



End-Stage Renal Disease
Network of New England

2012 Annual Report



Portland Lighthouse, Cape Elizabeth, ME

June 2013
Prepared by:
IPRO ESRD Network of New England
www.networkofnewengland.org

Submitted to:
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
for Contract Number HHSM-500-2013-NW001C

I. PREFACE

MESSAGE FROM THE CHAIR

As in previous years, The Network of New England's principal Quality Improvement Project was Fistula First. The Medical Review Board (MRB) and the Network Staff divided providers into 4 tiers defined by their prevalent AVF rates as of March 2012; the interventions were tailored to each tier. The minimum deficit reduction goal was an increased AVF rate of 0.5%. The MRB and the Network staff closely monitored and interacted with providers below 50% AVF rates. The Centers for Medicare and Medicare Services (CMS) set a prevalent AVF goal for Network 1 of 64.3% for September 2012. Provider data for vascular access is submitted through CROWNWeb. The due date for submission is December 31, 2012. The last Fistula First dashboard published June 14th 2012 indicates a 64.2% AVF rate for 2012 and a greater than 90 day catheter rate of 8.7%.

The Network used 2011 data to identify providers at risk of outlier status in two performance measures to be used by CMS in the 2013 Quality Incentive Program (QIP). An educational strategy to help all providers understand the impact of the 2013 QIP was deployed and focused interventions occurred with the eleven providers at risk for point reductions secondary to Hgb>12 and URR<65%.

The Network Specific Quality Improvement Project continued our emphasis on improved dialysis patient influenza vaccination rates and expanded into dialysis staff vaccination rates. The latter category has rarely been systemically addresses or targeted.

Our Facility Specific Quality Assessment and Improvement Project (QAIP) was the promotion of Patient Safety programs in each facility, specifically, the 5 Diamond Program. The goal for 2012 of 40% of Network 1 providers registered in the 5 Diamond Project was established and as of September 2012 there were 35% of providers registered.

The Board of Directors (BOD) and the Network Staff continued to monitor complaints and grievances insuring extensive evaluation of each contact. The strong educational commitment of Network 1 continued with more than 700 patients, providers and members of industry attending the Annual Meeting of the Network Council on October 23rd 2012. The Annual Network Dialysis Technician Meetings, which took place in April 2012 in two separate locales, attracted more than 200 technicians.

The Network continued its work in the area of Healthcare Associated Infections (HAI) and was awarded several additional non-CMS contracts. One of these contracts sponsored the production of "The Patient Speaks about HAI", an 8-minute patient education video for use in dialysis facilities.



End-Stage Renal Disease Network of New England

The most exemplary work of Network 1 occurred in November of 2012, when the Network Staff working without power, heat, or running water, continued to staff the office and provide emergency response to the dialysis facilities throughout New England affected by “Super storm Sandy.” In addition, the Network staff assisted facilities in New York searching for dialysis patients displaced to New England by this catastrophe. This selfless service is a clear reflection of the extraordinary dedication of the staff of Network 1. The Board of Directors and Medical Review Board applaud the staff of Network 1 for their unparalleled commitment to our patients and to the entire renal community.

A handwritten signature in blue ink that reads 'Candace Walworth'.

Candace Walworth, MD
Network Chair

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.

2012 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	7
	1. NETWORK STAFF	7
	2. COMMITTEE FUNCTION & ACTIVITY	9
	➤ Network Council: Facility Constituents	9
	➤ Board of Directors	9
	➤ Medical Review Board	11
	➤ Finance Committee	12
	➤ Network Advisory Committee	12
	➤ Nominating Committee	12
	➤ Ad Hoc Committees	13
	➤ Ad Hoc: 2012 Annual Meeting and Technician Meeting Committees	13
	➤ Patient Advisory Committee (PAC)	13
III.	CMS NATIONAL GOALS AND NETWORK ACTIVITIES	
	A. IMPROVE THE QUALITY AND SAFETY OF DIALYSIS RELATED SERVICES PROVIDED FOR INDIVIDUALS WITH ESRD	14
	➤ Quality Improvement Work Plan	14
	➤ National Fistula First Vascular Access Improvement Initiative (Task 1a)	14
	➤ Clinical Performance Measures (Task 1b)	19
	– National CMS Clinical Performance Measures Project	19
	➤ Network Specific Improvement Project (Task 1c)	21
	– Immunization Project	21
	➤ Facility Level Quality Assessment (Task 1d)	23
	– 5 Diamond Safety Project	23
	<i>Other Quality Improvement Activities in 2012</i>	25
	➤ Healthcare Associated Infections (HAI)	25
	➤ Patient Education Video	26

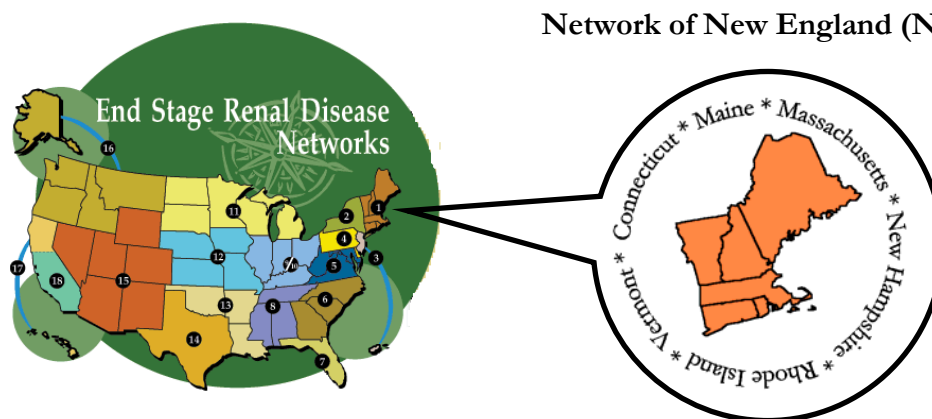
➤ FFBI Committee Work	27
➤ Clinical Technical Assistance	27
➤ Acute Dialysis Programs	27
➤ Assisting Facilities with Continuous Quality Improvement Activities	28
➤ Achieving Network #1 Goals in Quality of Care & Safety	28
B. IMPROVE THE INDEPENDENCE, QUALITY OF LIFE, AND REHABILITATION (TO THE EXTENT 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	29
➤ Prevalence Population and Employment Status	29
➤ Vocational Rehabilitation	29
➤ Network #1 Staff Provide Community Educational Materials	31
➤ Achieving Network #1 Goals in Quality of Life for ESRD Patients	31
C. IMPROVE PATIENT PERCEPTION OF CARE AND EXPERIENCE OF CARE, AND RESOLVE PATIENT'S COMPLAINTS AND GRIEVANCES	32
➤ Complaints, Grievances and Contact Report for 2012	32
➤ Network Notes Published in 2012	34
➤ Kidney Chronicles Published in 2012	35
➤ The Patient Advisory Committee (PAC) Remains Active in 2012	35
➤ Solomon Four Group Design Project	36
➤ Decreasing Patient Provider Conflict Toolkit	37
➤ CMS Dialysis Facility Compare	38
➤ Achieving Network #1 Goals to Address Patient Grievances and Experience of Care	38
➤ End of Life Coalition (EOL)	39
➤ Network 1 Collaborative with Donated Dental Services	39
➤ Achieving Network 1 Goals in collaboration with Other Organizations	39
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	40
➤ 24 th Annual Network of New England Educational Meeting	40

➤ Network of New England Technician Educational Meetings	42
➤ Emergency Preparedness	43
➤ Donate Life Connecticut	44
➤ Donor Designation Collaborative	45
➤ Forum of ESRD Networks	46
➤ State Survey Agencies	46
➤ Quality Improvement Organizations	46
➤ National Kidney Foundation Affiliates	46
➤ Network of New England Website	46
➤ Council on Renal Nutrition of New England (CRNNE)	47
➤ Connecticut Leadership for Quality Healthcare Coalition	48
➤ Achieving Network #1 Goals in Collaboration with Other Organizations	48
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	49
➤ Information Management	49
- System Architecture	49
➤ Network Role in Maintaining ESRD Data	50
- Patient Registry	50
- Updating Status of Medicare ESRD Beneficiaries	50
- Verification of Patient Data	51
- Provider and Personnel Database	52
➤ Quality Assurance of Patient Data	52
- CROWNWeb Generated 2728 Forms Validation	53
- DATA Systems	53
- Central-SIMS	53
- REMIS	54
- QualityNet Exchange	54
- REMEDY	55
- National Help Desk for ESRD CROWN System	55
- Electronic Laboratory Data Collection Project	55
- Fistula First Initiative	55
- United States Renal Data System (USRDS)	55
- Dialysis Facility Specific Reports	56
- Dialysis Facility Compare	56

- United Network for Organ Sharing (UNOS)	56
➤ Information Management Support for Quality Management Reports	57
➤ Information Management Support for Administrative Reports	57
➤ Information Management Support for Patient Services	57
➤ Information Management Support for Provider Education	57
- Statistical Summary Booklet	57
- Facility Directory	57
- Information for New Facility / Data Packet / QI Packet	57
- Information for New Patient Packets	58
- Technical Assistance	58
- Data Requests	58
- Disaster Preparedness and Business Continuity and Contingency Plan (BCCP)	58
- Development and Testing of ESRD Network Data and Data Systems	58
- Task Groups and Committees	59
➤ CROWNWeb	59
➤ Achieving Network #1 Goals in Data Management	60
IV. SANCTION RECOMMENDATIONS	61
V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES	62
VI. DATA TABLES	64
Table 1: ESRD Incidence	65
Table 2: ESRD Dialysis Prevalence	67
Table 3: Dialysis Modality by Self-Care Settings - Home	70
Table 4: Dialysis Modality by In-Center Settings	79
Table 5: Renal Transplants by State	88
Table 6: Renal Transplants by Transplant Type, Age, Race, Gender and Primary Diagnosis	89
Table 7: Dialysis Deaths	92
Table 8: Vocational Rehabilitation	94

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 December 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 2011 and 2012 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. CROWNWeb facilitates collection and maintenance of ESRD information directly from ESRD facilities using a web based system. CROWNWeb also requires 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 was rolled out in June 2012. For more information, please visit <http://www.projectcrownweb.org/crown/index.php>

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 providers as a “setting” in their plans for public reporting.

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 September of 2012 is 64.3% 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 challenges that the Network of New England faces in its oversight responsibilities, regarding patient access to ESRD services, 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 CROWNWeb. 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: 2012 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	643	180
Maine	1,328,188	1.18	95.23	190	143
Massachusetts	6,587,536	6.63	80.41	1,204	183
New Hampshire	1,318,194	1.14	93.89	130	97
Rhode Island	1,051,302	5.72	81.41	179	170
Vermont	626,431	1.00	95.29	47	75
Network	14,492,360	6.19	83.02	2,590**	179
National	311,591,917	12.6	72.4	Unknown	Unknown

**as of 11/10/2012

* 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 2011 to 2012 in the New England states compared to US where there is also a decrease of 1.16%. 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. This report is generated from CROWNWeb.

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). The prevalent ESRD population increased 2.2% from 2011 to 2012. This is less than the national increase of 3.2% from 2011 to 2012 (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
2012**	3,762	961	6,007	850	1,073	337	12,990

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

** CROWNWeb data as of 06/2013

The average age of a prevalent dialysis patient in New England is 65. Refer to Table 2 at the end of the report generated from CROWNWeb for a complete analysis of the prevalent ESRD population by age, gender, race, and primary diagnosis.

ESRD Facilities in New England States

There are 174 dialysis facilities in the Network 1 area at the end of 2012. 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 2012, xx% of the ESRD patients in New England were receiving dialysis in outpatient dialysis clinics called ESRD providers. XX percent of ESRD patients in New England were utilizing different forms of home dialysis (Table C). Of the XX home dialysis patients in New England, only XX% are on hemodialysis, XX% are on Continuous Cycling Peritoneal Dialysis (CCPD), and XX% are on Continuous Ambulatory Peritoneal Dialysis (CAPD). 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: 2012 Dialysis Prevalence by Modality: By State of Provider Service

State	In-center	Home Hemodialysis	IPD	CAPD	CCPD	Total Home	Other	Total Patients
CT	3,180	53	0	120	406	582	3	3,762
MA	5,438	71	0	98	400	569	0	6,007
ME	883	17	0	21	38	78	2	961
NH	780	14	0	8	48	70	0	850
RI	1,040	2	0	10	21	33	0	1,073
VT	308	7	0	6	8	29	8	337
Network 1	11,629	164	0	263	921	1,361	13	12,990

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, 2012, in the New England states was 3271 (CMS Facility Survey 2012). 43.5 percent of the total kidney transplants in 2012 were from living donors (18.5% living unrelated, 25% living related). Comparing 2011 to 2012, there is an overall decrease of 3.5% in kidney transplantation in the Network area. 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.

