as informed consumers. It is composed of a Chairperson, Vice-Chairperson, Secretary, and Treasurer, the Chairperson of the MRB, as well as nurses, social workers, dietitians, patients, and multidisciplinary members at large.

Candace Walworth, MD	Chairperson Nephrologist
Jay Ginsberg, MD Southeastern CT Nephrology	Vice-Chairperson Nephrologist
Helen Warner, RN Damariscotta Dialysis	Secretary Nurse Manager
Michael Somers, MD Children’s Hospital, Boston	Treasurer Pediatric Nephrologist

<u>Name</u>	<u>Facility</u>	<u>Discipline</u>
Howard Alfred, MD	PDI – Worcester	Medical Director
Lynne Bamford	Fresenius Medical Care	Director of Operations
Steve Bogatz, LCSW	Central CT Dialysis	Renal Social Worker
Andrew Brem, MD	Rhode Island Hospital	Pediatric Nephrologist
Doris Briggs, RN	Rhode Island Hospital	Nurse Manager
Mathew Brown, MD	Hartford Transplant Associates	Vascular Access Surgeon
Robert Brown, MD	Beth Israel Deaconess Medical Center – East	Nephrologist
Jane Connor, RN, CNN	Harvard Vanguard Medical Associates	Clinical Manager of Nephrology
Jodi Cooney, RN	Branford Dialysis	Facility Administrator
Robert Cooper*	Pittsfield, MA	TX Patient/Consumer
John D’Avella, MD	Hartford Hospital	Medical Director
Connie Devenger, RN	American Renal Associates	Clinical Coordinator
Mark DeWever	Casco Bay	TX Patient/PT Care Technician
Jill Goldstein, MSW, LICSW, LCSW	Western Mass Kidney Center	Renal Social Worker
Sandie Guerra Dean, MSW, LICSW	Fresenius Medical Care North America	Corporate Social Worker
Roberta Hoffman, MSW	Children’s Hospital	Social Worker
Betty Ann Hughson, MS, RN	Children’s Hospital Boston	Nurse Manager

Geraldine Hurley, RD	Berkshire Medical Center – Renal Division	Renal Dietitian
Susan Jamison, RN, BSN	Umbagog Dialysis Center	Renal Nurse
Carol Lee Lane	Seacoast Dialysis Center	Patient Care Technician
David Lockwood	West Haven, CT	Patient/Consumer
Charles McCoy, MD	Nephrology Associates, Inc.	Nephrologist
Klemens Meyer, MD*	New England Medical Center	Director, Dialysis Services
Paul Nussbaum, MD	Griffin Hospital	Medical Director
Dmitry Opolinsky, D.O.	MaineGeneral Medical Center	Nephrologist
Salah Reyad, MD	Norwood Dialysis	Medical Director
Ruth Rudnick, RN	Southwestern Vermont Medical Center	Nurse Manager
Deborah Savaria, RN	LifeChoice Donor Services	Executive Director
Douglas Shemin, MD	Rhode Island Hospital	Medical Director
Marion Smith, RN, CNN	New Hampshire Kidney Center (FMC)	Nurse Manager
Mary Sylvia-Reardon, RN DNP	Massachusetts General Hospital	Director of Nursing

The disciplines of professionals on the BOD are as follows:

Administrator	5	Renal Nurse:	1
Dietitian:	1	Nurse Manager:	6
Dialysis/Transplant Director:	6	Patient/Consumer:	2
Nephrologist:	7	Social Worker:	4
Vascular Access Surgeon:	1	Patient Care Technician:	2

Medical Review Board

As required by Public Law 95-292, the Network of New England established a Medical Review Board (MRB). The provisions of Network bylaws require representation from professional disciplines and consumers. The Medical Review Board is responsible for analyzing the comparative performance of facilities with regard to the volume of chronic in-center dialysis, home dialysis, and transplantation. Quality oversight utilizes the principles of continuous quality improvement by addressing management areas for potential improvement on issues of adequacy of dialysis, anemia, nutrition, and vascular access. The MRB also supervises study design and data analysis for Network quality management activities. The Grievance Committee, when necessary, seeks consultation for the MRB for intervention of clinical cases or patterns of care that do not meet acceptable standards of practice at the provider level.

John D'Avella, MD Chair
Consulting Neph and Internists of Hartford Medical Director

Paul Pronovost, MD Vice-Chair
Greater Waterbury Dialysis Nephrologist

<u>Name</u>	<u>Facility</u>	<u>Discipline</u>
Gilbert Bliss	Greenfield, NH	Patient/Consumer
Lorraine Dox, MS,RD,LDN,CNSD	Middlesex County Dialysis	Renal Dietitian
Bernadette Drinkwine, RN	Fresenius Medical Care (FMC)	Regional Quality Manager
Heather C. Johnston Nichols, RN	DaVita, Inc.	Acute Dialysis/Pheresis Nurse
Elizabeth Matteson, RN	Danbury Hospital	Nurse Manager
Douglas Mesler, MD	Nephrology Associates of Merrimack Valley	Clinical Director
Nancy Orlando, RD	DCI	Renal Dietician
Gloria Rispoli, RN, CDN	DaVita, Inc.	Director of Clinical Services
David Roer, MD	St. Mary's Hospital	Medical Director

Richard Rohrer, MD	Tufts Medical Center	Transp/Dialysis Access Surgeon
Niranjan Sankaranarayanan, MD	Carney & Moustakakis MDs LLC	Nephrologist
Isabelle Sargeant, RN	Fletcher Allen Healthcare	Director of Renal Services
Anne Steele, LICSW	Hyde Park Dialysis	Renal Social Worker
Laura Troidle, PA	New Haven CAPD	Physicians Assistant
Carol Tyksienski, MS, RN, APRN	Massachusetts General Hospital	Nurse Practitioner

The disciplines of professionals on the Network Medical Review Board are as follows:

Administrator:	3	Nurse Manager/Practitioner:	3
Dietitian:	2	Patient/Consumer:	1
Dialysis/Transplant Director:	3	Physician's Assistant:	1
Nephrologist/Surgeon:	3	Social Worker:	1

Finance Committee

The Finance Committee oversees the development of financial policies for acceptance of funds and reimbursement of expenses. The treasurer of the Finance Committee annually reviews the financial books and records of the Network and meets with the Executive Director and Financial Manager to provide oversight of financial matters. This committee participates in the development or revising of the budget as needed according to CMS requirements or state/federal laws.

Grievance Committee

The Grievance Chair conducts case review, makes recommendations, and communicates directly with the patient or professional as appropriate. The Grievance Committee becomes involved in serious complaints and handles formal grievances when necessary or appropriate that are filed with the Network. The Grievance Committee chair is a member of the Network BOD with a liaison position on the MRB. The Grievance Committee members are selected from the MRB and BOD to assure wide representation of professional backgrounds and geographic location and are called upon to review cases and provide expertise / input in situations as indicated by staff assessment. For example, if a case involves issues related to nutrition, an RD committee member will review the specifics and or consult directly with the patient as needed.

The Network staff handle patient/family inquires throughout each year – a summary can be seen in Section C of this report. All interventions and disposition of these contacts are entered into a database for reporting and data trending purposes.

Network Advisory Committee

This committee is comprised of the individuals who serve in leadership positions for the Network. The committee consists of the four Board officers, the MRB Chairperson, the MRB Vice-Chairperson, the past Chair of the Network Grievance Committee Chair, the Forum Medical Advisory Representative, the Network Executive Director, and a representative from the Patient Advisory Committee. These individuals are noted with an asterisk on prior pages. They meet by conference call and communicate regularly by email to develop recommendations regarding Network policy issues that impact patient care and the operational strategies of the Network. The committee determines the short and long-term objectives of the Network and makes recommendations to the Network Board.

Nominating Committee

The Network bylaws require the nominating committee to prepare a ballot bi-annually for electing Board officers and members of the BOD and Medical Review Board. In accordance with the bylaws, approximately one-third of the membership of both boards rotates every two years. The past Network President chairs this committee. The composition of the committee changes every two years.

Ad Hoc Committees

A task group or subcommittee of the Board of Directors or the Medical Review Board is appointed as necessary to fulfill the work of the CMS contract.

Ad Hoc: 2011 Annual Meeting and Technician Meeting Committee

The Annual Meeting Program Committee consists of the BOD Chair, BOD Vice-Chair, MRB Chair, Network Director, and Network Managers. This committee plans presentations on specific topics and identifies speakers based on requests and evaluations from the previous Annual Meeting. Because of the large annual attendance, topics are chosen that reflect the priority needs of the multidisciplinary audience.

Patient Advisory Committee (PAC)

During 2011, The New England Patient Advisory Committee (PAC) had 13 members, in total, who were on the committee during the course of the year.

During 2011 the PAC worked on several projects. They are listed below:

- Solomon Four Group Design Project-The PAC introduced the topic of how new patients do not retain information at start of dialysis (uremic, scared etc.). There has been ongoing concern that not enough patients know the role of the Network. The Network developed a rough draft of project with the PAC and consulted with statistician. New ideas emerged involving common knowledge and specific knowledge. The project will be completed in 2012.
- “Need Help Finding Your Way”- The PAC, Network PSC and Network COC completed the developmental process of a file folder; which will be a helpful tool orienting patients to Network services. Topics in the file folder include treatment options, vascular access management, patient rights and responsibilities, vocational rehabilitation, request to order materials, newsletters and how to file a complaint or grievance. This file folder will be used in the Solomon Design Project, which is a project educating new patients about the Network. It is also a useful tool for any renal patient.
- “Travelopoly”: A Renal Patient’s Guide to Traveling-The PAC decided that one of the topics they want to focus on is traveling on dialysis. The PAC is in the beginning stages of a brochure/flyer for both HD and PD patients. Due to the planning that goes into traveling for a dialysis patient the PAC feels a checklist would be helpful to patients

Every attempt is made to have the PAC comprised of members from all of the six New England states. In 2011, all states were represented with the exception of New Hampshire. The PAC was balanced representation in terms of age, gender, ethnicity, and treatment modality. Annually, the Network recruits patients for the PAC by way of email/fax blasts to facility staff, a description of the PAC in our patient and provider newsletter and by informing facility staff at in-person meetings. The PAC celebrated its 13th year of service in 2011. The PAC is advisory to the BOD, MRB, and Network staff and guided by the following mission statement.

The ESRD Network of New England Patient Advisory Committee (PAC) is committed to enhancing the quality of life for New England ESRD patients through education, communication, and active representation.

III. CMS NATIONAL GOALS AND NETWORK ACTIVITIES

A. IMPROVE THE QUALITY AND SAFETY OF DIALYSIS RELATED SERVICES PROVIDED FOR INDIVIDUALS WITH ESRD

Quality Improvement Work Plan

The major functions and responsibilities of all ESRD Networks are focused on quality improvement initiatives. These initiatives help ESRD providers develop, maintain, and modify, as needed, their internal processes to improve patient safety and quality of care and achieve better patient outcomes. Network 1 utilizes a Quality Improvement Work Plan (QIWP) to accomplish these objectives.

This Work Plan addresses targeted clinical or patient experience areas selected by Centers for Medicare & Medicaid Services (CMS) and the Network Medical Review Board (MRB) that indicate opportunities for improvement or are of such critical importance that ongoing surveillance is required. The work plan, at a minimum is updated twice a year after approval from the Network's CMS Contracting Officer Representative (COR). Revisions to specific sections are made during the year as tasks are accomplished or modifications to the plan become necessary. It is considered by the Network Board and staff an essential dynamic tool that provides a quality improvement road map for Network 1.

This QIWP is collaboratively developed by the Network of New England's Medical Review Board and Network professional staff to provide a structured method for the CMS contract year regarding the QI activities that are conducted to support specific national and New England goals. Four major QI strategies are included in the QIWP:

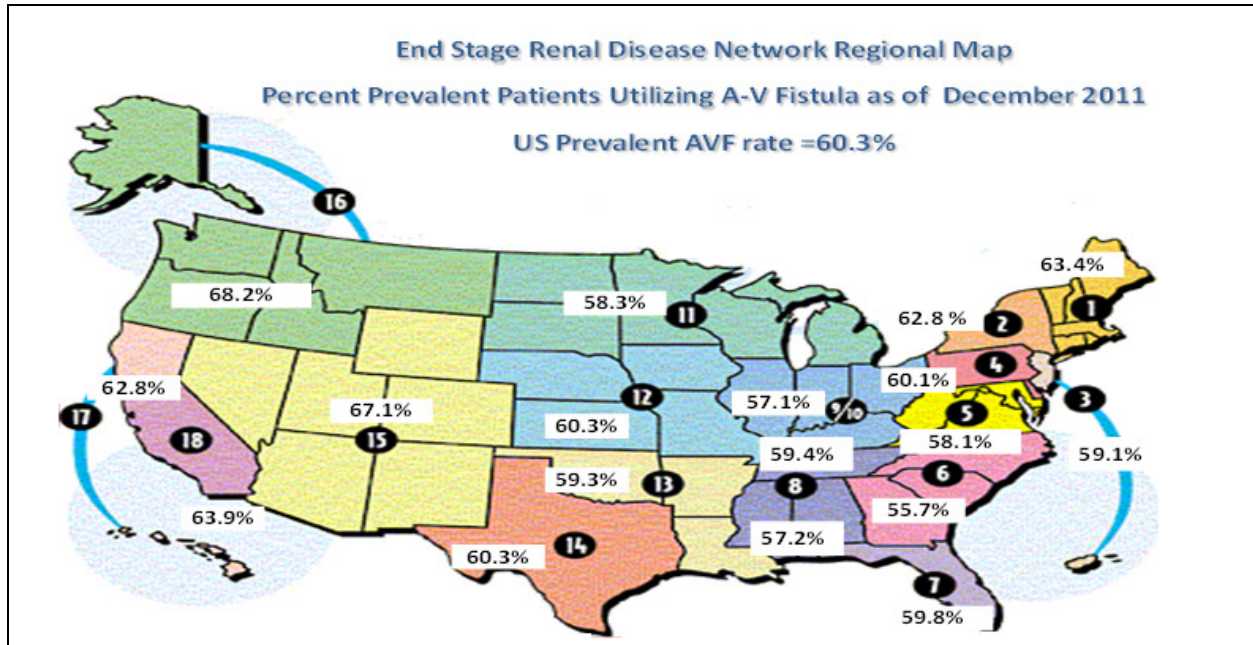
- Task 1a: Vascular Access: Fistula First National Initiative
- Task 1b: Clinical Performance Measures
- Task 1c: Network-Specific Improvement Projects
- Task 1d: Facility-Level Quality Assessment Activities

National Fistula First Vascular Access Improvement Initiative (Task 1a)

In July 2003, CMS committed the Networks to a system-wide national improvement project on vascular access. Fistula First became a CMS/Fistula First Breakthrough Initiative (FFBI). A national coalition of renal community stakeholders was established collaboratively to increase awareness of, and improvement in, the prevalent rate of AV fistulas in hemodialysis patients. Vascular access data is obtained from all providers on a monthly basis to allow for close assessment of provider changes in vascular access management. The large dialysis organizations download data directly to CMS, and the independent or hospital dialysis providers send their data to the Network. The Network staff enters the data on a monthly basis. CMS had established a new goal in 2006 for the initiative, that is, to have a 66% AVF rate for prevalent hemodialysis patients.

Due to the efforts put forth by the hemodialysis providers, nephrologists, and vascular surgeons, the national AVF in use rate among prevalent hemodialysis patients has increased to 60.3% in December of 2011, which is a 27.9 percentage point improvement from the baseline rate in 2002 of 32.4%. The Network of New England by the end of 2011 improved 21.4 percentage points since the onset of the project. Figure 4 illustrates that Network 1 was the 4th highest Network in the country for prevalent AVF rates as of December 2011.

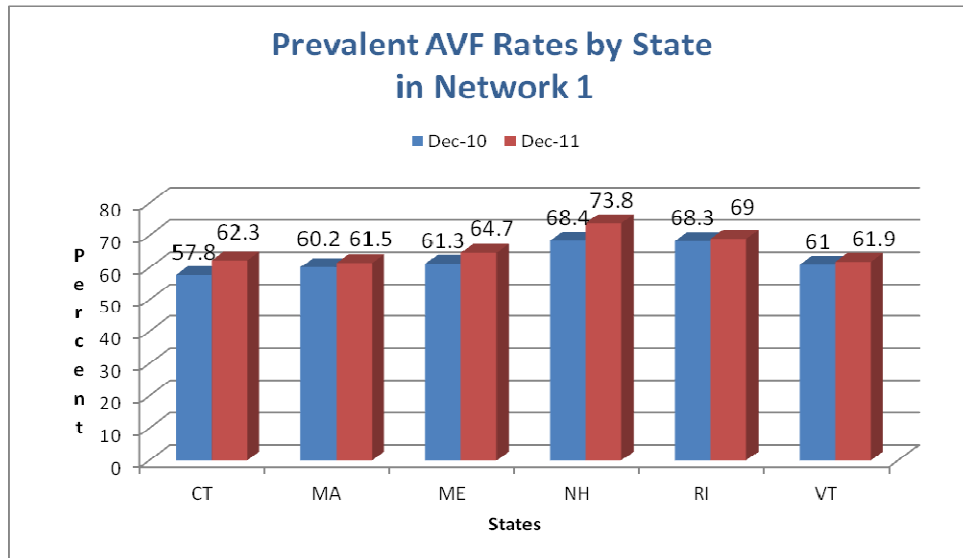
Figure 3



Data Source: Dashboard generated 2/13/2012
 100% facilities may not of reported into each Network

Each New England state had a higher rate then the national average as of December 2011. New Hampshire continues to have one of the highest rates in the country. Both New Hampshire and Rhode Island had prevalent AVF rates that surpassed the CMS goal of 66%. Figure 4 is a comparison of fistula rates by state:

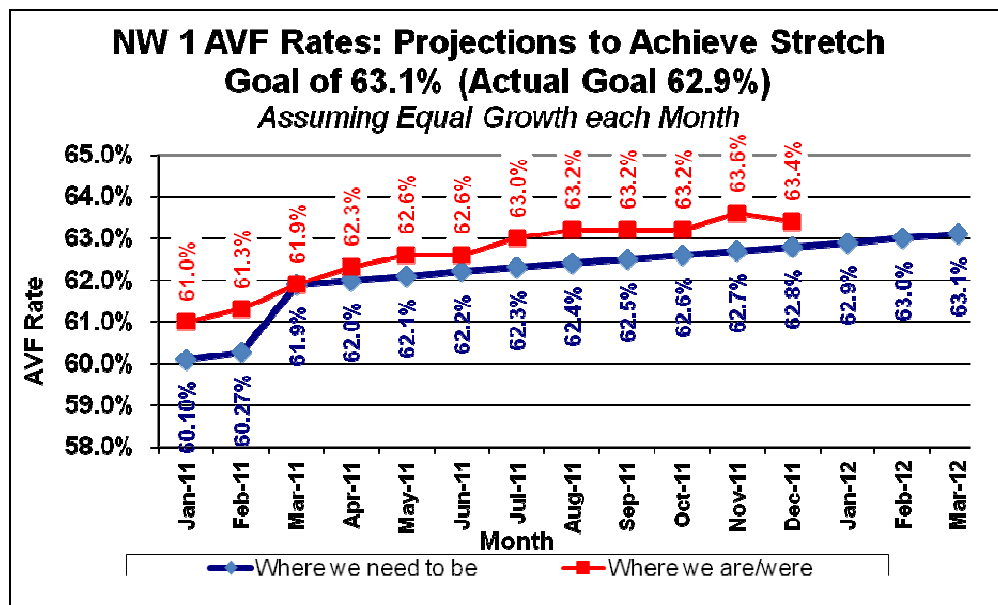
Figure 4



Source: fistulafirst.org

Each Network is assigned a contract goal based on the deficit reduction formula. Network of New England obtained a prevalent AVF rate of 61.9% in March of 2011 which surpassed the previous assigned CMS goal of 60.7%. The new CMS goal for prevalent AVF rates assigned for March of 2012 was 62.9% based on the deficit reduction formula. The following Figure 5 illustrates New England's prevalent AV fistula rate improved slightly each month to reach 63.4% by December 2011, this number surpasses both the CMS assigned goal of 62.9% and the Network stretch goal of 63.1%.

Figure 5



Source: Fistula First Dashboard

Assigning providers specific goals for AVF rates proved effective in 2010, and this approach was continued in 2011 as per Network MRB instructions. The Network Board of Directors (BOD) directed the MRB to establish a more stratified tiered approach in 2011. All providers with less than a 66% AVF rate received letters from the Network assigning specific goals to each clinic based on a quality reduction formula ($66\% - x\%$ multiplied by 0.2). The percent point increase requested ranged from a low of 1% to a high of 4%. Providers with prevalent AVF rates below 50% were expected to reach at least 50%. The following Table D illustrates the classification of the providers:

Table D

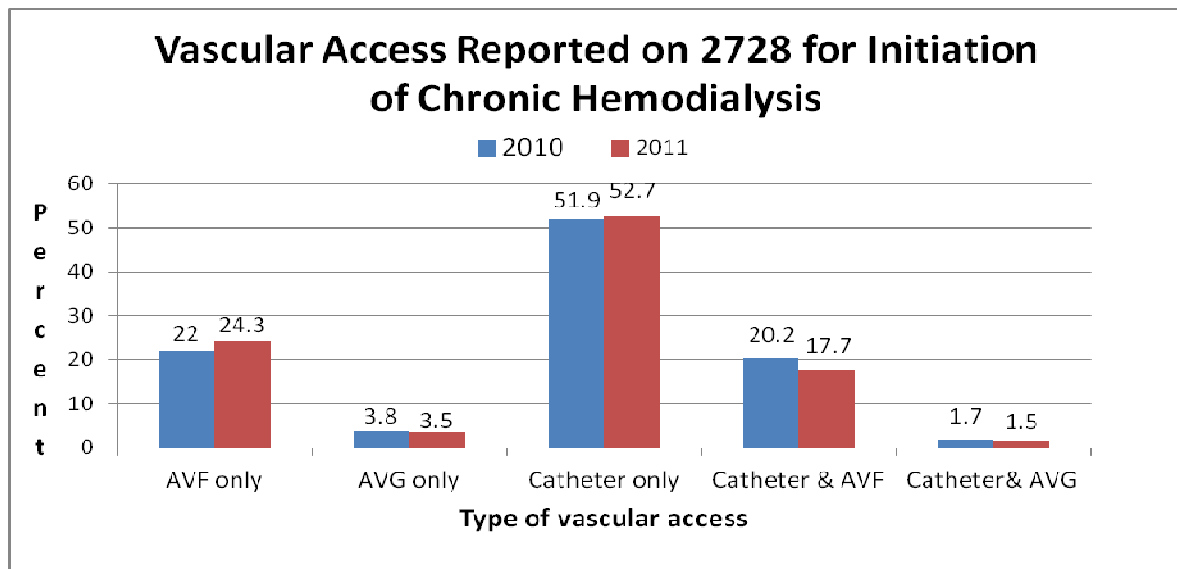
Baseline (3/11)	Classifications	AVF Groupings
Tier 1a 4 providers	<ul style="list-style-type: none"> Providers that received CMS letter of concern in 2010 that did not make their 50% AVF goal by March 2011 	<u>< 50% AVF</u>
Tier 1b 3 providers	<ul style="list-style-type: none"> Providers <50% AVF in 2010 that received letters of concern from Network MRB that continued to be <50% by March 2011 	<u>< 50% AVF</u>
Tier 2a 4 providers	<ul style="list-style-type: none"> Providers newly identified in March 2011 as <50% 	<u><50%AVF</u>
Tier 2b 38 providers	<ul style="list-style-type: none"> Providers below March 2011 National AVF rate of 58% 	<u>>50 - <58% AVF</u>
Tier 3a 50 providers	<ul style="list-style-type: none"> Midrange providers needing AVF improvement 	<u>58-66% or >AVF</u>
Tier 3b 60 providers	<ul style="list-style-type: none"> Providers that are high performers 	<u>=>66% AVF</u>
Total providers: 159 *note providers with less than 6 patients or special needs clinics were not included		

Different strategies were used depending upon the provider tier level. Examples of strategies included requests for provider management and medical director to appear before the Network Medical Review Board (underperforming providers), requests for quality assessment and performance improvement plans (QAPI) to be reviewed by Network quality improvement (QI) managers, and Network site visits to providers. In person and/or telephone consultation was given to surgeons and medical directors by representatives of the Medical Review Board. Suggestions for best practices and articles related to fistula creation were shared. Annual meetings for frontline caregivers were held where literature on best practice was disseminated and lectures were given by experts in this arena. High performing providers were commended and asked for suggestions on best practices.

