



End-Stage Renal Disease
Network of New England

2014 Annual Report



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EXECUTIVE SUMMARY

IPRO's End-Stage Renal Disease (ESRD) Network of New England serves as the federally-funded contractor for the six New England states, with a mission to promote quality healthcare for all ESRD patients that is safe, effective, efficient, patient-centered, timely, and equitable. To achieve this goal, Network staff works with providers, stakeholders, and patients toward improving care, engaging and empowering patients as consumers, and aligning with the three AIMs outlined in the National Quality Strategy and Centers for Medicare & Medicaid Services (CMS) priorities:

- Better care for the individual through beneficiary and family centered care
- Better health for the ESRD population
- Reduce costs of ESRD care by improving care

In 2014, the Network continued to demonstrate efficacy and leadership in the care of patients living with end-stage renal disease. Highlights of successes in meeting Network goals include:

Patient and Family Engagement

Patients are an integral part of the Network. In 2014, patients served as Subject Matter Experts (SMEs) in the Patient and Family Engagement Learning and Action Network (PFE LAN), and on Network leadership committees. These patients actively participated in the design of educational campaigns and quality improvement activities. The Network focused on enhancing the voice of the patient and promoting a model of healthcare that is respectful of, and responsive to, individual patient preferences, needs, and values. The Network conducted a number of successful initiatives designed to foster patient and family engagement at the facility level. In addition, the Network Patient Advisory Committee (PAC) members volunteer at the facility level and work with Network staff to develop and promote educational events, present on webinars, and educate patients, family members, and care partners on topics related to ESRD. By working in partnership with the Network, patients are able to bring a voice and experience in fulfilling the mission of the Network and assisting our peers in living an optimal life with ESRD.

- Through social media strategies, the Network engaged a record number of people from the New England ESRD community with the launch of a Facebook page geared towards patients and care partners—1,604 posts, likes, comments, and shares—resulted in a total reach to 15,082 individuals.
- The *Patient Advisory Committee Recruitment* project resulted in a 17.49% (32/183) improvement in the number of facilities patient with PAC members serving as peer-to-peer mentors.
- The *Hand Hygiene Awareness* project resulted in a 24.41% (1,076/1,390) improvement in patients' understanding of hand hygiene guidelines.
- The *Enhancing Patient-Provider Communication* project was conducted in five targeted facilities with a total of 90 patients (14% of the aggregate patients) successfully participating in the *Jeopardy* style educational activity.

Quality Improvement

In 2014, the Network worked with providers across New England to increase arteriovenous fistula (AVF) in use rates by greater than one percent and decrease long-term catheter (LTC) in use rates by two percent in prevalent patients. The Network developed a series of educational campaigns that targeted at-risk or deficient facilities for action plans, tracking the progress of fistula and catheter rates through data systems, and facility site visits. The Network was unable to achieve the two percent LTC reduction goal, but was able to achieve a 66.21% AVF in use rate, surpassing the established goal.

The Network also worked to reduce healthcare associated infections (HAI), the leading causes of morbidity and mortality in the United States and one of the most common types of adverse events in healthcare today. The Network organized a HAI Learning and Action Network (LAN) to identify best practices, barriers, and opportunities for improving quality measures, as well as the overall quality of care for patients by reducing HAI rates. The key initiative for this project included training and monitoring implementation of HAI surveillance audits.

- The *Healthcare Associated Infections* quality improvement activity resulted in a 95% (39/41) accuracy of observation audits in infection prevention being conducted correctly in targeted facilities.
- The *Transplant Coordination* innovation project was conducted in 18 targeted facilities, with a total of 96 patients or 11.6% of total patient census being referred to transplant. The Network achieved a 9.6% relative improvement in cumulative patient referrals, surpassing the five percent goal.

The Network's Population Health Innovation Project focused on increasing transplant referral rates in our eligible population by five percentage points, while demonstrating a one percent reduction in the identified disparity gap of age. The project included convening a Transplant Learning and Action Network (T-LAN), as well as educating staff and patients, providing technical assistance, and performing environmental scans to identify and address barriers. The Network met the referral goal of five percent, but did not meet the disparity reduction goal of one percent. As a result, staff members conducted a root cause analysis to identify strategies that will lead to successful outcomes in future projects.

Our Ongoing Commitment

IPRO remains intensely committed to supporting the ESRD Network Program in New England toward improving the lives of ESRD patients. We are proud of our progress to date and are pleased to present the Network's Annual Report, which covers the period of January 1, 2014–December 31, 2014. We hope you will find this report informative, and most importantly, helpful in understanding the initiatives that the Network has implemented to enhance patient and family engagement and improve the quality of care for individuals with ESRD across New England.

On behalf of our organization, we express our gratitude for the commitment of the many volunteers—patients, nurses, social workers, physicians, dietitians, and administrators—who partner with us to achieve our common goals.

INTRODUCTION

CMS' End Stage Renal Disease (ESRD) Network Organization Program

The End Stage Renal Disease Network Organization Program (ESRD Network Program) is a national quality improvement program funded by the Centers for Medicare & Medicaid Services (CMS). CMS is a federal agency, part of the U.S. Department of Health and Human Services.

CMS defines end stage renal disease (ESRD) as permanent kidney failure in an individual who requires dialysis or kidney transplantation to sustain life.

Under contract with CMS, 18 ESRD Network Organizations, or ESRD Networks, carry out a range of activities to improve the quality of care for individuals with ESRD. The 18 ESRD Networks serve the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.

Medicare Coverage for Individuals with ESRD

Medicare coverage was extended to most ESRD patients in the U.S. under the Social Security Act Amendments of 1972 (Public Law 92-603). Individuals with irreversible kidney failure are eligible for Medicare if they need regular dialysis or have had a kidney transplant and they meet (or their spouse or parent meets) certain work history requirements under the Social Security program, the railroad retirement system, or federal employment.

History of CMS' ESRD Network Organization Program

Following passage of the 1972 Amendments to the Social Security Act, in response to the need for effective coordination of ESRD care, hospitals and other health care facilities were organized into networks to enhance the delivery of services to people with ESRD.

In 1978, Public Law 95-292 modified the Social Security Act to allow for the coordination of dialysis and transplant services by linking dialysis facilities, transplant centers, hospitals, patients, physicians, nurses, social workers, and dietitians into Network Coordinating Councils, one for each of 32 administrative areas.

In 1988, CMS consolidated the 32 jurisdictions into 18 geographic areas and awarded contracts to 18 ESRD Network Organizations, now commonly known as ESRD Networks. The ESRD Networks, under the terms of their contracts with CMS, are responsible for: supporting use of the most appropriate treatment modalities to maximize quality of care and quality of life; encouraging treatment providers to support patients' vocational rehabilitation and employment; collecting, validating, and analyzing patient registry data; identifying providers that do not contribute to the achievement of Network goals; and conducting onsite reviews of ESRD providers as necessary.

IPRO ESRD Network of New England's Role in Improving the Quality of ESRD Care

The role of the IPRO ESRD Network of New England is to improve the quality of care for people who require dialysis, transplantation, and/or related life sustaining treatment for ESRD, in support of the three AIMS outlined in the Executive Summary. Our goals, our methodology for attaining them, and our achievements are described throughout this report.

The Network's Relationship with a Larger Corporate Structure

The ESRD Network of New England (the Network) serves dialysis providers and patients in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Network is one of 18 ESRD Network Organizations under contract to CMS and is operated by IPRO, a national organization.

Founded in 1984, IPRO holds contracts with federal, state, and local government agencies, as well as private sector clients, in more than 33 states and the District of Columbia. In 2014, IPRO established the Atlantic Quality Innovation Network (AQIN), one of 14 Medicare-funded Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) operating across the U.S. Led by IPRO, AQIN works in concert with healthcare providers in New York, the District of Columbia, and South Carolina to ensure care provided to Medicare beneficiaries is patient-centered, safe, and coordinated.

As an IPRO affiliate, the Network is provided direct access to technical assistance from a broad range of professionals in quality improvement, infection control, mental health, primary care, health policy, information technology, and communications. These partnerships further accelerate the Network's ability to engage and empower ESRD patients and work with dialysis providers to improve the quality of care they deliver. IPRO is fully committed to promoting and achieving the goals and vision of the ESRD Network Program, as well as providing support to the patients and providers within the Network service area.

Geographic Area Served by the IPRO ESRD Network of New England

The geographic area of the Network comprises six states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. According to Census Bureau data, the combined population of the aforementioned states is approximately 14.61 million people (2014 estimates based on 2010 census (<http://www.census.gov/>)). The Network's service area varies greatly in area and population. While individual New England states differ widely in demographic characteristics, in general, the New England area is considered urban/metropolitan. The variation in population and land area among different states in New England influences the availability of ESRD services and treatment choices. Maine is the largest of the six New England states, yet has the lowest population density. Rhode Island is the smallest state, however, with highest population density. The majority of the residents in Connecticut, Massachusetts, and Rhode Island live in metropolitan areas.

The Network's activities support approximately 13,400 dialysis patients reported as receiving treatment for ESRD as of December 2014. These patients are served by 186 Medicare certified dialysis facilities, 15 transplant centers and four Veterans Affairs (VA) hospitals.

For a complete analysis of ESRD patients, facilities, and transplant center census in New England, refer to Data Tables starting on page 33.

Table A. Dialysis Facilities and Transplant Centers in the IPRO ESRD Network of New England’s Service Area, as of December 31, 2014

Category	Number*
Number of Dialysis Facilities in IPRO ESRD Network of New England’s Service Area*	186
Number of Transplant Centers in IPRO ESRD Network of New England’s Service Area*	15

Source: End Stage Renal Disease National Coordinating Center (ESRD NCC) report to ESRD Forum.

*Counts of dialysis facilities and transplant centers may include a small number of facilities that closed during the calendar year but did not have a closing date recorded in CROWNWeb as of December 31, 2014.

Table B. Number of Dialysis Facilities in IPRO ESRD Network of New England’s Service and Number and Percent of Dialysis Facilities Offering Dialysis Shifts Starting after 5 PM, as of December 31, 2014

Category	Number*	Percent
Number of Dialysis Facilities in IPRO ESRD Network of New England’s Service Area*	186	N/A
Dialysis Facilities in IPRO ESRD Network of New England’s Service Area Offering Dialysis Shifts Starting after 5 PM*	62	33.5

Source of data for number of dialysis facilities: End Stage Renal Disease National Coordinating Center (ESRD NCC) report to ESRD Forum.

Source of data for dialysis facilities offering dialysis shifts starting after 5 PM: NCC Gap Report “Shifts After 5 PM.”

*Counts of dialysis facilities may include a small number of facilities that closed during the calendar year but did not have a closing date recorded in CROWNWeb as of December 31, 2014.

Network Goals

Each year, performance goals are developed by leadership in the ESRD Divisional Board, in concert with advice from the Network Council, Medical Review Board, Patient Advisory Committee, Grievance Committee, and Network sub-committees. These set goals are distributed to dialysis facilities, outlining expectations and responsibilities for achieving them. Additionally, State Survey Agencies use Network goals and initiatives as guidelines during facility evaluations.