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 2012, 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, CPHQ., 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 2012, there were 38 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
Mary Sylvia-Reardon, RN, DNP Massachusetts General Hospital	Secretary Director of Hemodialysis & CVVH Nursing
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
Gilbert W. Bliss	Greenfield, NH	Patient/Consumer
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
Ann Marie Correia, RN	FMC Fall River	Home Therapy Prgrm Manager
John D'Avella, MD	Hartford Hospital	Medical Director
Jill Goldstein, MSW, LICSW, LCSW	Western Mass Kidney Center	Renal Social Worker
Douglas Gooding, J.D.	Boston, MA	Patient/Consumer
Sandie Guerra Dean, MSW, LICSW	Fresenius Medical Care North America	Corporate Social Worker
Julie Higgins-Mordecai, RN	FMC Coastal Dialysis Center	Clinical Manager
Roberta Hoffman, MSW	Children's Hospital	Social Worker
Geraldine Hurley, RD	Berkshire Medical Center – Renal Division	Renal Dietitian
Susan Jamison, RN, BSN	Umbagog Dialysis Center	Renal Nurse
Geraldine Kastoff, RD	DaVita Greater Waterbury	Registered Dietitian
Michele Kurka, RN	American Renal Associates	Manager, Clinical & Regulatory
Carol Lee Lane	Seacoast Dialysis Center	Patient Care Technician
Elizabeth Matteson, RN	Danbury Hospital	Nurse Manager
Charles McCoy, MD	Nephrology Associates, Inc.	Nephrologist
Klemens Meyer, MD*	New England Medical Center	Director, Dialysis Services
Debbie Mitchell-Dozier, RN,BSN	Tufts Medical Center	CKD/XPLT Clinic Nurse
Julia Neuringer, MD	Newton-Wellesly Hospital	Asst. Chief Nephrology
Paul Nussbaum, MD	Griffin Hospital	Medical Director
Dmitry Opolinsky, D.O.	MaineGeneral Medical Center	Nephrologist
Paul Pronovost, MD	Greater Waterbury Dialysis	Medical Director



End-Stage Renal Disease Network of New England

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
Sheila Silsby, CNN-NP	Berkshire Medical Center	Nurse Practitioner
Laura Troidle, PA	New Haven CAPD	Physicians Assistant
John Kevin Tucker, MD	Brigham and Women's Hospital	Nephrologist

The disciplines of professionals on the BOD are as follows:

Administrator	4	Renal Nurse:	2
Dietitian:	2	Nurse Manager:	7
Dialysis/Transplant Director:	7	Patient/Consumer:	2
Nephrologist:	8	Social Worker:	3
Vascular Access Surgeon:	1	Patient Care Technician:	1
Physician Assistant	1		

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.

Paul Pronovost, MD	Chair
Greater Waterbury Dialysis	Nephrologist
Douglas Mesler, MD	Vice-Chair
Nephrology Associates of Merrimack Valley	Clinical Director

<u>Name</u>	<u>Facility</u>	<u>Discipline</u>
Steve Bogatz, LCSW	Central CT Dialysis	Renal Social Worker
Kathleen Botelho Kawa, RN	FMC, NA	Director of Clinical Technology
Jodi Cooney, RN	American Renal – Comprehensive Dialysis	Nurse Manager
Robert Cooper	Pittsfield, MA	TX Patient/Consumer
Lorraine Dox, MS, RD, LDN, CNSD	Burling Regional Dialysis - DaVita	Renal Dietitian
Bernadette Drinkwine, RN	Fresenius Medical Care (FMC)	Regional Quality Manager
Jay Ginsberg, MD	Southeastern CT Nephrology Assoc, PC	Nephrologist
David Henner, DO	Berkshire Medical Center	Medical Director
Betty Ann Hughson, MS, RN	Children's Hospital Boston	Nurse Manager
Heather C. Johnston Nichols, RN	DaVita, Inc.	Acute Dialysis/Pheresis Nurse



End-Stage Renal Disease Network of New England

David Lockwood	West Haven, CT	Patient/Consumer
Nancy Orlando, RD	DCI	Renal Dietician
Jeffrey Rimmer, MD	Fletcher Allen Health Care	Medical Director
Gloria Rispoli, RN, CDN	DaVita, Inc.	Survey Assessment Liaison
David Roer, MD	St. Mary's Hospital	Medical Director
Richard Rohrer, MD	Tufts Medical Center	Transp/Dialysis Access Surgeon
Sara Roesler, LISW	FMC Stoneham	Reg. Treatment Options Coord.
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:	4
Dietitian:	2	Patient/Consumer:	2
Dialysis/Transplant Director:	4	Social Worker:	2
Nephrologist/Surgeon:	3		

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.

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: 2012 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 2012, The New England Patient Advisory Committee (PAC) had 12 members, in total, who were on the committee during the course of the year.

During 2012 the PAC worked on several projects. They are listed below:

- Solomon Four Group Design Project- This PAC project 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 was completed in 2012.
- Dialysis Facility Performance Certificate poster-The PAC developed a poster to help patients understand the Medicare Quality Incentive Program and the Performance Score Certificate that is required, by federal regulation, to be posted in each dialysis facility. The poster informs patients of why this score is important and how it affects them. It also gives them questions to ask their healthcare team. This poster was fax/email blasted to all dialysis facilities and was disseminated at the annual meeting.

Every attempt is made to have the PAC comprised of members from all of the six New England states. In 2012, all states were represented with the exception of New Hampshire and Rhode Island. 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 14th year of service in 2012. 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)

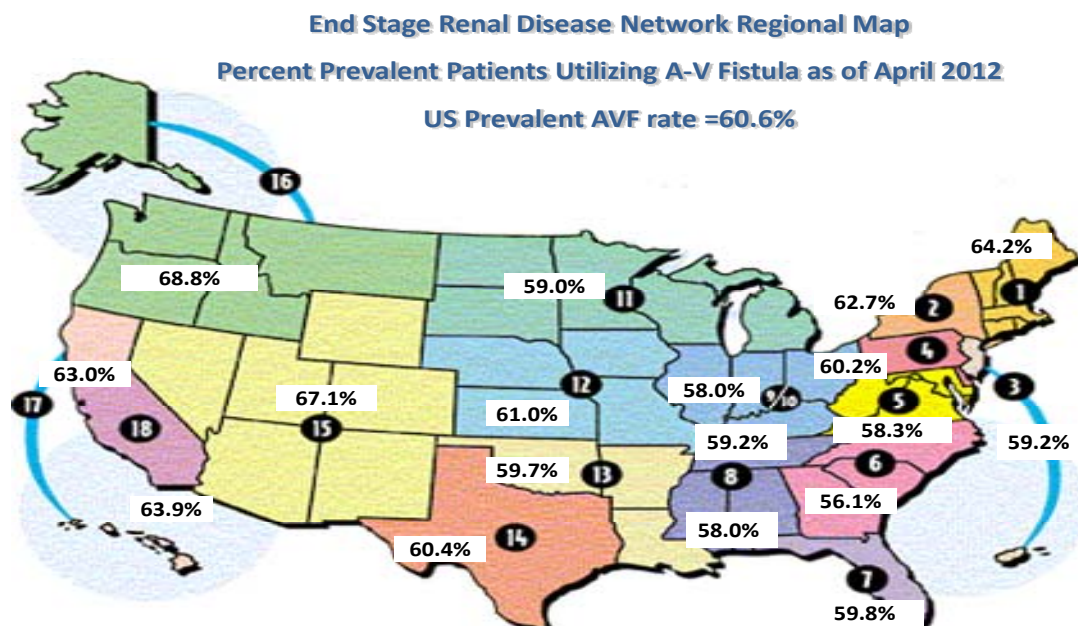
In July 2003, CMS committed the Networks to a system-wide national improvement project on vascular access. Fistula First became a CMS/Fistula First Breakthrough Initiative (FFBI). A national coalition of renal community stakeholders was established collaboratively to increase awareness of, and improvement in, the prevalent rate of AV fistulae in hemodialysis patients. CMS had established

a new goal in 2006 for the initiative, that is, to have a 66% AVF rate for prevalent hemodialysis patients.

Vascular access data was obtained from all providers on a monthly basis to allow for close assessment of provider changes in vascular access management. Until June 2012, the large dialysis organizations (LDOs) downloaded data directly to CMS, and the independent or hospital dialysis providers sent their data to the Network. The Network staff would enter the data on a monthly basis. In June 2012, the national rollout of CROWNWeb occurred and the Fistula First Dashboard was discontinued. Providers initiated vascular access data entry into CROWNWeb electronically either by batch, through NRAA, or manually. The submission deadline for vascular access data for May 2012 through August 2012 is November 30, 2012.

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 60.6% as of April 2012, which is a 28.2 percentage point improvement from the baseline rate in 2002 of 32.4%. Figure 1 illustrates that Network 1 was the 3rd highest Network in the country for prevalent AVF rates as of April 2012.

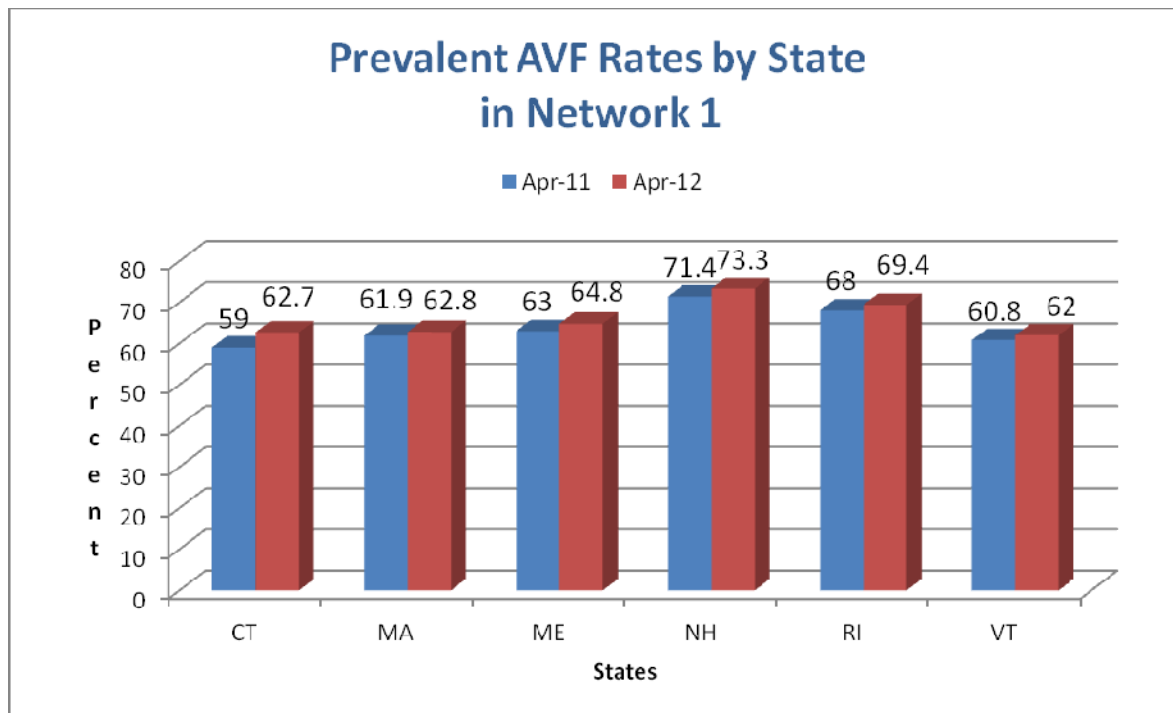
Figure 1



Data Source: Dashboard generated 06/14/2012
100% facilities may not of reported into each Network

Each New England state had a higher rate than the national average as of April 2012. New Hampshire continues to have one of the highest rates in the country. Figure 2 is a comparison of fistula rates by state:

Figure 2



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 63.8% in March of 2012 which surpassed the previous assigned CMS goal of 62.9%. The new CMS goal for prevalent AVF rate assigned for September of 2012 was 64.3% based on the deficit reduction formula. The current status of September 2012 prevalent AVF rate for Network 1 is unknown as vascular data entry for September 2012 has a December 30, 2012 deadline.

Assigning providers specific goals for AVF rates was effective in that over 50% of providers with AVF rates below 66% met or surpassed their assigned goal by March 2012. The Board of Directors (BOD) instructed the Network Quality Managers to continue the current strategy of assigning goals to providers. The providers that were less than 50% AVF rate and met before members of the Medical Review Board (MRB) had individualized, specific focused intervention as directed by the MRB. The dialysis providers were divided into four tiers dependent on their prevalent AVF rates as

of March 2012. Each provider was requested to increase their prevalent AVF percentage rate by 0.5%. The following table displays the different tiers and AVF groupings:

Table D

Baseline (3/12)	Classifications	AVF Groupings
Tier 1 14 providers	Providers below 50% that appeared before MRB, received CMS letter of concern, received Network letter of concern, and any new providers below 50% as of March 2012	< 50% AVF
Tier 2 31 providers	Providers below 58%	$\geq 50\%$ - <58% AVF
Tier 3 46 providers	Midrange providers needing AVF improvement	$\geq 58\%$ - <66%
Tier 4 71 providers	Providers that are high performers	$\geq 66\%$ AVF
Total providers: 162 *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 include Network site visits to providers and follow up to previously submitted quality assessment and performance improvement plans. In person and/or telephone consultation was given to surgeons and medical directors by Network Quality Managers. Suggestions for best practices and articles related to fistula creation were shared. The Network Annual Meeting featured a lecture on access surveillance and two Patient Care Technician Meetings had lectures on the buttonhole procedure. High performing providers were commended and asked for suggestions on best practices.