The Network partnered with the large dialysis organizations (LDO's) in efforts to promote fistula use and placement, and to support catheter reduction programs. This partnership included sharing data regarding clinics of concern with low AVF rates and/or high catheter rates and sharing quality improvement tracking tools and educational material. The Network also collaborated with two LDO's and The National Kidney Foundation to host the 18th Boston Area-Wide Inter-Hospital Renal Rounds Dinner on May 14th. This was a symposium on vascular access with case based discussions. There were over 125 attendees representing the major Boston medical centers including nephrologists, surgeons and nurses.

Several different feedback reports were sent to participating providers during 2011 by Network QI managers. Comparable vascular access data by state and nation were distributed each quarter so that the providers could benchmark their AVF rates to those of other dialysis providers. Other provider feedback reports included physician profile reports which were mailed to provider medical directors and nurse managers utilizing data from the ESRD Medical Evidence Report (Form 2728). The provider profile report identified the nephrologists by UPIN number and the number of incident patients he/she signed for in 2011, the length of time each patient was followed by a nephrologist, and the vascular access placed at the initiation of chronic hemodialysis. Comparative data by state and Network were also included. The purpose of these reports was to stimulate practice changes toward earlier referral for vascular access creation in incident CKD patients in the hope that the use of catheters would be reduced and use of incident AV fistulae would increase. Figure 6 illustrates an improvement in incident AV fistulae from 2010 to 2011:

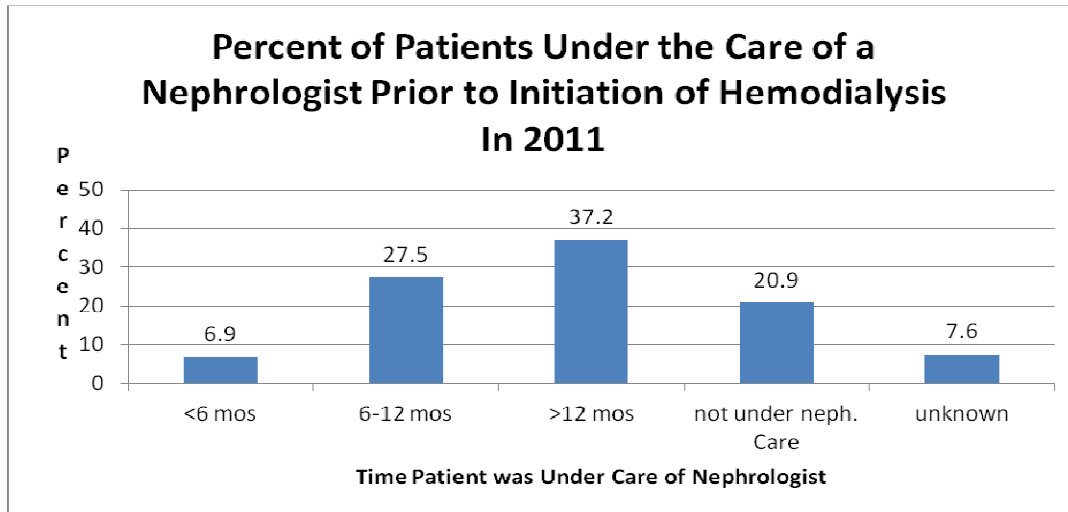
Figure 6



Source: Form 2728

The KDOQI guidelines has a goal of 50% AVF used in incident patients and a 10% catheter rate. There continues to be opportunities for improvement in this area. In 2011, 64.7% of incident ESRD patients were under the care of a nephrologist for six months or more; however, only 24.3% started chronic hemodialysis with an AVF (Figure 7). While there was a modest improvement in AVF placement, the incident catheter rate is still high. Lack of early referral for patients continues to pose a problem. The Network continues to work with the renal community to develop strategies that target early referral for those patients with CKD stages 3-4.

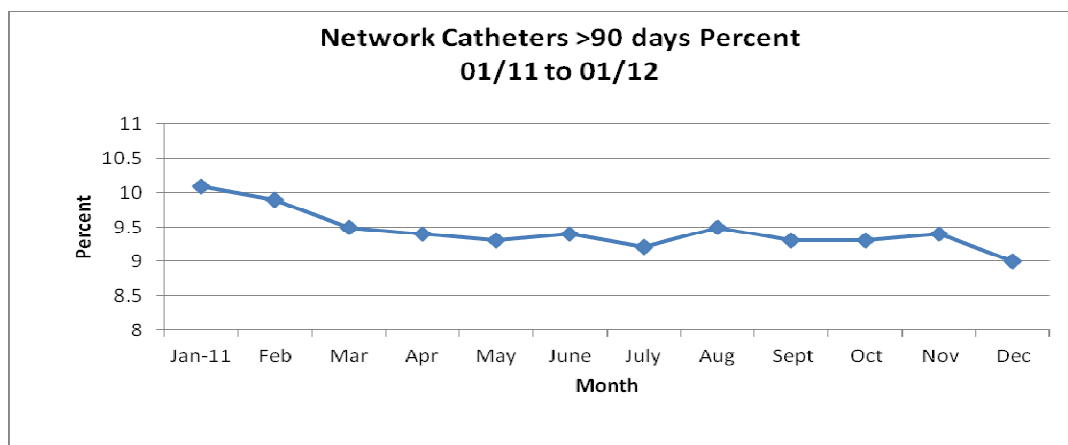
Figure 7



Source: Form 2728

Another very important strategy to increase prevalent AVF rates for eligible patients is hemodialysis catheter reduction. Use of catheters for long term vascular access should be discouraged due to the increased morbidity associated with infections and hospitalizations. A catheter remaining in a hemodialysis patient greater than 90 days is considered long-term and should be evaluated by the medical team to develop a plan to remove the catheter whenever possible. The increased complications of catheters create an increase in medical or surgical interventions and hospitalization thus reducing the quality of life for those patients and risk increasing higher mortality rates. Long-term catheters should be reserved as the last choice for vascular access except in a specific subset of patients such as pediatric patients soon to be transplanted and those patients with severe comorbidities such as severe peripheral vascular disease (PVD), the very elderly, patients with inadequate vascular anatomy, or patients with limited life expectancy. The following Figure 8 displays the progress made in this Network in decreasing 90 day catheter rates.

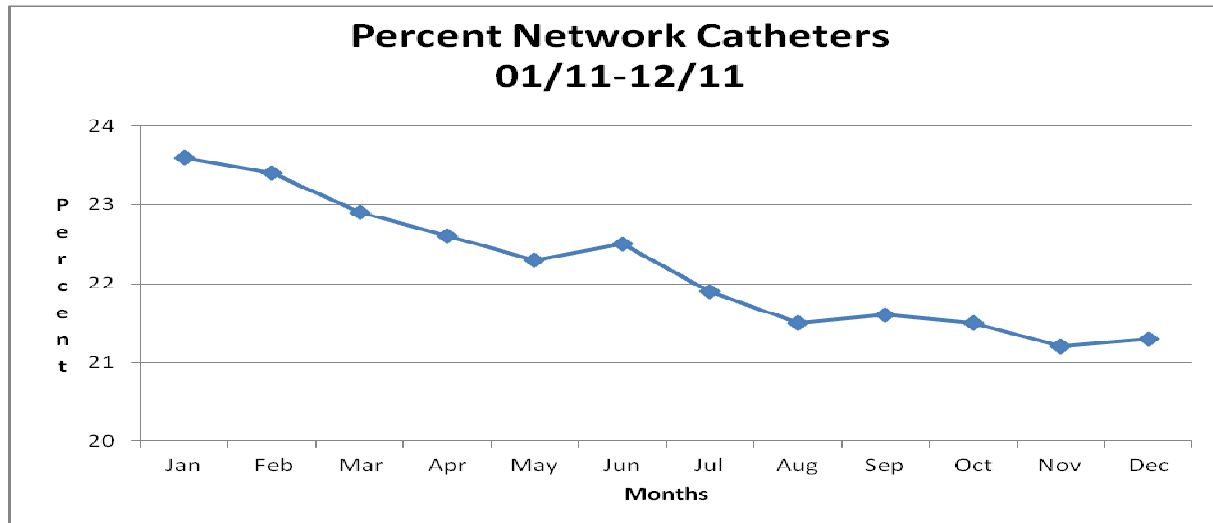
Figure 8



Source: fistulafirst.org

Providers have made great strides in increasing prevalent AVF rates and decreasing 90 day catheter rates. Another area for improvement is decreasing incident catheter placement and use. Overall catheter rate has declined as well, but remains above 20%. As demonstrated by Figure 9 below.

Figure 9



Source: Fistula First Data Page

Although a steady improvement in prevalent fistula rates is evident since the initiation of fistula first, more focus is needed on referring incident patients. Opportunities for patient education exist prior to patients needing to start dialysis and the importance and need for vascular access needs more emphasis in early stages of CKD.

Clinical Performance Measures (Task 1b)

▪ National CMS Clinical Performance Measures Project

The ESRD Clinical Performance Measures (CPM) Project, a national effort conducted by CMS and the 18 ESRD Networks was designed to give dialysis providers, the renal community and public policy agencies a report of clinical measures for determining Network level comparative quality performance data. This CPM project has expanded to a 100% national provider participation known as the Annual laboratory Data Collection.

CMS has contracted with Network 11 to coordinate this project by working with independent dialysis facilities and the large dialysis organizations (LDOs) to collect laboratory data on 100% of dialysis patients. The LDOs submit data electronically to Network 11 and the independent dialysis facilities submit data to their individual Networks. Network 11 merges all the data and returns comparative analysis data files to each Network. The data collected was for the 4th quarter of 2010. Network 1 has been involved in this project since 1999.

Upon completion of the merged data, Network 11 produces the following reports:

- Facility Characteristics
- HD Quality Indicators (tabular and graphic)
- PD Quality Indicators (tabular and graphic)
- HD Percentile Ranking
- PD Percentile Ranking
- HD Means and Median Report
- PD Means and Median Report
- Facility Hemoglobin Distribution Trends
- Final National Report approved by CMS

When the data files are received from Network 11, a unique provider specific report is prepared and distributed to all freestanding and hospital based providers in New England to allow each provider to see their performance compared to Network 1. The following table shows the indicators the MRB will be monitoring by national, Network and state results.

The Medical Review Board (MRB) annually evaluates these comparative data reports to benchmark the clinical performance indicators of New England as compared to national and other Network's results (Table E).

**Table E: 2011 CPM Project – Elab Data
All Adult Hemodialysis Patients Clinical Indicators*
Last Quarter of 2011 for State, National and Network**

Indicator	National Lab Data All Patients 2011 # 31,864	Network Lab Data All Patients 2011 # 11,059	Connecticut Lab Data All Patients 2011 # 3,200	Massachusetts Lab Data All Patients 2011 # 4,959	Maine Lab Data All Patients 2011 # 31,864	New Hampshire Lab Data All Patients 2011 # 703	Rhode Island Lab Data All Patients 2011 # 1,018	Vermont Lab Data All Patients 2011 # 303
% Patients with mean HGB < 10 g/dL	14.1	12.7	16.6	11.9	11.1	8.1	7.2	17.3
% Patients with mean HGB > 12 g/dL	20.4	11.2	9.0	11.5	13.1	12.7	13.9	9.6
Mean URR % ≥ 65**	95.2	96.7	96.9	96.6	96.1	95.8	98	93.9
Mean KT/V % ≥ 1.2**	97.2	97.9	98	97.5	97.9	97.7	98.6	99
Albumin % ≥ 4.0/3.7	42.2	41.5	42.9	41.5	50.0	42.8	37.3	14.6
Phos % ≥ 3.5 mg/dL and ≤ 5.5 mg/dL	57.1	56.6	58.8	56.8	57.9	52.4	53.6	46.2
Ca % 8.4 -10.2 mg/dL	82.3	80.4	78.3	80.7	82.8	82.5	83.8	74.1

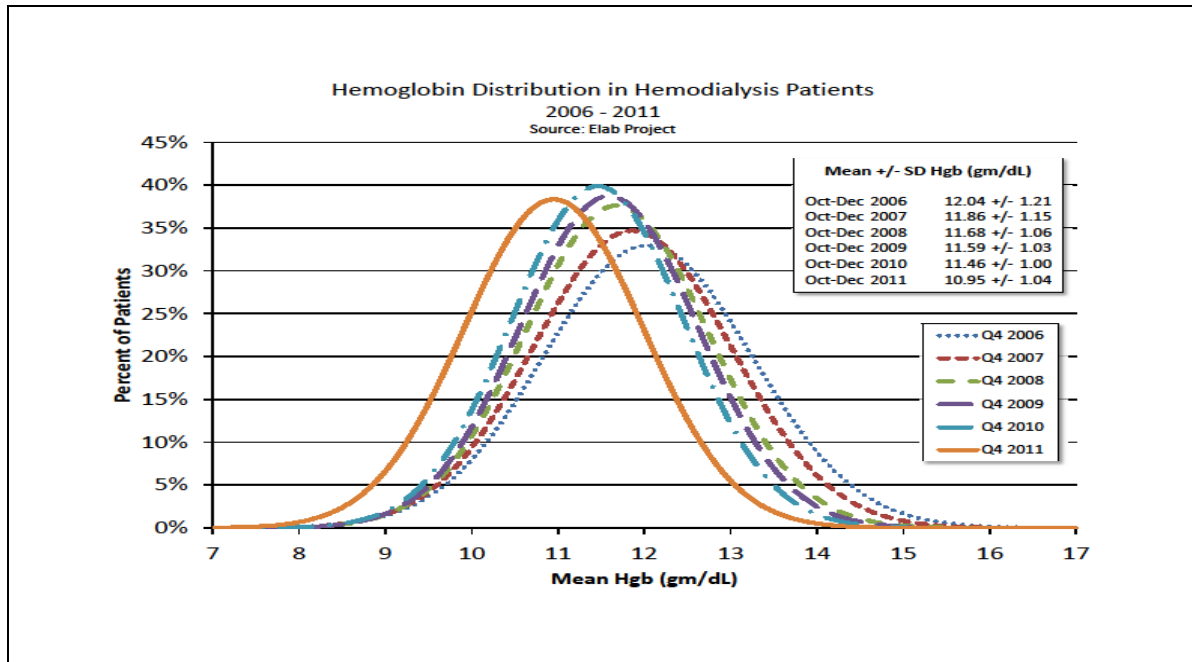
* Does not include pediatric patients

** URR > 90% or < 10% and KT/V derived from URR > 90% or < 10% not included

The MRB has selected anemia and adequacy to closely monitor due to the Quality Incentive Program performance criteria. In 2011, the Food and Drug Administration (FDA) released new recommendations for conservative dosing of Erythropoiesis Stimulating Agencies (ESAs) for treating anemia. The mean hemoglobin distribution rates have shifted lower each year since 2006. This Network will continue to identify provider hemoglobin levels that have 5% or more patients with Hgb < 10 g/dL to consider quality of life concerns.

Of the 48 dialysis providers in New England that experienced a Medicare payment reduction in 2012 due to the scoring of their 2010 performances for three measures (Hgb < 10 g/dL, Hgb > 12 g/dL and URR > 65%), the MRB focused intervention on only provider with an out or range score for Hgb > 12 g/dL and URR > 65%. These two measures reduced the intervention efforts to only 17 providers at risk of losing payment. The Network staff conducted focused telephone interview and provided technical assistance. By March 2012, eight of the ten providers had improved their URR levels. Of the 7 providers with score between 26-29 points for low URR percents, there were 71% of these providers that improved.

Figure 10



The institution by CMS of the Quality Incentive Program (QIP) which is linked to ESRD provider performance and payment (required under the MIPPA legislation) was deployed in 2011 with the distribution of the first provider performance reports. This new linkage of payment and quality management requires close monitoring and early intervention to address unintended consequences that may impact the quality of life of some dialysis patients. This will be done using the ELab provider specific data and the annual QIP reports.

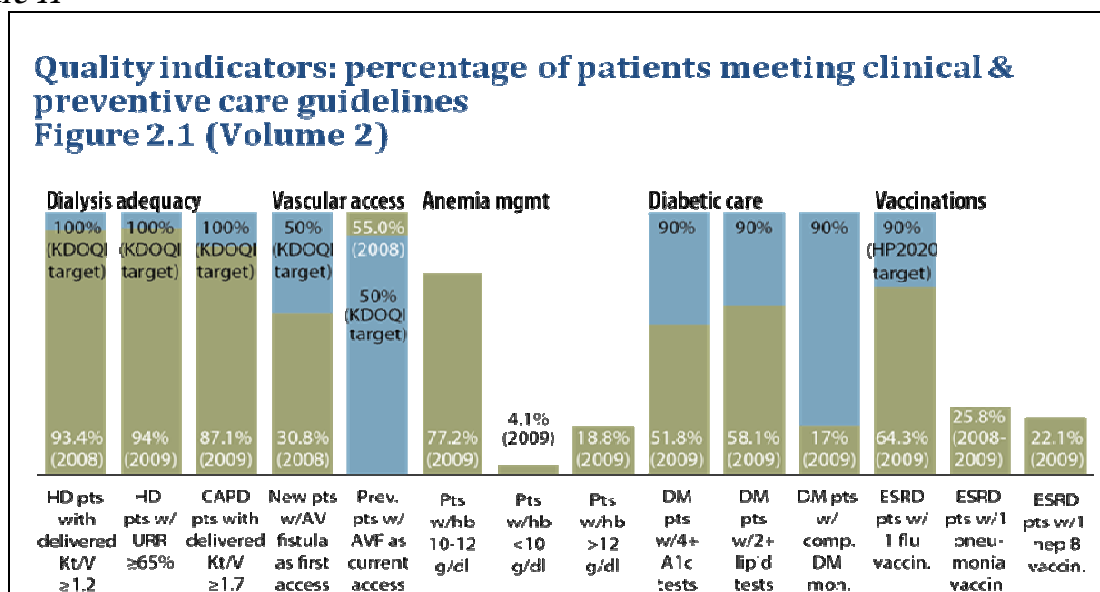
Early identification of dialysis providers that are at risk of receiving Medicare payment reductions under the QIP will allow the Network to give technical assistance and QI intervention to prevent or minimize these payment reduction and improve patient care. The MRB will monitor HGB > 12 g/dL and adequacy of dialysis using URR \geq 65 as these two measures will be in the QIP score for providers in 2013.

Network Specific Improvement Project (Task 1c)

- **Immunization Project**

The most recent Influenza vaccination data available on ESRD patients receiving the vaccine is from the 2011 United States Renal Data System (USRDS) report which contains 2009 vaccination data. The national ESRD vaccine rate based on Medicare claims data was 64.3% (Figure 11).

Figure 11



Source: 2011 USRDS Annual Report

Influenza is responsible for approximately 39,000 deaths per year in the US according to the Centers for Disease Control (CDC). Dialysis patients have compromised immune systems and multiple comorbid conditions that place them at a high risk of medical complication from influenza. Thus, this low vaccine rate of 64.3% for dialysis patients is an opportunity for improvement. A project was started in 2009 to determine the current vaccine rate in Network 1 was designed to obtain the vaccine rate for 2008 and compare it to 2009 by obtaining aggregate provider level data from the three large dialysis organizations (LDOs) in the region (Fresenius Medical Care, DaVita and Dialysis Clinics Inc.) because it was known that these three organizations collect patient vaccination data across the country. Therefore, no additional reporting burden would be placed on the provider staff to compile this information to submit to the Network. Educational materials, eblast reminders and CDC notifications were sent during the late summer and early fall by the Network to all dialysis providers about the importance of vaccination.

The result of the 2009-2010 project is that of the 8,352 dialysis patients offered the vaccine; 6,233 patients (adjusted for patients with allergies), 75% received the influenza vaccine.

Since immunization for seasonal flu is a high CMS priority, the Medical Review Board (MRB) decided to do this QI project again in 2010/2011 by inviting the hospital and independent providers to participate with the LDOs by submitting provider-level immunization vaccination information. The MRB set a Network goal of an 80% vaccination rate. The Network, during the year, provided educational materials, posters and e-blasts to promote the importance of seasonal vaccination for patients and staff.

The result of these efforts is that variation in vaccination rates was noted across all groups. The overall vaccination rate at the Network level has improved for all three years with the most current vaccination rate for 2011/2012 at 85% which was the goal set by the MRB (Table F).

Table F**Seasonal Flu Vaccination Results**

	Year		
	2009/2010	2010/2011	2011-2012
Group 1 Other	79%	86%	90%
Group 2 LDO	91%	92%	92%
Group 3 LDO	45% only in provider*	69%	81%
Group 4 LDO	62%	69%	78%*
Network	73%	79%	85%
Total patients	11,854	12,204	11,260
Total Providers	148	153	140

- Includes allergic patients in the denominator

Notes: The 2009-2010 project had only Large Dialysis Organizations. Data Submitted by corporation representative. The 2010-2011 project requested independents/hospitals to volunteer to participate by submitting data to the Network for both years. Large Dialysis Organizations submitted by corporation representative.

Facility Level Quality Assessment (Task 1d)

▪ **5 Diamond Safety Project**

In 2007, Network of New England (NW1) and Mid-Atlantic Renal Coalition (NW5) began the development of the web-based 5 Diamond Patient Safety Program to be used by dialysis providers as a template for in-service training for dialysis staff and patients. This voluntary program was launched in April 2008 and has gained momentum ever since. The purpose of this project is to provide dialysis providers with developed staff educational modules on different safety topics. Providers register to participate in the program and can select from a variety of safety modules, which include the tools and training resources necessary for implementation of each patient safety concept. Facilities may complete as many or as few components as they wish, with only one module, 'Patient Safety Principles', being mandatory. As each module is completed, the provider submits a reporting form to the Network, which acknowledges finished activities. Levels of provider recognition have been established as providers move from 1 diamond status to 5 diamonds. This voluntary program is an excellent complementary tool for identifying internal quality improvement opportunities. The initial launch of the program contained eight modules. They were:

- Patient Safety Principles (mandatory module)
- Hand Hygiene/Infection Control
- Influenza Vaccination
- Slips, Trips and Falls
- Emergency Preparedness
- Sharps Safety
- Decreasing Dialysis Patient Provider Conflict
- Medication Reconciliation

In 2011, four additional modules were launched to enhance the program. They are:

- Health Literacy
- Patient Self-Managed Care
- Stenosis Surveillance
- Transplantation

The goal of this safety initiative is to help dialysis facilities spread patient safety principles among both staff and patients.