The goals of the Network, and the activities conducted to achieve them, were established to fulfill the requirements set forth in the Social Security Act, Sections 1881(c)(2)(B) and 1881(c)(2)(H). In accordance with the legislative mandate for the ESRD Network Program—to assist CMS in meeting its goal of ensuring the right care for every person every time—and in keeping with sound medical practice, the strategic goals of the ESRD Network Program and the Network are to:

- Improve the quality and safety of dialysis related services provided for individuals with ESRD;
- Improve independence and quality of life of individuals through use of self-care modalities (such as transplantation, peritoneal dialysis, home hemodialysis), and self-directed care, as appropriate, through the end of life;
- Improve patient perception of care and experience of care and resolution of patient's complaints and grievances;

- Improve the individuals with ESRD rate of transplantation and use of self-care and self-directed modalities, when medically appropriate, in order to ensure patients achieve the maximum level of rehabilitation and independence possible;
- Improve collaboration with providers to ensure achievement of the goals; and
- Improve the collection, reliability, timeliness, and use of data to measure processes of care and outcomes, and to support the ESRD Network program.

Network Project Goals

Aim	Domain	Network Project	Goals
AIM 1: Better Care for the Individual	Patient and Family Engagement	Engagement through social media: the Network's Facebook page launch	<ul style="list-style-type: none"> • Impact 2,700 patients • 10% improvement in engagement from baseline
		Patient Advisory Committee Member Recruitment	<ul style="list-style-type: none"> • Impact 2,700 patients • 28 facilities with PAC members
		Hand-Hygiene Awareness	<ul style="list-style-type: none"> • Impact 1,350 patients • Five percent improvement in post-test knowledge assessment scores
	Patient Experience of Care and Appropriate Access to Care	Enhancing Patient-Provider Communication	<ul style="list-style-type: none"> • Impact 650 patients • Zero topic-area grievances reported
	Vascular Access Management	Improve Network Arteriovenous Fistula (AVF) by one percent	66.15% AVF in use rate
		Reduce Long Term Cather (LTC) by two percent in facilities with LTC rates >10%	12.64% LTC in use rate
	Patient Safety: Healthcare-Associated Infections (HAI)	HAI Quality Improvement Activity: 20% of Network facilities to complete required number of observation audits	100% compliance
AIM 2: Better Health for the ESRD Population	Population Health Innovation Pilot Project	Increase transplant referrals by five percent	≥ 9% referral rate
	Transplant Coordination with focus on disparities	Reduce age disparity gap by one percent	≤ Five percent disparity reduction
AIM 3: Reduce Costs of ESRD Care by Improving Care	Facility Compliance with Quality Incentive Program (QIP) Procedures	Monthly education: staff, state agencies	100%
		Quarterly education: patients, facility staff	100%

To support these goals, each year the Network collaborates with our Network Council, Medical Review Board, Patient Advisory Committee, Grievance Committee and Network sub-committees, and develops quality improvement projects with aim-specific goals based on the ESRD Network's statement of work (SOW). In 2014, the Network deployed interventions that targeted patients, dialysis and transplant providers, and other stakeholders. These interventions focused on engaging patients, reducing disparities, and improving quality of care and are detailed throughout this report.

PROFILE OF PATIENTS IN THE IPRO ESRD NETWORK OF NEW ENGLAND SERVICE AREA

The ESRD Network Program collects data on incident (new) ESRD patients, prevalent (currently treated) dialysis patients, and renal transplant recipients. The IPRO ESRD Network of New England uses data on patients' clinical characteristics—including primary cause of ESRD, treatment modality, and vascular access type—to focus its outreach and quality improvement activities.

Incident Patient Population

In 2014, the number of individuals new to ESRD treatment (incident population) increased by two percent to 3,615 patients. Females comprised 40% of the incident cases. Asian patients represented three percent of the new patient population. African American patients increased to 15%, whereas the white population decreased to 81%. The number of patients age 64 and younger increased from 46%, whereas the number of patient age 65 and older decreased from to 54%. Diabetes continues to be the number one primary diagnosis of incident patients, followed by hypertension/large vessel disease.

Prevalent Patient Population

Growth in the number of individuals receiving ESRD treatment in New England at year end (prevalent population) continued to steadily increase by 1.1% to 13,489 individuals. 58.3% of prevalent dialysis patients in New England were male. African Americans comprised 21.26% whereas 74.7% were white. Hispanics represented 10.7% of the prevalent population.

Renal Replacement Therapy

In 2014, 803 renal transplants were performed at 15 transplant centers throughout New England. This represents an 11.8% increase in renal transplants compared to the previous calendar year.

For a complete analysis of ESRD patients in New England, refer to Data Tables starting on page 33.

Table C. Clinical Characteristics of the ESRD Population in the Network area, Calendar Year 2014

Category	Number	Percent
Incident (New) ESRD Patients		
Number of Incident ESRD Patients, Calendar Year 2014	3,615	
Primary Cause of ESRD among Incident ESRD Patients		
Diabetes	1,477	40.8
Glomerulonephritis	368	10.2
Secondary Glomerulonephritis/Vasculitis	91	2.5
Interstitial Nephritis/Pyelonephritis	149	4.1
Hypertension/Large Vessel Disease	774	21.7
Cystic/Hereditary/Congenital Diseases	176	4.8
Neoplasms/Tumors	111	3.1
Miscellaneous Conditions	376	10.4
Not Specified	93	2.5
Prevalent Dialysis Patients		
Number of Prevalent Dialysis Patients as of December 31, 2014	13,489	

Category	Number	Percent
Treatment Modality of Prevalent Dialysis Patients as of December 31, 2014		
In-Center Hemodialysis or Peritoneal Dialysis	11,916	88.3
In-Home Hemodialysis or Peritoneal Dialysis	1,567	11.6
Vascular Access Type at Latest Treatment among Prevalent In-Center and In-Home Hemodialysis Patients as of December 31, 2014*	11,633	
Arteriovenous Fistula in Use	7,702	66.21
Arteriovenous Graft in Use	1,731	14.88
Catheter in Use for 90 Days or Longer	1,278	10.99
Renal Transplants		
Number of Renal Transplants, Calendar Year 2014	803	
Transplant from Deceased Donor	477	59.4
Transplant from Living Related Donor	166	20.6
Transplant from Living Unrelated Donor	151	18.8
Donor Information Not Available	9	1.1
Mortality		
Number of Deaths of ESRD Patients, Calendar Year 2014	2,591	

Source of data (except vascular access data): CROWNWeb Annual Report tables.

Source of vascular access data: End Stage Renal Disease National Coordinating Center (ESRD NCC) Fistula First Catheter Last (FFCL) Dashboard.

*Vascular access information reported in this table is based on facility-level data submitted to CMS. CMS has identified issues with data transmission and the application of vascular access data definitions and is correcting these errors by working directly with stakeholders and through the Networks.

IMPROVING CARE FOR ESRD PATIENTS

IPRO ESRD Network of Network England works closely with ESRD patients, patients’ family members and care partners, nephrologists, dialysis facilities and other healthcare organizations, ESRD advocacy organizations, and other ESRD stakeholders to improve the care for ESRD patients in New England.

Under contract with CMS, the IPRO ESRD Network of Network England is responsible for identifying opportunities for quality improvement and developing interventions to improve care for ESRD patients in New England; identifying opportunities for improvement at the facility level and providing technical assistance to facilities as needed; promoting the use of best practices in clinical care for ESRD patients; encouraging use of all modalities of care, including home modalities and transplantation, as appropriate, to promote patient independence and improve clinical outcomes; promoting the coordination of care across treatment settings; and ensuring accurate and timely data collection, analysis, and reporting by facilities in accordance with national standards.

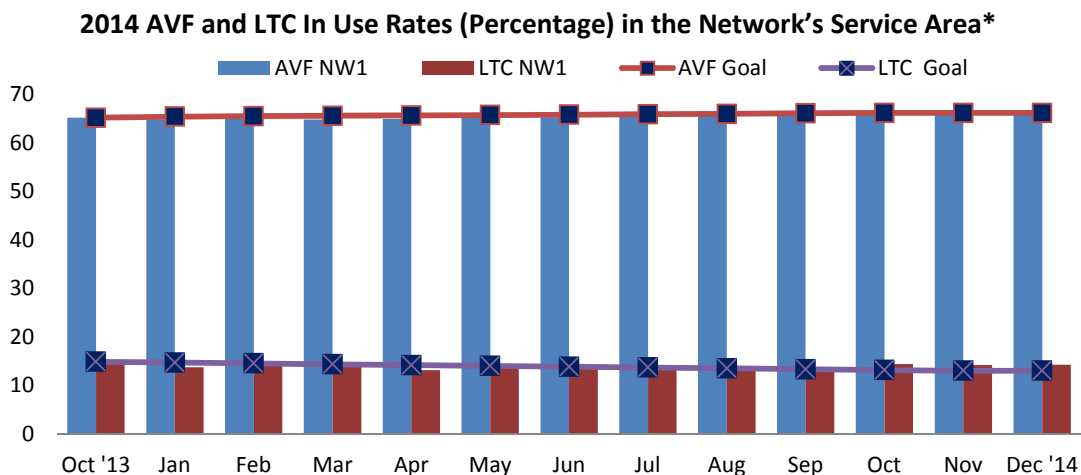
Vascular Access

Improve AVF in Use Rates for Prevalent Patients

In 2014, the Network goal was to achieve a one percent improvement rate goal of 66.15% AVF in use rate from a baseline rate of 65.15%. By the end of the calendar year, the Network AVF in use rate increased to 66.21%, surpassing the assigned goal of 66.15%.

Reducing Catheter Rates for Prevalent Patients

Network LTC use, defined as a catheter in use for >90 days, was 15.06% with a two percent reduction goal set to be achieved by September 2014. By the end of 2014, the LTC rate was 14.3%. While the two percent reduction was not achieved, the LTC rate for targeted facilities was reduced by 0.76%. Multiple factors contributed to a failure to achieve the LTC rate change including a shortage of peritoneal dialysis solution and reporting difficulties experienced by two Large Dialysis Organizations (LDOs). Data clean-up was initiated with facilities to improve the accuracy and reliability of data prior to closure of 2014 data to better prepare the Network for interventions in the coming year.



*Source: Fistula First Outcome Dashboard CY 2014

Vascular Access Quality Improvement Activities

To achieve goals for AVF increase and LTC reduction, the Network targeted 32 providers with AVF rates less than 58% and 69 providers with LTC rates greater than 10%. Interventions in 2014 were tailored to tiered groupings of providers to address those with poor rates more aggressively than high performers. Outcomes of these activities are illustrated below with the number of providers achieving individual goals noted in the far right column of the tables.