Partnership with Large Dialysis Organizations

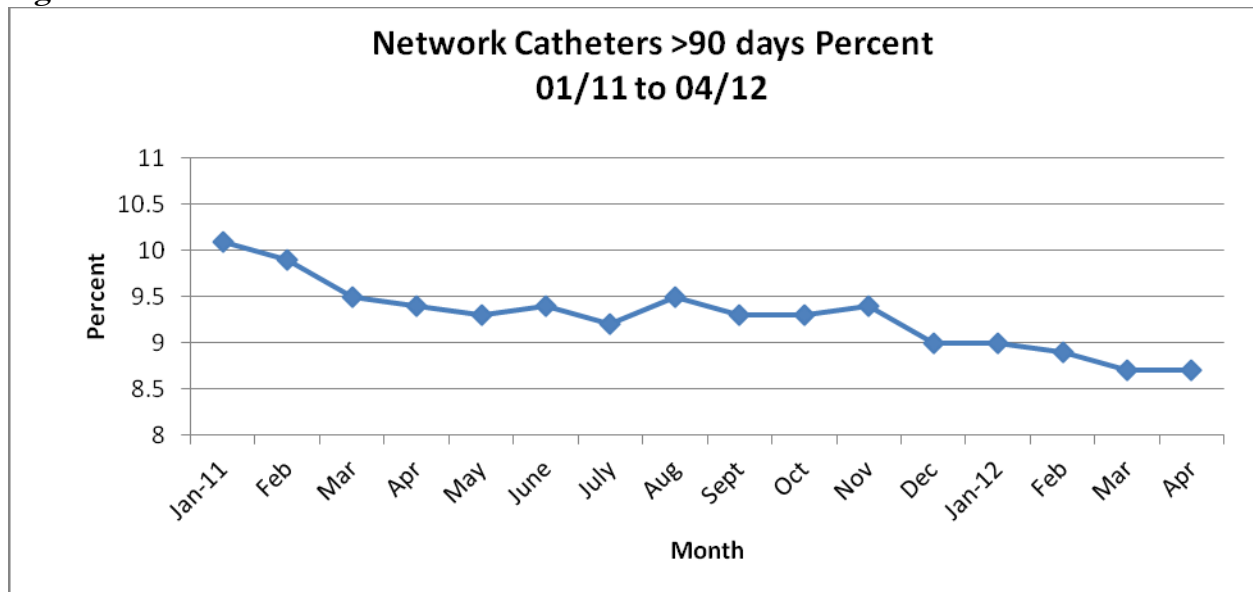
The Network partnered with the large dialysis organizations (LDO's) in efforts to promote fistula use and placement, and to support catheter reduction programs. This partnership included sharing data regarding clinics of concern with low AVF rates and/or high catheter rates and sharing quality improvement tracking tools and educational material. Representatives from the Network and LDO leadership attended several site visits.

Several different feedback reports were sent to participating providers during 2012 by Network QI managers. Comparable vascular access data by state and nation were distributed in March and June 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. A bar graph was also sent to providers which displayed where a particular provider placed based on AVF rate in their own state. The providers in the bar graph were displayed by code for privacy.

Another 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 co-morbidities such as severe peripheral vascular disease (PVD), the very elderly, patients with inadequate vascular anatomy, or patients with limited life expectancy. The following Figure 3 displays the progress made in this Network in decreasing 90 day catheter rates.

Figure 3



Source: fistulafirst.org

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 2011. 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

A unique provider specific report was prepared and distributed in June 2012 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.

Table E: 2012 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 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. With the introduction of CROWNWeb in June 2012, the above described data collection process has been discontinued as of June 30, 2012.

In 2011, the MRB selected anemia and hemodialysis adequacy to closely monitor due to the Quality Incentive Program (QIP) performance criteria. 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 providers with an out of range score for Hgb > 12 g/dL and/or URR > 65%. These two measures reduced the intervention efforts to only 17 providers at risk of losing Medicare

payment. The Network staff conducted focused telephone interviews and provided technical assistance. In January 2012, eight of the ten providers had improved their URR levels that had a performance score below 26. By April of 2012, 90% of providers had shown improvement. The two providers that lost points for Hgb>12g/dL both had improved as of April 2012. Of the 7 providers with a performance score between 26-29 points for low URR percents, there were 71% of these providers that improved by April of 2012.

This project has continued in 2012 utilizing the QIP Performance 2013 report based on 2011 data to identify providers that have a score of 29 points or less, ranked by measurement type; either 14% of patients with HGB >12g/dL and /or less than 97% of patients with URR >65%. Any provider with a score below 30 will face Medicare payment reduction in 2013. Eleven providers were identified.

Of these eleven providers, ten providers lost points due to URR and one provider lost points due to Hgb. Seventy percent of providers that lost points for URR have shown improvement and the remaining thirty percent have submitted QAPI plans. The provider that lost points for Hgb has only 2% of patients with Hgb > 12 as of July 2012.

Network Specific Improvement Project (Task 1c)

▪ *Immunization Project*

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, the low national vaccine rate of 64.3% reported by USRDS in 2011 report (2010 data) for dialysis patients is an opportunity for improvement.

The result of the 2009-2010 Network project is that of the 8,352 dialysis patients were offered the vaccine; 6,233 patients (adjusted for patients with allergies), 75% received the influenza vaccine. Using the baseline data, the MRB set a Network goal of an 80% vaccination rate for 2010/2011. 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 new 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.

■ ***Seasonal Flu Vaccination for Staff***

Influenza transmission to patients by healthcare personnel (HCP) is well documented. HCP can acquire and transmit influenza from patients or transmit influenza to patients and other staff. Vaccination remains the single most effective preventive measure available against influenza, and can prevent many illnesses, deaths, and losses in productivity. Despite the documented benefits of HCP influenza vaccination on patient outcomes and on reducing influenza infection among staff, vaccination coverage among HCP has remained well below the national objective. Several studies now demonstrate that influenza vaccination of healthcare personnel reduces patient mortality. Immunization of healthcare workers ensures patient safety and protects those individuals at high risk of developing complications of influenza.

A recent study in the Joint Commission Journal on quality and patient safety (2/2012 vol. 38 #2) titled “Estimated Costs Associated with Improving Influenza Vaccination for Healthcare Personnel (HCP) in Multi Hospital Health System” by Jeng Lin reports that healthcare personnel came to work despite having a respiratory illness. Data from CDC indicates an average HCP vaccination rate is less than 50% (2008 data).

A review of the NHSN 2011 annual facility survey completed by New England dialysis providers identified data elements about staff receiving seasonal flu vaccination. An electronic spreadsheet was developed to contain vaccination data for 147 providers for 2011/2012 information. This information contained provider’s baseline data to use for re-measurement after an educational campaign had been conducted by the Network.

Table G

Seasonal Flu Vaccination Rate for HCP in Dialysis Provider

State	# Providers with Data	% Influenza Vaccination of HCP
CT	37	55.54
ME	17	72.57
MA	61	60.32
NH	10	47.87
RI	15	53.26
VT	7	92.92

An informative news alert fax blast and electronic blast was distributed on September 25, 2012 to all providers about the importance of Health Care Personnel (HCP) getting vaccinated. A fact sheet on HCP vaccination was inserted in the annual educational meeting (October 23, 2012) for each attendee to be reminded to get the flu shot (attendees = 640 individuals). The Network educational/resource table at the annual meeting was maintained by the PAC which had immunization plastic pocket reference cards for nurses and physicians. The Network ordered over 300 from the CDC. Early results for 2012 indicate 8.6% of HCP have been vaccinated as of December 2012.

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

Four additional modules were launched in 2011. They were:

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

To enhance the program even further in 2012 two additional modules were added. They are:

- Communication
- Constant Site Cannulation

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 November 2012, there were 58 providers (34.7%) registered in this program of which 44 providers (75.9%) 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 2012

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

Results: Nine providers agreed to participate as intervention sites by selecting a specific intervention topic related to infection management. Six of the nine sites selected hand washing (staff and patients) as their area of focus. All providers were given feedback comparative data at the end of 2011 on their infection rates based on data in NHSN. This early notification gave 21 providers information to evaluate and conduct internal quality assessment work. Therefore, it is difficult to determine when intervention work actually began in these providers. Quality improvement is an ongoing continuous process. For the purpose of this project, the observation period is only 5 months for pre and post analysis of data (Figure 4). The overall reportable dialysis related HAI events were lower in all participating providers. The intervention group doing hand washing interventions were able to maintain their low blood stream infection (BSI) rates.

Figure 4

Of the Intervention Group, Hand Washing Intervention Sites Maintained Their Rates.						
	12/2011 to 04/2012			05/2012 to 09/2012		
	# Events	Access Related BSI	Positive Blood Cultures	# Events	Access Related BSI	Positive Blood Cultures
Intervention Sites 9	131 / 2795 = 4.68%	11 / 2795 = 0.35%	15 / 2795 = 0.54%	121 / 2805 = 4.31%	19 / 2805 = 0.67%	25 / 2805 = 0.89%
Non Intervention Sites 12	101 / 2498 = 4.04%	26 / 2498 = 1.04%	30 / 2498 = 1.2%	104 / 2837 = 3.66%	11 / 2837 = 0.39%	15 / 2837 = 0.53%
Hand Washing Intervention Sites 6	66 / 1808 = 3.65%	5 / 1808 = 0.22%	8 / 1808 = 0.44%	54 / 1792 = 3.01%	5 / 1792 = 0.28%	9 / 1792 = 0.50%
Non Hand Washing Intervention Sites 3	65 / 987 = 6.58%	6 / 987 = 0.61%	7 / 987 = 0.71%	64 / 1013 = 6.32%	14 / 1013 = 1.38%	16 / 1013 = 1.58%

Patient Education Video

Although dialysis providers have used a variety of modalities to address the impact of dialysis staff behavior and specific procedures on Healthcare Associated Infection (HAI), there has been little coordinated attention on dialysis patient behaviors and knowledge.

We have previously addressed a similar patient education gap in the area of dialysis access choice. We produced a short video, [The Patient Speaks](#), which shows real patients telling their stories of central venous catheter complications and personal successes with their arteriovenous fistulae. This video is now used in dialysis units across the country and in Chronic Kidney Disease Education Programs. It is available in Spanish and can be found on U Tube.

We used the same format for the HAI Patient Education Video. Real patients in a real dialysis unit interact with real dialysis staff to demonstrate patient responsibilities for infection control: access washing and protection, hand washing, and the use of gloves and masks. The video emphasizes the importance of patients asking questions and being vigilant about infection control measures as they impact the individual patient. The video is a visual translation of “No Germs In and No Germs Out” and “It’s your life and your health.” Funding for this video was provided by HHS Region I, Office of the Regional Health Administrator.

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

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 $\geq$ 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 new CMS goal for September 2012 for this Network is 64.3%. Data in CROWNWeb for vascular access for September will not be available until December. 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

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 2012, there were 3,284 dialysis patients in New England within the working-age range (See Table 8 in data tables sections). 22 patients or 0.7% were referred to or received VR services during the reporting year. 10.2% of this patient group were reported as either working or students.

Vocational Rehabilitation

Of the 12,996 ESRD prevalence patients residing in the six New England states at the end 2012, only 3,284 are of “working age” which is defined as between the ages of 18 to 54. That number represents 25% of the New England dialysis population.

Among the working age patients treated with dialysis 10.9% 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 H).

**Table H: Vocational Rehabilitation by State
Patients Aged 18 - 55 as of December 31, 2012**

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	1,019	3	91	1
MA	1,496	14	153	12
ME	220	2	34	1
NH	215	0	8	0
RI	263	3	27	3
VT	71	0	6	0
Network	3,284	22	319	17

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 the 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 five most often requested educational products in 2012 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*.
- *Finding Your Way* brochure

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 copies from the Network Coordinating Center. In 2011 Network 1 was able to assist Fresenius Medical Care in printing copies of *Preparing for Emergencies* for all their facilities in New England. The Network of New England was open to assisting DaVita, in both 2011 and 2012, with a similar printing, but has not received a response to date. These five popular 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 types of educational information or materials given to patients and providers of CKD/ESRD healthcare throughout the year:

- | | |
|---|--------------------------------------|
| • QI Information | • Transient Care |
| • Rights and Responsibilities | • What the Network functions are |
| • Data Research Information | • Website Referral (DFC) |
| • Complaints and Grievances | • Reimbursement Issues and Questions |
| • Treatment Options | • Coordination of Benefit Questions |
| • Vocational Rehabilitation Information | • KDQOL questions |
| • Information on Dental Services | • Other Requests |

Achieving Network 1 Goals in Quality of Life for ESRD Patients

The importance of patient quality of life remains 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.