- To build a patient safety culture in every dialysis unit
- To promote patient safety values
- To create an awareness of patient safety issues
- To help dialysis units learn more about specific areas of patient safety

As of December 2011, there were 60 providers (36.8%) registered in this program of which 46 providers (76.7%) achieved diamond status by completing at least 1 module. A combination of thirty providers successfully completed the required modules to achieve or maintained their 5-Diamond status.

All facilities that complete modules receive a letter of recognition and are listed on the Network of New England website. Facilities that complete the program, and achieve 5-Diamond status, receive a letter from the Chairperson and a plaque, as well as being recognized in the *Network Notes* newsletter. These facilities are also acknowledged at the Network Annual Educational Meeting and receive 2 complimentary passes to attend.

OTHER QUALITY IMPROVEMENT ACTIVITIES IN 2011

Healthcare Associated Infections (HAI)

Network of New England was awarded a pilot project on HAI from the Office Assistant Secretary for Health (OASH) in September of 2010. In the Year 1 project, the Network of New England established a regional advisory committee, enrolled 15 dialysis providers in Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) and submitted suggestions to CDC on the challenges associated with enrollment to NHSN. Most of these recommendations were accepted by CDC to improve the NHSN enrollment process.

The Network of New England was awarded a Year 2 project in September 2011 from the Office of Assistant Secretary for Health (OASH). The Year 2 project builds on Year 1 experience with focus on interventions in dialysis centers. The purpose of this contract is to generate and execute preventative and mitigating interventions for healthcare associated infections (HAI) in a wide variety of dialysis settings, based on the data collected in Year 1 by the same enrolled providers.

Project Objectives:

- Maintain participation of dialysis facilities in the Year 2 project
- Analyze NHSN data by facility and compare to the data from all facilities in NHSN database
- Design and execute preventative and mitigating interventions in seven Year 1 providers for identified HAI issues

Advisory Committee

- Renew, expand and maintain Region I Collaborative Advisory Committee (CAC)

Selection and Participation of Dialysis Providers: Region I dialysis centers enrolled in Year 1 are:

- Encouraged to continue participation of providers in Year 2 by entering data in NHSN
- Encouraged to participate as “intervention” sites
- Participate in customized interventions based on Year 1 data to prevent and reduce HAIs

QNet Meeting: On December 13th 2011, Jaya Bhargava and Ian Kramer gave a presentation on the results of the pilot HAI project funding by OASH.

HAI Activities with CT Department of Public Health (DPC): In March 2011, this Network was awarded an HAI contract (timeframe: 3/1/2011 to 12/29/2011). The major objectives of the project were to enroll at least 30 providers in NHSN to submit data to CDC, onsite data validation and development of a validation tool to educate staff in understanding the HAI dialysis event criteria. Random selection of patient records was conducted to determine potential missed HAI events. The Network hired a fulltime employee to be the project coordinator of this project. A final report of the validation renewal was submitted to CT DPH with recommendations to CDC for IT edits to assist in proper data entry by provider staff. An APIC webinar on dialysis HSN dialysis module was conducted on 12/20/2011. There were 474 attendees for this live event and an additional 193 individuals have viewed that archived presentation.

FFBI Committee Work

The Medical Quality Manager was an active participant on two FFBI national work groups: 1. The Clinical Practice Workgroup met monthly to work on a white paper concerning epicardial lead use in patients with advanced stages of chronic kidney disease. 2. The Website Revision Work group task was to update and revise the FFBI national website: www.fistulafirst.org.

Clinical Technical Assistance

Network 1 is fortunate to have very knowledgeable multidisciplinary members of the Network Board of Directors and Medical Review Board. Those members have volunteered to assist the Network staff with clinical questions and other issues that might be beyond the scope of the resources in the Network office.

While Network 1 can provide educational resources, staff always advise patients to check with their own physicians for comprehensive and specific answers to their questions. Many website resources are from professional and well-recognized reliable sources. Utilizing the team approach, Network 1 has a Patient Services Coordinator and two Medical Quality Managers (RNs) along with the Network staff, handle a number of clinical inquiries during 2011. These included:

- Acute dialysis issues that impact chronic dialysis patients
- Adequacy of dialysis
- Advance Practice Nurses/Physicians' Assistants in nephrology settings
- Articles on a variety of subjects (vascular access, infection control, cost containment, quality improvement, miscellaneous clinical issues, etc.)
- Behavior problems (management of patients/educational guidelines for staff)
- CQI resources (articles, educational programs, tool sheets)
- Dialysis of patients in rehabilitation centers or skilled nursing facilities
- Educational websites for staff and patients
- LPN or technician scope of practice
- OSHA regulations
- Pediatric management issues
- Safety/security issues in dialysis facilities
- Water treatment management

ELab

The Network Quality Manager served on a committee hosted by Network 11 to redesign the comparative ELab reports that will be used in 2011 as feedback report to dialysis providers.

Acute Dialysis Programs

While acute dialysis facilities are not in the scope of work for Network 1, the Network receives requests for assistance from acute care staff seeking clinical information. Network 1 provides as much information as possible, since the staff caring for acute dialysis patients has a large impact on ESRD care. Network 1 also sends meeting brochures to acute dialysis staff for the Network 1 educational programs. In addition, Network staff communicates with the specific public health departments when there are any dialysis water treatment issues that would affect acute dialysis facilities.

Assisting Facilities with Continuous Quality Improvement Activities

There has been an increase in requests for technical assistance with quality improvement management techniques, particularly for new dialysis Nurse Managers. The Network staff assisted providers with in depth QI information, which includes sample run charts, tracking/trending sheets, and tools from other QI sources. Network 1 continues to incorporate the concept of Quality Improvement in each Annual Network Meeting.

Achieving Network 1 Goals in Quality of Care and Safety

The outcome and process measurements reported in the national clinical indicator projects and the ELab Data project demonstrates an increased number of patients in New England achieving acceptable K-DOQI benchmarks. In the past year, this Network has exceeded the national mean for URR > 65% and KT/V \geq 1.2 and hemoglobin levels. Collective educational efforts by physicians, administrators, and dialysis patient care teams, and the collaborative role of Network 1 have

contributed to improvement in these CMS indicator targets. This Network has made improvements in lowering ≥ 90 day catheter reduction. Network 1 successfully completed, and CMS approved the annual QI Work Plan. As of December 2011, the Network has achieved the AVF goal of 63.4% which exceeds the CMS goal of 62.9% for March 2012. The Network is excited about the ongoing positive response from providers about the 5 Diamond Patient Safety Project.

The Medical Review Board has been increasingly aware of the benefits of collaboration within the renal community. The Fistula First Initiative offers new challenges to expand relationships with vascular surgeons, interventional radiologists, acute care settings, and QIOs.

B. IMPROVE THE INDEPENDENCE, QUALITY OF LIFE, AND REHABILITATION (TO THE EXTENT POSSIBLE) OF INDIVIDUALS WITH ESRD THROUGH TRANSPLANTATION, USE OF SELF-CARE MODALITIES (E.G. PERITONEAL DIALYSIS, HOME HEMODIALYSIS), IN-CENTER SELF-CARE, AS MEDICALLY APPROPRIATE, THROUGH THE END OF LIFE

Withdrawal from Dialysis Trends

End Stage Renal Disease imposes a high mortality burden. Life on dialysis has improved, but complex medical and emotional challenges remain. As dialysis has become increasingly accepted as a routine medical intervention, the population receiving this difficult and intrusive treatment has become more elderly, sick, fragile and vulnerable.

It is well known that every year, a substantial proportion of patient deaths are preceded by discontinuation of dialysis treatment. Discontinuation of dialysis means that the patient's regular course of kidney replacement therapy was stopped with the expectation that it would not be resumed even in response to life-threatening complications, and that the patient and / or health care agent made an explicit decision that kidney replacement therapy should be stopped permanently.

The Network of New England has followed the trends in this important area of end of life care. Table L contains the number of deaths reported in this Network for ESRD patients in the six states of New England from year 2000 to 2011. CMS Form 2746, the Death Notification Form, has data elements about discontinuation of dialysis. The data were analyzed for the number of patients that discontinued from dialysis prior to death and also by the primary cause of ESRD, diabetes.

Table G: Network 1 Annual Number of Deaths, Discontinuations by Diabetic Status

	Patient Deaths			Patient discontinued		Total Discontinued	
	Diabetic	Non-Diabetic	Total	Diabetic	Non-Diabetic	N	%
2000	1,081	1,583	2,665	261	552	813	31%
2001*	1,118	1,630	2,748	349	534	883	32%
2002**	1,139	1,638	2,777	338	558	896	32%
2003***	1,234	1,615	2,853	387	574	961	33%
2004	1,217	1,668	2,885	398	620	1,018	35%
2005	1,102	1,848	2,956	378	656	1,034	35%
2006	1,067	1,790	2,857	362	687	1,103	39%
2007	1,090	1,614	2,804	391	633	1,024	36%
2008	1,103	1,620	2,723	393	666	1,059	39%
2009	1,191	1,579	2,770	402	717	1,119	40%
2010	1,161	1,670	2,831	412	686	1,098	39%
2011	1,116	1,590	2,706	435	685	1,120	41%

Note: * Primary diagnosis was missing for 26 patients. ** Primary diagnosis was missing for 10 patients. ***Primary diagnosis is missing for 4 patients. These patients were grouped in the non-diabetic column for all years.

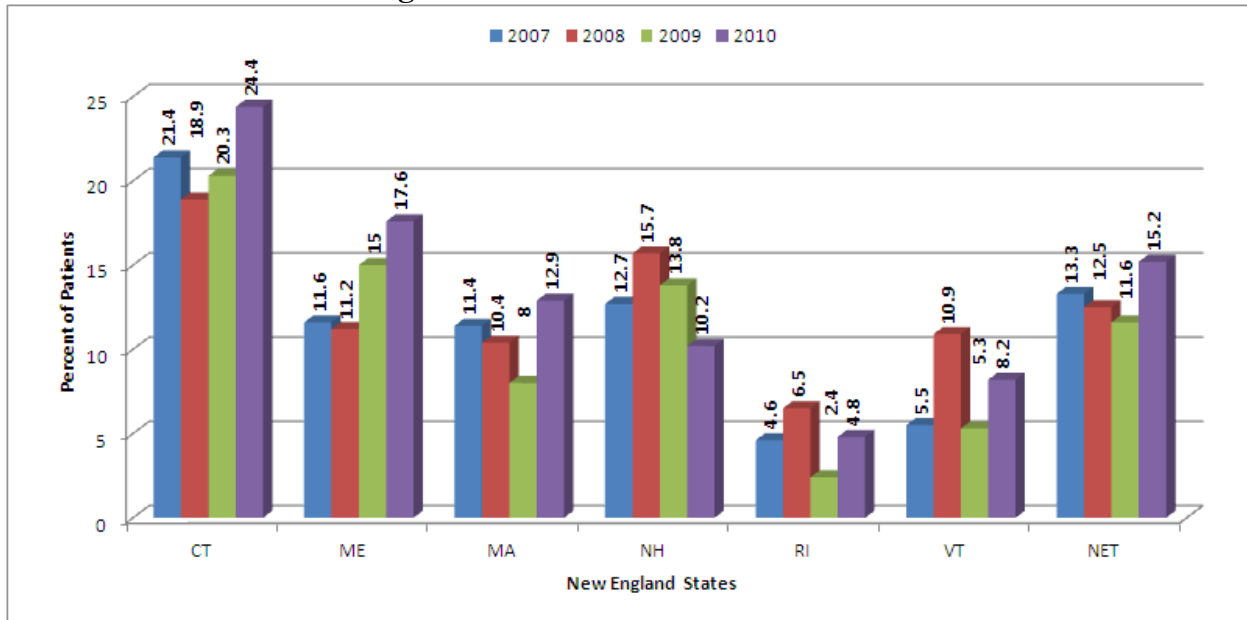
Source: CMS Form 2746

Profile Analysis of ESRD Incidence Population

Network 1 annually profiles the utilization of treatment options available to new patients with ESRD. Network 1 is interested in understanding facility selection of modality options by new patients during the first twelve months of their individual ESRD experience with the emphasis being on self care dialysis or transplantation. In order to accomplish a twelve-month retrospective analysis of “new patient” experiences, a full year must lapse for all patients in the study cohort. Therefore, the most recent data analyzed is representative of the 2010 incidence patient census by first ESRD provider of service.

The Network of New England promotes new patients select home dialysis within first one year of ESRD. This rate is 11.64% for the Network in 2010. However, the individual state experience ranged from a high of 20.3% in Connecticut to a low of 2.4 % in Rhode Island (Figure 12).

Figure 12: 2007, 2008, 2009 and 2010 Incidence Patients by First Provider of Service Selecting Home Self-Care With in First 12 Months

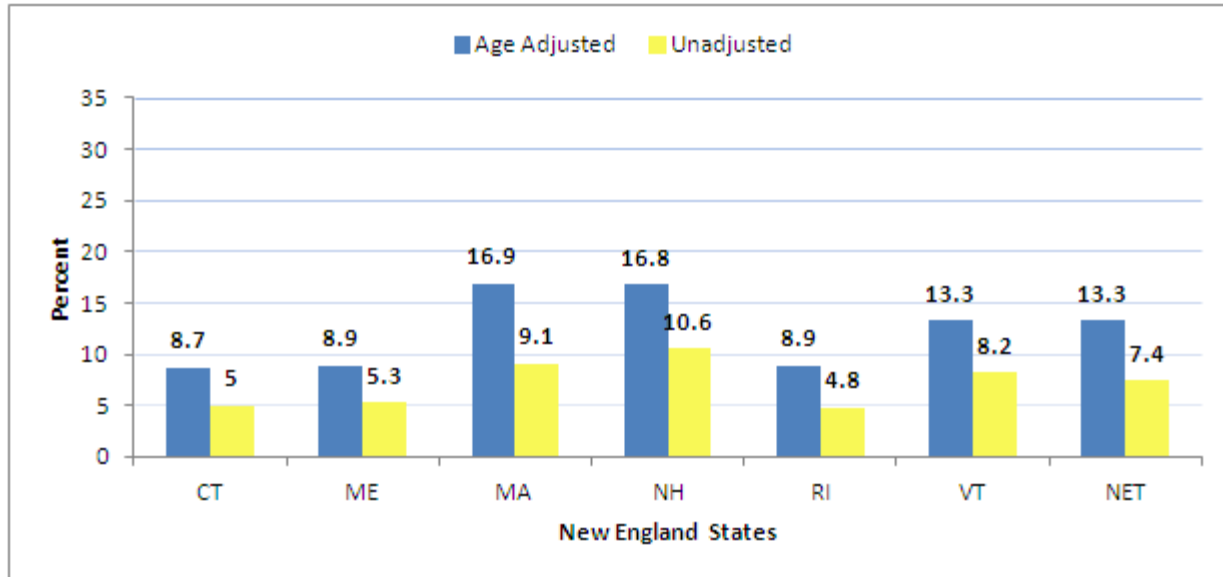


Note: Home patients for each state or Network are divided by the incident population for that state or Network. Source: SIMS data files

There continues to be high utilization of in-center treatment and steady slow growth in the total number of ESRD providers in New England. New England providers continue to expand the number of treatment stations at existing facilities or open treatment centers at new locations. This increased availability of treatment resources may be one factor contributing to a low percent of patients selecting home/self care.

The percent of new patients in 2010 who were transplanted in their first twelve-month experience was 7.4%. Adjusted for age by excluding patients over age 70 of the 2010 incidence population reveals a higher transplant activity rate of 13.3 % (Figure 13). Network of New England encourages new patients to select transplantation within the first year of ESRD, because of the high success rate and quality of life with a kidney transplant Table M provides the actual number of incident patients for the past three years.

Figure 13: Transplantation 2010: Incidence Patients Receiving Transplant Within First 12 Months



Adjusted = Denominator removes patients \geq Age 70

Note: Transplantations for each state or Network are divided by the incident population for state by residence or Network. Age adjusted category removes patients of age ≥ 70 from the denominator.

Source: SIMS data files

Table H: 2008 - 2010 Incidence Patients by State of Residence Selecting Home Dialysis By 1st ESRD Provider: First 12 Months ESRD Experience

State	New Patients			Transplanted			Home		
	2008	2009	2010	2008	2009	2010	2008	2009	2010
CT	1004	1058	1005	49	54	51	190	215	246
ME	322	271	261	9	12	14	36	41	46
MA	1762	1828	1731	154	147	158	183	146	225
NH	249	290	273	18	19	29	39	40	28
RI	338	363	310	14	15	15	22	9	15
VT	147	94	121	17	13	10	16	5	10
Total	3,859	3,908	3,728	261	260	277	483	455	570
Total %	100	100	100	6.8	6.6	7.4	12.5	11.6	15.3

Note: 37 patients residing in NY or other states are not in state totals for New England for YR 2008

38 patients residing in NY or other states are not in state totals for New England for YR 2009

27 patients residing in NY or other states are not in state totals for New England for YR 2010

Source: SIMS data files

Prevalence Population and Employment Status

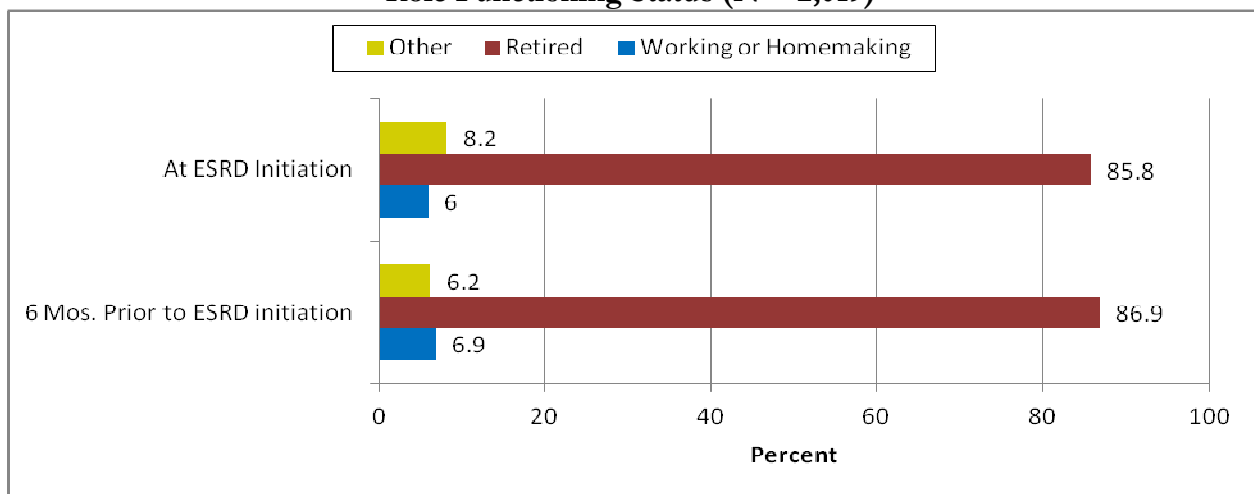
One of the functions of the ESRD Networks consistent with sound medical practice, is to encourage participation of patients and providers in utilizing the services of vocational rehabilitation (VR) programs. As part of the annual facility survey (form 2744), the Networks collect information on vocational rehabilitation referrals, employment and student status among patients between the ages of 18 to 54. This age-range cohort is often referred to as “working age”.

Based on the prevalent population as of December 31st 2011, there were 3209 dialysis patients in New England within the working-age range (See Table 8 in data tables sections). One hundred thirty seven patients or 4.3% were referred to or received VR services during the reporting year. Twenty nine percent (29%) of this patient group were reported as either working or students. Combined, 33.5 % of New England dialysis patients are actively involved in traditional life pursuits

Incident Population and Employment Status

Analysis of the Network of New England’s incident data gives insights into patients’ employment status 6-months prior and at the initiation of the ESRD. CMS’s Medical Evidence Report and Registration (Form 2728) form contains data elements, which provide comparison between patient employment status, six months prior to initiation of ESRD treatment, and at the initiation of ESRD treatment. This form also captures data on the type of employment, such as whether a patient is a student, homemaker, retired due to disability, or retired due to age/preference. In 2011 a total of 3662 individuals were registered as new patients for the New England states. Of those patients, 55% were over the age of 65 when first becoming ESRD patients. Analysis of the employment status of the incident population over the age of 65, 6-months prior to initiation of ESRD, indicates that 85.8% were retired due to disability, age or by preference, while 8.3% were working or homemaking. However, analysis of the employment status of the same population at the initiation of ESRD indicates that the number of retired increased to 87 % (Figure 14).

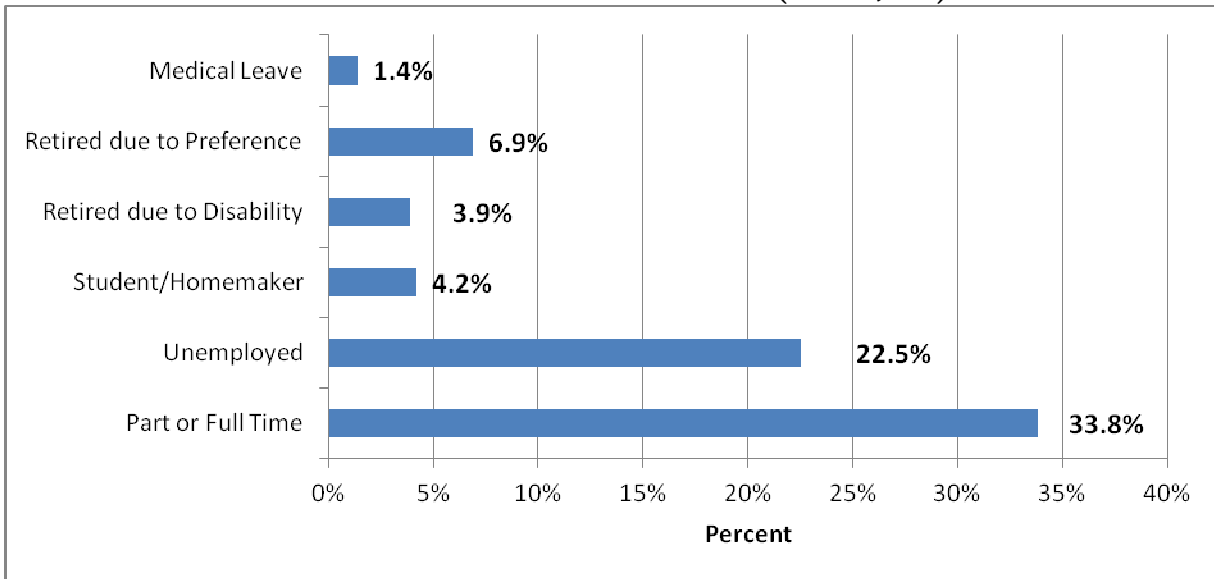
**Figure 14: 2011 Incidence Patients \geq 65 *
Role Functioning Status (N = 2,019)**



* Percent will not equal 100, due to other functional status categories not included in this figure.
Source: CMS Form 2728

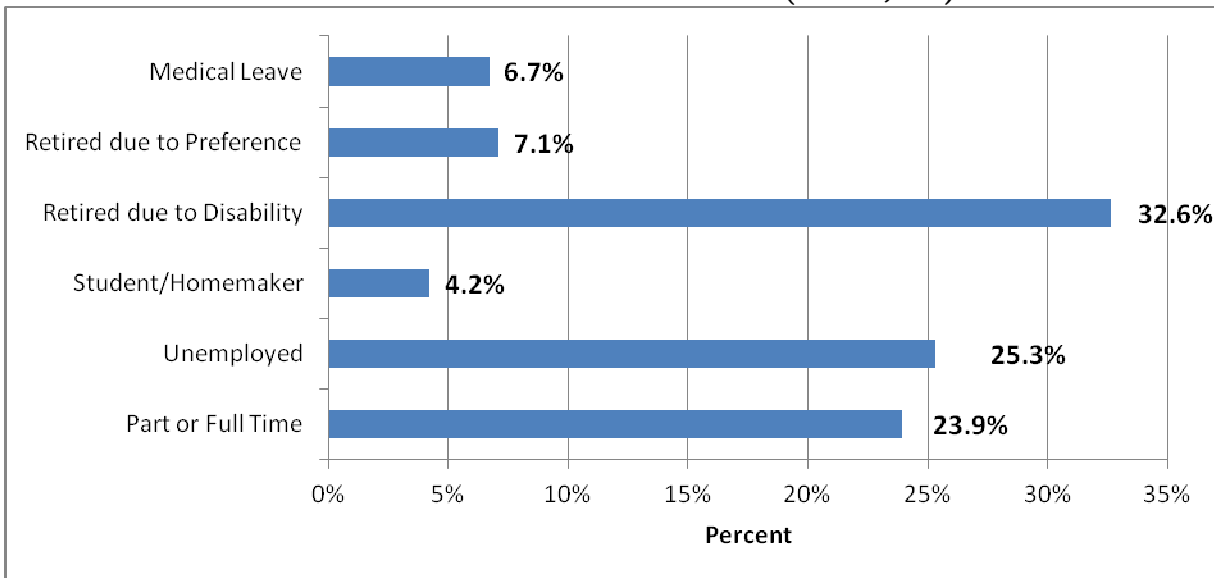
In 2011 there were 1,630 (44.6%) incident ESRD patients who were under age 65. Six months prior to initiation of ESRD treatment 36% of this cohort group was working, 3.2% were students or homemakers and 38% reported retired due to disability or age preference. Looking at the same group at the initiation of ESRD, 24% were working, 4.2% were students or homemaker, and 39.8% were reported retired due to disability or age preference (Figures 15 and 16).