Providers were given goals for each measure in February 2014, with progress updates provided throughout the year. The Network collaborated with LDOs to better reach and support facilities in their quality improvement goals throughout 2014. Due to data reliability concerns related to CROWNWeb challenges, the Network requested that providers perform validation of their vascular access data in the fall of 2014, including providing feedback on this process to the Network.

Tiered Groupings Based of Facility AVF In Use Rate

AVF Groupings	Classifications	Baseline (10/2013)	Interventions	Final (9/2014)
Tier 1 < 50% AVF	Providers that appeared before MRB, received CMS letter of concern, Network letter of concern, and any new providers below 50% as of October 2013	8 providers	<ul style="list-style-type: none"> Action plans Site visits Intensive data monitoring Progress reporting MRB review 	Two providers did not meet four percent increase goal
Tier 2 ≥50% - <58%	Providers at least 10% below Network	24 providers	<ul style="list-style-type: none"> Action plans Data monitoring Progress reporting MRB review for those not progressing 	11 providers did not meet goals from 2.04-3.51%
Tier 3 ≥58% - <68%	Midrange providers needing AVF improvement	65 providers	<ul style="list-style-type: none"> Data review Progress reporting 	31 providers did not meet goals from one to two percent
Tier 4 ≥68% AVF	High performers meeting goal	69 providers	<ul style="list-style-type: none"> Data review Progress reporting Recognition at Annual meeting 	16 provider did not maintain >68% 26 providers did not exceed stretch goal of one percent

Tiered Groupings Based of Facility LTC In Use Rate

LTC Groupings	Classifications	Baseline (10/2013)	Interventions	Final (9/2014)
Tier 1 >15% LTC >90 days	Providers with >15% LTC rates	24 providers	<ul style="list-style-type: none"> Action plans Site visits Intensive data monitoring Progress reporting Phone contact MRB review 	14 providers did not meet two percent reduction goal

LTC Groupings	Classifications	Baseline (10/2013)	Interventions	Final (9/2014)
Tier 2 >10-<15% LTC >90 days	Providers above 10% LTC rate but with less than 15% LTC	45 providers	<ul style="list-style-type: none"> Action plans Data monitoring Progress reporting MRB review for those not progressing 	15 providers did not meet two percent reduction goal

The Network's success in improving AVF rates was due to implementation of the following interventions:

- Action Plan Review and Progress Reporting.** Facilities in tiers 1 and 2 provided action plans including a root cause analysis of the current facility rates, plans for improvement, and designations for those involved in driving these improvements. These, coupled with ongoing data and progress toward goal, were reviewed by the Network. Feedback was provided to facilities to assist in improving local efforts. Best practices were shared with the Network community via email including well-developed action plans to serve as a guideline for future development.
- Quarterly Facility Specific Vascular Access Reports.** The Network provided all facilities with a quarterly report illustrating facility progress in meeting its goal, as well as inclusion of national benchmarks. These reports were shared with facility administration, medical directors, and vascular access coordinators to engage all team members in the process and ensure all were aware of progress.
- Site Visits.** Network staff provided in-person analysis, education, and resource review to staff at targeted facilities that did not demonstrate improvements in their vascular access rates. Four facilities were identified for site visits designed to address clinical issues as well as staff and patient engagement. Strategies for improvement were presented, action plans reviewed, and goals developed to drive vascular access outcomes. Of the facilities visited, three of the four improved by year's end, with only one facility needing further assistance.

Best Practice: Physician Engagement and Ownership of Outcomes

One facility located in an urban area was overwhelmingly successful in making practice and cultural changes related to vascular access. The facility had been struggling with vascular access outcomes for a number of years, even with Network assistance and intervention. This facility's medical director identified that the cultural shift required to effect change should involve not only facility staff, but also hospital surgical staff and administration. The medical director worked closely with facility staff, hospital administration, rounding nephrologists, surgeons, and LDO regional quality representatives to bring about cultural change through increased attention, review, and collaboration. The AVF rate increased from baseline (October 2012) to re-measure (December 2014) by more than 12%, from 44.2% to 57.78%

Patient Safety

Support for the National Healthcare Safety Network (NHSN)

The Network assists facilities in its service area with enrollment and reporting of dialysis events into the National Healthcare Safety Network (NHSN). The Network also works to ensure that all facilities in New England join the Network NHSN group and confer rights in order for Network staff to view their data. The Network was successful in enrolling 100% of eligible facilities in NHSN in 2014.

The Network conducts data quality checks, on a monthly basis, by reviewing three months of data for accuracy and completeness. Based on this data review, the Network identifies facilities that have incomplete data and those that have potentially entered data incorrectly. Accurate reporting in this system continues to be a challenge due to staff turnover and the Centers for Disease Control and Prevention (CDC) process for access to NHSN. Facilities with identified problems are contacted by the Network, given the areas of potential errors, and asked to review their data for accuracy and make appropriate corrections. The Network continually supported facilities through this process by providing “Quick Tip” sheets about data entry, one-on-one education, both in-person and by telephone.

In order to meet the Quality Incentive Program (QIP) requirements for NHSN reporting, facility staff must complete and submit a monthly reporting plan, a denominator data report, and dialysis events data. The Network runs an NHSN QIP report to identify facilities that are not meeting the reporting requirements and notifies these facilities. Of the 179 enrolled facilities in the Network’s service area, 176 (98.3%) met the QIP requirements in 2014.

Healthcare-Acquired Infection Learning and Action Network (LAN)

In 2013, the IPRO ESRD Network of New England established a LAN focused on patient safety in dialysis facilities, with a specific focus on reducing rates of healthcare-acquired infections (HAIs). The membership of the HAI LAN includes representatives from a broad range of organizations and professions including Network staff, Quality Improvement Organization (QIO) representatives, dialysis facility staff, state survey agencies, and CDC representatives.

The LAN actively developed slogans and resources during the beginning of 2014, but then redirected their focus to supporting HAI quality improvement activities (QIAs). Through monthly workgroup calls, LAN members provided insight for strategies to improve HAI rates within the New England region. To facilitate rapid cycle improvement, during each meeting, LAN members reviewed the outcomes of the previously conducted quality improvement audits (hand washing, catheter initiation/termination and cannulation/decannulation), and provided feedback to QIA participants about progress. Calls were held monthly with the LAN through the third quarter of 2014 when it was assessed through survey of the group that quarterly calls would be preferred and deemed to be more effective.

Reducing Rates of Healthcare-Acquired Infections

The Network worked with the HAI LAN throughout 2014 to establish best practices and foster ideas and interventions for dialysis facilities in order to facilitate effective infection control practice. The LAN discussed methods for promoting the use of available CDC resources, as well as ideas for possible ways to reduce the number of bloodstream infections (BSIs) while properly reporting and monitoring these in NHSN, the CDC's system of record.

Network goals for the year included implementation of a quality improvement activity (QIA) around use of the Centers for Disease Control and Prevention (CDC) audit tools surveying infection control practices. As part of the Network’s overall effort to work with facilities to reduce infection rates, the Network targeted 41 facilities (more than 20%) in the Network service area to facilitate performance of a minimum number of monthly observations. Every month, each facility is required to conduct the CDC prevention process audits, and to report both the number of audits completed and the number of successful audits. The observation audits include a minimum of 30 hand hygiene observations, 10 catheter connection/disconnection observations, and 10 fistula/graft cannulation observations.

This QIA included training on use of these tools for surveillance of infection control practices, reporting of the outcomes from this surveillance, and discussion of best practices associated with the identified opportunities for learning shown through completion of these audits. Facility implementation and proper use of audits improved from initiation in April through the project end in September as illustrated below.

HAI QIA Successful Implementation Results

	April 2014			September 2014		
	Hand Hygiene	Catheter Connection	AVF/AVG Cannulation	Hand Hygiene	Catheter Connection	AVF/AVG Cannulation
Successful Audits/Total Audits	34/41	36/41	35/41	37/41	38/41	39/41
Percent Successful	83%	88%	85%	90%	93%	95%

Support for the ESRD Quality Improvement Program (ESRD QIP)

Throughout 2014, the Network continued to support facilities with the ESRD Quality Incentive Program (QIP), a pay for performance program, by providing educational campaigns that assisted in increased understanding of the evolving metrics, and the program’s financial impact based on the facility’s total performance score. The Network has taken a multi-tiered approach in its QIP initiative, focusing on educating patients, care partners, family members, and provider staff on performance measures and required reporting. This initiative and its resources provide an opportunity for patients and provider staff to understand the implications of and influences on QIP measures.

Each of the Network’s 2014 educational activities for facility staff, patients and regional personnel of dialysis corporations included information and resources on the QIP and its impact on facilities.

Highlights of 2014 activities include:

- Integration of QIP education into all relevant education programs. Presentations were made at meetings with the following groups:
 - Network Council and Medical Review Board;
 - Patient and Family Engagement Learning and Action Network;
 - Patient Advisory Committee;
 - State Survey Agencies;

- ESRD Providers; and
- Other stakeholders.
- QIP initiatives included:
 - Conducted provider site visits, with focus on patient engagement, QIP measures, educational resources, and the requirement to post the QIP Performance Score Certificate (PSC);
 - Provided email and fax communication and one-on-one counseling to facilities that needed more intensive education on data compliance to prevent reductions in Medicare reimbursement;
 - Streamlined process for providing access to Master Account Holders, which reduced costs, time, and Network resource burden; and
 - Provided support and data to facilities below QIP benchmarks in order for them to develop Quality Assessment and Performance Improvement (QAPI) plan for improving QIP scores.
- The Network distributed periodic e-mails containing QIP updates and resources to more than 500 facility administrators, nurse managers, and medical directors listed in CROWNWeb. E-mails focused on topics such as proposed rules and comment periods, final rules, existing educational resources, DialysisReports.org, DialysisData.org, and strategies to educate patients on being informed healthcare consumers.
- The Network's website included a featured page, dedicated to providing updates and information on the QIP for both patients and professionals. This page is routinely updated to ensure that the most current information is always available. A link to the QIP resource page is a part of the resources footer in all Network announcement e-mails to the community.
- Articles were featured in the Network's publication for professionals, *Network Notes*, and in its monthly patient-focused newsletter, *Kidney Chronicles* (available in English and Spanish).
- The Network Council and Medical Review Board reviewed the proposed changes to the QIP and the newly developed 5 Star Rating System, providing comment and suggestions to CMS on several occasions between July and December 2014. These letters included feedback around QIP metrics and thoughtful consideration about the impact the proposed changes would have on providers and patients in the New England area.
- On a monthly basis, the Network communicated with key staff at non-compliant facilities regarding deadlines and missing data until the last day of close of clinical months.

The above activities resulted in:

- Facility attestations in CROWNWeb by all eligible facilities;
- Every facility posted their Performance Score Certificate;
- Every facility downloaded and reviewed their performance score reports and dialysis facility reports;
- Every facility accessed dialysisreports.org website using their Master Account Holder information; and
- 96.2% of facilities in the Network did not incur reductions in Medicare reimbursements.