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

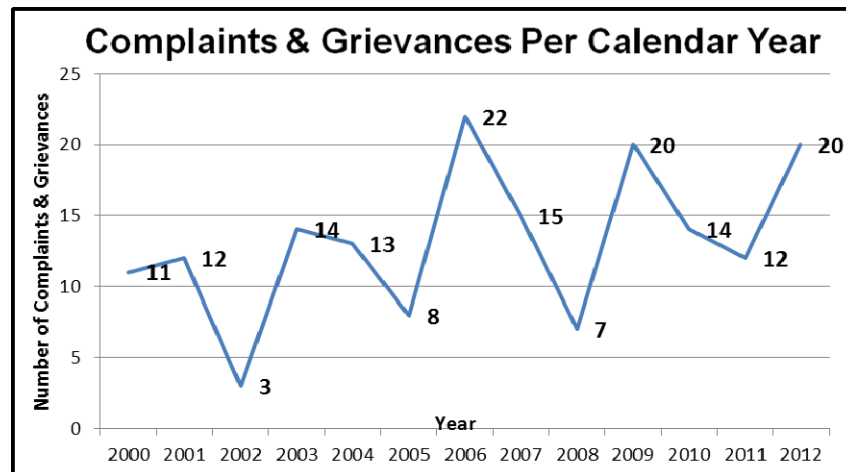
Complaint, Grievance and Contact Report for 2012

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

From January 1, 2012 through December 31, 2012, the Network of New England received 17 beneficiary complaints and 3 formal grievances. This represents an increase in the number of complaints and grievances from 2011. Complaint and general contact data has been captured and tracked for the past 12 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. Displayed here is a trend line for patient complaints.

Figure 5

Number of Complaints/Grievances



Source: SIMS database, Network Contact Utility.

The presenting issues for the 17 complaints and 3 formal grievances were in the categories of treatment related quality of care and staff related/professionalism. At the end of December 2012, all of the complaints/grievances were closed or resolved.

An emerging theme developing in complaints this year is related to patient perceived clinical quality of care complaints (i.e. dialysis prescription, staff not following safe procedures, etc.) with provider staff. Of the 20 complaints and grievances 10 were related to quality of care issues. Nine of the complaints and grievances were staff related. 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 2013, the Network will use the Subject Matter Experts (SME's) as part of the Learning and Action Network (LAN) to disseminate materials to providers on conflict resolution and quality improvement.

This year there were fewer complaints associated with involuntary discharges (IVD). According to Medicare's Conditions for Coverage (CfC), when a facility reports an IVD they are required to contact the Network. When the Network received an IVD, 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 2012, there were 13 involuntary discharges. Of the 13 discharges, 2 were averted as a result of early intervention and consultation with facility staff. The 13 discharges represent a decrease in IVD's from 2011, due to 20 patients being classified as IVD because their facility closed. With no facility closures in 2012, the 13 are actually an increase from the 7 IVD's in 2011.

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, 2012 through December 31, 2012 there were 75 facility concerns in a 12 month period, which represents a slight decrease from 2011's 115 concerns. This is most likely due to the high number of facility inquiries (139) that Network staff received about CROWNWeb assistance. In responding to these contacts, this Network fulfills an important role in providing education, mediation, and deescalating conflicts between patients and staff. This also helps the Network act as an advocate for patients.

Many of these consultations occur when staff notice repeated behavioral issues with patients that are beginning to escalate in a 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 I: Internal Monitoring of Contact Trends

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%

2012

Date	Patient/Family	Provider	Data	Other	Total
1/12-3/12	23	75	172	0	270
4/12-6/12	5	46	138	0	189
7/12-9/12	16	90	218	0	324
10/12-12/12	2	21	87	0	110
Total	46	232	615	0	893
% (Rounded)	5%	26%	69%	0%	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 2012

In the summer of 2012 the Network of New England issued Network Notes, the traditional newsletter for New England renal professionals. The 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 CROWN Web, Five Things Physicians and Patients Should Question, the Patient Experience, the Centers for Disease Control & Prevention's (CDC) National Healthcare Safety Network (NHSN), Data Dialogue, and Fistula First. 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 2012

In January of 2010 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 2012 included:

- Quality Incentive Program (QIP); Technical Assistance
- Vocational Rehabilitation
- The Patient Experience; Patient Feedback Questionnaire
- Traveling While on Dialysis; Dialysis Facility Compare
- Donated Dental Services; Albumin
- Treatment Options
- Medication Do's and Don'ts
- The Patient Experience; Word Search
- National Preparedness Month
- Vaccinations
- Patient Advisory Committee (PAC); The Patient Experience
- 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 by the software tool called Constant Contacts

The Patient Advisory Committee (PAC) Remains Active Throughout 2012

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 14th year of service in 2012. The PAC is advisory to the BOD, MRB, and Network staff and guided by the following mission statement. Since its inception the Patient Advisory Committee has held to a meeting schedule of face-to-face gatherings, telephone conference calls and group e-mails as indicated by the work at hand. The following information describes the PAC's activities throughout 2012.

In 2012, the PAC members, the Network Executive Director and the Network PSC attended 2 meetings in Sturbridge, Massachusetts, one telephone conference calls and several email discussions. During 2012, The New England Patient Advisory Committee (PAC) had 12 members, in total, who were on the committee during the course of the year.

During 2012 the PAC has been engaged in several projects. They are listed below:

- Solomon Four Group Design Project- This PAC project 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 was completed in 2012.

- Dialysis Facility Performance Certificate poster-The PAC developed a poster to help patients understand the Medicare Quality Incentive Program and the Performance Score Certificate that is required, by federal regulation, to be posted in each dialysis facility. The poster informs patients of why this score is important and how it affects them. It also gives them questions to ask their healthcare team. This poster was fax/email blasted to all dialysis facilities and was disseminated at the annual meeting.

The PAC held its annual event on October 12, 2012 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. This year the 6 attending PAC members rotated coverage of the booth throughout October 23, 2012 Network annual meeting. 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. The Network is proud to report that there is an active and “working” PAC giving guidance to ESRD leadership.

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 was stratified to be contacted at different times by phone. Network staff had a scripted interventions tool. Phone alert calls told 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 Network Coordinating Center NEPOP.

Patients	1st Contact	Educational Tool	Post Intervention
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

The intent of this proof of concept project was to test for the degree to which patients can recall receiving educational materials about ESRD and the role of the Network. Four different information approaches were used with one consistent tool, the NEPOP being sent to all new ESRD patients from a central source. In 2012 the Network completed this project. The extensive Network staff work effort to contact these patients by phone resulted in a very few patients and/or family members being reached and were fewer individuals recalling materials sent. There were 4 Network personnel making calls for an estimated 130 hours making phone calls and an additional 40 hours of administrative work.

Due to the small size of respondents, limited conclusions can be made and there is no statistical significance between the “with” or “without” advance organizer groups (phone alert). It is of interest that in Groups 1 and 2, more patients recalled the NEPOP packet when compared to Groups 3 and 4 that received both types of information the NEPOP and the Network booklet.

The second type of recall was about the role/function of the Network. In Groups 1 and 3 with advance organizer and pre-test post-test calls, 24 patients were interviewed. There were 9 of 14 patients (64%) that recalled the Network based on NEPOP information. The Group 3, that received both the NEPOP and Network flyer, only 3 of 10 patients (30%) recalled the Network role. Based on these results, the recommendation to CMS is that early distribution of educational material is not retained by new ESRD patients that are overwhelmed by their new chronic illness.

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 2012 Annual Meeting, a session on Patient Satisfaction, Experience of Care and QAPI was given by Dr. Klemens Meyer. He described explained the distinction between satisfaction and experience of care. Dr. Meyer also discussed the differences among facility-level and patient-level variation in questionnaire responses. Lastly, he summarized the content of ICH-CAPHS and the findings of initial quality improvement studies using this instrument. Also at the annual meeting there was a patient panel of 2 renal patients and one caregiver who spoke about professionalism and boundary issues.

During the 2012 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 requires a DPC training to be conducted. Occasionally, the PSC will conduct onsite training for the facility. This proves to be 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 and 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 choices and find answers for many questions about ESRD Medicare services.

During 2012 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 primary related to verbal interaction with staff members. The conduct, professionalism and communication behavior 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 2012. 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 2012, 54 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 35 years of this Network. The Patient Advisory Committee is now 15 years old and many of its members serve on other 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 the new service for patients to receive donated dental care has been helpful in getting more 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

24th Annual Network of New England Educational Meeting

The annual meeting “Staying A-Float in a Sink or Swim Environment” was held in Sturbridge, MA on Tuesday, October 23, 2012. Topics were:

- “Transparency in Healthcare: What Does it Mean?”
- “Quality Measures and Performance: Expectations for the Future”
- “Patient Satisfaction: Experience of Care and QAPI”
- “Length of Hemodialysis Matters: The Importance of Longer Hemodialysis Treatments in Improving Outcomes”
- Patient Panel: “A Patient’s Voice: Listen Before Being Heard”
- “Vascular Access Surveillance: Does it Make A Difference in Outcomes?”
- “Bed Bugs: Who Are You Sleeping With?”
- “Avoid Blame: Using QAPI Techniques to Create a Blameless Environment”
- “Humor in the Workplace: It’s Good For You”

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 J: Network Annual Meeting Attendance

Year:	2006	2007	2008	2009	2010	2011	2012
Total Attendance:	537	554	668	670	662	688	580
Patient Advisory Committee	6	8	7	8	10	10	10
Administrators/Regional Managers (not including Nurse Managers)	6	10	10	16	31	36	18
Technicians	18	20	30	60	94	97	90
Physicians	15	10	17	16	20	31	15
Dietitians	37	39	56	60	40	54	36
Social Workers	63	64	72	89	80	78	46
Nurses	304	319	390	358	322	314	300
35 Exhibitors	72	56	70	63	65	68	65

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

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

LOGISTICS:	2005	2006	2007	2008	2009	2010	2011	2012
Survey response rate based on total attendance at each Annual Meeting	37% (N=534)	53% (465)	31% (498)	36% (591)	30% (607)	29% (662)	26% (598)	37% 515
Actual number of surveys returned	195	247	153	212	185	194	156	190

RESPONDENTS BY DISCIPLINE:	2005	2006	2007	2008	2009	2010	2011	2012
Physicians / Physician Assistants	2%	2%	2%	1%	1%	2%	3%	1%
Social Workers	58%	52%	42%	45%	41%	38%	34%	32%
Nurses	27%	24%	28%	27%	20%	22%	37%	43%
Dietitians	11%	9%	8%	13%	14%	16%	6%	4%
Administrators	1%	2%	5%	2%	1%	5%	2%	2%
Patients	<1%	0	<1%	0	0	0	0	0
Technicians (formerly in “other” category)	-----	-----	-----	12%	22%	12%	18%	17%
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%	1%

Key Findings:

- Over 99% of respondents indicated that the Network staff responded promptly and were able to provide specific documents and respond to questions.
- Over 97% of respondents felt the Network was a resource for quality related topics or patient/staff issues.
- Over 95% of respondents felt the Network was a resource for statistical and ESRD related regulations.
- Over 60% of respondents had used the Decreasing Patient Provider Conflict toolkit.
- Over 95% of respondents felt the Network was a resource for dealing with disruptive patients.
- Over 90% of respondents found the Network website useful.

Network of New England Technician Educational Meetings: “Translating Knowledge into Action”

During April 2012, 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 5.1 contact hours through the National Association of Nephrology Technicians/Technologists (NANT). A total of 220 technicians attended. The topics discussed were:

- “\$ \$ Cash for Care: How Money Relates to Quality”
- “I Want to get off the Machine: Adverse Symptoms During Hemodialysis Treatments”
- “Advanced CKD and ESRD in the Very Elderly”
- “Nap Time: Coaching Dialysis Patients about Sodium, Fluid, Phosphorus”
- “Beyond Universal Precautions: Challenges for Infection control in Hemodialysis”
- “The Buttonhole Technique: What you Need to Know”

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

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

Question	2011		Did Not Use	2012		
	Yes	No		Yes	No	Did Not Use
Was the information presented useful to your daily work:	98%	2%	NA	75%	21%	4%
Were the speakers well organized, prepared and easy to follow?	97%	3%	NA	68%	2%	5%
Was the sign-up and payment process efficient?	86%	6%	8%	66%	29%	5%
Would you attend another meeting like this next year?	98%	2%	NA	98%	2%	NA

When asked “what were the two most important things you learned today?” 69% responded more focus on non-complaint and difficult patients and how to deal with anger management and understanding more about kidney transplants. Twenty-four percent (24%) said a better understanding of end of life issues and decisions to withdraw from dialysis.

Emergency Preparedness

ESRD is a life threatening condition that affected over 12,500 dialysis patients (hemodialysis and peritoneal) and approximately 9,100 patients who had a functioning kidney transplant in the New England region by November 2012, 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 10 (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 10. 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 serve on the Facility Operations response team by participating in periodic conference calls, development of resource tools, mock drills and coordinating disaster assistance.

▪ *Large Scale Natural Disaster*

On October 29, 2012, Hurricane Sandy and subsequent flooding was a large scale natural disaster that challenged access to dialysis services in this Network. The lack of power and IT communication at the Network office, staff, Centers for Medicare & Medicaid Services and dialysis provider locations stressed and tested the Network BCCP and internal emergency plan. Severe weather advisory emails were sent to Network of New England providers, which alerted them about Hurricane Sandy, provided insight into the projected path and level of threat, offered evacuation information by state, hurricane preparedness information for dialysis patients, dialysis provider "To Do" list and patient hotline numbers. Key Network staff participated in daily conference calls hosted by KCER in response to the impact of Hurricane Sandy on the renal community. These calls were conducted to report degree of impact and resources needed by Network, providers, corporate ownership and affiliate organizations. Direct contact was made with dialysis provider staff along the shoreline - facilities at greater risk - to determine operational status as a result of the storm and assess resources needed. After much coordination and resource planning, there were minimal interruptions for New England dialysis providers to provide treatment for their patients.