Figure 15: 2011 Adult Incidence Patients Age <65 Functional Status 6 Mos. Prior to ESRD Initiation (N = 1,630)



Source: CMS Form 2728

Figure 16: 2011 Incidence Patients Age < 65 Functional Status At Initiation of ESRD Treatment (N = 1,630)



Source: CMS Form 2728

Vocational Rehabilitation

Of the 12,698 ESRD prevalence patients residing in the six New England states at the end 2011, only about 3609 are of “working age” which is defined as between the ages of 18 to 55. That number represents 25.3% of the New England dialysis population.

Among the working age patients treated with dialysis 33.6% are working, going to school or are receiving vocational rehabilitative services. This percentage of patients who are engaged in work related life activities is a relatively good outcome. This outcome is considered reasonable when taking into account the number of challenges associated with the demands of a thrice-weekly dialysis schedule, fatigue, medical complications and barriers to employment (Table I).

**Table I: Vocational Rehabilitation by State
Patients Aged 18 - 55 as of December 31, 2011**

PROVIDER STATE	NUMBER OF DIALYSIS PATIENTS AGED 18 –54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL-TIME OR PART-TIME
CT	1,029	43	247	23
MA	1,436	73	394	61
ME	212	5	55	9
NH	191	2	63	6
RI	271	12	63	9
VT	67	2	9	4
Network	3,206	137	831	112

Source: CMS Form 2744

The Network of New England continues to encourage individual patients to retain or pursue their careers upon initial diagnosis of ESRD and throughout their adjustment to treatment. Network 1 posts current contact information for the six New England State Vocational Rehabilitation programs on its website and distributes educational materials to patients and providers regarding the importance of employment retention for dialysis and transplant patients. Network 1 also serves as an advocate on behalf of patients when requested by social workers or patients, when a patient is threatened with job loss. In these cases advocacy takes the form of telephone conferencing, directing correspondence to existing or potential employers and referral to partner agencies such as Life Options, the Medical Education Institute, AAKP and the Americans with Disabilities Act administered by the US Justice Department.

Network 1 Staff Provide Community Educational Materials

Pre-dialysis, dialysis or transplant patients and provider staff rely on ESRD Networks as a resource for educational materials. Network 1 warehouses printed materials in large quantities for distribution at no cost to renal healthcare providers in New England upon request. The four most often requested educational products in 2011 were:

- *Your New Life* (New England PAC)
- *Preparing For Emergencies – A Guide for People on Dialysis* (CMS)
- *ESRD Medicare Coverage for Dialysis and Transplantation* (CMS)
- “BEE” *Informed of Your Rights and Responsibilities*. (Network 1)

Network 1 difficulties this year were that some of the requests could not be fulfilled because CMS exhausted stock of *Preparing for Emergencies*. However, Network 1 obtained some additional copies from the Network Coordinating Center. In addition, Network 1 was able to assist Fresenius Medical Care in printing copies of *Preparing for Emergencies* for all their facilities in New England. These four popular multi-page booklets are designed to orient and educate members of the renal community, both patients and providers, on the many aspects of End Stage Renal Disease.

The following educational information or materials frequently given to patients and providers of CKD/ESRD healthcare throughout the year were:

- | | |
|---|--------------------------------------|
| • QI Information | • Transient Care |
| • Rights and Responsibilities | • Network Functions and Role |
| • Data Research Information | • Website Referral |
| • Complaints and Grievances | • Reimbursement Issues and Questions |
| • Treatment Options | • Coordination of Benefit Questions |
| • Vocational Rehabilitation Information | • KDQOL questions |
| • Information on Dental Services | |

Achieving Network 1 Goals in Quality of Life for ESRD Patients

The importance of patient quality of life has been a high priority for Network 1. The provision of educational materials on the website and distribution efforts to patients and professionals is an ongoing activity. Random feedback of utilization and effectiveness of these materials is conducted by Network staff. Network 1 leadership serves on the steering committee of the ESRD National End of Life Coalition. Analysis of access to services and employment status of dialysis population is reported annually to the Network Board to assure adequate regional availability of dialysis treatment to help employed patients. A vocational rehabilitation report with comparative data is sent to each dialysis social worker for internal performance assessment.

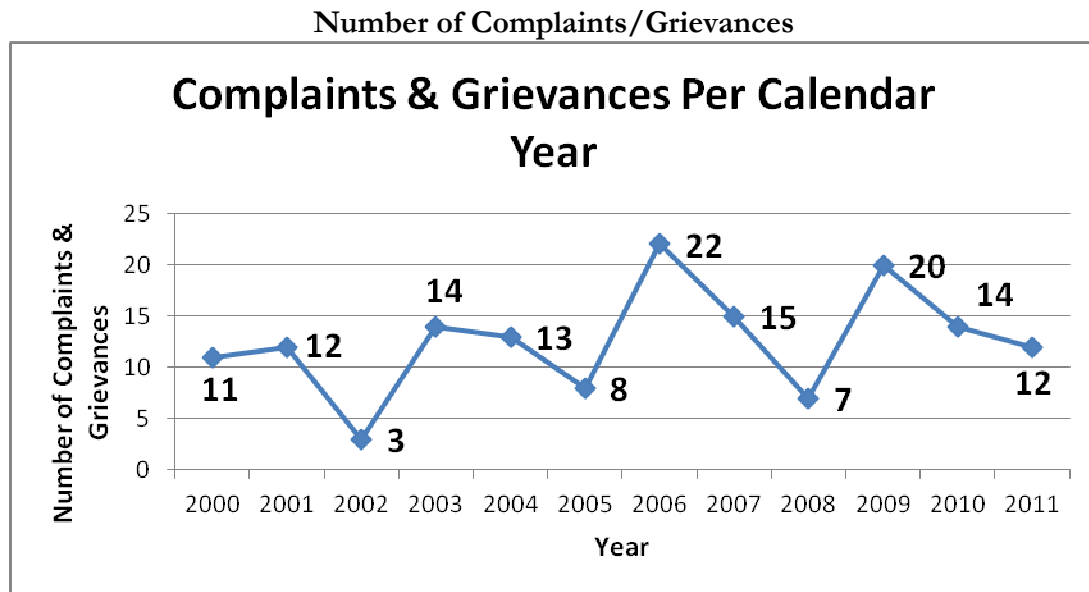
C. IMPROVE PATIENT PERCEPTION OF CARE AND EXPERIENCE OF CARE, AND RESOLVE PATIENT'S COMPLAINTS AND GRIEVANCES

Complaint, Grievance and Contact Report for 2011

All ESRD Network Organizations are required by the Centers for Medicare and Medicaid Services (CMS) to report annually on complaints and grievances. The Network trends these data quarterly and report results in the quarterly report as required by CMS.

From January 1, 2011 through December 31, 2011, the Network of New England received 12 beneficiary complaints and 0 formal grievances. This represents a slight decrease in the number of complaints from 2010. Complaint and general contact data has been captured and tracked for the past 11 years (since 2000) in the SIMS database, and now the New Contact Utility (NCU) used by all ESRD Networks. Displayed here is a trend line for patient complaints.

Figure 17



Source: SIMS database, Network Contact Utility.

The presenting issues for the 12 complaints were in the categories of treatment related quality of care, staff related/professionalism and physical environment. At the end of December 2011, 2 of the 12 complaints remained open.

An emerging theme developing in complaints this year is related to professionalism or boundary issues with provider staff. Of the 12 complaints 7 were related to staff being rude, disrespectful or not listening to the patients by their own report. The Network investigates these situations, assists in facilitating a resolution, and suggests an intervention such as the Decreasing Patient Provider

Toolkit (DPC). This toolkit contains training on professional boundaries, communication skills and conflict resolution. To address this theme in 2012, the Network PSC will develop a webinar for providers about Professionalism/Boundaries which will be made available to all facility staff.

Another theme, consistent with 2010, is complaints related to involuntary discharges (IVD). According to Medicare's Conditions for Coverage (CfC), when a facility reports an IVD they are required to contact the Network. There have been a small number of complaints related to IVD's. The Network inquires about the situation, assists in mediating, and at times is able to both resolve the complaint and avert the IVD. The Network PSC trends data to see not only which complaints are IVD related, but also how many facilities that discharge patients have unrelated complaints. In 2011 there were 7 patients at risk of involuntary discharge. The Network worked with these facilities by providing consultation and facilitation to keep the patient in the facility. In 2011 there were 27 involuntary discharges. Of the 27 discharges, 20 were due to a facility closure where all patients were transferred to another dialysis provider. Of the remaining 7 discharges, 1 was averted as a result of early intervention and consultation with facility staff.

Aside from the complaints noted above, there is a secondary data set in the NCU that is the general contact data on facility concerns. It is because of these types of facility contacts that the Network is able to intervene with technical assistance and education before a conflict escalates into a patient complaint. From January 1, 2011 through December 31, 2011 there were 115 cases logged into the NCU in the category of facility concerns. The 115 facility concerns in a 12 month period represent a slight decrease from 2010's report of 143 concerns but a spike from 2009's report of 99 facility concerns in a 12 month period. In responding to these contacts, this Network fulfills an important role in providing education, mediation, and deescalating conflicts between patients and staff. This work also helps the Network act as an advocate for patients.

Many of these consultations occur when staff notices repeated behavioral issues with patients that are beginning to escalate in verbal or disruptive behavior. The provider staff will call the Network for an early intervention and suggestions to avoid a more serious situation. The Network PSC and Medical Quality Managers confer with facility staff for possible solutions to patient related issues. This type of support for facility staff – the teach-the-teacher method – works well in this Network as providers welcome the support and guidance.

Primary staff responsibility for receiving complaints is with the Network Patient Services Coordinator, with contributing teamwork from the Network Executive Director, Medical Quality Managers and the Medical Review Board Grievance Chair. Cases related to clinical matters are given to the Medical Quality Managers to investigate/evaluate. The PSC investigates all behavioral, psychosocial and staff related cases. This Network strongly prefers facility consultation before a patient complaint or involuntary discharge occurs. This team philosophy fosters intervention, mediation and problem solving when potential compliant situations become known in their early stages.

**Table J: Internal Monitoring of Contact Trends
2010**

Date	Patient/Family	Provider	Data	Other	Total
1/10-3/10	20	132	114	37	303
4/10-6/10	39	103	105	15	262
7/10-9/10	37	172	98	22	329
10/10-12/10	21	126	114	32	293
Total	117	533	431	106	1,187
% (Rounded)	10%	45%	36%	9%	100%

2011

Date	Patient/Family	Provider	Data	Other	Total
1/11-3/11	18	195	94	37	344
4/11-6/11	14	109	127	37	287
7/11-9/11	20	90	106	31	247
10/11-12/11	9	58	102	28	197
Total	61	452	429	133	1,075
% (Rounded)	6%	42%	40%	12%	100%

Source: Contact Utility by Contacts by Classification

Patient/Family = Beneficiary, Complaint, Grievance

Provider = Facility Concerns, Facility Inquiry

Data = Copy of Forms, Data Processing

Other = All other Classifications

Notes:

1. This analysis reports only action taken by staff to incoming calls, faxes, email or mail.
2. The data reported is for primary and secondary "area of concern".

Network Notes Published in 2011

In the summer of 2011 the Network of New England issued Network Notes, the traditional newsletter for New England renal professionals. This publication is sent to alert, inform, clarify and educate renal caregivers about current events, updates on Medicare rules, and other topics of relevance. The Network newsletter is attractive in appearance and generates positive responses from facility staff. This four-page issue included information about Bloodstream Infections in Hemodialysis Patients with Central Lines, Healthcare Associated Infections, The Patient Experience, Vocational Rehabilitation, Bed Bugs, Water Treatment Safety Alert, and 5 diamond provider activity statuses. The 2011 winter edition of Network Notes was the largest issue to date. It included articles on the ESRD Quality Incentive Program (QIP), New England Dialysis Collaborative on Healthcare Associated Infections (HAI), the Patient Advisory Committee (PAC), handwashing, fistula first, New Policy Reduces Racial Disparities in Transplantation, The Patient Experience and Explore Transplant. Network Notes is distributed to New England Renal Nurses, Medical Directors, Facility Administrators, Social Workers, Dietitians, State Surveyors and the CMS Network Contracting Officer Representative (COR).

Kidney Chronicles Published in 2011

In January of 2012 the Network Patient Services Coordinator (PSC) and Community Outreach Coordinator (COC) started a monthly patient educational newsletter that offers information relevant to dialysis patients. Topics in 2011 included:

- What is the ESRD Network of New England?” explaining the Network’s services to dialysis patients
- Dialysis Facility Compare, Technical Assistance & Dialysis Friendly Recipe.
- Slips, Trips & Falls Patient Safety.
- Sex and intimacy with End Stage Renal Disease.
 - ESRD Patient Rights and Responsibilities.
 - Staff Appreciation
 - “Understanding Cultural Differences”. This brochure was published in Spanish as well.
 - “Understanding Your Medications”.
 - “Support Groups”.
 - Infection Control
 - American Diabetes Month
 - Medicare General Enrollment Period (GEP)

Each issue also includes Kidney Questions which are answered in the next month’s newsletter. Kidney Chronicles continues to be disseminated to each dialysis provider for distribution to patients by the software tool called Constant Contacts

The Patient Advisory Committee (PAC) Remains Active Throughout 2011

The PAC is comprised of members from the six New England states and has balanced representation in terms of age, gender, ethnicity, and treatment modality. The PAC celebrated its 13th year of service in 2011. The PAC is advisory to the BOD, MRB, and Network staff. Since its inception the Patient Advisory Committee has held to a meeting schedule of face-to-face work sessions, telephone conference calls and group e-mails as indicated by the work at hand. The following information describes the PACs activities throughout 2011.

The PAC members, the Network Executive Director and the Network PSC attended 1 meeting in Sturbridge, Massachusetts, two telephone conference calls and several email discussions. During 2011, The New England Patient Advisory Committee (PAC) had 13 members, in total, who were on the committee during the course of the year.

During 2011 the PAC has been engaged in several projects this year. They are listed below:

- Solomon Four Group Design Project-The PAC introduced the topic of how new patients do not retain information at start of dialysis (uremic, scared etc.). There has been ongoing concern that not enough patients know the role of the Network. The Network developed a rough draft of project with the PAC and consulted with statistician. New ideas emerged involving common knowledge and specific knowledge. The project will be completed in 2012.
- “Need Help Finding Your Way”- The PAC, Network PSC and Network COC completed the developmental process of a file folder; which will be a helpful tool orienting patients to Network

services. Topics in the file folder include treatment options, vascular access management, patient rights and responsibilities, vocational rehabilitation, request to order materials, newsletters and how to file a complaint or grievance. This file folder will be used in the Solomon Design Project, which is a project educating new patients about the Network. It is also a useful tool for any renal patient.

- “Travelopoly”: A Renal Patient’s Guide to Traveling-The PAC decided that one of the topics they want to focus on is traveling on dialysis. The PAC is in the beginning stages of a brochure/flyer for both HD and PD patients. Due to the planning that goes into traveling for a dialysis patient the PAC feels a checklist would be helpful to patients.

The PAC held its biggest annual event on October 12, 2011 in conjunction with the ESRD Network Annual Meeting. According to tradition, the PAC plays an important role each year at the Annual Meeting by staffing the Network educational exhibit. The PAC Educational Exhibit was once again a big success as members of the PAC distributed printed patient and professional educational items to the New England renal community.

The New England PAC continues to be a functional model for operation of ESRD Network patient involvement to foster patient centered concepts. Some PAC members also serve on the Network BOD and MRB. Next year there are plans to add more members to the PAC and continue to develop patient centered material. The Network is proud to report that there is an active and “working” PAC giving guidance to ESRD leadership.

“Need Help Finding Your Way”

In 2011, Network staff, with input from the Network Patient Advisory Committee developed the ESRD file folder “Need Help Finding Your Way” which will be a helpful tool orienting patients to Network services. Topics in the file folder include treatment options, vascular access management, patient rights and responsibilities, vocational rehabilitation, request to order materials, newsletters and how to file a complaint or grievance. This file folder was developed be used in the Solomon Design Project, which is a project educating new patients about the Network. It is also a useful tool for any renal patient.

Solomon Four Group Design Project

The objective of the project is to:

- Test informational methods to assist with new ESRD patients in retaining information about the role of & function of the ESRD Network
- Evaluate the retention & mental capacity of new ESRD patients to recall educational information sent to the patient from
- CMS(NEPOP materials)
- Network of New England packet (Need Help Finding Your Way)
- Quantify the Network staff effort and contact technique (direct phone calls) required to communicate information about the Network with new patients.

The project design has 4 groups of patients. Each group of patients is stratified to be contacted at different times by phone. Network staff has a scripted interventions tool. Phone alert calls will tell

the patient what material is coming and the role of the Network. Follow up calls are to evaluate what patients can recall about the contents of the Network flyer and/or NEPOEP.

Group A	phone alert		NEPOP	follow up call
Group B	no call		NEPOP	follow up call
Group C	phone alert	Network flyer	NEPOP	follow up call
Group D		Network flyer	NEPOP	follow up call

In 2012 the Network will complete the work on this project and report results.

Decreasing Patient Provider Conflict Toolkit

Decreasing Dialysis Patient-Provider Conflict (DPC) is a national CMS collaborative effort involving multiple ESRD agencies and all of the ESRD Networks. The CMS funded initiative involved several key action items, including development of a taxonomy, provider manual, and toolkit. Training of dialysis staff related to noncompliant patients and how to relate more empathically and effectively with them.

The Decreasing Patient Provider Conflict Toolkit is the recommended resource for facility staff education for dealing with conflict at the facility level. Network 1 has used every opportunity to promote this useful tool. It is distributed in the new facility packets, used for staff in-service when a complaint is filed and is presented at renal social worker meetings. In addition, the following outreach techniques were used.

At the October 2011 Annual Meeting, a session on Managing Challenging Situations in the ESRD Setting "Can't We All Just Get Along?" was given by Mark Meier, MSW, LICSW. He described 3 approaches to preventing conflict in the ESRD setting. Mark also discussed the role of the interdisciplinary team in reducing conflict in the ESRD setting. Lastly, he summarized the impact of living with a chronic illness and how this impacts a patient's ability to problem solve effectively in difficult situations

During the 2011 Annual Network meeting the Patient Advisory Committee (PAC) had a booth where providers were able to talk with patients and see the new information the PAC has revised for the year. The PAC distributed DPC information to providers.

Whenever a complaint case has communication or professional boundary violations the PSC will require a DPC training to be conducted. Occasionally, the PSC will conduct onsite training for the facility. This technique has been an effective means of improving communication between the staff and patients.

CMS Dialysis Facility Compare

The Network of New England informs patient and providers of Dialysis Facility Compare website. The website address is www.Medicare.gov/dialysis was added to the Medicare website as a way for new or current dialysis patients to find information about dialysis providers all over the country including their "home" facility. By visiting the site users can identify the geographic location of

dialysis facilities, compare quality of care measures, make informed treatment choices and find answers for many questions about ESRD Medicare services.

During 2011 the Network staff responded to a number of individual contacts, as captured in the New Contact Utility, for information about, referral to, or assistance with, navigating the DFC website. The PSC guided patients with internet access through the website when they had questions about how to use it. Those without internet access were mailed the DFC informational card or mailed the requested information from the website by the PSC.

Achieving Network 1 Goals to Address Patient Grievances and Experience of Care

The goal in this Network is to educate patients and providers about the role of the Network and the complaint and grievance process. Another goal is to prevent patient provider discord through education, mediation and conflict resolution. Complaints and grievances subside as more direct-care staff learn about professional interaction, appropriate communication skills and professional boundaries. Network 1 has experienced increased volume of inquiries associated with patient and staff conflicts. Current practice in the delivery of dialysis involves patient conflict to be primarily related to verbal interaction with staff members. The conduct, professionalism and communication skills of dialysis staff with patients are central to achieving appropriate patient care. Professional boundaries and behavior was a major topic at the Annual Meeting held by the Network in 2011. Network 1 will reinforce the complaint process through strengthened internal case review and continue conflict prevention consultation. Empowering patients with information and options is an ongoing effort for providers and the Network.

End of Life Coalition (EOL)

This coalition was established in 2005 as one of the CMS special funded projects in 2005/2006. The funding was awarded to the Mid-Atlantic renal coalition (Network 5). The coalition continues to function due to the volunteer efforts of several professionals (www.kidneyeol.org). The mission of the coalition is to promote effective interchange between patients, families, caregiver, payers and providers in support of integrated patient centered end of life care of chronic kidney disease patients. The Network Director of the Network of New England continues to serve on the steering committee for this coalition.

Network 1 Collaborative with Donated Dental Services

Since January 2010, The Network of New England has facilitated referrals to Donated Dental Services (DDS) which assists renal patients with severe dental problems. According to the Founder, DDS is a national humanitarian initiative through which 14,000 volunteer dentists assisted by 2,800 laboratories have contributed \$150 million in comprehensive therapies to 90,000 needy disabled, elderly, and medically compromised individuals in the United States.

This program is a helpful resource for patients who have exhausted every other financial option seeking needed assistance for dental work. Only the most severe patient cases are considered for these services.