Provider Education

Learning and Action Networks (LANs)

In 2014, the Network provided ESRD professionals in its service area daily technical assistance and a robust provider education program. Additionally, we convened three LANs:

- Patient and Family Engagement Learning and Action Network (PFE LAN). A detailed description of activities can be found on page 26.
- Healthcare Associated Infections Learning and Action Network (HAI LAN). A detailed description of activities can be found on page 12
- Transplant Learning and Action Network (Transplant LAN). A detailed description of activities can be found on page 20.

These three LANs brought together on a regular basis provider staff members, patients, family members, care partners, and ESRD stakeholders, culminating in educational initiatives that benefitted the whole community. This model was used to educate provider staff and patients in all LAN projects and activities.

Highlights of Network provider educational activities are described below.

Newsletters: *Network Notes*

The Network of New England published *Network Notes*, a newsletter for New England renal professionals, in both the summer and fall/winter of 2014. The publication is sent to inform, clarify, alert, 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. *Network Notes* is distributed to 1,267 New England renal nurses, medical directors, facility administrators, social workers, dietitians, state surveyors, and the CMS Network Contracting Officer's Representative (COR). 2014 Article topics included:

- Navigating through the 2014 Hurricane Season
- Feds Issue ESRD Facility Emergency Preparedness Rules
- New Requirements for the In-Center Hemodialysis Consumer Assessment of Health Care Providers and Systems (ICH CAHPS) Survey
- The CDC Announces NHSN Dialysis Event Module Updates
- Preventing Health-care Associated Infection
- Saving Your Patient's Lifeline
- Traveling on Dialysis: Helping Patients Plan for Vacations
- 5-Diamond Patient Safety Program
- Learning and Action Networks
- Performance Score Certificate/ Quality Incentive Program
- Patient and Family Engagement: Network Project Updates
- Important CROWNWeb Updates
- Staff Changes? Access to Crucial Data Systems
- 2014 Annual Meeting Summary
- Vascular Access
- Increasing Patient-Provider Communication
- Five Star Rating Program
- Winter Weather Preparedness
- National Health Safety Network (NHSN): Did You Know?
- Network Innovative Project: Transplant Referrals
- The Attitude of Dialysis
- Navigating Insurance Resources

Bi-Weekly Electronic Communication: *Provider Insider*

The Network collaborates with multiple stakeholders and partners to promote a synergistic community for achieving patient and family centered care for all ESRD patients in the New England area. The primary target audience includes staff at ESRD facilities and dialysis and transplant patients, and their care partners.

In addition, other stakeholders such as independent providers, Small Dialysis Organizations (SDOs), LDOs, QIOs, the National Kidney Foundation (NKF), the American Nephrology and Nurses Association (ANNA), and the American Association of Kidney Patients (AAKP) support the ESRD community and have major roles in influencing cultural change.



In 2014, the Network launched a bi-weekly electronic email communication, *Provider Insider*, as a way to streamline essential information for the Network's diverse group of stakeholders without overwhelming inboxes with multiple email blasts. This marketing tactic resulted in improved email open rates from a low of 11.6% prior to launch to a high of 60.0% in 2014.

Psycho-Social Care Focused Education

Dialysis providers often look to the ESRD Network of New England for guidance when encountering unique or challenging circumstances in the course of patient care. During 2014, the Network Patient Services department was available to educate facilities on a wide range of topics including: patient non-adherence, access to care, mental health concerns, specialized patient placement, behavioral concerns, cultural considerations, and mediation techniques. The Network has access to a wide range of stakeholder agencies and community based resources as well as Medical Review board members and Network Committee members. These outside resources are called upon as needed to ensure that all efforts are made to provide education and to link facility staff to helpful resources. As appropriate, the Network also provides education to facilities on the CMS Conditions for Coverage as they relate to a given circumstance.

In an effort to educate the ESRD community and strengthen the support of the Network at the facility level, the following materials were mailed to all 183 facilities in the Network's service area:

- English and Spanish posters explaining patients' rights and responsibilities, and
- Speak Up! Grievance Posters (English and Spanish) illustrating how patients can file a grievance with the Network, their state, and their facility.

Anecdotally, Network staff found that providers positively responded to new materials, as demonstrated by the fact that more than 90% of visited facilities have displayed the posters.

Additionally, Network staff implemented projects including the "Enhancing Patient-Provider Communication" QIA, in which site visits and supportive phone conferences were conducted with providers to support enhanced patient care. Details of the QIA are provided on page 30.

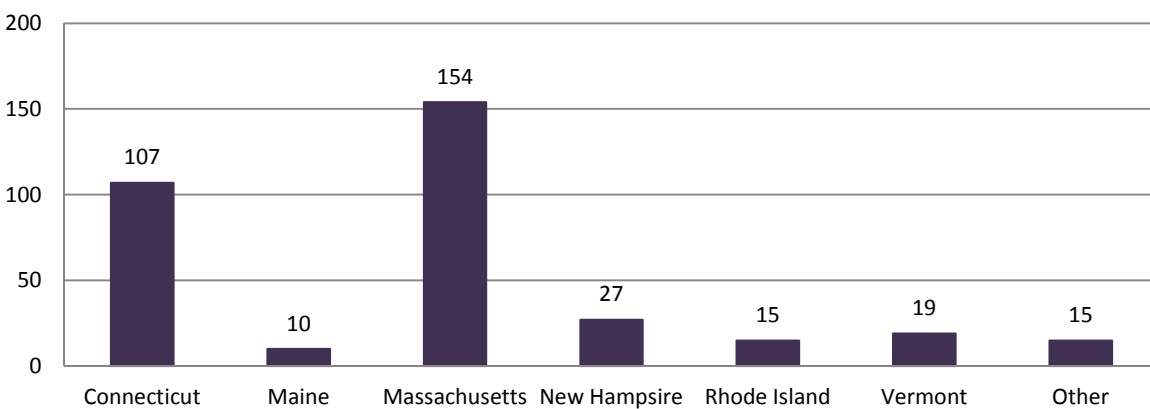
Annual Meeting

The Network of New England's Annual Meeting, in collaboration with two local chapters of the American Nephrology Nurses Association (ANNA), took place on October 23, 2014. This meeting included a patient panel, led by a speaker who presented on patient centered care practices. The moderator elicited conversation by asking the patient panel questions related to their experiences with ESRD. The panel captivated the audience and the Network received positive feedback from attendees through anonymous evaluations. The panel was rated among the top three components most enjoyed by attendees. The meeting hosted close to 400 professionals, educational vendors, and speakers who

touched on important topics that addressed Network goals and challenging issues providers face on a daily basis. Of those participating, 99% responded that they felt that the meeting met their professional needs, with 98% responding that they would attend a similar regional meeting next year if given the opportunity.

The meeting, which was attended by multi-disciplinary ESRD professionals including administrators, dietitians, nurses, patient-consumers, pharmacists, physicians, social workers, surveyors, technicians, and other interested health care professionals, presented an opportunity for colleagues to network and share ideas as well as obtaining 7 continuing education units. Positive feedback was returned to the Network regarding the format and content of the meeting. The collaboration is planned to continue into 2015.

Annual Meeting Attendance by States in Network Service Area*



*Does not include vendor participants

Regional Technician Meetings

Recognizing the critical role that technicians play in the lives of ESRD patients, the Network provided two regional educational trainings for technicians in the New England area in 2014. These meetings included education on Network activities and the important professional role technicians can play in their facilities related to vascular access, transplant, water treatment, patient interactions, and infection control. Approximately 150 technicians from all 6 states in the Network service area, representing 69 facilities, participated in the two meetings, each earning 7.2 continuing education units (CEUs) toward recertification. Positive feedback (91% excellent content evaluation ratings), CEUs, and interaction by Network staff with direct care staff were the most important outcomes associated with these events.

Site Visits

Network staff conducted 33 site visits in 2014, and presented information and training on topics that included patient engagement, transplant, healthcare-associated infections, communication, the ESRD QIP, and vascular access.

Stakeholder Meetings

Network staff attended multiple regional meetings held by LDOs throughout 2014. These meetings included representatives from throughout the region. Network staff shared Network goals and objectives, responded to inquiries about Network projects, and assisted representatives in identifying Network staff to assist with future questions and needs through these interactions.

Contributions to the Professional Literature

In calendar year 2014, the Network did not submit any articles or book chapters for publication.

Ensuring Data Quality

Throughout 2014, the Network continued to improve CROWNWeb data management processes. The Network trained and assisted dialysis facilities in achieving compliance with data submission requirements and deadlines, while emphasizing QIP and its implications for reducing Medicare payments. This new focus engaged provider staff all the way up to the Medical Directors in achieving data submission compliance. Key to our success was to keep CROWNWeb email addresses current, providing the information as needed to only those who needed it.

To eliminate rework or duplicative work by dialysis facilities and the Network, we worked with batch-submitting organizations to continuously reinforce that any changes made in CROWNWeb must be reflected in the facility's own data systems to ensure the proper flow of data. The Network provided one-on-one technical assistance, augmenting training provided by the CMS CROWNWeb contractor. Network staff also provided in-person training to groups of facilities. Several facilities with high levels of data submission compliance were recognized at the Network annual meeting.

CROWNWeb

The Network enforced monthly Patient Attributes and Related Treatments (PART) Verifications that require dialysis facilities to validate patient census by the 10th of every month. Greater than 95% of facilities in the Network area verified their PART monthly due to continual email reminders to non-compliant facilities.



Missing 2728 and 2746 forms were monitored using an innovative mail merge process to provide CROWNWeb Unique Patient Identifiers (UPI) to facilities.

Action items that created data discrepancies were cleared using a new process to reduce duplicative work for the Network, dialysis facility staff, and batch submitting organizations. This process was communicated to all facilities monthly, with additional tips and training provided to facilities that needed them.

The Network also developed a method to balance annual facility survey data using misaligned treatment data. This allowed 100% completion of facility surveys with minimum work for facility staff. The surveys were completed ahead of time.

CROWNWeb Clinical

Network staff worked with dialysis corporations to increase clinical data submission compliance, especially vascular access data submission. In December 2014, 97.7% of facilities were at greater than 90% submission rate. In December 2014, 97.7 % of patient data was submitted.

Veterans' Healthcare Administration (VHA)

In 2014, all four VHA facilities in the Network's service area performed data entry (including clinical data entry) in CROWNWeb.

Transplant Facility Data Submission

Eight of the fifteen transplant centers use CROWNWeb.