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 2012 several activities and projects were successfully completed and participated in by Network of New England staff through its collaboration with Donate Life Connecticut, including:

- Hosting the 22nd 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 37 students, selected out of over 400 posters submitted, at the Annual Donate Life Month Celebration at the Connecticut State Capitol in April.

- Recruiting 68 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.
- In partnership with Donate Life Connecticut, volunteer, Peter Kupczak, lead a campaign to raise awareness of the importance of registering as an organ and tissue donor, and in memory of his daughter, Jessica Marie, by having a billboard placed on Connecticut’s interstate I95 during the month of April. April is National Donor Awareness month, and 2012 marks the 10 year anniversary of Jessica’s “Gift of Life”. Peter promoted his cause to over a hundred businesses, friends and family members in hopes of raising money to support the financial obligations of creating the billboard.
- Hosting the 4th Annual ‘Toast to Life’ fundraising event at Gouveia Vineyards in June. The sold out event was attended by 200 Donate Life supporters, raising over \$19,000. 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 – for the second year in a row - as an official charity of the 2012 Hartford ING Marathon (half, relay and 5K). DLC provided 45 volunteers for the marathon to help organize the start of the race! In addition, DLC had 109 runners and raised more than \$25,000.
- ‘I AM HOPE’ videos were filmed during the first quarter in support of the National Donate Life America campaign, “20 Million in 2012”. The inspirational stories were from DLC transplant recipients or donor families describing how organ and tissue donation changed their lives.

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 2012, 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. In May, the Network hosted a webinar on the topic of fluid management and blood pressure presented by Kay Deck RN, Director of Nursing NxStage Medical. 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. The vice president of Mass PRO serves on the HAI Advisory Committee. The Network Director serves on the CT Leadership Quality Coalition coordinated by Qualidign.

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 in 2013 hired a new director. The Network Director met with her to explore future collaborations especially in the area of transplantation. The New England NKF office is located in Norwood, MA. The Network receives inquiries 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 2012, 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.*

Council on Renal Nutrition of New England (CRNNE)

The CRNNE held their annual education conference on November 7th 2012 in Holyoke, MA. The Network Executive Director was invited for the second year in a row to give a presentation on the ESRD national initiatives that contribute to management of dialysis patients in outpatient dialysis providers. Topics addressed in the presentation were:

- Describe the government's plan for value based purchasing of medical services
- Provide an overview of the current and future dialysis clinical/administrative measures being used for provider performance
- Explain the function and scope of CROWNWeb data system to support ESRD program for oversight and quality of care

Connecticut Leadership for Quality Healthcare Coalition

During 2012, under the leadership of Qualidigm (CT Quality Improvement Organization), the leaders from several treatment types, healthcare payers and state agencies have come together to form a coalition. The Network is a member of the coalition. The vision is to achieve the triple aims of the National Quality Strategy: Better Care, Healthy People/Healthy Communities and Affordable Care. The mission of the Coalition is to align healthcare quality improvement and patient safety initiatives in Connecticut to assure efficient, cost-effective and coordinated efforts among its healthcare providers and stakeholders.

As a first initiative, the group is embarking on a sustainable consumer education campaign to educate the public on how to manage their health and how to interact with the healthcare system. The following topics are under development:

TOPIC	INTERVENTION
Cultural Competency	Health Information Technology / Exchange
Literacy / Health Literacy	Patient Education
Person / Family Engagement	Provider Education
Measuring Patient-centeredness	Patient Incentives
	Provider Incentives

Achieving Network 1 Goals in Collaboration with Other Organizations

Partnerships with ESRD providers and renal professionals have taken many shapes during the past 35 years of this Network. The Patient Advisory Committee is now 14 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) are 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 Facilities by establishing CROWNWeb. Reliable linkages were built between REMIS and CROWNWeb 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 CROWNWeb 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 CROWNWeb is of great importance.

– Patient Registry

The Network of New England ensures data submission into CROWNWeb by ESRD providers. The Network also validates and analyzes the 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 monitors submission of 2728 forms into CROWNWeb by providers by running saved status and audit reports in CROWNWeb. Providers also submit a death notification form (CMS Form 2746) when a patient dies. All the required forms and educational material to submit forms were posted to the Network of New England website at www.networkofnewengland.org/dataforms.htm, as well as to Project CROWNWeb website at www.projectcrownweb.org. In 2012 the number of 2728 forms in CROWNWeb were 3,939 (including supplemental forms), the number of 2746 forms in were 2,732.

– Updating Status of Medicare ESRD Beneficiaries:

Depending on the type of facility ownership, the process of updating the status of the ESRD beneficiaries into CROWNWeb is different. Large Dialysis Organizations (LDO's such as FMC, DaVita and DCI) and National Renal Administrators Association (NRAA) Health Information Exchange (HIE) conduct electronic batch data submission to CROWNWeb to reduce burden of manual data entry. The accuracy and completeness of the data is still the responsibility of the provider.

Facilities affiliated with LDO's are requested to consult their organization about monthly electronic batch data submission schedule. Furthermore, they are required to

- Submit forms 2728 and 2746.
- “Verify” PART in CROWNWeb to sign off on patient census on monthly basis
- Assure clinical data, specially vascular access data, is complete and accurate by the end of the month

Dialysis Facilities not affiliated to Large Dialysis Organizations can submit data electronically rather than manually entering into CrownWeb through NRAA Health Information Exchange (HIE) data submission process. The facility must register with the NRAA HIE. For further information, please visit <http://www.nraa.org/index.php/resources-top/hie>.

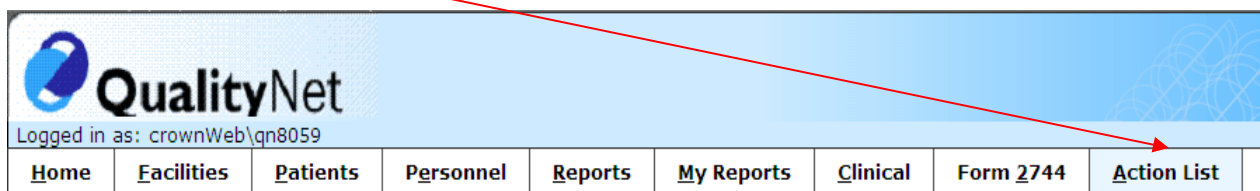
Independent facilities not belonging to any of the above batch submitting organization should submit data manually.

The compliance of data submission according to the provider schedule referred at http://projectcrownweb.org/pages/CROWNWeb_Data_Submission_Provider_Schedule is required by the Conditions for Coverage.

The Network staff track change of treatment, provider and modality for each patient through reporting of events in CROWNWeb. 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.

– **Verification of Patient Data:**

The patient data is also verified through the process of accretions and notifications that are received from CMS as “Action List” in CROWNWeb. Accretions are ESRD patients that do not exist in CROWNWeb but are known to CMS through other related data systems. Notifications are mismatches in data elements in CROWNWeb for existing patients in the database 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 and facility staff work on “Action List” in CROWNWeb and make required changes on a weekly basis to resolve notifications.



Failure to resolve notifications under action list can lead to mismatches in batch data submission when data is submitted by dialysis corporations. While resolving notifications it is important to note that facility should make changes to the data in their corporate systems as well. Please visit <http://www.projectcrownweb.org/lms/curriculums/view/4> to view a video on how to resolve notifications that are listed in action list.

In 2012 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 validation and 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 CROWNWeb 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 CROWNWeb 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 CROWNWeb 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 ensures accurate ESRD patient information for six New England states 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 forms reports and saved forms report from CROWNWeb to facilities. This process allows the facilities to 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 L: Facility Forms Submission Compliance 2009 - 2012

	Annual compliance below 90%			
	Jan – Dec			
	2009	2010	2011	2012
# Facilities	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 2012, none of the transplant centers were delinquent with 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.

– **CROWNWeb 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 2012.
- b. Total number of forms requested from VISION or CROWNWeb facilities.
- c. Total number of forms received from VISION or CROWNWeb facilities.
- d. Total percent of forms validated from VISION or CROWNWeb facilities.

- **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.

- **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 CROWNWeb is replicated to the SIMS central repository.

- **REMIS:**

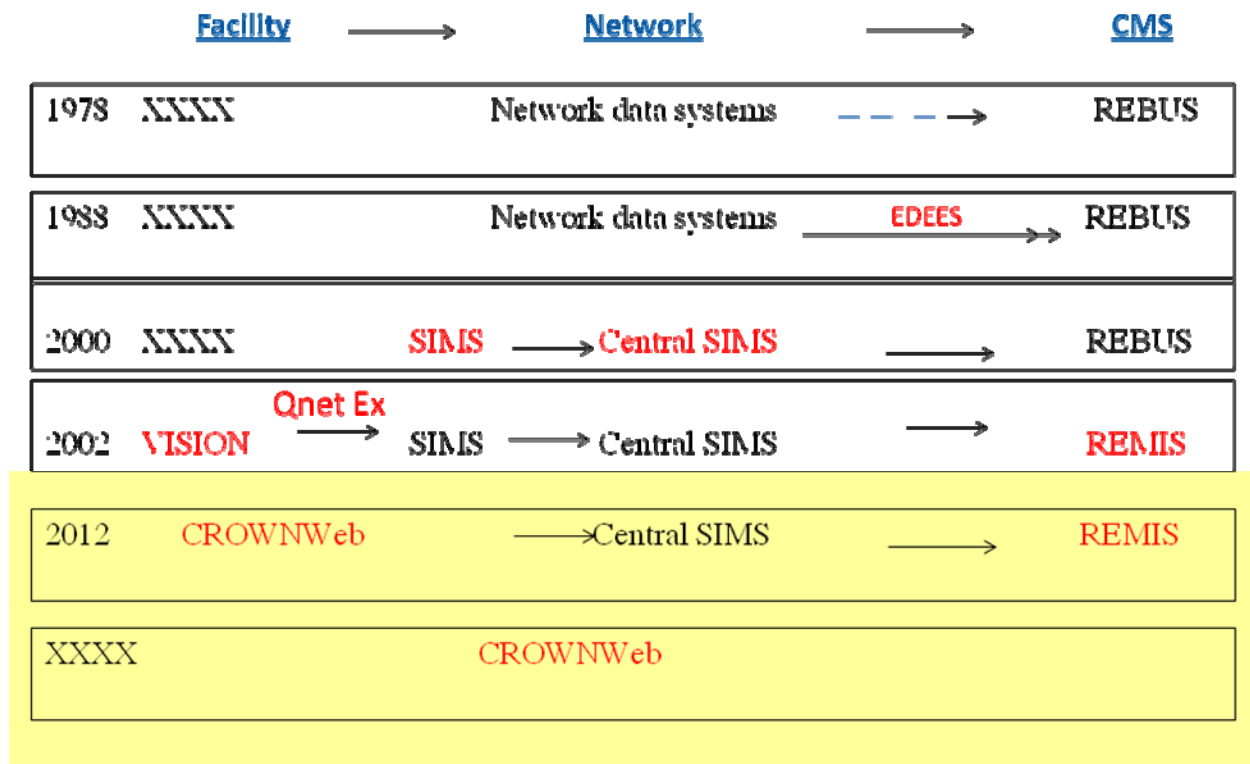
The Renal Management Information System which determines the Medicare coverage periods for ESRD patients and serves as the primary mechanism to store and access ESRD patient and facility information in the ESRD Program Management and Medical Information System Database. REMIS includes an operational 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 6 indicates the changes in data flow from facility to CMS and different systems used in the process from 1978.

Figure 6



- **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 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 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 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 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 CROWNWeb, 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

CROWNWeb 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 CROWNWeb. 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. It can be found on the Network website at 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:

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 2012 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.

VISON and Network SIMS databases were replaced with CROWNWeb in June of 2012. CROWNWeb was 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 Phase IIE of CROWNWeb was implemented. Since June 2012 national release of CROWNWeb, using CROWNWeb for data submission is a requirement for ESRD facilities under the ESRD Conditions for Coverage. Network of New England enrolled providers into CROWNWeb for the national release of CROWNWeb. Other tasks conducted for and after national release were to help providers for data entry and enrollment in QIMS. Network data staff also obtained data from CROWNWeb to enter in SIMS to reduce data submission burden on the facilities until national release of CROWNWeb.

Technical Assistance: Following national release of CROWNWeb, technical support was provided to facilities. 315 hrs out of 510 total calls (317 data processing \CW calls) compared to 140 hrs out of total calls of 345 (215 data processing \CW calls) the previous quarter.

Table M

	Total calls	Data Processing \ CW calls	Time for the Data Processing \ CW calls (< 15 min = 15 min, 15min to 1 hr = 60 min, 1to 2 hrs = 120 min, More than 2 hrs = 180 min)
Jul to Sept	510	317	315 hrs
Mar to Jun	345	215	140 hrs

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 CROWBWeb 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 National release in June 2012

In preparation for CROWNWeb national implementation in 2012, data in SIMS was cleaned up in 2012. 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. 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 2012, 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 2012, 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 three years 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 kidney injury (AKI) patient population. 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. In October 2012, CMS established a Medicare billing code to allow only hospitals to provide AKI patients outpatient dialysis. This creates an access to dialysis services issue when an AKI patient lives closer to a freestanding provider than a hospital.