The Network has collaborated with DDS to serve as a “middle man” to help the patients needing essential dental care services. The Network notified all the ESRD clinics and transplant facilities in all six states of this program by several mailings of the application and the medical triage forms. The Network

does not choose which applications will be submitted to this program. The Network coordinates the application process. When the applications from the facilities are submitted, they are coded and sent to the appropriate address by state. The Network staff received many calls from providers who had questions about the Donated Dental Service and who wanted applications and the medical triage form. During 2011, 36 referral applications were submitted to DDS.

Explore Transplant Workshop

In 2011 Network 1 partnered with Amy Waterman, PhD and Christina Goalby, MSW developers of Explore Transplant, an educational program to educate renal providers on the benefit of transplant referral. The theoretical basis for the Explore Transplant education is Prochaska's Transtheoretical Model (TTM). Transplant education commonly recommends that patients take actions like calling a transplant center to initiate evaluation or asking loved ones to consider being living donors. These recommendations assume that a patient is very close to pursuing transplant and may cause patients who have not yet decided to feel pressured or stop learning. Because patients are in different stages of readiness to learn about different health behaviors, Explore Transplant assesses patients' level of transplant readiness first, and then provides factual information and recommendations that are individually tailored to each patient's Stage of Readiness to meet them educationally where they are and to reduce resistance to learning.

The three objectives of this grant proposal, covering four ESRD Networks (1, 4, 7 & 16 covering 14 states serving 20,000 transplant-eligible dialysis patients), were:

- to develop and conduct in-person and webinar Explore Transplant trainings with over 500 dialysis providers serving 20,000 transplant-eligible patients.
- to assess, six months after the trainings, dialysis providers' use of and success in educating 2,500 dialysis patients about deceased and living donation using Explore Transplant,
- to assess whether dialysis patients presenting for transplant evaluation who received Explore Transplant had more living donation knowledge than those who did not receive Explore Transplant.

The Network of New England hosted 2 training sessions; training one was in Framingham, MA on May 12, 2011 and the second was in Portsmouth, NH on May 26, 2011. There were 106 Providers (58, Framingham; 48, Portsmouth) in attendance at the meetings, with 76 of 172 dialysis centers reached in New England. The attendees were given a pre/post education attitude test on their confidence in ability to answer transplant questions and knowledge about transplant topics. The post-test had a 40-50% positive response increase.

Achieving Network 1 Goals in Collaboration with Other Organizations

Partnerships with ESRD providers and renal professionals have taken many shapes during the past 34 years of this Network. The Patient Advisory Committee is now 13 years old and many of its members serve on different Network 1 committees. The PAC advice and viewpoint is always valued. The Connecticut Coalition of Organ and Tissue Donation (Donate Life) is 26 years in existence. The addition of a part-time program manager for Donate Life has greatly enhanced the activities and accomplishments of Donate Life Connecticut. The Network 1 annual meeting, technician meeting and professional newsletters have become a regional tradition. Emergency coordination and regional planning continues to require identification of new partners for updating an effective emergency response and coordination plan. The deployment of a new service for patients to receive donated dental care has been helpful in getting patients on transplant waiting lists.

D. IMPROVE COLLABORATION WITH PROVIDERS TO ENSURE ACHIEVEMENT OF THE GOALS THROUGH THE MOST EFFICIENT AND EFFECTIVE MEANS POSSIBLE, WITH RECOGNITION OF THE DIFFERENCES AMONG PROVIDERS (E.G., INDEPENDENT, HOSPITAL-BASED, MEMBER OF A GROUP, AFFILIATE OF AN ORGANIZATION) AND THE ASSOCIATED POSSIBILITIES/CAPABILITIES

23rd Annual Network of New England Educational Meeting

The annual meeting “New Approaches to old Problems” was held in Sturbridge, MA on Thursday October 13th 2011. Topics were:

- “A National Priority: Reducing Health Care Associated Infections”
- “Dialysis bone and Mineral Metabolism Constants and Changes: Physiology , Preferences (Diet), Protocols and Payment Policy”
- “Home Dialysis and the Changing Landscape of ESRD Care”
- “Palliative Care for Dialysis Patients”
- “A Brief Walk in the World of Renal Transplantation”
- “Eliminating Catheter Related Bloodstream Infections in the Dialysis Unit”
- “Assessment and Maintenance: Preserving Our Patients Lifeline”
- “Don’t Let the “QIP” be the “RIP” of your Unit”
- “Can’t We All Just Get Along? Managing Challenging Situations in the ESRD Setting”

There were a variety of posters from professionals ESRD disciplines with a total of over 600 attendees, 35 exhibitors with 89% of Network providers represented.

Table K: Network Annual Meeting Attendance

Year:	2006	2007	2008	2009	2010	2011
Total Attendance:	537	554	668	670	662	688
Patient Advisory Committee	6	8	7	8	10	10
Administrators/Regional Managers (not including Nurse Managers)	6	10	10	16	31	36
Technicians	18	20	30	60	94	97
Physicians	15	10	17	16	20	31
Dietitians	37	39	56	60	40	54
Social Workers	63	64	72	89	80	78
Nurses	304	319	390	358	322	314
35 Exhibitors	72	56	70	63	65	68

An optional customer evaluation was completed by those who only have had contact with the Network in the past year.

Table L: The Network of New England Annual Meeting Customer Evaluations:

LOGISTICS:	2005	2006	2007	2008	2009	2010	2011
Survey response rate based on total attendance at each Annual Meeting (N=534)	37%	53%	31%	36%	30%	29%	26%
Actual number of surveys returned	195	247	153	212	185	194	156

RESPONDENTS BY DISCIPLINE:	2005	2006	2007	2008	2009	2010	2011
Physicians / Physician Assistants	2%	2%	2%	1%	1%	2%	3%
Social Workers	58%	52%	42%	45%	41%	38%	34%
Nurses	27%	24%	28%	27%	20%	22%	37%
Dietitians	11%	9%	8%	13%	14%	16%	6%
Administrators	1%	2%	5%	2%	1%	5%	2%
Patients	<1%	0	<1%	0	0	0	0
Technicians (formerly in "other" category)	-----	-----	-----	12%	22%	12%	18%
Other (Pharmacist(s) or <i>Non-specified attendees who completed a form, but left the category for their discipline blank</i>)	<1%	11%	14%	0	1%	5%	5%

Key Findings:

- Over 98% of respondents indicated that the Network staff responded promptly and were able to provide specific documents and respond to questions.
- Over 94% of respondents felt the Network was a resource for quality related topics or patient/staff issues.
- Over 94% of respondents felt the Network was a resource for statistical and ESRD related regulations.
- Over 70% of respondents had used the Decreasing Patient Provider Conflict toolkit.
- Over 96% of respondents felt the Network was a resource for dealing with disruptive patients.
- Over 86% of respondents found the Network website useful.

Network of New England Technician Educational Meetings: “The Importance of Dialysis Technicians in Caring for ESRD Patients”

During April 2011, Network 1 hosted 2 educational meetings, one in Portsmouth, NH and one in Sturbridge, MA. The purpose of the meetings was to discuss clinical issues related to the care of ESRD patients. The program was approved for 5.4 contact hours through the National Association of Nephrology Technicians/Technologists (NANT). A total of 219 technicians attended. The topics discussed were:

- “There is No “T” in Team, but There is a “T”
- Vascular Access: The Patient’s Life Line: Assessment, Complications and Interventions”
- Handling Anger in the Dialysis Unit”

- “Diabetes: A Growing Problem in the United States and in the Dialysis Unit”
- “Challenges and Strategies in Infection Control”
- “The Principles of Kidney Transplant Surgery”

An optional survey sheet was also completed by the technicians with a 90% response rate (Table S).

Table M: The Network of New England Technician Meeting Customer Evaluations:

Question	2010		2011		
	Yes	No	Yes	No	Did Not Use
Was the information presented useful to your daily work:	100%	-	98%	2%	NA
Were the speakers well organized, prepared and easy to follow?	100%	-	97%	3%	NA
Was the sign-up and payment process efficient?	100%	-	86%	6%	8%
Would you attend another meeting like this next year?	98%	2%	98%	2%	NA

When asked “what were the two most important things you learned today?” 69% responded how to deal with anger management and understanding more about kidney transplants. Twenty-four percent (24%) said a better understanding of vascular access and diabetes. Seven percent (7%) said the importance of infection control and awareness of bundling.

Overall, for educational meetings Table S depicts the number of providers that were represented at these meetings during 2010/2011. Eighty-nine percent (89%) of the Network 1 providers were represented with a range of 1-16 professionals from each facility.

**Table N: Dialysis Providers Represented at Network of New England Educational Meetings 2010/2011
Range of Attendees 1-16**

State	Total Providers 2010	Total Providers 2011	Annual Meeting		Technician – 2 Meetings	
			Providers Represented 2010	Providers Represented 2011	Providers Represented 2010	Providers Represented 2011
CT	39	43	36	37	17	17
ME	19	18	14	16	14	13
MA	75	75	64	66	37	48
NH	11	11	10	10	8	7
RI	15	17	12	16	7	7
VT	8	8	6	8	8	5
TOTAL	167	172	142	153	91	97

Emergency Preparedness

ESRD is a life threatening condition that affected 12,670 dialysis patients (hemodialysis and peritoneal) and approximately 9,103 patients who had a functioning kidney transplant in the New England region in 2011, all of which necessitate unique emergency needs in the event of a major disaster. ESRD patients require either medications to prevent rejection of a transplanted kidney, or regular kidney dialysis treatments to clean their blood of toxins as frequently as three to four times a week. Missing even a few dialysis treatments (2-3 days) can result in severe complications or even death.

The availability of community resources vary depending on the type of emergency encountered, and must be considered in any disaster planning. Subsequent to past national disasters, dialysis facilities, transplant centers, patients and professional organizations, and other strategic partners involved in kidney disease recognized the need to improve planning and preparedness for major emergencies. As a result of this need, the Network of New England developed an emergency and pandemic work plan to ensure emergency operations support and coordination of activities in the event of a disaster, and to assist ESRD facilities in the Network 1 area in the development or improvement of its provider-specific emergency preparedness plan for its facility and patients.

- ***Network Business Continuity and Contingency Plan***

Network of New England maintains a Business Continuity and Contingency Plan (BCCP) document, as required by CMS. This document lists roles and responsibilities for staff at times of emergencies to the Network of New England's physical site and information technology infrastructure. As stated in the BCCP, Network 9 (The Renal Network, Inc.) and Network 1 (Network of New England) will provide reciprocating back-up services in the event of an emergency, assuming responsibilities when, and if, Network staff are unable to perform their duties. The BCCP is annually reviewed, updated and shared with Network staff and Network 9. As required by the contract, the BCCP is submitted to CMS Project Officer.

- ***Kidney Community Emergency Response (KCER) Coalition***

In January 2006, CMS coordinated a National Disaster Summit to develop and coordinate disaster response in the ESRD community, to plan for the future, and to initiate the formation of a national coalition, "Kidney Community Emergency Response Coalition" (KCER) www.KCERcoalition.com. KCER is comprised of representatives from the renal community (patient and professional organizations, practitioners, ESRD Networks, large dialysis organizations, independent dialysis and transplant facilities, suppliers, and state survey and certification and emergency representatives, as well as CMS, FDA, CDC, and other Federal agencies), and an administrative core group from Network 7. Eight workgroups have been developed to work on individual parts of the overall plan (Patient Assistance, Communication, Facility and Patient Tracking, Federal Response, Facility Operations and Industry Supplies and Services, Coordination of Staff and Volunteers, Physician Placement and Assistance, and Pandemic Preparedness). In addition to being a KCER Steering Committee member, the Network Community Development Coordinator serves on two of the eight response teams – Facility Operations and Pandemic Preparedness - participating in periodic conference calls, development of resource tools, mock drills and disaster assistance.

Donate Life Connecticut

Donate Life Connecticut (DLC) is a statewide coalition of volunteer agencies and individuals with shared interest in public education about organ and tissue donation, and increasing the number of transplanted organs and tissues, which give new life and hope to people suffering from a fatal illness or life threatening injury. This coalition is a non-profit corporation, with a 501(c)(3) tax exempt status. Activities are coordinated by the Director, with support from the Board of Directors, volunteers and agency members contributing time and in-kind resources. The Board of Directors meets face-to-face bi-monthly at the Connecticut Hospital Association. An Annual Meeting for general membership is held in November. The Network Executive Director serves as an officer on the Board of Directors in the capacity of Treasurer. The Network Community Development Coordinator also serves as a Board member.

In 2011 several activities and projects were successfully completed and participated in by Network of New England staff through its collaboration with Donate Life Connecticut, including:

- Growing the partnership with the Connecticut Department of Motor Vehicles (DMV). Each branch of the DMV had at least one DLC volunteer visit monthly to appreciate and encourage employees' efforts to ask 'every customer, every time' if they would be interested in joining the State Donor Registry. Customized Donate Life Connecticut inserts are included in every license renewal form mailed from the DMV, which highlights a local story featuring five year old Aaron of Seymour. Aaron received a heart transplant in 2007.
- Sponsoring the 2nd Annual Volunteer Workshop through Transplant Speaker's International for 39 DLC volunteers to improve their public speaking skills when taking about the importance of organ and tissue donation. The half-day workshop taught volunteers how to better communicate personal donation and transplantation stories to best impact and educate the public.
- Hosting the 21st Annual High School Poster Contest. Each year, DLC invites all Connecticut high school students to submit artwork (free-hand or digital) illustrating the life-saving benefits of organ and tissue donation. This contest is often coupled with in-class educational presentations with volunteers sharing their personal experiences. The goal is to introduce the topic of donation to teens and encourage discussions with their families. Awards were presented to 24 students, selected out of over 200 posters submitted, at the Annual Donate Life Month Celebration at the Connecticut State Capitol in April.
- Recruiting 64 towns across Connecticut to join the national initiative *Flags Across America* that honors local donors who chose to give the 'gift of life', celebrates the lives saved through donation and brings awareness about the numerous people still waiting. Donate Life flags raised remind citizens of the importance of organ and tissue donation.
- Honoring ICU nurses with the 'Thanks for Asking / Caring Campaigns.
- Hosting the 3rd Annual 'Toast to Life' fundraising event at Gouveia Vineyards in June. The sold out event was attended by 200 Donate Life supporters, raising over \$24,000. Special awards were presented to transplant surgeons who have championed DLC's mission: Dr. Sukru Emre (Yale-New Haven Hospital) and Dr. David Hull (Hartford Hospital). The event was emceed by Channel 8 news anchor, Kristen Cusato.
- Fundraising as an official charity of the 2011 Hartford ING Marathon (half, relay and 5K). DLC provided 39 volunteers for the marathon to help organize the start of the race! In addition, DLC had 28 runners and raised more than \$8,000.

Donor Designation Collaborative

The Network 1 Community Development Coordinator continues to serve as a representative of Network of New England, by participating in the National Donate Life America's Donor Designation Collaborative to help increase the number of actionable donor designations in New England. The focus of this collaborative effort is built on the successful use of the "Model for Improvement". The Donor Designation Collaborative is designed to assist regional and state-based teams in founding (establishing), fixing (improving), or filling (promoting) donor registries and tracking progress towards state and national donor designation goals. The Donor Designation Collaborative identifies and spreads best practices in the areas of measurement and analysis, effective partnerships and relationships, registry development, management and promotion, and to apply proven methods for organizational change and improvement. Through bi-monthly conference calls and various local activities, the New England team has planned, designed, tested and implemented measureable changes in its respective states.

Forum of ESRD Networks

Network Executive Director and the Network 1 past chair and Network Grievance Chair currently serve on the Forum Board of Directors. During 2011, the Forum as a voting member of the National Quality Forum has commented and voted on clinical measures of importance to ESRD patients. This organization is also a member of the Kidney Care Quality Alliance. The Forum has communicated with CMS/QCSQ leadership on topics related to Networks such as National CKD Priorities, Quality Incentive Program and CROWNWeb.

State Survey Agencies

Network 1 maintains a registry of state ESRD surveyors in all six New England states. Each year resource material on ESRD data and Network 1 activities are shared with the state surveyors. Consultation and information sharing on provider performance and policy issues are provided as requested. Monthly structured conference calls with the six states are held with an agenda to share emerging issues and potential barriers to proper deployment for regulations. More frequent requests from state surveyors seeking background information prior to provider site visits are taking place.

Quality Improvement Organizations (QIO's)

In New England there are four QIOs that cover the six states. These organizations hold CMS Medicare contracts to address quality of care in several clinical settings (hospitals, nursing homes and professional offices). The Network has a working relationship with each QIO in this region. Network 1 staff has given articles and presentations to QIO clients in different settings.

National Kidney Foundation Affiliates (NKF)

There is one NKF affiliate in New England. During 2011, the National Kidney Foundation has instituted a new organizational structure. Connecticut NKF has retained their local office and staff. The New England NKF office is located in Norwood, MA. The Network receives inquires from NKF staff and referrals related to patient complaints.

Network of New England Website

The usability and usefulness of information on an organization's website is only good if the site is content rich and easily navigated. The Internet has become an essential part of all comprehensive communications systems for organizations seeking two-way access to their target audience. All Networks are urged to maintain a website as an important way to provide community outreach and an educational resource. The Network of New England continues to make strides in reorganizing their website to allow for greater accessibility and downloading of data. Periodic updates and improvements to the site are done internally, with the aid of technological advancements and trained staff.

Since 2007, the Network of New England has maintained a website that meets government 508 compliance regulations*. Throughout 2011, the Network site continued to be enhanced with new postings, useful links and by providing informative downloads in the following areas:

- About Us
- Annual Report
- Community Partnerships
- Conditions for Coverage
- CROWNWeb
- Data Reporting
- Dialysis Facility Compare (DFC)
- Emergency Preparedness
- ESRD Networks
- ESRD Quality Incentive Program
- Fistula First
- Grievance Policy
- Immunizations
- Infections
- Kidney Chronicles Patient Newsletter
- Network Goals
- Network Meeting Information
- Network Notes Professional Newsletter
- Network Staff Directory
- Patient Advisory Committee
- Patient Safety (5 Diamond Program)
- Patient Services and Community
- Quality Improvement
- Recall Alerts
- Statistical Highlights
- Vocational Rehabilitation
- What's New

* *Section 508, an amendment to the United States Workforce Rehabilitation Act of 1973, is a federal law mandating that all electronic and information technology developed, procured, maintained, or used by the federal government be accessible to people with disabilities.*

Network Publication

The Network, in partnership with representatives from St. Raphael's Hospital New Haven, CT, published in the Advances in Peritoneal Dialysis Volume 26, 2011 "Trends in Chronic Peritoneal Dialysis Utilization in New England."

Network 1 Collaborative with Donated Dental Services

Since January 2010, The Network of New England has facilitated referrals to Donated Dental Services (DDS) which assists renal patients with severe dental problems. According to the Founder, DDS is a national humanitarian initiative through which 14,000 volunteer dentists assisted by 2,800

laboratories have contributed \$150 million in comprehensive therapies to 90,000 needy disabled, elderly, and medically compromised individuals in the United States.

This program is a helpful resource for patients who have exhausted every other financial option seeking needed assistance for dental work. Only the most severe patient cases are considered for these services.

The Network has collaborated with DDS to serve as a “middle man” to help the patients needing essential dental care services. The Network notified all the ESRD clinics and transplant facilities in all six states of this program by several mailings of the application and the medical triage forms. The Network does not choose which applications will be submitted to this program. The Network coordinates the application process. When the applications from the facilities are submitted, they are coded and sent to the appropriate address by state. The Network staff received many calls from providers who had questions about the Donated Dental Service and who wanted applications and the medical triage form. During 2010, 38 referral applications were submitted to DDS.

Achieving Network 1 Goals in Collaboration with Other Organizations

Partnerships with ESRD providers and renal professionals have taken many shapes during the past 34 years of this Network. The Patient Advisory Committee is now 13 years old and many of its members serve on different Network 1 committees. The PAC advice and viewpoint is always valued. The Connecticut Coalition of Organ and Tissue Donation (Donate Life) is 26 years in existence. The addition of a part-time program manager for Donate Life has greatly enhanced the activities and accomplishments of Donate Life Connecticut. The Network 1 annual meeting, technician meeting, professional and patient newsletter have become a regional tradition. Emergency coordination and regional planning continues to require identification of new partners for updating an effective emergency response and coordination plan. The continued deployment of a new service for patients to receive donated dental care has been helpful in getting patients on transplant waiting lists.

E. IMPROVE THE COLLECTION, RELIABILITY, TIMELINESS, AND USE OF DATA TO MEASURE PROCESSES OF CARE AND OUTCOMES; MAINTAIN PATIENT REGISTRY; AND TO SUPPORT THE ESRD NETWORK PROGRAM

Information Management

Background:

Centers for Medicare and Medicaid Services (CMS) is charged with the effective administration of Medicare benefits to eligible persons with ESRD. Integral to the effective management of the ESRD program is the operation of a comprehensive data system covering medical and demographic information for the ESRD population. In 1978, the Department of Health and Human Services established the Program Management and Medical Information Systems (PMMIS) as a repository of Medicare ESRD beneficiary information. This system, as required by public law 95-292, section (c) (1) (A), is designed to serve the needs of the Department of Health and Human Services in support of ESRD program analysis, policy development, and epidemiological research. Currently it is accessed through Renal Management Information System (REMIS).

CMS standardized the collection, storage, and reporting of patient registry data by ESRD Network Organizations by establishing the Standard Information Management System (SIMS). Data from individual Network Organization's SIMS database is replicated on a nightly basis to Central SIMS. Reliable linkages were built between REMIS and SIMS system, allowing data matching based on the unique patient identification number. REMIS connects with other ESRD registry components such as the Social Security Administration's Master Beneficiary Record, Medicare Enrollment and entitlement database and National Medicare claims databases. REMIS is used to determine Medicare coverage periods for ESRD patients and serves as the primary mechanism to track the ESRD patient population for both Medicare and non-Medicare patients.

– System Architecture:

IT Infrastructure: CMS provides computers and a standard desk top image for Network Organizations. This IT infrastructure provides security required to protect confidential information according to Federal Information Systems Security Guidelines that CMS and its contractors have to follow.

Security: System security and data security are high priority for CMS and Network Organizations. Networks have to comply with Federal Information Systems Security Guidelines for security of the physical access and data access. This includes having policies and procedures for security. Network of New England developed a security statement and posted it on Network website. All security breaches are tracked and education provided to the person responsible for the breach. All Network staff complete annual security awareness training.

Network Role in Maintaining ESRD data

Currently SIMS is the authoritative source for CMS forms 2728, 2746, 2744, and patient event/status information. The accuracy and completeness of the patient data and patient status in SIMS is of great importance. The SIMS database is the central source database for the Networks to use in performing all of their quality of care and oversight activities. CROWNWeb will replace SIMS in 2012 (see below for information on CROWNWeb).

– Patient Registry

The Network of New England collects, maintains, validates and analyzes the end stage renal disease (ESRD) patient data for individuals receiving ESRD services in the six New England states as mandated by the Social Security Act. The purpose of maintaining the patient registry is to ensure a patient's renal medical condition has reached end stage and to register all ESRD patients (Medicare and Non-Medicare) with the National Renal Registry as mandated by law. The first step in the process of registering a patient as ESRD is to submit a Medical Evidence form (CMS Form 2728-U4) by the dialysis or transplant facility. Network 1 staff enters the information on the 2728 form in to SIMS database using SIMS software program. Providers also submit a death notification form (CMS Form 2746) when a patient dies. All the required forms and educational material to submit those forms were posted to Network of New England website at <http://www.networkofnewengland.org/dataforms.htm>. In 2011 the number of 2728 forms processed was 3939 (including supplemental forms), the number of 2746 forms processed was 2732.