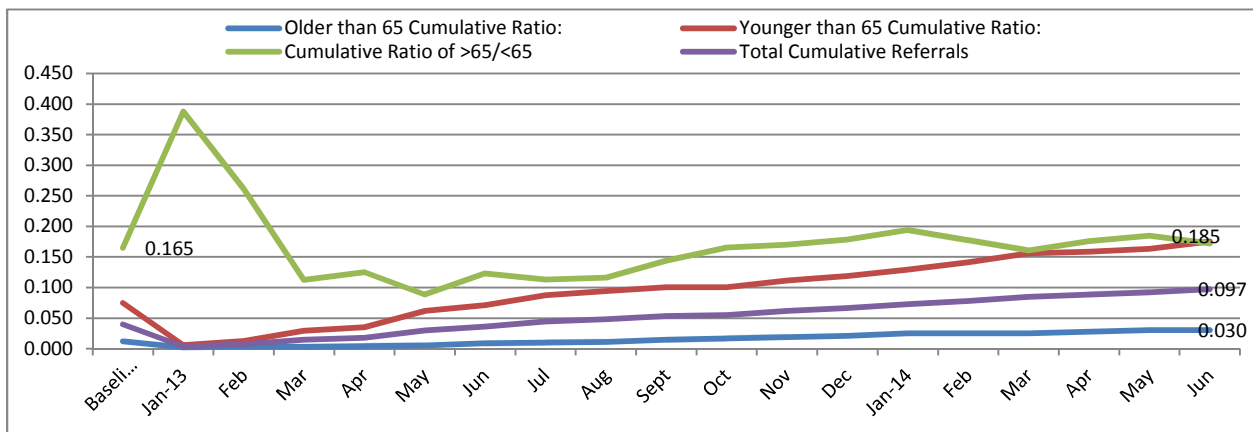
Support Facilities' CROWNWeb Data Submission Efforts

The Network supported dialysis facilities in enrollment, data submission, and data cleanup processes by providing technical assistance and education. This included using email to remind facilities of deadlines. In a six month period, the Network communicated with facilities in 3,025 separate instances about CROWNWeb data and responded to 578 facility requests for technical assistance or information.

DISPARITIES IN ESRD CARE

The Network AIM 2 activities focused on improving the quality of and access to ESRD care through a Population Health Innovation Pilot Project in the CMS prioritized area of “Improve Transplant Coordination.” The Network’s project focused on increasing transplant referral rates in our eligible population, while demonstrating a reduction in the identified disparity. A disparity assessment of Network facilities’ transplant population identified age, those ≥ 65 years, to be the highest ordered disparity; thus, the goal of the project is to decrease this disparity while also increasing referrals in general. The Network has taken an innovative approach to this project. At the project’s end, the Network had significantly increased referrals to transplant in the disparate group in participating facilities, as shown in the disparity ratio table below indicating where interventions were implemented. The ratio of percent referrals for those >65 years of age to those <65 years of age increased from 16.5% at baseline (July-December of 2012) to 17.2% at re-measure (September of 2014) which indicates that the disparity is decreasing. The Network was not successful, however, in decreasing the disparity by one percent between the two groups by project’s end.

Disparity Ratio Improvement- Transplant Referral



The Network worked with dialysis and transplant providers throughout the course of this project on a number of interventions to improve coordination of transplant referrals for patients in the New England area. Educational materials, conference calls, and technical assistance were provided to aid in improving the process of transplant referrals, as well as to assist in identifying best practice and overcome identified barriers to referral. The Transplant Learning and Action Network (T-LAN) worked to develop, review, and contribute to resources for both providers and patients throughout the course of the project, aiding in the effectiveness of information shared with the community, and to ensure that the needs of patients and providers were represented throughout this process. Research¹ indicates that patients relate well to other patients when discussing their experiences with End Stage Renal Disease (ESRD). The Network worked collaboratively with other Networks and the ESRD National Coordinating

¹ National Kidney Foundation. (2014). *Peer mentoring*. Retrieved from <http://www.nkfm.org/get-involved/peer-mentoring>

Center to create a book of patient and donor stories centered on the transplant experience titled *Transplant Stories: Your Life, Your Choice*. This publication, introduced in the fall of 2014, identifies each participating Network’s identified patient disparity and serves as an inspiring educational piece to address these disparities and increase referrals to transplant.

Summary of Interventions by Target Audience
Key: D=Dialysis providers; T=Transplant providers

Intervention Tools and Strategies	Providers		Patients	Number Distributed
	D	T		
Staff education in the form of webinars, brochures, and materials to improve coordination of transplant referrals between providers, patients, and transplant centers	•	•		210
Patient education in the form of materials, brochures, and patient stories to assist patients in understanding the transplant process, frequently asked questions, and transplant center criteria			•	625
Technical assistance to improve reporting of referrals	•	•		36
Learning Action Networks (T-LAN) to review and contribute to developed resources including a book of patient stories about experiences with transplant	•	•	•	210
Action plans: dialysis facilities and transplant facilities	•	•		36
Transplantation option tool	•	•	•	625
Develop tracking referral form	•	•	•	21
Referral coordination through discussion, resource development, and best practice sharing via the T-LAN and provider education	•	•	•	N/A
Bimonthly teleconferences with the T-LAN	•	•	•	N/A
Patient question brochure to ask providers about transplantation			•	625

PARTNERSHIPS AND COALITIONS

American Nephrology Nurses Association (ANNA)

The Network collaborated with two New England ANNA chapters (Mass Bay and Colonial Chapter) to expand the resources available for education of the renal community in New England. This partnership has allowed the Network to continue to offer continuing education credit and information to the Network community through a multidisciplinary educational event (please refer to the Annual Meeting section on page 16 for additional details).

Dental Lifeline Network

Since January 2010, the Network has facilitated referrals to Dental Lifeline Network's flagship program, Donated Dental Services (DDS), which provides access to dental care and education for people who cannot afford it and have a permanent disability, are elderly (age 65 or older), or who are medically compromised. The deployment of the service for ESRD patients to receive donated dental care has been helpful in getting more patients on the transplant waiting list.

The Network has collaborated with DDS to serve as a "middle man" to help ESRD patients needing essential dental care services. The Network does not choose which applications will be submitted to this program, but rather coordinates the application process. When the applications from the facilities are submitted to the Network, they are coded and sent to the appropriate address by state. Network staff members receive many calls from providers who have questions about DDS, and who are requesting applications and the medical triage form required for consideration. During 2014, 21 referral applications were submitted to DDS.

Donor Designation Collaborative

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. Enrichment activities are coordinated with support from the Board of Directors, volunteers, and agency members contributing time and in-kind resources. Network staff members have served on the Board of Directors since 2005 and actively support outreach efforts that align with and strengthen the Network's presence within the community.

The Donor Designation Collaborative (DDC), launched by National Donate Life America in 2006, was developed to help increase the number of actionable donor designations in the United States. The collaborative is designed to assist regional and state-based teams in establishing, improving, or filling promoting donor registries, and tracking progress towards state and national donor designation goals. DDC identifies and spreads best practices in the areas of measurement and analysis, effective partnerships and relationships, registry development, management and promotion, and applying proven methods for organizational change and improvement.

Since the inception of this national collaborative, the Network has partnered with the two New England Organ Procurement Organizations, LifeChoice Donor Services and New England Organ Bank, as well as Donate Life Connecticut, and the state Department of Motor Vehicles to grow the donor registry.

Every year, Donate Life America tracks progress to determine the increase in donor designation by state. Data is compiled and analyzed to establish Donor Designation, Donor Designation Share, and Donor Designation Rate measures, defined as follows:

- *Donor Designation* - Documented, legally authorized commitment by an individual to make an anatomical gift that cannot be revoked by anyone other than the registered donor
- *Donor Designation Share* - Total number of designated donors, as a percentage of all state residents age 18 and older
- *Donor Designation Rate* - Rate at which individuals join the state donor registry as a percentage of all driver's licenses and ID cards issued within a specific period of time

This information is critical in identifying states that excel at donor designation so that successful programs can be replicated by other states. As a result of educational campaigns conducted throughout the year, the donor designation rate of each of the states in the Network's service area exceeded the national goal of 42%.

New England and Nation Comparative Donor Designation*

States in Network's Service Area	Donor Designation	State Population 18+ Years Old	Donor Designation Share	Donor Designation Rate	Registry Inception
Connecticut	1,169,601	2,810,514	42%	43%	2005
Massachusetts	2,791,579	5,298,878	53%	46%	2006
Maine	618,035	1,067,026	58%	52%	2007
New Hampshire	549,754	1,052,337	52%	53%	2009
Rhode Island	431,995	837,524	52%	46%	2005
Vermont	91,111	503,929	18%	^	2009
National	108,963,015	240,378,322	45%	42.0%	N/A

*The 2014 Report is based on 2013 year-end data

^State is unable to report Donor Designation Rate

Source: 2014 National Donor Designation Report Card, Donate Life America

State Survey Agencies (SSAs)

The Network worked with six SSAs to ensure comprehensive communication about efforts and surveys in the New England area. A lack of participation from all states in the prior year led to an internal quality control review of the monthly SSA calls held by the Network. The Network QID began making individual appointments with those SSAs unable to attend the monthly calls held by the Network, which led to increased participation in these monthly calls by the end of 2014. Early in 2014, only one or two states were represented; by the end of 2014, typically five states were represented, including consistent representation from the Boston regional survey and certification office.

Throughout 2014, the Network supported the training of providers on the new ESRD Core Survey process, which included review of "core" activities at the facility level and "triggers" that indicate the presence of adverse conditions/situations and/or deficient practice, in order to assist state surveyors in their survey process. At the suggestion of the Network, facilities began keeping a survey binder with all materials required within four hours of SSA arrival. This change in practice led to surveys that were more

efficient and increased compliance with the core survey process at the facility level as evidenced by feedback received from SSAs and facility staff.

Additionally, the Network was asked to educate Connecticut SSAs across all settings about home dialysis at a yearly educational opportunity held in September 2014. Positive feedback from the Connecticut Department of Public Health was received, including increased collaborative efforts to meet the needs of providers across all settings to improve patient safety.

ESRD Forum

The Forum of ESRD Networks is a not-for-profit organization that advocates on behalf of its membership and coordinates projects and activities of mutual interest to ESRD Networks. All 18 ESRD Networks are members of the Forum, which facilitates the flow of information and advances a national quality agenda with CMS and other renal organizations. The mission of the Forum is to support the ESRD Networks in promoting and improving the quality of care to patients with renal disease, through education and the collection, analysis, and dissemination of data and information.