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 18% hospital-owned dialysis facilities in New England. There are LDO discussions with at least three of these hospitals underway at the end of 2012. 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. The new Quality Incentive program that reduces Medicare payment based on performance scores has created more restrictive admission criteria for some freestanding providers for new patients.

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 only increases this access barrier for new ESRD patients. This is an unintended complication of electronic technology that CMS should evaluate.

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

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 1: ESRD INCIDENCE – ONE YEAR STATISTICS

01/01/2012 - 12/31/2012

AGE GROUP	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
00-04	0	3	0	0	0	0	2	5
05-09	1	4	2	1	1	1	0	10
10-14	3	3	0	0	1	1	1	9
15-19	6	10	1	0	1	0	0	18
20-24	8	17	1	1	1	2	1	31
25-29	9	28	3	2	3	1	2	48
30-34	14	25	4	7	3	1	3	57
35-39	16	38	5	7	5	1	1	73
40-44	49	52	9	11	6	3	4	134
45-49	49	79	15	11	10	7	2	173
50-54	78	133	22	21	23	7	8	292
55-59	100	155	30	25	25	10	7	352
60-64	106	179	50	32	29	11	7	414
65-69	105	192	37	27	31	5	8	405
70-74	90	187	41	39	22	16	7	402
75-79	83	200	29	40	29	12	12	405
80-84	79	157	20	21	29	10	4	320
>=85	81	160	9	11	29	4	7	301
Total	877	1,622	278	256	248	92	76	3,449

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 1 CONTINUED: ESRD INCIDENCE – ONE YEAR STATISTICS

01/01/2012 - 12/31/2012

RACE	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
American Indian/ Alaska Native	3	1	0	0	1	0	0	5
Asian	14	58	1	3	3	1	2	82
Black or African American	204	234	1	4	23	1	11	478
Multiracial	0	6	0	0	1	0	0	7
Native Hawaiian or Other Pacific Islander	3	10	0	0	0	1	0	14
White	651	1,311	276	249	220	89	63	2,859
Not Specified	2	2	0	0	0	0	0	4
Total	877	1,622	278	256	248	92	76	3,449

GENDER	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Female	353	656	106	98	116	35	30	1,394
Male	524	966	172	158	132	57	46	2,055
Not Specified	0	0	0	0	0	0	0	0
Total	877	1,622	278	256	248	92	76	3,449

PRIMARY DIAGNOSIS	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Cystic/Hereditary/Congenital Diseases	49	77	17	14	15	5	2	179
Diabetes	351	631	112	91	101	33	30	1,349
Glomerulonephritis	82	148	26	26	21	10	5	318
Hypertension/Large Vessel Disease	202	391	47	55	57	21	14	787
Interstitial Nephritis/Pylonephritis	40	76	14	12	9	3	2	156
Miscellaneous Conditions	90	178	38	34	32	11	9	392
Neoplasms/Tumors	21	48	16	10	10	4	2	111
Secondary GN/Vasculitis	22	42	7	5	3	1	2	82
Not Specified	20	31	1	9	0	4	10	75
Total	877	1,622	278	256	248	92	76	3,449

Source of information: CROWNWeb

Date of Preparation: June 2013

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

Diagnosis: The categories are from the CMS-2728.

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 35 patients receiving treatment at VA facilities.

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 2: ESRD DIALYSIS PREVALENCE – ONE YEAR STATISTICS

01/01/2012 - 12/31/2012

AGE	CT	MA	ME	NH	Other	RI	VT	TOTAL
00-04	0	1	0	0	1	0	0	2
05-09	1	3	0	0	0	0	0	4
10-14	4	4	0	0	2	1	0	11
15-19	5	15	3	1	0	3	0	27
20-24	17	46	1	5	3	9	4	85
25-29	42	88	15	9	1	12	4	171
30-34	71	111	10	18	3	20	2	235
35-39	95	162	18	20	3	30	5	333
40-44	207	241	41	34	4	35	14	576
45-49	261	329	65	59	5	55	22	796
50-54	318	502	72	67	11	80	26	1,076
55-59	426	582	94	69	16	87	42	1,316
60-64	464	739	146	104	21	99	40	1,613
65-69	445	730	136	85	8	121	57	1,582
70-74	444	664	132	96	18	96	53	1,503
75-79	374	672	113	109	17	117	42	1,444
80-84	325	549	86	67	12	106	44	1,189
>=85	264	519	67	58	12	89	24	1,033
Total	3,763	5,957	999	801	137	960	379	12,996

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 2 CONTINUED: ESRD DIALYSIS PREVALENCE – ONE YEAR STATISTICS

01/01/2012 - 12/31/2012

RACE	CT	MA	ME	NH	Other	RI	VT	TOTAL
American Indian/ Alaska Native	8	11	5	0	0	4	2	30
Asian	52	242	9	11	4	29	2	349
Black or African American	1,279	1,194	22	25	24	153	14	2,711
More than one race selected	3	17	1	1	0	9	0	31
Native Hawaiian or Other Pacific Islander	18	25	0	1	0	8	1	53
White	2,403	4,468	962	763	109	757	360	9,822
Total	3,763	5,957	999	801	137	960	379	12,996

GENDER	CT	MA	ME	NH	Other	RI	VT	TOTAL
Female	1,612	2,485	421	324	59	437	172	5,510
Male	2,151	3,472	578	477	78	523	207	7,486
Total	3,763	5,957	999	801	137	960	379	12,996

ETHNICITY	CT	MA	ME	NH	Other	RI	VT	TOTAL
Hispanic or Latino	471	696	3	15	25	100	2	1,312
Not Hispanic or Latino	3,292	5,261	996	786	112	860	377	11,684
Total	3,763	5,957	999	801	137	960	379	12,996

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 2 CONTINUED: ESRD DIALYSIS PREVALENCE – ONE YEAR STATISTICS

01/01/2012 - 12/31/2012

PRIMARY DIAGNOSIS	CT	MA	ME	NH	Other	RI	VT	TOTAL
Tubular necrosis (no recovery)	67	122	13	17	4	59	2	284
Polycystic kidneys, adult type (dominant)	133	199	39	31	5	38	18	463
Hypertension: Unspecified with renal failure	763	1,208	176	139	21	172	60	2,539
Glomerulonephritis (GN)	308	438	50	55	9	79	20	959
Etiology uncertain	138	232	53	35	4	30	18	510
Complications of transplanted kidney	71	122	20	20	4	43	10	290
Diabetes	1,540	59	2,363	424	326	351	155	5,218
Others	743	1,273	224	178	31	188	96	2,733
Total	3,763	5,957	999	801	137	960	379	12,996

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 3: DIALYSIS PATIENTS MODALITY & SETTING – IN HOME

FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		CAPD		CCPD		OTHER		TOTAL	
CT	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
070025	0	0	11	0	6	10	0	0	17	10
070035	0	0	1	1	14	16	0	0	15	17
07003F	0	0	0	0	1	0	0	0	1	0
072501	3	2	28	18	32	49	0	0	63	69
072503	0	0	4	11	56	55	0	0	60	66
072504	8	7	2	4	10	13	0	0	20	24
072505	0	0	4	4	1	3	0	0	5	7
072506	0	0	0	0	0	0	0	0	0	0
072507	8	4	11	8	58	52	0	3	77	67
072508	1	1	2	1	3	3	0	0	6	5
072509	0	0	8	6	6	8	0	0	14	14
072510	0	0	0	0	0	0	0	0	0	0
072511	0	0	8	5	35	41	0	0	43	46
072512	3	4	0	0	0	0	0	0	3	4
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	1	2	14	13	0	0	15	15
072516	0	0	20	12	11	16	0	0	31	28
072517	0	0	0	0	0	0	0	0	0	0
072518	17	13	7	4	2	6	0	0	26	23
072519	0	0	6	6	5	8	0	0	11	14
072520	0	0	4	2	8	7	0	0	12	9
072521	0	0	2	3	6	6	0	0	8	9
072522	0	0	0	0	0	0	0	0	0	0
072523	0	0	3	7	20	14	0	0	23	21
072524	0	0	5	1	9	12	0	0	14	13

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 3 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING – IN HOME
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		CAPD		CCPD		OTHER		TOTAL	
072527	2	1	2	3	9	9	0	0	13	13
072528	0	1	0	2	0	4	0	0	0	7
072529	0	0	2	0	13	17	0	0	15	17
072530	0	0	0	0	0	0	0	0	0	0
072531	0	0	2	2	0	3	0	0	2	5
072532	0	0	1	3	6	5	0	0	7	8
072533	16	20	0	0	0	0	0	0	16	20
072534	0	0	1	0	1	4	0	0	2	4
072535	0	0	0	0	0	0	0	0	0	0
072536	0	0	0	1	1	1	0	0	1	2
072537	0	0	0	0	0	0	0	0	0	0
072538	0	0	0	1	8	8	0	0	8	9
072539	0	0	1	0	2	5	0	0	3	5
072540	0	0	6	3	2	3	0	0	8	6
072541	0	0	1	0	0	2	0	0	1	2
072542	0	0	5	6	0	2	0	0	5	8
072543	0	0	0	0	0	0	0	0	0	0
072544	0	0	0	3	0	11	0	0	0	14
072545	0	0	2	0	13	0	0	0	15	0
CT TOTALS	N/A	53	N/A	120	N/A	406	N/A	3	N/A	582

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 3 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING – IN HOME
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
MA	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
220028	0	0	2	0	17	18	0	0	19	18
220036	0	0	3	0	1	0	0	0	4	0
220046	3	1	5	2	2	1	0	0	10	4
220071	0	0	16	11	13	12	0	0	29	23
220081	0	0	0	0	0	0	0	0	0	0
220082	0	0	5	2	13	10	0	0	18	12
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	7	9	1	1	2	3	0	0	10	13
222501	2	2	4	2	5	8	0	0	11	12
222502	0	0	0	0	0	0	0	0	0	0
222503	0	0	0	0	8	8	0	0	8	8
222504	0	0	0	0	0	0	0	0	0	0
222505	0	0	0	0	1	0	0	0	1	0
222506	0	0	0	0	0	0	0	0	0	0
222507	0	2	0	0	0	0	0	0	0	2
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	1	1	1	0	0	3	2
222513	0	0	0	0	9	13	0	0	9	13
222515	0	0	0	0	5	0	0	0	5	0
222516	0	0	2	4	4	9	0	0	6	13
222517	3	6	5	2	4	6	0	0	12	14
222519	0	0	0	0	0	0	0	0	0	0

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 3 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING – IN HOME
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
MA	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
222520	0	0	2	1	9	8	0	0	11	9
222521	2	2	2	2	5	9	0	0	9	13
222523	0	0	4	0	4	10	0	0	8	10
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	7	18	40	42	0	0	47	60
222529	0	2	3	13	24	25	0	0	27	40
222530	0	2	4	1	2	6	0	0	6	9
222532	0	0	0	0	0	0	0	0	0	0
222533	0	0	2	1	13	10	0	0	15	11
222534	0	0	0	1	0	5	0	0	0	6
222535	0	0	0	0	0	0	0	0	0	0
222536	0	0	2	1	14	16	0	0	16	17
222537	0	0	0	0	0	0	0	0	0	0
222538	5	8	0	0	0	0	0	0	5	8
222539	0	0	4	1	2	8	0	0	6	9
222542	1	4	2	2	2	4	0	0	5	10
222543	0	0	0	0	8	6	0	0	8	6
222544	0	0	0	0	0	0	0	0	0	0
222545	0	2	2	3	5	11	0	0	7	16
222546	0	0	0	0	4	5	0	0	4	5
222548	0	0	0	0	0	0	0	0	0	0
222549	3	7	8	10	27	37	0	0	38	54
222550	4	4	0	1	6	5	0	0	10	10
222551	0	0	2	0	3	2	0	0	5	2
222552	0	0	10	6	29	25	0	0	39	31
222553	0	0	1	4	6	3	0	0	7	7
222556	0	0	3	5	5	4	0	0	8	9
222557	0	0	0	0	0	0	0	0	0	0

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 3 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING – IN HOME
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
MA	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
222559	0	0	0	0	0	0	0	0	0	0
222560	0	0	0	0	2	0	0	0	2	0
222561	1	0	0	0	0	0	0	0	1	0
222562	1	0	0	0	1	2	0	0	2	2
222564	9	9	0	0	14	19	0	0	23	28
222565	5	5	1	1	5	4	0	0	11	10
222566	0	0	0	0	6	0	0	0	6	0
222567	1	0	0	0	2	6	0	0	3	6
222568	0	0	0	0	0	0	0	0	0	0
222570	0	0	2	1	4	7	0	0	6	8
222571	1	0	0	0	19	21	0	0	20	21
222572	1	0	0	0	4	2	0	0	5	2
222573	1	1	1	1	2	1	0	0	4	3
222574	0	0	0	0	0	1	0	0	0	1
222575	3	5	0	0	1	1	0	0	4	6
222576	0	0	0	0	0	0	0	0	0	0
222577	N/A	0	N/A	0	N/A	0	N/A	0	N/A	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
MA Total	56	71	107	98	360	400	0	0	523	569