– Updating Status of Medicare ESRD Beneficiaries:

The Network staff track change of treatment, provider and modality for each patient through reporting of events in SIMS. Each provider submits event changes through a reporting tool called Monthly Patient Activity Report (MPAR) on a monthly basis. The events for change of treatment provider can be transfer-in, transfer-out or transplant and events of different treatment setting can be a change to home dialysis from in-center hemodialysis. Annually, all ESRD providers submit the year-end CMS Facility Survey Form (CMS 2744) reconciling all the patients at the facility as of December 31st. The number of events processed in 2011 is 14, 441.

– Verification of Patient Data:

The patient data is also verified through the process of accretions and notifications that are received from CMS. Accretions are ESRD patients that do not exist in SIMS database but are known to CMS through other related data systems. Notifications are mismatches in data elements in SIMS database for existing patients with other renal related data systems including Social Security Administration database. These mismatches could be due to reporting or data entry errors in different data systems. Network staff verify accretions and notifications with the facilities or REMIS and either rejects or accepts the changes to data elements. In 2011 the Network processed 6,074 notifications. REMIS alerts are discrepancies in the patient entitlement status. When CMS is unable to resolve a patient's status a request for clarification is sent to the Network staff to verify and correct these discrepancies. Data processing, validation, compliance monitoring and data verification are daily activities conducted by Network data staff.

– Provider and Personnel Database

The Network of New England maintains a provider database in its SIMS database. This information is updated when the Department of Public Health from various states inform the Network of certification of a new facility or ownership updates, or changes in services provided for existing facilities. Providers update personnel names and position information on an annual basis.

The current and active provider information maintained in SIMS database is uploaded by CMS to maintain demographic information on providers listed on CMS's Dialysis Facility Compare (DFC) website <http://www.medicare.gov/Dialysis>.

The Network also maintains facility personnel information in its SIMS database. This information is used to communicate with the facility personnel as well as to distribute educational materials. The Network staff communicates with facilities via regular mail and also uses email and fax to broadcast important alerts and emergency information.

Quality Assurance of Patient Data

The primary function of the Network of New England is to identify opportunities to improve health care related quality and appropriateness of ESRD patient care. The basis for objective and informed decisions about quality of patient care is reliable patient data. Network 1 not only obtains and maintains the ESRD patient information as described above but also verifies the data for completeness and accuracy. The completeness and accuracy of the data in the SIMS database is maintained due to the cooperation and dialogue between the Network data staff and the staff of each dialysis and transplant program in New England. Network of New England provides reports such as missing data-element or reject reports and missing forms reports to facilities. This process allows the facilities to update missing data and submit missing forms. Biannually, Network of New England provides required forms submission compliance reports to the facilities. Facilities are expected to maintain more than 90% compliance in forms submission. Table O shows the comparative number of facilities that met CMS compliance goal annually. Several tools are provided to facilities to maintain 90% compliance as shown in the data packet manual posted to Network Website at:

http://www.networkofnewengland.org/InformationManagement/Data_Packet_Manual.pdf.

Table O: Facility Forms Submission Compliance 2008 - 2011

	Annual compliance below 90%			
	Jan – Dec			
	2008	2009	2010	2011
# Facilities	30	15	21	21

In 1994, the United Network for Organ Sharing (UNOS) and the Centers for Medicare & Medicaid Services developed a process of reporting transplantation events to the National Renal Registry. The Network of New England receives kidney transplant updates from UNOS. The data received from UNOS is compared and validated with the data submitted by transplant facilities in the New

England states. Transplant data validation and compliance reporting is still the responsibility of the Network. On a quarterly basis the Network notifies the transplant centers of delinquent registration and follow up forms that need to be submitted to UNOS. In 2011, transplant centers were delinquent with three transplant related forms. The Network staff also processes the data submitted by Veteran's Health Administration (VHA) facilities as there is an agreement between VHA and CMS for this activity.

– **VISION Generated 2728 Forms Validation**

When Network 1 receives VISION data electronically, it is directly imported into the SIMS database. Also Network 1 extracts data from CROWNWeb submitted by pilot facilities and enters in to SIMS for facilities involved in Phased implementation of CROWNWeb. The 2728 forms imported via VISION or extracted from CROWNWeb do not have physician or patient's signatures. The facilities are required to generate the form after it is completed in VISION / CROWNWeb and obtain both patient's and physician's signature in blue ink. The person submitting the form via VISION / CROWNWeb verifies the signatures and enters the dates of the signatures in VISION / CROWNWeb. This necessitates the validation of the forms submitted using VISION / CROWNWeb for signatures of both physician and patient and the dates of those signatures. In order to perform validation of forms, 3% of the total forms were randomly selected and validated. The following are the results of the verification process.

a. Number of forms imported from VISION or CROWNWeb for 2011.	508
b. Total number of forms requested from VISION or CROWNWeb facilities.	15
c. Total number of forms received from VISION or CROWNWeb facilities.	15
d. Total percent of forms validated from VISION or CROWNWeb facilities.	100%

– **DATA SYSTEMS:**

All ESRD Networks rely on several data sources to fulfill their CMS contractual obligations for conducting quality improvement projects, providing technical assistance to ESRD providers and professionals, and responding to patient inquiries. These data systems are maintained and developed by CMS contractors. The following summaries briefly describe the scope and type of data available to ESRD Networks and CMS in each system.

– **VISION:**

The Vital Information System to Improve Outcomes in Nephrology (VISION) is a program that supports electronic data entry and storage of patient information at the facility level. Using this software, facilities can encrypt the data and transmit directly to their respective Networks via a secure, Web-enabled environment called "QualityNet Exchange". This program is going to become obsolete once CROWNWeb is implemented. Networks currently download VISION data from Qualitynet (see below) and import it into SIMS.

– **SIMS:**

The ESRD Standard Information Management System (SIMS) is a program that allows the data entry, storage and retrieval of the patient data by each Network. It also supports the business processes of the ESRD Network such as maintaining provider information and personnel information. This program is going to become obsolete once CROWNWeb (see below) is implemented. Several contractors use SIMS data to provide required program management reports to CMS.

– **Central-SIMS:**

The Central ESRD Standard Information Management System is a repository that holds patient and provider data from all ESRD Network Organizations. Data from individual Network SIMS server is replicated nightly to the SIMS central repository.

– **REMIS:**

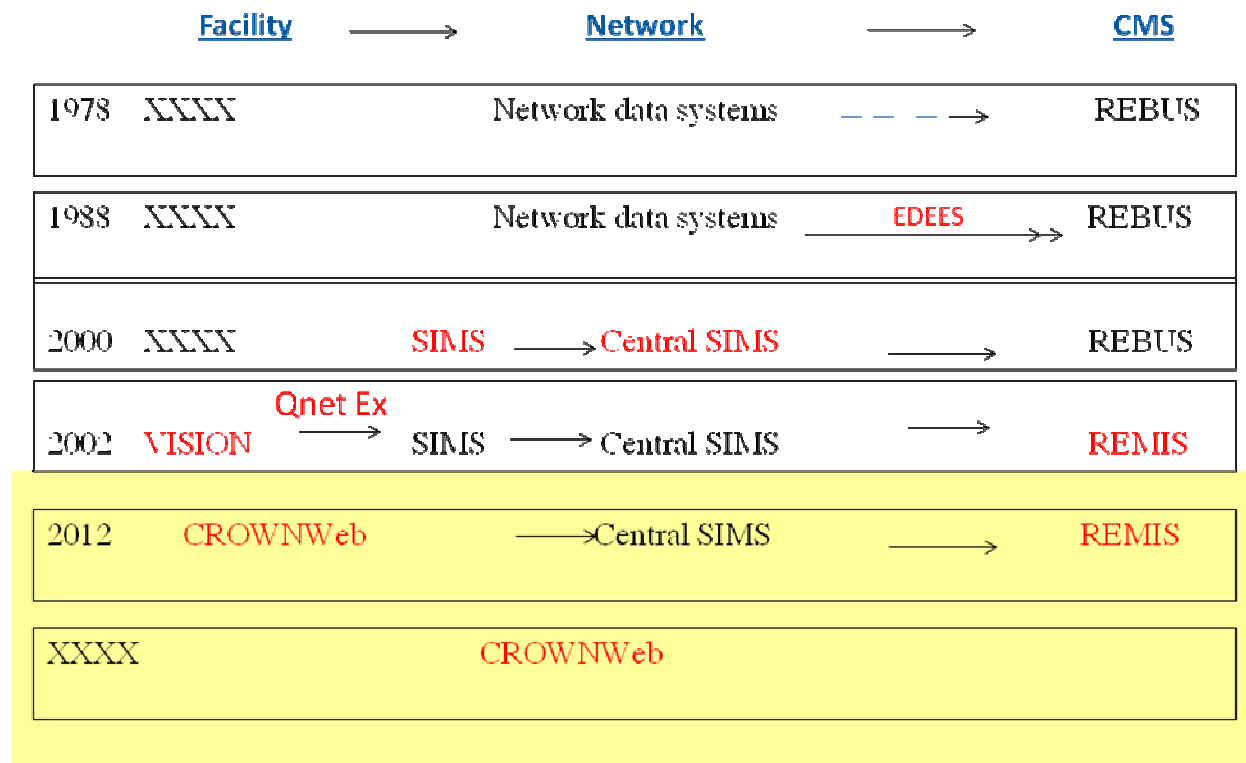
The Renal Management Information System which determines the Medicare coverage periods for ESRD patients and serves as the primary mechanism to store and access ESRD patient and facility information in the ESRD Program Management and Medical Information System Database. REMIS includes an operational interface to the SIMS Central Repository; and it interacts with Enrollment, Medicare entitlement, National Medicare claims and Social Security Administration databases. REMIS acts as renal registry as both Medicare and Non-Medicare ESRD patient’s information is maintained in REMIS.

– **QualityNet Exchange:**

QNet Exchange provides a secure web site for electronic transmission of confidential data. Dialysis facilities, Network Organizations and CMS contractors use Qualitynet to exchange confidential data.

Below, Figure 18 indicates the changes in data flow from facility to CMS and different systems used in the process from 1978.

Figure 18



– **REMEDY:**

Remedy is an inventory management system. Networks are required to purchase and use CMS approved software and hardware for conducting their business using REMEDY and to maintain their inventory. REMEDY also tracks help desk tickets.

– **National Help Desk for ESRD CROWN System:**

In order to support the use of VISION, SIMS, Qualitynet, REMIS, CROWNWeb and Qualitynet Identity Management System (QIMS) by Network Organizations, CMS has provided Help Desk support via Qnet Help Desk. Networks and facilities can request help and direction in using the above systems.

– **Electronic Laboratory Data Collection Project**

Through the Electronic Laboratory Data Collection (Elab) Project, the ESRD Network Program collects laboratory data from independent dialysis facilities and Large Dialysis Organizations (LDO's) to produce facility-specific reports. This allows comparisons of dialysis facilities to each other, the state, Network and National. The LDOs submit data electronically to a CMS contractor. CMS Contractor then forwards the data to Network 11 to be compiled. Independent dialysis facilities voluntarily submit patient-specific data files to the Networks for data entry by Network staff. Maintaining confidentiality, the Networks send these data to Network 11. Network 11 compiles data from LDOs and independent dialysis facilities to generate facility-specific reports that are returned to the Networks for distribution to providers. This process allows for both provider-specific reports and Network trending reports for specific clinical indicators and helps Network Medical Review Boards improve patient outcomes through focused quality improvement initiatives.

– **Fistula First Initiative**

In 2003, the LDOs began submitting aggregate provider level vascular access data electronically to CMS. Independent, hospital-based, and Veterans Health Administration dialysis clinics submit their aggregate vascular access data to the Networks. The data from both sources are compiled on a monthly basis by a CMS contractor. Each Network is able to create standardized feedback reports for all providers participating in the Fistula First Initiative and provide status report on a quarterly basis. CMS produces a monthly Fistula First Outcomes Dashboard, which depicts each Network's progress in increasing arteriovenous fistula (AVF) placement rates as well as Network- and national level data. For further information on dashboard please visit <http://www.esrdncc.org/index/fistula-first>.

– **United States Renal Data System (USRDS):** USRDS required by law to analyze information about ESRD in the United States on an annual basis. The USRDS Coordinating Center produces an Annual Data Report (ADR) on ESRD in the United States, fulfills data requests, provides standard analysis files and specialized datasets to researchers, and presents the results of its research at national conferences and in peer-reviewed journals. For further information please visit <http://www.usrds.org/>

– **Dialysis Facility Specific Reports:** Provider-specific data reports are generated annually based on data from Medicare dialysis hospitalization claims, Medical Evidence Reports (CMS-2728), Death Notification Forms (CMS-2746), Annual Facility Survey Reports (CMS-2744), and other events data from SIMS. The University of Michigan Kidney Epidemiology and Cost Center UM-KECC

conducts statistical analyses of the information provided in these reports with funding from CMS. Beginning 2010, Dialysis Facility Reports (DFR) is distributed via web-based only. Dialysis facilities accessed their report via secure Web site www.DialysisReports.org which is administered by [Arbor Research Collaborative for Health](#) and the University of Michigan [Kidney Epidemiology and Cost Center \(KECC\)](#). These reports facilitate comparisons of patient characteristics, treatment patterns, transplantation rates, hospitalization rates, and mortality rates to local and national averages. For further information please see <http://www.dialysisreports.org>. KECC also provides dialysis facility specific quality scores for pay for performance.

– **Dialysis Facility Compare**

CMS is committed to providing consumers with information to empower them to make more informed decisions regarding their health care. The Dialysis Facility Compare (DFC) on www.medicare.gov allows consumers to review and compare facility characteristics and quality information on all Medicare approved dialysis facilities in the United States. This information can help consumers, especially dialysis patients, choose a dialysis facility that meets their needs and/or stimulate patients to discuss this information with their dialysis care giver. Another goal of the website is to drive quality improvement efforts by the dialysis facilities by publicly reporting facility-specific information. For information on Dialysis Facility Compare, please go to <http://www.medicare.gov/Dialysis/Home.asp>

– **United Network for Organ Sharing**

The United Network for Organ Sharing (UNOS) is a nonprofit scientific and educational organization funded by CMS contract that administers the nation's only Organ Procurement and Transplantation Network (OPTN). UNOS facilitates the organ matching and organ placement process including kidney transplants. UNOS also collects and manages data about every transplant event occurring in the United States and brings together medical professionals, transplant recipients, and donor families to develop organ transplantation policy. For further information please visit <http://www.unos.org/>

Information Management Support for Quality Management Reports

Several reports required for quality management are run using data from SIMS, Lab data collection, and vascular access data. Based on the data fields related to vascular access on 2728 form, Network of New England generates reports specific to nephrologists' and provider. These report cards are also sent to providers on a half yearly and yearly basis.

Information Management Support for Administrative Reports

SIMS has the capability to generate reports that allow the Networks to conduct internal data audit functions. All data tables in this annual report are generated from SIMS. This report generation process produces standardized information across all Networks.

Information Management Support for Patient Services

Contacts utility was created to track professional and patient contacts received by the Networks in preparation for CROWNWeb implementation. These contacts are classified as grievances, complaints, facility concerns, facility enquiries and data management related contacts. There are different areas of concern under these different classes of contacts that are also captured in contacts utility. Reports can be generated on the contacts received and are used for quality improvement purposes.

Information Management Support for Provider Education

– Statistical Summary Booklet

Annually, the Network of New England publishes the statistical highlights report containing data by each state and was posted on the Network of New England's website <http://www.networkofnewengland.org/statis.htm>. This report has comparative data from 1989. It illustrates trends in incident and prevalent patients and analysis of the patient characteristics. Statistical analysis such as crude mortality rates, trends in transplantations are included in this statistical summary.

– Facility Directory

Once a year, the Network of New England prepares a facility directory that contains administrative information on all the facilities in the New England area. This booklet contains information such as the address, telephone and fax numbers of the facility, key staff positions, and types of services provided. This directory is distributed to all the providers in New England states. This information has been a useful tool for providers and hospitals in the placement of patients and in patient referrals.

– Information for New Facility / Data Packet / QI Packet

Network 1 provides a new facility packet, which contains information on federal ESRD regulations, QI material as well as information on how to submit required data to the Network. A data packet was developed that accompanies the new facility packet. This data packet contains several educational tools for providers to complete and submit required data to Network 1 as well as CMS manual "Instruction Manual for Renal Providers" that was updated by Network of New England. This information was posted to Network Web site at:

<http://www.networkofnewengland.org/InformationManagement/Data Packet Manual.pdf>

A CROWNWeb data packet and a QI data packet were developed to be included in the new facility kit. These tools provide information regarding data submission requirements as well as how the data is used for CMS reports.

– Information for New Patient Packets

CMS, via Network Coordinating Center, mails informational materials to all new ESRD patients. The patient's addresses are obtained from Networks' SIMS databases on a monthly basis. Any mailings that are returned are held in a central place until each Network investigates the reasons as to why the materials did not reach the intended party. Network 1 monitors the monthly return rate

as part of its internal quality control activities. Network 1 consistently stayed below a 10% return rate this past year.

– **Technical Assistance**

Technical assistance provided by the information management consists of data processing related request from providers. These are data related information, requests for technical assistance, request for forms such as ESRD Medical Evidence form and data requests such as patient count by zip code.

– **Data Requests**

Throughout the year, the Network 1 staff responds to written data requests for special data analysis from facility personnel, researchers, corporations, managed care organizations, State Health Departments and health care consultants. Data that are released comply with CMS contractual requirements and HIPAA regulations to protect patient and facility confidentiality.

– **Disaster Preparedness and Business Continuity and Contingency Plan (BCCP)**

In order to prepare for disasters such as hurricane Katrina, CMS required each Network to outline its disaster preparedness plans in the form of a document called Business Continuity and Contingency Plan. This document requires the Network to outline the roles and responsibilities of its staff, and the CMS contractors who are in-charge of maintaining Network IT infrastructure. A copy of the plan is sent each year to the backup Network, Network 10. The plan allows for the prevention, assessment, and recovery operations in case of disasters and contains contact information. A copy of the plan and a set of back up data tapes are kept off site. This plan also allows for maintenance of Network 1 oversight as well as provision for assistance to dialysis facilities during disasters.

– **Development and Testing of ESRD Data and Data Systems**

Network of New England staff reviewed and provided comments on the ESRD Kidney Data Dictionary definitions, data management constraints, on the business requirements and file specifications for the batch transmission of ESRD data. Network staff also participated in testing ESRD CROWNWeb.

– **Task Groups and Committees**

The Network 1 staff participates in task groups, committees, and beta testing of software before release. These committees meet by conference calls on a regular basis. The intent is to engage the end users of the software in the establishment of the business rules that are used in the software development as well as to standardize the policies across all 18 Networks. One of the major quality improvement activities conducted in the past few years, the National Vascular Access Improvement Initiative, has several committees in which the Network staff are involved. One of the new major initiatives, CROWNWeb, the Network 1 staff are involved in many committees to create a Web based ESRD data system. In 2011 Network 1 was involved in several CROWNWeb related committees including batch submission error task group.

CROWNWeb

According to ESRD conditions for coverage of ESRD facilities, dialysis facility must furnish ESRD data and information to CMS for Program Administration. This includes forms 2728 and 2746 that allow for the coverage of benefits, treatment and modality events that allow for the adjustment of benefits coverage. CMS is working with several contractors and the Network Organizations to build the CROWNWeb system, which will facilitate the collection and maintenance of information directly from ESRD facilities using a web based system. CROWNWeb will also require facilities to enter clinical data on all dialysis patients and report administrative information on facility personnel and dialysis services. CROWNWeb system is accessed by CMS, the Networks, and facility users, with role-based access.

Initially, VISON and Network SIMS data bases will be replaced with CROWNWeb when CROWNWeb is fully implemented. CROWNWeb will be implemented in a phased manner. The first phase was rolled out in Feb of 2009 that consists of four Networks and eight dialysis facilities. Phase II of CROWNWeb consisted of all Networks and 10 facilities in each Network area and was implemented in July of 2009. In 2011, the Network was involved in Phase IIE of CROWNWeb. After the national release of CROWNWeb, using CROWNWeb for data submission will be a requirement for ESRD facilities under the ESRD Conditions for Coverage. Network of New England enrolled providers to participate in Phase IIE of CROWNWeb. Twenty six providers were enrolled in Phase IIE of CROWNWeb deployment, half of those facilities belonging to large dialysis organizations. Other tasks conducted were to help providers for data entry, obtaining data from CROWNWeb to enter in SIMS to reduce data submission burden on the facilities, submitting monthly deliverables to CMS.

Access CROWNWeb

QualityNet Identity Management System (QIMS) account form has to be completed in order to access CROWNWeb. CMS rolled out QIMS in Dec 2011, initially opened for dialysis facilities that are involved in CROWNWeb pilot. The Network of New England must ensure that all facilities have End User Manager (EUM), Security Official (SO) and End User (EU) as required by the new QIMS process before the national release of CROWNWeb

Delegation of Authority Form

Dialysis facilities that are affiliated with large dialysis organizations such as DaVita, DCI and FMC should complete a CMS-10268, Delegation of Authority Form to allow for CROWNWeb Batch Data Submission.



Project CROWNWeb

CMS has offered QIMS/CROWNWeb on line training courses to dialysis facilities. Several self paced and WebEx training modules are posted to this Web site <http://www.projectcrownweb.org/assets/crownweb>. CROWNWeb training and communications are performed by CMS contractor called Renal Communication, Outreach and Training Contractor (RCT). They provide latest updates to CROWNWeb on the **Project CROWNWeb web site** at <http://www.projectcrownweb.org/crown/index.php>.

Preparation of SIMS Database for Data Import into CROWNWeb for Phase III

In preparation for CROWNWeb Phase III implementation in 2012, data in SIMS was cleaned up in 2011. The Network also provided several recommendations to CMS on data quality as well as suggestions for data processing improvements.

Achieving Network 1 Goals in Data Management

Network 1 successfully met all data related deliverables to CMS for data processing, validation and CMS required forms submission compliance monitoring. Network 1 also achieved its goals in providing support to develop data systems especially CROWNWeb in 2011 by participating in Phase IIE of CROWNWeb deployment. The Network developed several policies and procedures for data management and also conducted several Internal Quality Improvements (IQI) activities to constantly improve internal processes to be more efficient in data management.

IV. SANCTION RECOMMENDATIONS

Public Act 98-369 amends Section 1881(c) of the Social Security Act states; the ESRD Network can recommend to CMS the imposition of an alternative sanction when the Network submits documents that an ESRD provider is not cooperating in achieving Network goals. The Federal Regulations that implement this statute are contained in 42 CFR §405.2181.

The philosophy of Network 1 has always been to foster partnerships and cooperation with ESRD providers to seek collaborative methods to improve patient care. This Network continues to offer technical assistance, quality improvement coaching, and educational venues for professionals to enhance their ESRD knowledge and skill sets. The Network Board of Directors and Medical Review Board review coded comparative provider information to determine patterns of performance in quality and information management. When indicated, Network 1 has conducted focused interventions and performed site visits with the leadership of specific providers. These providers and their Medical Directors have been responsive to addressing the identified areas of concern. In 2011, Network 1 has been more aggressive with their quality improvement agenda by increasing specific provider-level clinical goals for AVF rates. In addition, specific identified providers were given written CMS notice of performance concerns related to their AVF rate. Unique providers with ongoing AVF challenges presented their QI plans for AVF improvement at face-to-face meetings with Medical Review Board representatives. During 2011, no sanctions were recommended to CMS regarding any ESRD providers in this Network region.