The Network has designated representatives to serve on the following Forum membership governing bodies and committee:

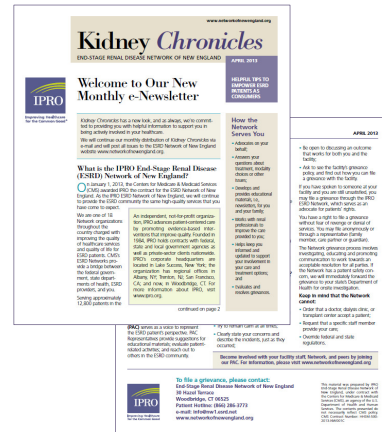
- Executive Directors Advisory Council (EDAC)
- Medical Advisory Council (MAC)
- Beneficiary Advisory Council (BAC) and
- Forum Quality Conference Planning Committee

PATIENT AND FAMILY ENGAGEMENT

Education for ESRD Patients and Caregivers

Kidney Chronicles, Patient Engagement Newsletter

In 2014, the Network continued to engage ESRD beneficiaries and family members through the monthly patient educational newsletter, *Kidney Chronicles*. The newsletter is disseminated via email to all 184 New England dialysis providers. All dialysis providers have been instructed to print articles on a monthly basis and provide them to their patients. Additionally, the Network emails articles on a monthly basis directly to patients who are registered to receive electronic communication from the Network. An estimated 13,000 patients were impacted in 2014 with these educational articles on a variety of topics, including:



- Your Facility Performance Score: How to Read This and What it Means to You
- February is American Heart Month
- March is National Kidney Month
- World Kidney Day
- March is Nutrition Month
- April is National Donate Life Month
- Traveling on Dialysis
- May is National Mental Health Awareness Month
- May is National Fitness and Sports Month
- Introducing the ESRD Network of New England Facebook Page
- Make a Difference as a PAC Representative!
- Mike's Story
- Hand Hygiene: Take Preventative Action in Your Healthcare
- Communication is Key!
- September is National Emergency Preparedness Month- Be Ready, Be Prepared
- Emergency Diet Guidelines for People on Dialysis
- "Trick or Treat" and Your Treatments
- Festive Fall Recipe
- November is National Caregivers Month-An Open Letter from an Anonymous Caregiver
- Season's Greetings!
- Tis' the Season for Traveling!

Patient and Family Engagement through Facility Site Visits

The Network evaluated the process by which site visits were conducted through rapid cycle analysis. In order to ensure that each Network staff member conducted site visits in a similar manner, the Network developed a site visit "kit" for key facility staff members. Site visit kits included LANs' conference call information, PAC recruitment information, CROWNWeb updates and information, transplant resources, and any necessary, facility-specific information from the QID. The purpose of developing this kit was to ensure that the same information was relayed to every facility that was visited, regardless of which staff member was conducting the site visit. Network staff members conducted 33 site visits throughout 2014.

Social Media

Social media has become an immensely popular platform to broaden marketing efforts in the health care industry. As a result of recent trends, the Network integrated social media as a way to virtually engage the ESRD community with near real time interaction.

The Network's Facebook page has enriched engagement between ESRD beneficiaries and care partners by helping patients take an active role in their healthcare through education and direct access to Network resources. Details of the PFE LAN educational campaign are provided on page 26.

Patient Engagement Learning and Action Network (LAN)

IPRO ESRD Network of New England is committed to incorporating the perspective of patients, family members, and other caregivers into its quality improvement activities. In 2014, the Network established the PFE LAN.

Throughout 2014, the PFE LAN grew to be a cohesive unit with active participation of patients and providers. The LAN consisted of 12 patient Subject Matter Experts (SMEs) and nine stakeholders. Conference calls were held quarterly and discussion between SMEs and stakeholders was both beneficial and inspiring. The three project topics for 2014 consisted of one QIA: *Hand Hygiene Awareness* and two educational campaigns: *Patient and Family Engagement through Social Media* and *Patient Advisory Committee Recruitment*. All three projects exceeded the desired goals set by CMS.

Quality Improvement Activity (QIA): Hand-Hygiene Awareness

Targeted facilities were provided with an initial pre-test that focused on the importance of hand hygiene. Facilities were not provided with any educational resources² prior to the initial test. The returned test results served as a baseline for patient understanding regarding the importance of hand hygiene prior to QIA interventions. Pre-test results demonstrated a scoring of 53%. Upon receipt of the pre-test results, the Network rolled out educational interventions to facilities and patients. At the conclusion of the interventions, the Network distributed a post-test utilizing the same questions as the baseline measure. Post-testing resulted in a score of 77.4%. Analysis of improvement of understanding was determined by the number of correct answers for the post-test compared to the number of correct answers from the pre-test, with the difference indicating the level of improvement.

The Network set a goal for this QIA to achieve at least a five percent relative improvement in understanding and awareness. The Network far exceeded this goal by demonstrating a 24.4% improvement in test scores, reflecting increased understanding of the subject matter.

Educational Campaign 1: Patient and Family Engagement through Social Media

On May 5, 2014, The Network launched the Network's Facebook page as the first PFE LAN educational campaign with the intent of communicating directly with the ESRD community by sharing valuable resources and information. Within the first few months of launching the Network's Facebook page, this marketing initiative far exceeded initial expectations. At the end of 2014, the Network page had over 300 followers and reached nearly 20,000 unique viewers and allowed the Network to experience close to 1,300 moments of direct engagement with the ESRD community. Social Media "business cards" were

² Centers for Disease Control and Prevention. (2013, September 17). *Dialysis safety: Patient information*. Retrieved from <http://www.cdc.gov/dialysis/patient/index.html>

developed to promote the page and were distributed to PFE LAN and PAC members, as well as at all site visits.

The Network set a goal for this campaign to achieve at least a 10% relative improvement in engagement. The Network exceeded this goal by demonstrating an improvement rate of 11.7%.

Patient and Family Engagement Social Media Trending

	April	May	June	July	Aug	Sep	Oct	Nov
# of Activity*	0	339	515	658	909	1012	1233	1604
# of Post Reach**	0	2,391	5,136	7,476	9,652	11,200	13,016	15,082
% of Engagement***	0%	14.2%	10.0%	8.8%	9.4%	9.0%	9.5%	10.6%
Relative Improvement	N/A	14.2%	11.7%	9.8%	10.3%	10.0%	10.4%	11.7%

*Likes, Comments, Shares

** Number of followers that viewed the post.

*** Numerator = Activity, Denominator = Post Reach

Educational Campaign 2: Patient Advisory Committee (PAC) Recruitment

Recruitment of PAC members was an intense focus of the LAN's second educational campaign for 2014. The Network developed PAC recruitment posters and brochures to be distributed in New England facilities. *Kidney Chronicles* was used to promote membership, along with various e-mail correspondences sent to both patients and providers. PAC recruitment information was posted to the Network's website and Facebook page. Hard-copy forms were mailed to all outpatient dialysis facilities in New England for facility staff to nominate patients and/or family members.

The Network set a goal for this campaign to achieve at least a 10% relative improvement in the number of facilities represented by a PAC member. The Network exceeded this goal by demonstrating a 14.02% relative improvement in PAC membership; having increased the PAC from nine to 62 members representing 32 facilities.

Patient Advisory Committee Recruitment Trending

	April	May	June	July	Aug	Sep	Oct	Nov
# of Facilities (Members)	9	9	9	14 (26)	22 (41)	28 (53)	32(62)	32 (62)
# of Facilities in Network	183	183	183	183	183	183	183	183
Relative Improvement	0%	0%	0%	2.7%	7.3%	11.2%	14.02%	14.02%

Source: Network project tracking tool

Support for ICH CAHPS

The Consumer Assessment of Healthcare Providers and Systems In-Center Hemodialysis Survey (ICH CAHPS) annually measures the experiences of people receiving in-center hemodialysis care from Medicare-certified dialysis facilities. The survey measures were endorsed by the National Quality Forum (NQF) in 2007.

During 2014, 100% of the facilities within the Network's service area indicated eligibility for ICH CAHPS and confirmed their participation in the survey or indicated that they were excluded as a non-eligible facility due to patient census. Network staff remained available throughout the year to provide technical assistance to facility staff.

GRIEVANCES AND ACCESS TO CARE

IPRO ESRD Network of New England responds to grievances filed by or on behalf of ESRD patients in Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, and Vermont.

In many instances, the Network works with individual facilities to identify and address difficulties in placing or maintaining patients in treatment. These access to care cases may come to the Network’s attention in the form of a grievance, or may be initiated by facility staff.

Access to care cases include those involving involuntary discharge, involuntary transfer, and failure to place. An involuntary discharge is a discharge initiated by the treating dialysis facility without the patient’s agreement. An involuntary transfer occurs when the transferring facility temporarily or permanently closes due to a merger, or due to an emergency or disaster situation, or due to other circumstances, and the patient is dissatisfied with the transfer to another facility. A failure to place is defined as a situation in which no outpatient dialysis facility can be located that will accept an ESRD patient for routine dialysis treatment.

In 2014, the Network responded to 22 grievances, none of which related to access to care. The Network responded to 17 additional non-grievance access to care cases brought to the Network’s attention by facility staff.

Table D. Grievances and Non-Grievance Access to Care Cases, Calendar Year 2014

Category	Number
Number of Grievance Cases Opened by IPRO ESRD Network of New England in Calendar Year 2014*	22
Number (Percent) of Grievance Cases Involving Access to Care	0
Number of Non-Grievance Access to Care Cases Opened by IPRO ESRD Network of New England in Calendar Year 2014	17
Total Number of Grievance and Non-Grievance Cases Involving Access to Care in Calendar Year 2014	17
Number of Cases Involving Involuntary Transfers**	0
Number of Cases Involving Involuntary Discharges**	5
Number of Cases Involving Failure to Place**	0

Source of data: Patient Contact Utility.

**Includes grievance cases involving access to care.*

***Includes grievance cases involving access to care as well as non-grievance access to care cases.*

Patient-Appropriate Access to Dialysis Care

In 2014, the Network assisted facilities with a total of 11 patients that were considered “at risk.” Through Network interventions, these cases were resolved without having to move forward with an Involuntary Discharge or any other action. Additionally, the Network assisted facilities with three total Immediate Involuntary Discharges, one Lost to Follow Up case, and two Averted Involuntary Discharges. The Network did not have any Involuntary Transfers or Failure to Place cases in 2014.

Grievance Quality Improvement Activity

The Network utilized the Patient Contact Utility to conduct a focused audit of all grievances filed within the fourth quarter of 2013 and the first quarter of 2014 in order to identify a systemic issue or trend in grievances received at the Network level. Data was analyzed, and five facilities shared a common trend of a lack of professionalism/communication at the facility level between patients and providers. The number of grievances (five) received in the audited time frame (October through December 2013, and January through March 2014) served as baseline data. *Enhancing Patient-Provider Communication* was developed and implemented to address the identified trend of professionalism/communication.

The Network goal was to decrease grievances in the topic area, from baseline (April) to re-measure (monthly, May-October). The six months that were audited served as the baseline period. The re-measurement period is the time frame in which this project was conducted. The numerator is the total number of topic area grievances received, and the denominator is the total patient census (monthly totals ranged from 645 to 650 patients throughout the project) at the five facilities participating in the QIA. Of the facilities involved in this QIA, each had one grievance within the baseline period. Zero topic area grievances were reported in these facilities throughout the QIA, resulting in the Network having met the project goals.

Best Practice: Leveraging Unique Partnership

Technician involvement was vital to optimize the potential benefits of this QIA due to their essential role in the daily communication with patients. The Network conducted site visits with all five facilities to introduce the goals and objective of the QIA and gain buy-in for participation. The innovative format of the QIA was designed to resemble the popular game show program, Jeopardy. The interactive nature encouraged patients and provider staff to work together while simultaneously opening lines of communication.