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 3 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING – IN HOME
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
ME	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
200018	0	0	1	0	0	0	0	0	1	0
200033	2	1	5	13	9	11	0	0	16	25
200039	3	4	1	1	6	2	0	1	10	8
20003F	0	0	0	0	0	0	0	0	0	0
202500	3	5	1	1	8	6	0	0	12	12
202501	0	0	0	0	0	0	0	0	0	0
202502	1	1	3	1	1	4	0	1	5	7
202503	0	2	4	0	7	5	0	0	11	7
202504	0	0	0	0	0	0	0	0	0	0
202505	0	0	0	0	1	1	0	0	1	1
202506	3	3	2	2	10	7	0	0	15	12
202507	2	1	0	2	1	0	0	0	3	3
202508	0	0	0	0	0	0	0	0	0	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	1	0	1	0	0	0	2
203500	0	0	0	0	0	0	0	0	0	0
203501	0	0	0	0	0	0	0	0	0	0
ME Total	14	17	17	21	44	38	0	2	75	78

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 3 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING – IN HOME
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
NH	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
302500	2	2	4	0	4	6	4	0	4	8
302501	1	1	4	1	4	8	4	0	4	10
302502	2	0	4	2	4	9	4	0	4	11
302503	0	0	0	0	0	0	0	0	0	0
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	5	7	3	3	3	14	3	0	3	24
302508	0	0	0	0	0	0	0	0	0	0
302509	7	4	0	1	0	5	0	0	0	10
302510	0	0	0	0	0	0	0	0	0	0
302511	0	0	0	1	0	5	0	0	0	6
302512	N/A	0	N/A	0	N/A	1	N/A	0	N/A	1
302513	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0
NH Total	17	14	15	8	15	48	15	0	15	70

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities

TABLE 3 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING – IN HOME
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
RI	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
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	2	1	2	1	2	0	2	4
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	0	2	0	2	0	0	0	4
412506	0	0	0	6	0	8	0	0	0	14
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	0	1	0	10	0	0	0	11
412514	0	0	0	0	0	0	0	0	0	0
413500	3	0	3	0	3	0	3	0	3	0
RI Total	5	2	5	10	5	21	5	0	5	33

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 3 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING – IN HOME
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
VT	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
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	1	0	0	0	0	0	0	0	1
473502	0	0	0	0	0	0	0	0	0	0
473503	5	5	5	6	5	8	5	8	5	27
473504	0	1	0	0	0	0	0	0	0	1
VT Total	5	7	5	6	5	8	5	8	5	29
Network Total	155	164	155	263	155	921	155	13	155	1,361

Source of Information: Facility Survey (CMS 2744) and CROWNWeb

Date of Preparation: June 2013

This table includes 0 Veterans Affairs Facility patients for 2012

2011 Survey Year Data is not available in CROWNWeb

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 4: DIALYSIS PATIENTS MODALITY & SETTING - IN-CENTER

FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2011	2012	2011	2012	2011	2012	2011	2012
CT								
070025	182	169	182	0	182	169	182	179
070035	123	102	123	0	123	102	123	119
07003F	35	33	35	0	35	33	35	33
072501	282	244	282	0	282	244	282	313
072503	60	0	60	0	60	0	60	66
072504	157	132	157	0	157	132	157	156
072505	62	50	62	0	62	50	62	57
072506	59	61	59	0	59	61	59	61
072507	188	99	188	3	188	102	188	169
072508	68	56	68	0	68	56	68	61
072509	94	82	94	0	94	82	94	96
072510	88	87	88	0	88	87	88	87
072511	175	124	175	0	175	124	175	170
072512	157	94	157	0	157	94	157	98
072513	62	72	62	0	62	72	62	72
072514	83	82	83	0	83	82	83	82
072515	103	84	103	0	103	84	103	99
072516	156	128	156	0	156	128	156	156
072517	63	58	63	0	63	58	63	58
072518	84	53	84	0	84	53	84	76
072519	77	65	77	0	77	65	77	79
072520	81	76	81	0	81	76	81	85
072521	132	126	132	0	132	126	132	135
072522	74	80	74	0	74	80	74	80
072523	82	60	82	0	82	60	82	81

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 4 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING - IN-CENTER

FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
CT	2011	2012	2011	2012	2011	2012	2011	2012
072524	92	76	92	0	92	76	92	89
072527	76	47	76	0	76	47	76	60
072528	70	71	70	0	70	71	70	78
072529	83	81	83	0	83	81	83	98
072530	29	27	29	0	29	27	29	27
072531	48	43	48	1	48	44	48	49
072532	68	59	68	0	68	59	68	67
072533	59	55	59	0	59	55	59	75
072534	38	38	38	0	38	38	38	42
072535	38	39	38	0	38	39	38	39
072536	23	23	23	0	23	23	23	25
072537	51	66	51	0	51	66	51	66
072538	38	45	38	0	38	45	38	54
072539	35	49	35	0	35	49	35	54
072540	14	30	14	0	14	30	14	36
072541	10	15	10	0	10	15	10	17
072542	25	36	25	1	25	37	25	45
072543	5	27	5	0	5	27	5	27
072544	N/A	122	N/A	0	N/A	122	N/A	136
072545	N/A	0	N/A	0	N/A	0	N/A	0
CT Total	3,168	3,175	3,168	5	3,168	3,180	3,168	3,762

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 4 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING - IN-CENTER

FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2011	2012	2011	2012	2011	2012	2011	2012
MA	2011	2012	2011	2012	2011	2012	2011	2012
220028	68	69	0	0	68	69	87	87
220036	102	94	0	0	102	94	106	94
220046	111	109	0	3	111	112	121	116
220071	2	2	0	0	2	2	31	25
220081	5	5	0	0	5	5	5	5
220082	186	182	186	0	186	182	186	194
22010F	26	25	26	0	26	25	26	25
220110	0	3	0	0	0	3	0	3
220123	4	6	4	0	4	6	4	6
220163	2	3	2	0	2	3	2	3
221302	20	21	20	0	20	21	20	21
222006	16	13	16	0	16	13	16	13
222500	87	94	87	0	87	94	87	107
222501	72	82	72	0	72	82	72	94
222502	127	128	127	0	127	128	127	128
222503	120	109	120	0	120	109	120	117
222504	87	91	87	0	87	91	87	91
222505	71	64	71	0	71	64	71	64
222506	81	86	81	0	81	86	81	86
222507	95	97	95	0	95	97	95	99
222508	98	101	98	0	98	101	98	101
222511	96	79	96	0	96	79	96	79
222512	115	108	115	0	115	108	115	110
222513	66	66	66	0	66	66	66	79
222515	84	77	84	0	84	77	84	77
222516	54	72	54	0	54	72	54	85

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 4 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING - IN-CENTER
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
MA	2011	2012	2011	2012	2011	2012	2011	2012
222517	95	98	95	1	95	99	95	113
222519	63	78	63	0	63	78	63	78
222520	54	56	54	0	54	56	54	65
222521	74	69	74	0	74	69	74	82
222523	103	116	103	0	103	116	103	126
222524	62	64	62	0	62	64	62	64
222525	106	100	106	0	106	100	106	100
222526	171	165	171	1	171	166	171	226
222529	149	136	149	0	149	136	149	176
222530	88	96	88	0	88	96	88	105
222532	31	32	31	0	31	32	31	32
222533	69	56	69	0	69	56	69	67
222534	6	51	6	0	6	51	6	57
222535	59	58	59	0	59	58	59	58
222536	87	97	87	0	87	97	87	114
222537	56	54	56	0	56	54	56	54
222538	128	115	128	0	128	115	128	123
222539	53	51	53	0	53	51	53	60
222542	85	87	85	0	85	87	85	97
222543	87	92	87	0	87	92	87	98
222544	26	0	26	0	26	0	26	0
222545	77	86	77	0	77	86	77	102
222546	74	82	74	0	74	82	74	87
222548	19	19	19	0	19	19	19	19
222549	85	75	85	0	85	75	85	129
222550	94	103	94	0	94	103	94	113

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 4 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING - IN-CENTER
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2011	2012	2011	2012	2011	2012	2011	2012
MA	2011	2012	2011	2012	2011	2012	2011	2012
222551	68	89	68	0	68	89	68	91
222552	111	122	111	0	111	122	111	153
222553	52	58	52	0	52	58	52	65
222556	85	76	85	0	85	76	85	85
222557	55	60	55	0	55	60	55	60
222559	40	39	40	0	40	39	40	39
222560	75	79	75	0	75	79	75	79
222561	67	76	67	0	67	76	67	76
222562	44	47	44	0	44	47	44	49
222564	129	123	129	0	129	123	129	151
222565	119	112	119	0	119	112	119	122
222566	68	70	68	0	68	70	68	70
222567	84	82	84	0	84	82	84	88
222568	68	41	68	0	68	41	68	41
222570	63	68	63	0	63	68	63	76
222571	66	77	66	0	66	77	66	98
222572	40	49	40	0	40	49	40	51
222573	70	100	70	0	70	100	70	103
222574	75	85	75	0	75	85	75	86
222575	9	8	9	0	9	8	9	14
222576	4	22	4	0	4	22	4	22
222577	N/A	3	N/A	0	N/A	3	N/A	3
223302	18	20	18	0	18	20	18	26
223501	94	98	94	0	94	98	94	98
223504	5	7	5	0	5	7	5	7
MA Total	5,314	5,433	5,314	5	5,314	5,438	5,314	6,007

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 4 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING - IN-CENTER
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2011	2012	2011	2012	2011	2012	2011	2012
ME	2011	2012	2011	2012	2011	2012	2011	2012
200018	45	43	45	0	45	43	45	43
200033	120	122	120	0	120	122	120	147
200039	46	43	46	0	46	43	46	51
20003F	19	19	19	0	19	19	19	19
202500	89	87	89	0	89	87	89	99
202501	52	51	52	0	52	51	52	51
202502	50	51	50	0	50	51	50	58
202503	71	75	71	0	71	75	71	82
202504	62	56	62	0	62	56	62	56
202505	89	83	89	0	89	83	89	84
202506	54	57	54	0	54	57	54	69
202507	24	18	24	0	24	18	24	21
202508	34	30	34	0	34	30	34	30
202509	23	29	23	0	23	29	23	29
202510	18	18	18	0	18	18	18	19
202511	17	21	17	0	17	21	17	23
203500	46	47	46	0	46	47	46	47
203501	33	33	33	0	33	33	33	33
ME Total	892	883	892	0	892	883	892	961

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 4 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING - IN-CENTER
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2011	2012	2011	2012	2011	2012	2011	2012
NH	2011	2012	2011	2012	2011	2012	2011	2012
302500	58	75	58	0	58	75	58	83
302501	70	86	70	0	70	86	70	96
302502	95	102	95	0	95	102	95	113
302503	46	40	46	0	46	40	46	40
302504	60	63	60	0	60	63	60	63
302505	88	80	88	0	88	80	88	80
302506	52	52	52	0	52	52	52	52
302507	90	94	90	0	90	94	90	118
302508	34	29	34	0	34	29	34	29
302509	82	78	82	0	82	78	82	88
302510	26	35	26	0	26	35	26	35
302511	22	28	22	0	22	28	22	34
302512	N/A	18	N/A	0	N/A	18	N/A	19
NH Total	723	780	723	0	723	780	723	850

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 4 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING - IN-CENTER
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2011	2012	2011	2012	2011	2012	2011	2012
RI								
410007	3	1	3	0	3	1	3	1
410012	1	2	1	0	1	2	1	2
41002F	25	29	25	0	25	29	25	29
412501	126	115	126	0	126	115	126	119
412502	47	38	47	0	47	38	47	38
412503	67	65	67	0	67	65	67	65
412504	91	87	91	0	91	87	91	87
412505	94	95	94	0	94	95	94	99
412506	93	77	93	0	93	77	93	91
412507	47	43	47	0	47	43	47	43
412508	63	76	63	0	63	76	63	76
412509	73	78	73	0	73	78	73	78
412510	73	69	73	0	73	69	73	69
412511	58	58	58	0	58	58	58	58
412512	73	67	73	0	73	67	73	78
412514	75	72	75	0	75	72	75	72
413500	68	68	68	0	68	68	68	68
RI Total	1,077	1,040	1,077	0	1,077	1,040	1,077	1,073

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 4 CONTINUED: DIALYSIS PATIENTS MODALITY & SETTING - IN-CENTER
FOR SURVEY YEARS 2011 AND 2012

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2011	2012	2011	2012	2011	2012	2011	2012
VT								
470003	8	10	8	0	8	10	8	10
472500	37	42	37	0	37	42	37	42
472501	22	28	22	0	22	28	22	28
473500	38	36	38	0	38	36	38	36
473501	49	51	49	0	49	51	49	52
473502	34	36	34	0	34	36	34	36
473503	80	85	80	1	80	86	80	113
473504	21	19	21	0	21	19	21	20
VT Total	289	307	289	1	289	308	289	337
Network Total	11,435	11,618	11,435	11	11,435	11,629	11,435	12,990

Source of Information: Facility Survey (CMS 2744) and CROWNWeb

Date of Preparation: June 2013

1 The last column of the report displays the total from Table #3 plus total from Table #4

This table includes 106 Veterans Affairs Facility patients for 2012

2011 Survey Year Data is not available in CROWNWeb

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 5: RENAL TRANSPLANTS BY TRANSPLANT CENTER