V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES

The following concerns were noted in the past two year of this Annual Report. These issues continue to exist.

Challenging Patients

The increasing number of challenging or disruptive patients requires unique staff communication and interpersonal skills. Consideration by CMS of “unique needs” dialysis clinics with additional provider reimbursement, to allow for higher staff-to-patient ratios, would reduce the number of patients experiencing involuntary discharges from dialysis units. This Network once again recommends a pilot project be developed to test the feasibility of this dialysis treatment model. There is the potential cost savings by reducing the number of challenging dialysis patients receiving dialysis in emergency rooms or in hospitals as inpatients.

Acute Outpatient Dialysis

There are a small number of medically stable patients who require a short-term course of dialysis in an outpatient dialysis program, usually requiring less than 3 months of dialysis. The increased pressure from managed care plans and shorter inpatient hospital stays has created this new acute injury patient population. The Network recommends that CMS develop Medicare billing codes for this patient population. Consideration by State Departments of Public Health (DPH) and CMC should address policy issues for these non-chronic ESRD patients requiring short-term outpatient dialysis treatment. The current system limiting Medicare payments for acute outpatient dialysis to hospitals submitting the claims is a complicated process since most of these patients are treated in freestanding dialysis clinics. A stakeholders committee with CMS should be established to seek a more effective, clearer payment process.

Hospital-Based Providers

This Network has observed, during the past few years, a major change in type of ownership of outpatient dialysis facilities with the majority of free standing facilities owned by large dialysis for-profit corporations. Currently, there are only 31 hospital-owned dialysis facilities (18% of all dialysis facilities) in New England (Table P). There are LDO discussions with at least two of these hospitals underway at the end of 2011. These hospital facilities have a unique patient case mix due to complex acuity levels of these patients. The burden of uninsured and patients with complex medical conditions places extra financial and staff pressure to provide dialysis services by hospitals because freestanding providers will not accept these patients. Medicare bundled payment may decrease these dialysis service barriers.

Table P: Dialysis Providers by Ownership 12/31/2011

	National Chain	VA Hospital	Hospital	Independent	Total
CT	40	1	3	0	44
MA	55	1	14	5	75
ME	12	1	5	0	18
NH	11	0	0	1	12
RI	13	1	3	0	17
VT	1	0	6	1	8
Total	132	4	31	7	174
Percent	76%	2%	18%	4%	100%

Note: Percents may not equal 100% due to rounding

Access to ESRD Medicare Benefits Related to Administration of Form 2728

Several years ago, the process of completing the Medical Evidence Form (Form 2728) was changed. This electronic process requires the form to be completed by the ESRD provider. Therefore, patients with long complicated hospitalizations who start a regular course of dialysis while in the hospital will not have Form 2728 initiated. The patient must be discharged or transferred to an outpatient dialysis provider to begin the application process, delaying their access to Medicare ESRD benefits. The launching of CROWNWeb in 2012 will only increase this access barrier for new ESRD patients. This is an unintended complication of electronic technology that CMS should address.

VI. DATA TABLES

The following required data tables are displayed in the format established by CMS.

Table 1: ESRD Incidence

Table 2: ESRD Dialysis Prevalence

Table 3: Dialysis Modality by Self-Care Settings - Home

Table 4: Dialysis Modality by In-Center Settings

Table 5: Renal Transplants by State

Table 6: Renal Transplants by Transplant Type, Age, Race, Gender and Primary Diagnosis

Table 7: Dialysis Deaths

Table 8: Vocational Rehabilitation

TABLE 1: ESRD INCIDENCE

NEWLY DIAGNOSED CHRONIC ESRD PATIENTS (ESRD INCIDENCE)

NEWLY DIAGNOSED CHRONIC ESRD PATIENTS BY STATE OF RESIDENCE,
AGE, RACE, GENDER, AND PRIMARY DIAGNOSIS FOR CALENDAR YEAR 2011

AGE	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
00-04	1	3	0	2	1	0	1	8
05-09	1	3	0	0	0	0	1	5
10-14	0	2	2	0	0	0	0	4
15-19	2	10	1	2	1	0	1	17
20-24	7	9	1	2	3	2	1	25
25-29	9	23	5	1	3	1	2	44
30-34	16	29	3	2	6	1	0	57
35-39	17	51	5	2	4	2	0	81
40-44	39	72	10	8	12	2	1	144
45-49	58	79	22	17	13	6	1	196
50-54	65	131	15	21	19	5	1	257
55-59	84	161	33	27	30	8	2	345
60-64	127	217	34	25	35	14	3	455
65-69	111	204	41	31	39	23	0	449
70-74	96	200	23	33	39	15	3	409
75-79	110	213	37	38	38	13	3	452
80-84	116	212	24	22	39	9	2	424
>=85	72	148	12	22	27	7	2	290
Missing	0	0	0	0	0	0	0	0
Total	931	1,767	268	255	309	108	24	3,662

TABLE 1 CONTINUED

NEWLY DIAGNOSED CHRONIC ESRD PATIENTS (ESRD INCIDENCE)

NEWLY DIAGNOSED CHRONIC ESRD PATIENTS BY STATE OF RESIDENCE,
AGE, RACE, GENDER, AND PRIMARY DIAGNOSIS FOR CALENDAR YEAR 2011

RACE	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
American Indian/ Alaska Native	0	4	1	0	4	0	0	9
Asian	16	75	5	2	5	1	0	104
Black or African American	236	259	6	7	31	2	1	542
More than one race selected	1	10	0	0	0	0	0	11
Native Hawaiian or Other Pacific Islander	5	14	0	0	1	0	0	20
White	673	1,405	256	246	268	105	23	2,976
Missing	0	0	0	0	0	0	0	0
Total	931	1,767	268	255	309	108	24	3,662

GENDER	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Female	380	698	116	99	134	40	9	1,476
Male	551	1,069	152	156	175	68	15	2,186
Missing	0	0	0	0	0	0	0	0
Total	931	1,767	268	255	309	108	24	3,662

DIAGNOSIS	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Cystic Kidney	15	72	10	15	11	2	4	129
Diabetes	379	706	110	103	118	43	3	1,462
Glomerulonephritis	93	168	20	36	30	15	2	364
Hypertension	201	426	66	49	67	23	1	833
Other	177	290	45	41	76	18	12	659
Other Urologic	18	28	7	1	5	3	0	62
Missing	0	0	0	0	0	0	0	0
Unknown	48	77	10	10	2	4	2	153
Total	931	1,767	268	255	309	108	24	3,662

Source of information: Network SIMS database

Date of Preparation: April 2012

Race: The categories are from the CMS-2728 Form.

Diagnosis: Categories are from the CMS-2728. A diagnosis of 'unknown' is ICD-9 code 7999.

This table cannot be compared to the CMS facility survey because the CMS Facility Survey is limited to dialysis patients receiving outpatient services from Medicare approved dialysis facilities.

This table includes 146 patients with transplant therapy as an initial treatment.

This table includes 39 patients receiving treatment at VA facilities.

TABLE 2: ESRD DIALYSIS PREVALENCE

LIVING ESRD DIALYSIS PATIENTS

ALL ACTIVE ESRD DIALYSIS PATIENTS BY STATE OF RESIDENCE, AGE, RACE, GENDER,
AND PRIMARY DIAGNOSIS AS OF DECEMBER 31, 2011

AGE	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
00-04	0	1	0	1	0	0	0	2
05-09	0	2	0	0	0	0	0	2
10-14	4	6	1	0	0	0	1	12
15-19	6	14	1	1	2	0	0	24
20-24	20	33	4	6	12	5	0	80
25-29	47	75	14	11	12	4	0	163
30-34	77	108	16	13	25	5	0	244
35-39	104	159	24	14	31	5	2	339
40-44	177	238	41	27	37	15	1	536
45-49	268	337	54	52	59	25	1	796
50-54	338	470	64	65	78	18	3	1,036
55-59	378	565	98	74	81	40	5	1,241
60-64	460	737	135	95	115	44	9	1,595
65-69	449	708	150	92	109	48	4	1,560
70-74	438	638	122	93	100	51	7	1,449
75-79	390	636	134	82	118	42	6	1,408
80-84	336	577	86	64	109	40	3	1,215
>=85	273	492	57	59	85	26	4	996
Missing	0	0	0	0	0	0	0	0
Total	3,765	5,796	1,001	749	973	368	46	12,698

TABLE 2 CONTINUED

LIVING ESRD DIALYSIS PATIENTS

ALL ACTIVE ESRD DIALYSIS PATIENTS BY STATE OF RESIDENCE, AGE, RACE, GENDER,
AND PRIMARY DIAGNOSIS AS OF DECEMBER 31, 2011

RACE	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
American Indian/ Alaska Native	14	21	6	1	7	0	0	49
Asian	61	244	12	14	33	2	0	366
Black or African American	1,323	1,208	27	25	166	10	8	2,767
More than one race selected	12	46	2	3	10	0	0	73
Native Hawaiian or Other Pacific Islander	18	32	1	2	11	1	0	65
White	2,337	4,245	953	704	746	355	38	9,378
Missing	0	0	0	0	0	0	0	0
Total	3,765	5,796	1,001	749	973	368	46	12,698

GENDER	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Female	1,619	2,420	418	296	423	159	20	5,355
Male	2,146	3,376	583	453	550	209	26	7,343
Missing	0	0	0	0	0	0	0	0
Total	3,765	5,796	1,001	749	973	368	46	12,698

DIAGNOSIS	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Cystic Kidney	120	213	37	29	37	18	5	459
Diabetes	1,515	2,325	435	314	340	156	22	5,107
Glomerulonephritis	489	731	90	86	132	37	5	1,570
Hypertension	834	1,315	215	149	191	66	7	2,777
Other	580	850	150	122	211	53	5	1,971
Other Urologic	76	128	30	16	25	16	1	292
Missing	0	0	0	0	0	0	0	0
Unknown	151	234	44	33	37	22	1	522
Total	3,765	5,796	1,001	749	973	368	46	12,698

Source of information: Network SIMS Database

Date of Preparation: April 2012

Race: The categories are from the CMS-2728 Form.

Diagnosis: Categories are from the CMS-2728. A diagnosis of 'unknown' is ICD-9 code 7999.

This table cannot be compared to the CMS facility survey because the CMS Facility Survey is limited to dialysis patients receiving outpatient services from Medicare approved dialysis facilities.

The numbers may not reflect the true point prevalence due to different definitions for transient patients.

This table includes 105 patients receiving treatment at VA facilities.

TABLE 3: DIALYSIS MODALITY - HOME

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
 SELF-CARE SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
CT										
070025	0	0	6	11	6	6	0	0	12	17
070033	0	0	5	4	6	8	0	0	11	12
070035	0	0	0	1	16	14	0	0	16	15
07003F	0	0	0	0	2	1	0	0	2	1
072501	2	3	28	28	29	32	0	0	59	63
072503	0	0	6	4	60	56	0	0	66	60
072504	7	8	2	2	11	10	0	0	20	20
072505	0	0	4	4	1	1	0	0	5	5
072506	0	0	1	0	3	0	0	0	4	0
072507	7	8	10	11	52	58	0	0	69	77
072508	1	1	3	2	5	3	0	0	9	6
072509	0	0	9	8	7	6	0	0	16	14
072510	0	0	0	0	0	0	0	0	0	0
072511	0	0	32	8	7	35	0	0	39	43
072512	2	3	0	0	0	0	0	0	2	3
072513	0	0	0	0	0	0	0	0	0	0
072514	0	0	0	0	0	0	0	0	0	0
072515	0	0	2	1	14	14	0	0	16	15
072516	0	0	21	20	15	11	0	0	36	31
072517	0	0	0	0	0	0	0	0	0	0
072518	15	17	7	7	0	2	0	0	22	26
072519	0	0	5	6	9	5	0	0	14	11
072520	1	0	3	4	8	8	0	0	12	12
072521	0	0	0	2	5	6	0	0	5	8
072522	0	0	0	0	0	0	0	0	0	0
072523	0	0	5	3	18	20	0	0	23	23
072524	0	0	5	5	10	9	0	0	15	14
072527	0	2	7	2	0	9	0	0	7	13

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
CT										
072528	0	0	0	0	0	0	0	0	0	0
072529	0	0	2	2	15	13	0	0	17	15
072530	0	0	0	0	0	0	0	0	0	0
072531	0	0	1	2	0	0	0	0	1	2
072532	0	0	2	1	5	6	0	0	7	7
072533	10	16	0	0	0	0	0	0	10	16
072534	0	0	0	1	2	1	0	0	2	2
072535	0	0	0	0	0	0	0	0	0	0
072536	0	0	0	0	0	1	0	0	0	1
072537	0	0	0	0	1	0	0	0	1	0
072538	0	0	0	0	5	8	0	0	5	8
072539	0	0	1	1	1	2	0	0	2	3
072540	0	0	2	6	2	2	0	0	4	8
072541#	0	0	0	1	0	0	0	0	0	1
072542#	0	0	0	5	0	0	0	0	0	5
072543#	0	0	0	0	0	0	0	0	0	0
078802#	0	0	0	0	0	0	0	0	0	0
078803#	0	0	0	0	0	0	0	0	0	0
CT Total	45	58	170	153	315	347	0	0	529	557

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
MA										
220028	0	0	3	2	10	17	0	0	13	19
220036	0	0	3	3	1	1	0	0	4	4
220046	4	3	3	5	2	2	0	0	9	10
220071	0	0	12	16	13	13	0	0	25	29
220081	0	0	0	0	0	0	0	0	0	0

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
MA										
220082	1	0	6	5	11	13	0	0	18	18
22010F	0	0	0	0	0	0	0	0	0	0
220110	0	0	0	0	0	0	0	0	0	0
220123	0	0	0	0	0	0	0	0	0	0
220163	0	0	0	0	0	0	0	0	0	0
221302	0	0	0	0	0	0	0	0	0	0
222006	0	0	0	0	0	0	0	0	0	0
222500	6	7	1	1	2	2	0	0	9	10
222501	0	2	4	4	6	5	0	0	10	11
222502	0	0	0	0	0	0	0	0	0	0
222503	0	0	0	0	3	8	0	0	3	8
222504	0	0	0	0	0	0	0	0	0	0
222505	2	0	0	0	0	1	0	0	2	1
222506	0	0	0	0	0	0	0	0	0	0
222507	0	0	0	0	0	0	0	0	0	0
222508	0	0	0	0	0	0	0	0	0	0
222511	0	0	0	0	0	0	0	0	0	0
222512	0	0	2	2	3	1	0	0	5	3
222513	0	0	1	0	12	9	0	0	13	9
222515	0	0	0	0	0	5	0	0	0	5
222516	2	0	4	2	3	4	0	0	9	6
222517	6	3	0	5	9	4	0	0	15	12
222519	0	0	0	0	0	0	0	0	0	0
222520	0	0	8	2	3	9	0	0	11	11
222521	1	2	0	2	5	5	0	0	6	9
222523	0	0	6	4	7	4	0	0	13	8
222524	0	0	0	0	0	0	0	0	0	0
222525	0	0	0	0	0	0	0	0	0	0
222526	0	0	6	7	39	40	0	0	45	47
222529	0	0	7	3	18	24	0	0	25	27
222530	1	0	6	4	1	2	0	0	8	6

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

SELF-CARE SETTINGS – HOME

PROVIDER MA	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
222532	0	0	0	0	0	0	0	0	0	0
222533	0	0	0	2	10	13	0	0	10	15
222534	0	0	0	0	4	0	0	0	4	0
222535	0	0	0	0	0	0	0	0	0	0
222536	0	0	5	2	12	14	0	0	17	16
222537	0	0	0	0	0	0	0	0	0	0
222538	8	5	0	0	0	0	0	0	8	5
222539	0	0	4	4	4	2	0	0	8	6
222542	0	1	1	2	2	2	0	0	3	5
222543	0	0	0	0	6	8	0	0	6	8
222544	1	0	0	0	0	0	0	0	1	0
222545	2	0	1	2	7	5	0	0	10	7
222546	0	0	1	0	3	4	0	0	4	4
222547^	0	0	0	0	0	0	0	0	0	0
222548	0	0	0	0	0	0	0	0	0	0
222549	4	3	3	8	28	27	0	0	35	38
222550	2	4	0	0	6	6	0	0	8	10
222551	0	0	1	2	5	3	0	0	6	5
222552	0	0	17	10	15	29	0	0	32	39
222553	0	0	1	1	4	6	0	0	5	7
222554	0	0	0	0	0	0	0	0	0	0
222555^	0	0	0	0	0	0	0	0	0	0
222556	0	0	3	3	2	5	0	0	5	8
222557	0	0	0	0	0	0	0	0	0	0
222559	0	0	0	0	0	0	0	0	0	0
222560	0	0	0	0	2	2	0	0	2	2
222561	3	1	0	0	0	0	0	0	3	1
222562	0	1	0	0	2	1	0	0	2	2
222563#	19	0	0	0	0	0	0	0	19	0
222564	7	9	2	0	15	14	0	0	24	23
222565	4	5	0	1	5	5	0	0	9	11

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
MA										
222566	0	0	0	0	5	6	0	0	5	6
222567	1	1	0	0	2	2	0	0	3	3
222568	0	0	0	0	0	0	0	0	0	0
222570	0	0	0	2	3	4	0	0	3	6
222571	0	1	0	0	15	19	0	0	15	20
222572	0	1	1	0	4	4	0	0	5	5
222573	0	1	0	1	1	2	0	0	1	4
222574	0	0	0	0	1	0	0	0	1	0
222575#	0	3	0	0	0	1	0	0	0	4
222576#	0	0	0	0	0	0	0	0	0	0
223302	0	0	0	0	6	6	0	0	6	6
223501	0	0	0	0	0	0	0	0	0	0
223504	0	0	0	0	0	0	0	0	0	0
228801#	0	3	0	0	0	1	0	0	0	4
229999	0	0	0	0	0	0	0	0	0	0
MA Total	74	56	112	107	317	360	0	0	503	523

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
ME										
200018	0	0	0	1	1	0	0	0	1	1
200033	2	2	4	5	12	9	0	0	18	16
200039	3	3	0	1	4	6	0	0	7	10
20003F	0	0	0	0	0	0	0	0	0	0
202500	2	3	1	1	5	8	0	0	8	12
202501	0	0	0	0	0	0	0	0	0	0
202502	0	1	0	3	2	1	0	0	2	5
202503	1	0	0	4	6	7	0	0	7	11
202504	0	0	2	0	0	0	0	0	2	0
202505	0	0	0	0	0	1	0	0	0	1

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
ME										
202506	2	3	0	2	10	10	0	0	12	15
202507	1	2	0	0	2	1	0	0	3	3
202508	2	0	1	0	4	0	0	0	7	0
202509	0	0	0	0	0	0	0	0	0	0
202510	0	0	0	0	1	1	0	0	1	1
202511	0	0	0	0	0	0	0	0	0	0
203500	0	0	0	0	0	0	0	0	0	0
203501	0	0	0	0	0	0	0	0	0	0
ME Total	13	14	8	17	47	44	0	0	68	75

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
NH										
302500	4	2	3	4	1	3	0	0	8	9
302501	0	1	3	4	7	5	0	0	10	10
302502	1	2	3	4	7	8	0	0	11	14
302503	0	0	0	0	1	1	0	0	1	1
302504	0	0	0	0	0	0	0	0	0	0
302505	0	0	0	0	0	0	0	0	0	0
302506	0	0	0	0	0	0	0	0	0	0
302507	6	5	4	3	5	5	0	0	15	13
302508	0	0	0	0	0	0	0	0	0	0
302509	7	7	4	0	7	4	0	0	18	11
302510	0	0	0	0	0	0	0	0	0	0
302511	0	0	0	0	3	3	0	0	3	3
NH Total	18	17	17	15	31	29	0	0	66	61

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
 SELF-CARE SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
RI										
410007	0	0	0	0	0	0	0	0	0	0
410012	0	0	0	0	0	0	0	0	0	0
41002F	0	0	0	0	0	0	0	0	0	0
412501	2	2	5	1	0	0	0	0	7	3
412502	0	0	0	0	0	0	0	0	0	0
412503	0	0	0	0	0	0	0	0	0	0
412504	0	0	0	0	0	0	0	0	0	0
412505	0	0	4	2	4	1	0	0	8	3
412506	0	0	0	6	7	5	0	0	7	11
412507	0	0	0	0	0	0	0	0	0	0
412508	0	0	0	0	0	0	0	0	0	0
412509	0	0	0	0	0	0	0	0	0	0
412510	0	0	0	0	0	0	0	0	0	0
412511	0	0	0	0	0	0	0	0	0	0
412512	0	0	4	2	10	6	0	0	14	8
412514	0	0	0	0	0	0	0	0	0	0
413500	1	3	0	0	0	0	0	0	1	3
RI Total	3	5	13	11	21	12	0	0	37	28

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
VT										
470003	0	0	0	0	0	0	0	0	0	0
472500	0	0	0	0	0	0	0	0	0	0
472501	0	0	0	0	0	0	0	0	0	0
473500	0	0	0	0	0	0	0	0	0	0
473501	0	0	0	0	0	0	0	0	0	0
473502	0	0	0	1	0	0	0	0	0	1
473503	5	5	3	3	12	7	1	1	21	16
473504	0	0	0	0	0	0	0	0	0	0
VT Total	5	5	3	4	12	7	1	1	21	17
Network Total	158	155	323	307	743	799	1	1	1,224	1,261

Source of Information: Network SIMS Database

Date of Preparation: April 2011

This table cannot be compared to the CMS Facility Survey because the CMS Facility Survey is limited to dialysis patients receiving outpatient services from Medicare approved dialysis facilities.