The five categories of the Jeopardy game were as follows:

- Knowing Your Facility
- Decreasing Conflict
- Finding Resolutions
- Work with Your Dialysis Patient Care Technician's by Being Aware
- How The Network Serves You

At the conclusion of the activity, the patients and technicians were asked to complete an evaluation regarding how successful the QIA was in creating opportunities for further understanding of how to effectively communicate at the facility level. The five targeted facilities launched their QIA on a staggered project timeline to provide rapid cycle improvement opportunities throughout the entire project. This QIA received National attention and was presented on the October 2014 Forum of ESRD Networks national conference call (Executive Director Advisory Committee). Hard-copies were requested by and mailed to all 18 Networks for possible implementation.

The Network set an additional goal to impact at least 10% of patients in the targeted facilities. This was demonstrated by patients completing evaluations of the effectiveness of the Jeopardy intervention. The Network exceeded this goal; 90 patients, or 13.9% of the targeted population returned evaluations. Evaluations resulted in positive feedback from patients and providers regarding participation.

Anecdotal feedback from patient evaluations:

- “It was fun! Thanks for the information. It’s always good to educate yourself on as much as possible.”
- “I would like to do more activities with [technician’s name]. She was a pleasure to work with.”

Anecdotal feedback from provider evaluations:

- Lead Technician: “I found that some of the patients really enjoyed the game and I also enjoyed doing it with them as well.”
- Social Worker: “Overall, the game went well with the patients and they responded well to the questions.”
- Lead Technician: “Thank you for giving me the opportunity to lead this Quality Improvement Activity, in an effort to increase comfort in communication.”

Grievances and Non-Grievance Access to Care Cases Referred to State Survey Agencies

The ESRD Network of New England referred four cases to the State Survey Agency (SSA). The first case, closed in January, was filed by a patient requesting revocation of his nephrologist’s medical license. Two cases closed in March were filed by two separate patients in the same facility regarding the facility’s re-use policy and procedure. Both patients requested an on-site investigation. The fourth case, closed in May, was filed by a patient advocate regarding the care received at a nursing home. This was referred to the appropriate SSA, as it was out of the Network’s purview.

Recommendations for Sanctions

During 2014, the Network did not recommend any sanctions for any ESRD provider in its service area.

Recommendations to CMS for Additional Facilities

The Network did not recommend any additional facilities in this region in 2014.

EMERGENCY PREPAREDNESS AND RESPONSE

Response Efforts

For individuals who have been diagnosed with ESRD, missed dialysis treatments can have serious adverse health effects. This makes the ESRD patient population especially vulnerable during emergencies and disasters. Therefore, in 2014, the Network continued to communicate with facilities directly before, during, and after emergency situations.

Key Network accomplishments in 2014 included:

- Updating the Network's website with current dialysis-specific emergency preparedness education for both patients and providers,
- Communicating with facilities in the event of an emergency by fax, email blasts, and phone calls,
- Partnering with Kidney Community Emergency Response (KCER) coalition and the ESRD Network Coordinating Center (NCC),
- Collaborating with the Network Emergency Management Committee (NEMC) to address identified emergency challenges and develop corrective plans. The NEMC is comprised of representatives from LDOs, SDOs, state departments of public health, state offices of emergency management, local first responders, police and fire departments, and other renal partners.

KCER National Tabletop Exercise – NexUS

On October 8, 2014 the Network participated in a National Tabletop Exercise coordinated by the NCC. The scenario involved a natural event in which there was an outbreak of a novel influenza pandemic. The exercise was designed to establish a learning environment for participating ESRD Networks across the country. The goal of this exercise was to test Network-level emergency response plans, policies, and procedures as they pertain to an affected Network's geographic area of responsibility. To ensure an effective exercise, Network staff along with SMEs and local representatives from numerous agencies participated in the planning process and assisted with conducting and evaluating the exercise. The three major strengths identified during this event are as follows:

- Communication
- Individualized Specialties/Knowledge
- Internal Quality Control Processes

Emergency Events During 2014

- The Network successfully managed six winter storm emergency events that required facility notification, intervention, response, and tracking.
- The Network coordinated with LDOs, KCER, and other stakeholders regarding the normal saline shortage in order to obtain current information, which was provided to all New England facilities.



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Important Note Regarding Data Tables

The data presented in these tables were extracted from a snapshot of CROWNWeb as of 6/11/2015.

Because data in CROWNWeb can be updated by facilities through the Single User Interface (SUI) or batch submission at any time, these data may neither be identical to data extractions on different dates, nor match data reported in the Annual Survey. Please note that the responsible party for verifying, correcting and updating patient data in CROWNWeb changed from ESRD Networks to Medicare certified dialysis facilities.

DATA TABLES

Data Table 1: ESRD Incidence - One Year Statistics

1/1/2014 – 12/31/2014

Age Group	CT	MA	ME	NH	RI	VT	Other	Total
00-04	2	5	1	0	1	0	0	9
05-09	0	1	1	0	2	0	1	5
10-14	5	5	1	1	1	0	2	15
15-19	3	6	3	1	0	0	1	14
20-24	9	23	2	2	1	0	2	39
25-29	6	26	4	2	2	0	2	42
30-34	14	30	2	6	6	2	1	61
35-39	31	30	9	5	8	4	1	88
40-44	33	53	8	11	6	2	4	117
45-49	52	95	13	16	21	8	4	209
50-54	86	138	21	16	23	4	3	291
55-59	104	180	32	21	30	8	5	380
60-64	99	166	45	15	34	7	10	376
65-69	129	225	52	33	42	13	5	499
70-74	112	193	43	32	39	11	5	435
75-79	99	200	35	32	28	12	3	409
80-84	84	154	21	20	25	7	8	319
>=85	87	161	15	15	24	4	2	308
Total	955	1,691	308	228	293	82	59	3,616

Gender	CT	MA	ME	NH	RI	VT	Other	Total
Female	382	657	134	95	110	38	27	1,443
Male	573	1,034	174	133	183	44	32	2,173
Total	955	1,691	308	228	293	82	59	3,616

Race	CT	MA	ME	NH	RI	VT	Other	Total
American Indian/Alaska Native	2	2	0	0	0	0	0	4
Asian	17	62	3	4	4	0	1	91
Black or African American	228	249	11	7	26	1	13	535
Multiracial	2	4	1	1	0	0	1	9
Native Hawaiian or Other Pacific Islander	6	2	0	0	2	0	0	10
White	694	1,361	292	213	260	81	44	2,945
Not Specified	6	11	1	3	1	0	0	22
Total	955	1,691	308	228	293	82	59	3,616

Table 1: ESRD Incidence - One Year Statistics (continued)

1/1/2014 – 12/31/2014

Primary Diagnosis	CT	MA	ME	NH	RI	VT	Other	Total
Cystic/Hereditary/Congenital Diseases	46	79	21	11	12	5	2	176
Diabetes	381	706	137	82	118	37	18	1,479
Glomerulonephritis	88	174	33	25	38	5	6	369
Hypertension/Large Vessel Disease	230	359	51	47	58	14	17	776
Interstitial Nephritis/Pyelonephritis	37	70	12	7	13	4	6	149
Miscellaneous Conditions	99	172	36	23	32	11	3	376
Neoplasms/Tumors	28	44	11	11	12	4	1	111
Secondary GN/Vasculitis	29	36	5	7	6	2	6	91
Not Specified	17	51	2	15	4	0	0	89
Total	955	1,691	308	228	293	82	59	3,616

Source of Information: CROWNWeb

Race: The categories are from the CMS-2728 Form

Diagnosis: The categories are from the CMS 2728 Form

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 167 patients with transplant therapy as an initial treatment.

This table includes 27 patients receiving treatment at VA facilities.

Data Table 2: ESRD Dialysis Prevalence - One Year Statistics

1/1/2014 – 12/31/2014

Age Group	CT	MA	ME	NH	RI	VT	Other	Total
00-04	1	3	1	0	0	0	0	5
05-09	0	2	1	0	0	0	0	3
10-14	5	5	0	1	1	0	0	12
15-19	7	15	2	2	0	1	0	27
20-24	16	43	3	6	1	7	0	76
25-29	45	93	11	8	4	12	5	178
30-34	78	117	14	13	5	22	4	253
35-39	116	155	32	23	2	33	6	367
40-44	163	213	39	38	8	34	10	505
45-49	264	389	51	56	9	62	18	849
50-54	353	515	77	73	11	93	27	1,149
55-59	449	697	116	81	11	106	38	1,498
60-64	505	721	138	94	18	111	43	1,630
65-69	509	824	160	111	17	132	49	1,802
70-74	434	734	121	102	22	110	49	1,572
75-79	391	655	114	87	17	100	45	1,409
80-84	312	533	69	82	11	92	37	1,136
>=85	286	492	56	54	12	89	32	1,021
Total	3,934	6,206	1,005	831	149	1,004	363	13,492

Gender	CT	MA	ME	NH	RI	VT	Other	Total
Female	1,668	2,527	425	346	70	433	144	5,613
Male	2,266	3,679	580	485	79	571	219	7,879
Total	3,934	6,206	1,005	831	149	1,004	363	13,492

Ethnicity	CT	MA	ME	NH	Other	RI	VT	Total
Hispanic or Latino	505	767	1	20	33	124	2	1,452
Not Hispanic or Latino	3,429	5,433	1,004	811	116	880	361	12,034
Not Specified	0	6	0	0	0	0	0	6
Total	3,934	6,206	1,005	831	149	1,004	363	13,492

Race	CT	MA	ME	NH	RI	VT	Other	Total
American Indian/Alaska Native	7	11	5	0	0	3	2	28
Asian	67	282	11	12	5	31	2	410
Black or African American	1,362	1,272	31	29	16	149	9	2,868
Multiracial	3	16	2	1	0	7	0	29
Native Hawaiian or Other Pacific Islander	24	24	0	1	1	10	0	60
White	2,470	4,596	956	788	127	804	350	10,091
Not Specified	1	5	0	0	0	0	0	6
Total	3,934	6,206	1,005	831	149	1,004	363	13,492

Table 2: ESRD Dialysis Prevalence - One Year Statistics (continued)