01/01/2012 – 12/31/2012

TX CENTER	TOTAL TRANSPLANTS PERFORMED		PATIENTS WAITING FOR TRANSPLANT	
	2011	2012	2011	2012
CT				
070022	110	106	533	485
070025	43	53	324	356
State Total	153	159	N/A*	841
MA				
220031	27	30	207	338
220071	76	84	254	415
220077	31	27	153	179
220086	51	46	340	351
220110	45	53	332	157
220116	42	25	195	227
220163	55	50	202	130
220171	40	43	161	168
223302	27	23	3	7
State Total	394	381	N/A*	1,972
ME				
200009	46	45	112	55
State Total	46	45	N/A*	55
NH				
300003	57	37	47	96
State Total	57	37	N/A*	96
RI				
410007	49	66	173	189
State Total	49	66	N/A*	189
VT				
470003	36	23	100	118
State Total	36	23	N/A*	118
Total	735	711	N/A*	3271

2011 Survey Year Data is not available in CROWNWeb

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 6: RENAL TRANSPLANTS BY TRANSPLANT TYPE

01/01/2012 – 12/31/2012

AGE GROUP	TRANSPLANT TYPE				TOTAL
	DECEASED	LIVING RELATED	LIVING UNRELATED	UNKNOWN	
00-04	1	1	2	0	4
05-09	4	4	1	0	9
10-14	5	3	1	0	9
15-19	7	7	1	0	15
20-24	7	6	1	0	14
25-29	12	12	5	0	29
30-34	19	10	4	0	33
35-39	24	12	10	0	46
40-44	31	7	11	0	49
45-49	43	12	19	0	74
50-54	47	23	18	0	88
55-59	58	26	20	0	104
60-64	65	25	21	0	111
65-69	44	19	9	0	72
70-74	24	8	5	0	37
75-79	10	2	3	0	15
80-84	1	1	0	0	2
>=85	0	0	0	0	0
Total	402	178	131	0	711

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 6 CONTINUED: RENAL TRANSPLANTS BY TRANSPLANT TYPE

01/01/2012 – 12/31/2012

RACE	TRANSPLANT TYPE				TOTAL
	DECEASED	LIVING RELATED	LIVING UNRELATED	UNKNOWN	
American Indian/Alaska Native	0	0	0	0	0
Asian	12	2	3	0	17
Black or African American	83	14	8	0	105
Multiracial	0	2	0	0	2
Native Hawaiian or Other Pacific Islander	1	2	0	0	3
White	304	158	118	0	580
Not Specified	2	0	2	0	4
Total	402	178	131	0	711

GENDER	TRANSPLANT TYPE				TOTAL
	DECEASED	LIVING RELATED	LIVING UNRELATED	UNKNOWN	
Female	135	73	48	0	256
Male	267	105	83	0	455
Total	402	178	131	0	711

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities

TABLE 6 CONTINUED: RENAL TRANSPLANTS BY TRANSPLANT TYPE

01/01/2012 – 12/31/2012

PRIMARY DIAGNOSIS	TRANSPLANT TYPE				TOTAL
	DECEASED	LIVING RELATED	LIVING UNRELATED	UNKNOWN	
Tubular necrosis (no recovery)	3	2	2	0	7
Polycystic kidneys, adult type (dominant)	32	16	19	0	67
Hypertension: Unspecified with renal failure	45	15	8	0	68
Glomerulonephritis (GN)	53	30	13	0	96
Etiology uncertain	25	9	11	0	45
Complications of transplanted kidney	15	3	3	0	21
Diabetes	112	29	23	0	164
Others	117	74	52	0	243
Total	402	178	131	0	711

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 7: DIALYSIS DEATHS

01/01/2012 - 12/31/2012

AGE	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
00-04	0	1	0	0	0	0	1	2
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	0	0	0
25-29	2	0	0	1	0	0	0	3
30-34	3	3	0	3	0	0	0	9
35-39	2	2	2	1	1	0	0	8
40-44	6	12	3	1	2	0	0	24
45-49	8	18	5	7	5	3	1	47
50-54	21	35	9	5	8	4	0	82
55-59	23	49	14	14	8	6	0	114
60-64	46	65	27	19	8	11	0	176
65-69	55	112	42	18	21	7	1	256
70-74	76	122	35	35	19	13	1	301
75-79	63	139	35	19	24	17	6	303
80-84	99	164	24	16	36	14	3	356
>=85	125	214	14	17	40	12	5	427
Total	529	936	210	156	172	87	18	2,108

RACE	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Multiracial	1	2	0	0	1	0	0	4
Native Hawaiian or Other Pacific Islander	0	2	0	1	1	1	0	5
White	528	931	210	155	170	86	18	2,098
Not Specified	0	1	0	0	0	0	0	1
Total	529	936	210	156	172	87	18	2,108

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 7: DIALYSIS DEATHS

01/01/2012 - 12/31/2012

GENDER	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Female	210	369	81	67	62	29	7	825
Male	319	567	129	89	110	58	11	1,283
Not Specified	0	0	0	0	0	0	0	0
Total	529	936	210	156	172	87	18	2,108

DIAGNOSIS	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Cystic/Hereditary/Congenital Diseases	12	21	6	3	2	1	0	45
Diabetes	216	413	111	66	67	40	5	918
Glomerulonephritis	37	52	11	18	19	1	2	140
Hypertension/Large Vessel Disease	129	248	43	38	44	26	6	534
Interstitial Nephritis/Pyelonephritis	33	46	10	4	6	6	0	105
Miscellaneous Conditions	62	91	15	18	23	11	3	223
Neoplasms/Tumors	26	42	11	7	9	2	1	98
Secondary GN/Vasculitis	10	18	3	1	2	0	1	35
Not Specified	4	5	0	1	0	0	0	10
Total	529	936	210	156	172	87	18	2,108

CAUSE OF DEATH	CT	MA	ME	NH	RI	VT	OTHER*	TOTAL
Cardiac	179	346	73	45	63	29	12	747
Gastro-Intestinal	7	9	3	0	0	2	1	22
Infection	71	96	27	14	19	7	2	236
Liver Disease	13	13	1	3	2	0	0	32
Other	151	277	79	59	66	31	2	665
Unknown	50	87	12	17	7	14	1	188
Vascular	23	39	8	2	8	0	0	80
Not Specified	35	69	7	16	7	4	0	138
Total	529	936	210	156	172	87	18	2,108

Source of information: CROWNWeb

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

Diagnosis: Categories are from the CMS-2728.

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 22 patients receiving treatment at VA facilities.

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

CT

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part- Time	Patients Attending School Full-Time or Part-Time
070025	80	0	3	0
070033	0	0	0	0
072521	33	0	3	0
070035	20	0	1	0
07003F	5	0	0	0
072501	107	0	5	0
072503	23	1	3	0
072504	30	0	3	0
072505	17	0	0	0
072506	13	0	3	0
072507	68	0	2	0
072508	19	0	0	0
072509	26	0	0	0
072510	13	0	1	0
072511	52	0	1	0
072512	31	0	2	0
072513	24	0	1	0
072514	18	0	1	0
072515	24	0	0	0
072517	18	0	0	0
072518	24	0	0	0
072519	22	0	3	0
072516	43	0	11	0
072522	7	0	1	0
072524	18	0	4	0
072520	18	0	3	0

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8 CONTINUED: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

CT

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
072523	21	1	0	1
072527	17	0	1	0
072528	10	0	1	0
072532	13	0	0	0
072529	20	0	6	0
072530	6	0	0	0
072531	24	0	2	0
072533	27	0	2	0
072534	7	0	0	0
072535	11	0	2	0
072536	10	0	2	0
072537	16	0	6	0
072538	13	0	2	0
072539	14	0	2	0
072540	8	0	1	0
072541	4	0	0	0
072542	9	0	2	0
072543	5	0	0	0
072544	24	1	11	0
072545	0	0	0	0
CT Total	1,019	3	91	1

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8 CONTINUED: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

MA

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part- Time	Patients Attending School Full-Time or Part-Time
220028	16	0	1	0
220031	0	0	0	0
220036	15	0	0	0
220046	29	0	5	0
220071	15	0	2	0
220071	0	0	0	0
220077	0	0	0	0
220081	1	0	1	0
220082	36	0	5	0
220086	0	0	0	0
22010F	0	0	0	0
220110	1	0	0	0
220110	0	0	0	0
220116	0	0	0	0
220123	2	0	0	0
220163	0	0	0	0
220163	0	0	0	0
222556	14	0	3	0
220171	0	0	0	0
222006	8	0	0	0
222500	46	0	4	0
222501	18	0	1	0
222502	45	0	0	0
222504	21	0	5	1
222506	18	0	0	0

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8 CONTINUED: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

MA

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
222507	30	0	1	0
222508	29	3	13	2
222511	12	0	0	0
222512	23	0	0	0
222513	20	0	0	0
222515	15	0	0	0
222516	31	0	3	0
222517	18	0	1	0
222519	21	0	1	0
222520	9	0	3	0
222521	33	0	3	0
222523	18	0	2	0
222524	13	0	2	0
222525	31	0	0	0
222526	89	0	4	0
222529	54	3	12	0
222530	33	0	1	0
222532	4	0	0	0
222533	11	0	1	0
222534	5	0	1	0
222535	17	0	1	0
222536	44	0	0	0
222537	4	0	1	0
222538	48	0	2	0
222539	13	0	4	0
222542	26	0	2	0

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8 CONTINUED: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

MA

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
222546	18	0	7	0
222543	26	1	4	1
222545	26	0	1	0
222548	2	0	0	0
222549	36	2	11	0
223302	14	2	1	4
223302	0	0	0	0
223501	17	0	0	0
222551	14	0	0	0
222550	16	0	1	0
222553	13	0	1	0
222552	40	0	2	0
222557	6	0	0	0
222561	19	0	0	0
222559	5	0	1	0
222560	18	0	1	0
223504	1	0	1	0
222562	11	0	1	0
222564	50	3	9	3
222565	33	0	0	0
222566	10	0	1	0
222567	15	0	1	0
222568	3	0	1	0
222570	15	0	5	0
222571	25	0	5	1

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8 CONTINUED: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

MA

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
221302	5	0	1	0
222572	3	0	0	0
222574	26	0	3	0
222573	32	0	8	0
222503	35	0	1	0
222576	5	0	1	0
222544	0	0	0	0
222505	16	0	0	0
222575	3	0	0	0
222577	2	0	0	0
MA Total	1,496	14	153	12

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8 CONTINUED: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

ME

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part- Time	Patients Attending School Full-Time or Part-Time
200009	0	0	0	0
200018	12	0	0	0
200033	38	0	6	0
200039	10	0	3	0
20003F	4	0	0	0
202500	27	0	3	0
202501	10	1	2	0
202502	14	0	5	0
202503	17	1	4	1
202504	16	0	2	0
203500	8	0	0	0
202506	14	0	1	0
202505	17	0	4	0
202507	3	0	0	0
202509	4	0	2	0
202510	4	0	0	0
202508	8	0	0	0
203501	8	0	1	0
202511	6	0	1	0
ME Total	220	2	34	1

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8 CONTINUED: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

NH

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part- Time	Patients Attending School Full-Time or Part-Time
300003	0	0	0	0
302507	36	0	1	0
302500	22	0	0	0
302501	19	0	3	0
302502	28	0	0	0
302503	15	0	0	0
302504	15	0	2	0
302505	20	0	0	0
302506	10	0	0	0
302510	6	0	0	0
302509	18	0	1	0
302508	9	0	0	0
302511	11	0	1	0
302512	6	0	0	0
302513	0	0	0	0
302514	0	0	0	0
NH Total	215	0	8	0

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8 CONTINUED: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

RI

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part- Time	Patients Attending School Full-Time or Part-Time
410007	0	0	0	0
410007	0	0	0	0
410012	1	0	1	0
41002F	2	0	0	1
412501	38	0	2	0
412502	6	0	0	0
412503	13	0	0	0
412504	19	1	3	0
412505	27	0	6	0
412506	30	0	2	0
412507	6	0	0	0
412508	11	0	1	0
412509	9	0	0	0
412510	22	0	1	0
412511	17	0	4	1
412512	22	1	6	1
412514	8	1	1	0
413500	32	0	0	0
RI Total	263	3	27	3

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.

TABLE 8 CONTINUED: VOCATIONAL REHABILITATION

01/01/2012 - 12/31/2012

VT

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part- Time	Patients Attending School Full-Time or Part-Time
470003	2	0	0	0
470003	0	0	0	0
473500	8	0	1	0
473501	9	0	2	0
473502	7	0	1	0
472500	7	0	0	0
473503	24	0	2	0
473504	7	0	0	0
472501	7	0	0	0
VT Total	71	0	6	0
Total NW	3,284	22	319	17

The enclosed data was pulled from a snapshot of CROWNWeb as of 6/5/2013. As data in CROWNWeb can be updated by facilities through the SUI or batch submission at any time, these numbers may not match what was extracted on earlier or later dates. Due to the transition to the new CMS system, CROWNWeb in June 2012, there may also be greater variances in data between 2011 and 2012 than in prior years. It should also be noted that with the national release of CROWNWeb, the responsibility for verifying, correcting and updating patient data changed from Networks to the Medicare Certified dialysis facilities.