This table includes 2 Veterans Affairs Facility patients for 2010 and 1 Veterans Affairs Facility patient for 2011

Provider not operational in 2010

^ Provider not operational in 2011

TABLE 4: DIALYSIS MODALITY - IN-CENTER

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
CT	2010	2011	2010	2011	2010	2011	2010	2011
070025	171	165	0	0	171	165	183	182
070033	114	116	0	0	114	116	125	128
070035	109	108	0	0	109	108	125	123
07003F	39	34	0	0	39	34	41	35
072501	216	219	0	0	216	219	275	282
072503	0	0	0	0	0	0	66	60
072504	138	137	0	0	138	137	158	157
072505	58	57	0	0	58	57	63	62
072506	62	59	0	0	62	59	66	59
072507	129	111	0	0	129	111	198	188
072508	90	62	0	0	90	62	99	68
072509	86	80	0	0	86	80	102	94
072510	81	88	0	0	81	88	81	88
072511	144	132	0	0	144	132	183	175
072512	169	154	0	0	169	154	171	157
072513	69	62	0	0	69	62	69	62
072514	83	83	0	0	83	83	83	83
072515	94	88	0	0	94	88	110	103
072516	122	125	0	0	122	125	158	156
072517	59	63	0	0	59	63	59	63
072518	76	58	0	0	76	58	98	84
072519	69	66	0	0	69	66	83	77
072520	75	69	0	0	75	69	87	81
072521	115	124	0	0	115	124	120	132
072522	78	74	0	0	78	74	78	74
072523	56	59	0	0	56	59	79	82
072524	81	78	0	0	81	78	96	92
072527	64	63	0	0	64	63	71	76

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
CT	2010	2011	2010	2011	2010	2011	2010	2011
072528	59	70	0	0	59	70	59	70
072529	81	83	0	0	81	83	98	98
072530	32	29	0	0	32	29	32	29
072531	48	48	0	0	48	48	49	50
072532	63	68	0	0	63	68	70	75
072533	61	59	0	0	61	59	71	75
072534	39	38	0	0	39	38	41	40
072535	34	38	0	0	34	38	34	38
072536	18	23	0	0	18	23	18	24
072537	44	51	0	0	44	51	45	51
072538	28	38	0	0	28	38	33	46
072539	25	35	0	0	25	35	27	38
072540	9	14	0	0	9	14	13	22
072541#	0	10	0	0	0	10	0	11
072542#	0	25	0	0	0	25	0	30
072543#	0	5	0	0	0	5	0	5
078802#	0	0	0	0	0	0	0	0
078803#	0	0	0	0	0	0	0	0
CT Total	3,188	3,168	0	0	3,188	3,168	3,717	3,725

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
MA	2010	2011	2010	2011	2010	2011	2010	2011
220028	64	68	0	0	64	68	77	87
220036	95	102	0	0	95	102	99	106
220046	130	111	0	0	130	111	139	121
220071	1	2	0	0	1	2	26	31
220081	5	5	0	0	5	5	5	5

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
MA	2010	2011	2010	2011	2010	2011	2010	2011
220082	170	186	0	0	170	186	188	204
22010F	27	26	0	0	27	26	27	26
220110	3	0	0	0	3	0	3	0
220123	5	4	0	0	5	4	5	4
220163	1	2	0	0	1	2	1	2
221302	17	20	0	0	17	20	17	20
222006	18	16	0	0	18	16	18	16
222500	82	87	0	0	82	87	91	97
222501	70	72	0	0	70	72	80	83
222502	145	127	0	0	145	127	145	127
222503	131	120	0	0	131	120	134	128
222504	85	87	0	0	85	87	85	87
222505	70	71	0	0	70	71	72	72
222506	77	81	0	0	77	81	77	81
222507	71	95	0	0	71	95	71	95
222508	98	98	0	0	98	98	98	98
222511	82	96	0	0	82	96	82	96
222512	113	115	0	0	113	115	118	118
222513	68	66	0	0	68	66	81	75
222515	89	84	0	0	89	84	89	89
222516	52	54	0	0	52	54	61	60
222517	113	95	0	0	113	95	128	107
222519	55	63	0	0	55	63	55	63
222520	56	54	0	0	56	54	67	65
222521	81	74	0	0	81	74	87	83
222523	104	103	0	0	104	103	117	111
222524	60	62	0	0	60	62	60	62
222525	106	106	0	0	106	106	106	106
222526	165	171	0	0	165	171	210	218

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
MA	2010	2011	2010	2011	2010	2011	2010	2011
222529	129	149	0	0	129	149	154	176
222530	69	88	0	0	69	88	77	94
222532	32	31	0	0	32	31	32	31
222533	59	69	0	0	59	69	69	84
222534	2	6	0	0	2	6	6	6
222535	59	59	0	0	59	59	59	59
222536	91	87	0	0	91	87	108	103
222537	59	56	0	0	59	56	59	56
222538	117	128	0	0	117	128	125	133
222539	47	53	0	0	47	53	55	59
222542	73	85	0	0	73	85	76	90
222543	78	87	0	0	78	87	84	95
222544	40	26	0	0	40	26	41	26
222545	75	77	0	0	75	77	85	84
222546	76	74	0	0	76	74	80	78
222547^	0	0	0	0	0	0	0	0
222548	29	19	0	0	29	19	29	19
222549	92	85	0	0	92	85	127	123
222550	96	94	0	0	96	94	104	104
222551	62	68	0	0	62	68	68	73
222552	112	111	0	0	112	111	144	150
222553	52	52	0	0	52	52	57	59
222554	17	0	0	0	17	0	17	0
222555^	0	0	0	0	0	0	0	0
222556	79	85	0	0	79	85	84	93
222557	59	55	0	0	59	55	59	55
222559	49	40	0	0	49	40	49	40
222560	68	75	0	0	68	75	70	77
222561	54	67	0	0	54	67	57	68

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
MA	2010	2011	2010	2011	2010	2011	2010	2011
222562	43	44	0	0	43	44	45	46
222563#	0	0	0	0	0	0	19	0
222564	111	129	0	0	111	129	135	152
222565	96	119	0	0	96	119	105	130
222566	64	68	0	0	64	68	69	74
222567	72	84	0	0	72	84	75	87
222568	85	68	0	0	85	68	85	68
222570	60	63	0	0	60	63	63	69
222571	60	66	0	0	60	66	75	86
222572	45	40	0	0	45	40	50	45
222573	49	70	0	0	49	70	50	74
222574	43	75	0	0	43	75	44	75
222575#	0	9	0	0	0	9	0	13
222576#	0	4	0	0	0	4	0	4
223302	16	18	0	0	16	18	22	24
223501	91	94	0	0	91	94	91	94
223504	5	5	0	0	5	5	5	5
228801#	0	9	0	0	0	9	0	13
MA Total	5,124	5,314	0	0	5,124	5,314	5,627	5,837

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
ME	2010	2011	2010	2011	2010	2011	2010	2011
200018	47	45	0	0	47	45	48	46
200033	102	120	0	0	102	120	120	136
200039	49	46	0	0	49	46	56	56
20003F	19	19	0	0	19	19	19	19
202500	78	89	0	0	78	89	86	101

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
ME	2010	2011	2010	2011	2010	2011	2010	2011
202501	49	52	0	0	49	52	49	52
202502	39	50	0	0	39	50	41	55
202503	79	71	0	0	79	71	86	82
202504	59	62	0	0	59	62	61	62
202505	86	89	0	0	86	89	86	90
202506	45	54	0	0	45	54	57	69
202507	25	24	0	0	25	24	28	27
202508	30	34	0	0	30	34	37	34
202509	25	23	0	0	25	23	25	23
202510	20	18	0	0	20	18	21	19
202511	18	17	0	0	18	17	18	17
203500	52	46	0	0	52	46	52	46
203501	32	33	0	0	32	33	32	33
ME Total	854	892	0	0	854	892	922	967

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
NH	2010	2011	2010	2011	2010	2011	2010	2011
302500	67	58	0	0	67	58	75	67
302501	68	70	0	0	68	70	78	80
302502	102	95	0	0	102	95	113	109
302503	39	46	0	0	39	46	40	47
302504	64	60	0	0	64	60	64	60
302505	87	88	0	0	87	88	87	88
302506	52	52	0	0	52	52	52	52
302507	88	90	0	0	88	90	103	103
302508	39	34	0	0	39	34	39	34
302509	81	82	0	0	81	82	99	93

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
NH	2010	2011	2010	2011	2010	2011	2010	2011
302510	26	26	0	0	26	26	26	26
302511	21	22	0	0	21	22	24	25
NH Total	734	723	0	0	734	723	800	784

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
RI	2010	2011	2010	2011	2010	2011	2010	2011
410007	2	3	0	0	2	3	2	3
410012	3	1	0	0	3	1	3	1
41002F	22	25	0	0	22	25	22	25
412501	113	123	0	0	113	123	120	126
412502	42	47	0	0	42	47	42	47
412503	59	67	0	0	59	67	59	67
412504	91	91	0	0	91	91	91	91
412505	83	91	0	0	83	91	91	94
412506	77	82	0	0	77	82	84	93
412507	43	47	0	0	43	47	43	47
412508	67	63	0	0	67	63	67	63
412509	63	73	0	0	63	73	63	73
412510	68	73	0	0	68	73	68	73
412511	54	58	0	0	54	58	54	58
412512	66	65	0	0	66	65	80	73
412514	73	75	0	0	73	75	73	75
413500	57	65	0	0	57	65	58	68
RI Total	983	1,049	0	0	983	1,049	1,020	1,077

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2010 AND DECEMBER 31, 2011

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2010	2011	2010	2011	2010	2011	2010	2011
VT	2010	2011	2010	2011	2010	2011	2010	2011
470003	8	8	0	0	8	8	8	8
472500	42	37	0	0	42	37	42	37
472501	26	22	0	0	26	22	26	22
473500	46	38	0	0	46	38	46	38
473501	49	49	0	0	49	49	49	49
473502	34	34	0	0	34	34	34	35
473503	79	80	0	0	79	80	100	96
473504	22	21	0	0	22	21	22	21
VT Total	306	289	0	0	306	289	327	306
Network Total	11,190	11,435	0	0	11,190	11,435	12,415	12,696

*Source of Information: Facility Survey (CMS 2744) and Network SIMS Database*Total from Table #3 plus total from Table #4 (for last column of report year)*

Date of Preparation: April 2012

This table cannot be compared to the CMS Facility Survey because the CMS Facility Survey is limited to only Medicare approved facilities.

This table includes 107 Veterans Affairs Facility patients for 2010 and 104 Veterans Affairs Facility patients for 2011.

Provider not operational in 2010

^ Provider not operational in 2011

TABLE 5: RENAL TRANSPLANTS BY STATE

NUMBER OF RENAL TRANSPLANTS PERFORMED BY TRANSPLANT CENTERS WITHIN THE
NETWORK AREA
CALENDAR YEAR 2010 AND CALENDAR YEAR 2011

TX CENTER	TOTAL TRANSPLANTS PERFORMED		PATIENTS WAITING FOR TRANSPLANT	
	2010	2011	2010	2011
CT				
070022	125	110	506	533
070025	53	43	329	324
State Total	178	153	N/A*	N/A*
MA				
220031	36	27	183	207
220071	83	76	367	254
220077	40	31	158	153
220086	61	51	232	340
220110	70	45	339	332
220116	37	42	200	195
220163	49	55	197	202
220171	44	40	144	161
223302	23	27	2	3
State Total	443	394	N/A*	N/A*
ME				
200009	41	46	103	112
State Total	41	46	N/A*	N/A*
NH				
300003	57	57	111	47
State Total	57	57	N/A*	N/A*
RI				
410007	49	49	134	173
State Total	49	49	N/A*	N/A*
VT				
470003	42	36	99	100
State Total	42	36	N/A*	N/A*
Total	810	735	N/A*	N/A*

Source of information: Network SIMS Database/CMS-2744

Date of Preparation: April 2012

* These numbers are not added to State or Network totals because some patients may be placed on more than one waiting list.
The numbers are only accurate for each center.

Provider not operational in 2010

^ Provider not operational in 2011

TABLE 6: RENAL TRANSPLANTS BY TRANSPLANT TYPE

RENAL TRANSPLANT RECIPIENTS FOR TRANSPLANT CENTERS
WITHIN THE NETWORK AREA
BY TRANSPLANT TYPE; AGE, RACE, GENDER AND PRIMARY DIAGNOSIS
CALENDAR YEAR 2011

AGE	CADAVERIC	LIVING RELATED	LIVING UNRELATED	TOTAL
00-04	5	5	1	11
05-09	4	4	0	8
10-14	3	2	1	6
15-19	5	6	3	14
20-24	8	10	4	22
25-29	10	9	2	21
30-34	12	13	9	34
35-39	29	9	8	46
40-44	29	15	19	63
45-49	55	14	24	93
50-54	47	8	24	79
55-59	59	21	20	100
60-64	79	11	17	107
65-69	52	12	12	76
70-74	30	7	1	38
75-79	10	3	2	15
80-84	0	0	0	0
>=85	2	0	0	2
Missing	0	0	0	0
Total	439	149	147	735

TABLE 6 CONTINUED

RENAL TRANSPLANT RECIPIENTS FOR TRANSPLANT CENTERS
WITHIN THE NETWORK AREA
BY TRANSPLANT TYPE; AGE, RACE, GENDER AND PRIMARY DIAGNOSIS
CALENDAR YEAR 2010

RACE	CADAVERIC	LIVING RELATED	LIVING UNRELATED	TOTAL
American Indian/ Alaska Native	1	0	1	2
Asian	21	3	7	31
Black or African American	93	11	13	117
More Than One Race Selected	5	1	2	8
Native Hawaiian or Other Pacific Islander	1	0	0	1
White	318	134	124	576
Missing	0	0	0	0
Total	439	149	147	735

GENDER	CADAVERIC	LIVING RELATED	LIVING UNRELATED	TOTAL
Female	155	46	52	253
Male	284	103	95	482
Missing	0	0	0	0
Total	439	149	147	735

DIAGNOSIS	CADAVERIC	LIVING RELATED	LIVING UNRELATED	TOTAL
Cystic Kidney	39	14	28	81
Diabetes	125	23	17	165
Glomerulonephritis	84	36	41	161
Hypertension	51	14	17	82
Other	105	50	30	185
Other Urologic	11	2	5	18
Missing	0	0	0	0
Unknown	24	10	9	43
Total	439	149	147	735

Source of information: Network SIMS Database

Date of Preparation: April 2012

Race: The categories are from the HCFA-2728 Form.

Diagnosis: Categories are from the HCFA-2728. A diagnosis of 'unknown' is ICD-9 code 7999.

This table includes 0 patients receiving treatment at VA facilities.

TABLE 7: DIALYSIS DEATHS

DEATHS OF DIALYSIS PATIENTS BY STATE OF RESIDENCE, AGE, RACE, GENDER,
PRIMARY DIAGNOSIS AND CAUSE OF DEATH
CALENDAR YEAR 2011

AGE	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
00-04	0	1	0	0	0	0	0	1
05-09	0	0	0	0	0	0	0	0
10-14	0	0	0	0	0	0	0	0
15-19	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	1	0	1
25-29	2	1	0	1	0	1	0	5
30-34	6	3	0	1	2	0	0	12
35-39	6	4	0	0	2	0	0	12
40-44	9	14	5	4	3	1	0	36
45-49	24	31	7	6	3	4	1	76
50-54	31	55	8	11	13	5	0	123
55-59	38	48	36	15	7	6	0	150
60-64	58	108	15	17	20	7	1	226
65-69	100	131	26	22	28	17	0	324
70-74	81	176	17	35	23	11	5	348
75-79	111	179	35	35	33	12	4	409
80-84	126	224	27	31	42	7	2	459
>=85	142	261	32	36	40	11	2	524
Missing	0	0	0	0	0	0	0	0
Total	734	1,236	208	214	216	83	15	2,706

RACE	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
American Indian/ Alaska Native	2	2	0	1	0	0	0	5
Asian	5	24	2	1	3	0	1	36
Black or African American	161	135	3	7	10	1	1	318
More Than One Race Selected	1	2	0	0	1	0	0	4
Native Hawaiian or Other Pacific Islander	2	4	0	0	1	0	0	7
White	563	1069	203	205	201	82	13	2336
Missing	0	0	0	0	0	0	0	0
Total	734	1,236	208	214	216	83	15	2,706

TABLE 7 CONTINUED

DEATHS OF DIALYSIS PATIENTS BY STATE OF RESIDENCE, AGE, RACE, GENDER,
PRIMARY DIAGNOSIS AND CAUSE OF DEATH
CALENDAR YEAR 2011

GENDER	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Female	322	514	84	106	97	36	4	1163
Male	412	722	124	108	119	47	11	1543
Missing	0	0	0	0	0	0	0	0
Total	734	1,236	208	214	216	83	15	2,706

DIAGNOSIS	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Cystic Kidney	8	28	5	6	3	1	0	51
Diabetes	332	481	94	89	80	36	4	1116
Glomerulonephritis	46	87	18	20	15	5	2	193
Hypertension	180	365	52	53	59	17	4	730
Other	114	201	25	29	48	18	3	438
Other Urologic	13	23	3	8	5	1	0	53
Missing	0	0	0	0	0	0	0	0
Unknown	41	51	11	9	6	5	2	125
Total	734	1,236	208	214	216	83	15	2,706

CAUSE OF DEATH	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Cardiac	269	436	68	74	102	25	5	979
Gastro Intestinal	13	19	1	2	0	0	0	35
Infection	107	148	24	24	24	4	2	333
Liver Disease	8	18	2	2	1	1	0	32
Vascular	38	46	17	5	9	3	1	119
Missing	0	0	0	0	0	0	0	0
Other	220	422	79	80	65	35	6	907
Unknown	79	147	17	27	15	15	1	301
Total	734	1,236	208	214	216	83	15	2,706

Source of information: Network SIMS Database

Date of Preparation: April 2012

Race: The categories are from the CMS-2728 Form.

Diagnosis: Categories are from the CMS-2728. A diagnosis of 'unknown' is ICD-9 code 7999.

This table cannot be compared to the CMS Facility Survey because the CMS Facility Survey is limited to those deaths reported by only Medicare-approved facilities.

This table includes 29 patients receiving treatment at VA facilities.

TABLE 8: VOCATIONAL REHABILITATION

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2011

PROVIDER CT	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
070025	77	2	19	7	Y	
070033	25	1	8	0	Y	
070035	19	0	5	1		N
07003F	4	0	1	0		N
07100P	10	0	0	0		N
072501	102	3	27	1		N
072503	24	2	8	1		N
072504	36	0	12	1	Y	
072505	23	0	5	0		N
072506	14	0	5	0		N
072507	81	2	22	2		N
072508	20	0	7	0		N
072509	32	2	6	0		N
072510	9	0	5	0		N
072511	53	0	11	0	Y	
072512	49	0	0	0	Y	
072513	14	1	5	1	Y	
072514	19	1	3	0		N
072515	25	0	1	0		N
072516	42	0	10	1	Y	
072517	18	0	0	0		N
072518	28	9	13	2		N
072519	25	0	7	0		N
072520	14	11	8	0		N
072521	40	2	11	0		N
072522	8	0	2	0		N

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2011

PROVIDER CT	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
072523	22	1	2	1		N
072524	22	0	4	0		N
072527	21	2	6	1		N
072528	9	0	2	0		N
072529	16	0	2	1	Y	
072530	5	0	0	0		N
072531	21	0	2	0		N
072532	13	0	1	0		N
072533	23	0	3	2		N
072534	6	0	1	0		N
072535	8	1	2	1		N
072536	8	0	2	0		N
072537	7	0	1	0	Y	
072538	15	1	6	0		N
072539	9	0	5	0		N
072540	3	0	3	0		N
072541	2	0	1	0		N
072542	6	2	2	0		N
072543	2	0	1	0		N
078802	0	0	0	0		N
078803	0	0	0	0		N
CT Total	1,029	43	247	23		

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2011

PROVIDER MA	NUMBER OF DIALYSIS PATIENTS AGED 18-54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
220028	18	0	6	1		N
220036	15	0	7	0	Y	
220046	31	5	8	0	Y	
220071	15	0	6	2	Y	
220082	40	1	11	2	Y	
22010F	1	0	1	0	1	N
220110	0	0	0	0	0	N
220123	1	0	0	0	1	N
221302	4	0	2	0		N
222006	11	0	0	0		N
222500	41	0	11	0		N
222501	14	0	5	0	Y	
222502	47	0	3	1	Y	
222503	28	0	6	3		N
222504	19	2	10	1		N
222505	19	0	3	0	Y	
222506	20	0	7	0	Y	
222507	24	0	10	2		N
222508	29	1	14	1	Y	
222511	16	1	4	1		N
222512	26	1	9	0	Y	
222513	20	7	6	5	Y	
222515	16	0	6	0	Y	
222516	19	3	3	2		N
222517	15	0	10	0		N
222519	17	0	2	0	Y	
222520	10	0	4	0		N
222521	32	5	13	2	Y	

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2011

PROVIDER MA	NUMBER OF DIALYSIS PATIENTS AGED 18-54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
222523	12	3	6	0	Y	
222524	10	0	5	1	Y	
222525	41	2	9	3		N
222526	80	1	18	4		N
222529	50	2	14	0		N
222530	30	0	2	0	Y	
222532	7	0	1	2		N
222533	15	0	7	0		N
222534	0	0	0	0		N
222535	18	1	1	1		N
222536	37	0	6	0	Y	
222537	4	0	0	0	Y	
222538	42	1	13	3	Y	
222539	10	0	4	0		N
222542	24	0	7	0		N
222543	27	0	8	2		N
222544	5	0	0	0	Y	
222545	19	1	3	0		N
222546	18	0	8	1	Y	
222548	5	0	0	0		N
222549	33	4	11	0		N
222550	10	0	4	0	Y	
222551	13	0	5	0		N
222552	41	1	17	4		N
222553	10	0	7	0		N
222554	0	0	0	0		N
222556	12	2	1	0		N
222557	9	1	0	1	Y	

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2011

PROVIDER MA	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
222559	5	0	1	0		N
222560	20	5	4	2		N
222561	20	0	6	1		N
222562	8	0	1	0	Y	
222563	0	0	0	0		N
222564	45	0	8	2	Y	
222565	41	1	10	0	Y	
222566	14	1	1	0		N
222567	16	0	2	1		N
222568	8	0	2	0		N
222570	18	0	6	1		N
222571	23	1	2	1	Y	
222572	4	0	3	0		N
222573	23	0	5	0		N
222574	25	0	9	4		N
222575	2	1	1	0	Y	
223302	12	2	2	4		N
223501	17	17	6	0	Y	
223504	1	0	0	0		N
228801	2	0	0	0		N
229999	1	0	0	0		N
MA Total	1,436	73	394	61		

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2011

PROVIDER ME	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
200018	10	0	2	0		N
200033	31	2	3	0		N
200039	9	0	5	0	Y	
20003F	2	0	0	1		N
202500	25	0	8	2	Y	
202501	7	1	1	2		N
202502	13	0	5	0	Y	
202503	21	0	5	1	Y	
202504	13	0	3	2	Y	
202505	18	1	5	0	Y	
202506	20	1	5	1		N
202507	5	0	3	0		N
202508	9	0	3	0		N
202509	5	0	2	0		N
202510	4	0	0	0		N
202511	5	0	1	0		N
203500	6	0	1	0		N
203501	9	0	3	0		N
ME Total	212	5	55	9		

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2011

PROVIDER NH	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
302500	19	0	8	1		N
302501	16	0	9	0	Y	
302502	31	1	5	0	Y	
302503	16	0	2	0		N
302504	12	0	4	0		N
302505	23	0	9	0	Y	
302506	6	1	2	0		N
302507	29	0	13	0		N
302508	9	0	1	0	Y	
302509	18	0	4	0	Y	
302510	6	0	1	0	Y	
302511	6	0	5	5		N
NH Total	191	2	63	6		

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2011

PROVIDER RI	NUMBER OF DIALYSIS PATIENTS AGED 18 –54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
410012	0	0	0	0		N
41002F	1	0	0	0		N
412501	35	1	15	0	Y	
412502	9	1	3	0		N
412503	15	0	2	0		N
412504	19	0	4	0		N
412505	36	1	5	2	Y	
412506	27	1	8	1		N
412507	5	0	5	0		N
412508	11	2	1	1		N
412509	12	1	2	1		N
412510	23	2	2	0		N
412511	20	0	7	2		N
412512	20	0	3	1		N
412514	4	0	0	0		N
413500	33	3	6	1		N
RI Total	271	12	63	9		

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2011

PROVIDER VT	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART-TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
470003	2	0	0	1		N
472500	6	0	3	1	Y	
472501	7	0	0	0		N
473500	8	1	0	0	Y	
473501	10	0	2	1	Y	
473502	7	1	1	1		N
473503	23	0	3	0	Y	
473504	4	0	0	0	Y	
VT Total	67	2	9	4		
Network Total	3,206	137	831	112		

Source of Information: Network SIMS Database/CMS-2744 Form

Date of Preparation: May 2012