1/1/2014 – 12/31/2014

Primary Diagnosis	CT	MA	ME	NH	RI	VT	Other	Total
Acquired obstructive uropathy	47	82	14	11	1	11	8	174
Acute interstitial nephritis	6	14	2	1	0	2	1	26
AIDS nephropathy	42	36	1	3	1	12	0	95
Amyloidosis	14	25	4	3	1	8	1	56
Analgesic abuse	6	7	1	3	0	1	1	19
Cholesterol emboli, renal emboli	20	24	2	5	0	5	1	57
Chronic interstitial nephritis	48	96	4	10	1	12	2	173
Chronic pyelonephritis, reflux nephropathy	12	18	7	7	1	2	4	51
Complications of transplanted bone marrow	1	1	0	0	0	0	0	2
Complications of transplanted heart	3	7	3	2	0	2	0	17
Complications of transplanted kidney	101	172	23	19	2	42	12	371
Complications of transplanted liver	7	6	0	1	0	3	1	18
Complications of transplanted lung	0	2	1	0	0	0	0	3
Complications of transplanted organ unspecified	4	2	1	0	0	0	0	7
Congenital nephrotic syndrome	6	7	1	3	0	0	0	17
Congenital obstruction of ureterpelvic junction	7	3	2	1	0	1	0	14
Congenital obstruction of uretrovesical junction	1	3	1	3	0	1	0	9
Cystinosis	0	0	0	1	0	0	0	1
Dense deposit disease, MPGN type 2	3	3	2	0	0	1	1	10
Diabetes with renal manifestations Type 1	158	271	49	30	5	57	17	587
Diabetes with renal manifestations Type 2	1,472	2,260	390	294	56	321	140	4,933
Drash syndrome, mesangial sclerosis	1	0	1	0	0	0	0	2
Etiology uncertain	148	212	51	42	6	28	16	503
Fabry's disease	2	2	0	0	0	0	0	4
Focal Glomerulonephritis, focal sclerosing GN	149	257	29	30	7	34	7	513
Glomerulonephritis (GN) (histologically not examined)	159	187	21	24	6	41	9	447
Goodpasture's syndrome	6	16	2	1	2	1	0	28
Gouty nephropathy	1	2	1	1	1	1	0	7
Hemolytic uremic syndrome	3	9	1	0	0	0	0	13
Henoch-Schonlein syndrome	2	2	1	1	0	0	0	6
Hepatorenal syndrome	4	5	2	2	0	3	1	17
Hereditary nephritis, Alport's syndrome	4	10	4	1	0	1	2	22
Hypertension: Unspecified with renal failure	842	1,263	162	149	34	195	54	2,699

Table 2: ESRD Dialysis Prevalence - One Year Statistics (continued)

1/1/2014 – 12/31/2014

Primary Diagnosis	CT	MA	ME	NH	RI	VT	Other	Total
IgA nephropathy, Berger's disease (proven by immunofluorescence)	46	150	17	18	3	14	5	253
IgM nephropathy (proven by immunofluorescence)	1	18	3	1	0	1	0	24
Lead nephropathy	2	0	0	0	0	0	0	2
Lupus erythematosus, (SLE nephritis)	53	85	4	4	2	11	2	161
Lymphoma of kidneys	1	3	0	0	0	0	1	5
Medullary cystic disease, including nephronophthisis	4	5	2	1	0	0	0	12
Membranoproliferative GN type 1, diffuse MPGN	30	37	6	6	0	10	1	90
Membranous nephropathy	21	44	5	10	0	15	6	101
Multiple myeloma	15	25	10	11	2	6	4	73
Nephrolithiasis	7	12	4	2	1	0	1	27
Nephropathy caused by other agents	22	57	20	4	3	13	5	124
Nephropathy due to heroin abuse and related drugs	3	2	0	0	0	0	0	5
Other (congenital malformation syndromes)	9	16	4	3	0	0	1	33
Other Congenital obstructive uropathy	13	16	8	4	0	5	2	48
Other disorders of calcium metabolism	1	1	0	2	0	0	0	4
Other immuno proliferative neoplasms (including light chain nephropathy)	3	8	1	2	0	0	0	14
Other proliferative GN	22	32	7	5	0	6	3	75
Other renal disorders	44	78	14	15	3	6	11	171
Other Vasculitis and its derivatives	11	23	4	2	1	6	4	51
Polyarteritis	1	0	2	0	0	2	1	6
Polycystic kidneys, adult type (dominant)	139	192	40	39	3	38	18	469
Polycystic, infantile (recessive)	1	5	0	0	0	1	0	7
Post infectious GN, SBE	7	13	2	1	0	0	0	23
Post-partum renal failure	2	2	1	1	0	0	0	6
Primary oxalosis	1	2	0	0	0	0	0	3
Prune belly syndrome	1	0	1	0	0	0	0	2
Radiation nephritis	0	0	0	0	0	1	0	1
Renal artery occlusion	5	11	2	3	0	4	0	25
Renal artery stenosis	32	74	16	7	1	7	7	144
Renal hypoplasia, dysplasia, oligonephronia	3	17	9	3	0	2	0	34
Renal tumor (benign)	0	2	0	0	0	0	0	2
Renal tumor (malignant)	11	28	8	4	2	2	1	56
Renal tumor (unspecified)	2	1	1	0	0	2	1	7
Scleroderma	0	5	0	1	0	3	1	10
Secondary GN, other	12	15	6	3	1	0	0	37
Sickle cell disease/anemia	5	6	0	0	0	0	0	11

Table 2: ESRD Dialysis Prevalence - One Year Statistics (continued)
1/1/2014 – 12/31/2014

Primary Diagnosis	CT	MA	ME	NH	RI	VT	Other	Total
Sickle cell trait and other sickle cell (HbS/Hb other)	0	1	0	0	0	0	0	1
Traumatic or surgical loss of kidney(s)	9	5	2	0	0	0	1	17
Tuberous sclerosis	2	8	0	0	1	3	0	14
Tubular necrosis (no recovery)	64	103	7	12	1	52	3	242
Urinary tract tumor (benign)	0	0	0	1	0	0	0	1
Urinary tract tumor (malignant)	3	5	1	1	0	2	0	12
Urinary tract tumor (unspecified)	1	0	0	0	0	0	0	1
Urolithiasis	1	3	1	0	0	0	0	5
Wegener's granulomatosis	11	34	5	2	1	0	3	56
With lesion of rapidly progressive GN	13	11	6	1	0	3	3	37
Not Specified	21	47	3	14	0	4	0	89
Total	3,934	6,206	1,005	831	149	1,004	363	13,492

When a category count = 0, the category may not be displayed on the report.

This table cannot be compared to the CMS facility survey Table 4 because the CMS Facility Survey is limited to dialysis patients receiving outpatient services from Medicare approved dialysis facilities.

Data Table 3: Dialysis Patients Modality and Setting - In Home

For Survey Years 2013 and 2014

Connecticut

Facility CCN	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
070025	0	0	4	4	3	4	0	0	7	8
07003F	0	0	0	0	1	0	0	0	1	0
070035	0	0	0	0	18	13	0	0	18	13
072501	4	3	15	12	53	56	0	0	72	71
072503	0	0	13	12	48	50	0	0	61	62
072504	5	4	3	3	20	21	0	0	28	28
072505	0	0	3	3	6	4	0	0	9	7
072506	0	0	0	0	0	0	0	0	0	0
072507	5	9	8	9	54	48	1	0	68	66
072508	1	0	1	0	3	4	0	0	5	4
072509	0	0	6	3	10	15	0	0	16	18
072510	0	0	0	0	0	0	0	0	0	0
072511	0	0	12	6	40	42	0	0	52	48
072512	8	8	0	0	0	0	0	0	8	8
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	1	13	15	0	0	14	16
072516	0	0	8	5	17	20	0	0	25	25
072517	0	0	0	0	0	0	0	0	0	0
072518	14	13	2	2	6	8	0	0	22	23
072519	0	2	6	9	9	9	0	0	15	20
072520	0	0	5	7	8	13	0	0	13	20
072521	0	0	3	2	13	12	0	0	16	14
072522	0	0	0	0	0	0	0	0	0	0
072523	0	0	8	2	15	18	0	0	23	20
072524	0	0	1	3	9	6	0	0	10	9
072527	1	0	1	0	10	5	0	0	12	5
072528	2	7	2	0	6	14	0	0	10	21
072529	0	0	1	1	17	16	0	0	18	17
072530	0	0	0	0	0	0	0	0	0	0
072531	0	0	2	2	4	2	0	0	6	4
072532	0	0	0	0	0	0	0	0	0	0
072533	24	24	0	0	0	0	0	0	24	24
072534	0	1	0	1	3	2	0	0	3	4
072535	0	0	0	0	0	0	0	0	0	0
072536	0	0	0	0	0	1	0	0	0	1
072537	0	0	0	0	0	0	0	0	0	0
072538	0	0	4	2	8	10	0	0	12	12
072539	3	3	5	3	9	15	0	0	17	21

Table 3: Dialysis Patients Modality and Setting - In Home (continued)

For Survey Years 2013 and 2014

Connecticut (continued)

Facility CCN	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
072540	0	0	2	3	10	12	0	0	12	15
072541	0	0	0	0	2	1	0	0	2	1
072542	0	0	3	5	6	5	0	0	9	10
072543	0	0	0	0	0	0	0	0	0	0
072544	0	0	6	5	14	10	0	0	20	15
072545	0	0	1	0	0	0	0	0	1	0
072546^	0	0	0	0	0	0	0	0	0	0
CT Total	68	74	126	105	435	451	1	0	630	630

Massachusetts

Facility CCN	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
22010F	0	0	0	0	0	0	0	0	0	0
220028	0	0	1	0	17	19	0	0	18	19
220036	0	0	2	4	0	0	0	0	2	4
220046	2	2	3	2	6	9	0	0	11	13
220071	0	0	15	12	7	7	0	0	22	19
220081	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	8	5	1	0	6	5	0	0	15	10
222501	2	2	1	2	11	6	0	0	14	10
222502	0	0	0	0	0	0	0	0	0	0
222503	1	0	1	2	8	4	0	0	10	6
222504	1	2	0	0	1	4	0	0	2	6
222505	0	0	0	0	0	0	0	0	0	0
222506	0	0	0	0	0	0	0	0	0	0
222507	3	4	0	0	0	0	0	0	3	4
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	1	2	1	2	0	0	2	4
222513	0	0	1	1	18	15	0	0	19	16
222515	0	0	0	1	5	3	0	0	5	4
222516	0	0	4	1	10	10	0	0	14	11
222517	3	7	2	2	6	6	0	0	11	15
222519	0	0	0	0	0	0	0	0	0	0
222520	0	0	1	1	10	12	0	0	11	13
222521	1	0	2	1	7	12	0	0	10	13

Table 3: Dialysis Patients Modality and Setting - In Home (continued)
For Survey Years 2013 and 2014

Massachusetts (continued)

Facility CCN	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
222523	0	0	6	6	8	6	0	0	14	12
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	5	10	54	49	0	0	59	59
222529	7	10	10	10	21	19	0	0	38	39
222530	2	3	1	1	8	8	0	0	11	12
222532	0	0	0	0	0	0	0	0	0	0
222533	0	0	1	2	9	7	0	0	10	9
222534	0	0	2	1	6	10	0	0	8	11
222535	0	0	0	0	0	0	0	0	0	0
222536	0	0	3	0	15	12	0	0	18	12
222537	0	0	0	0	0	0	0	0	0	0
222538	9	7	0	0	0	0	0	0	9	7
222539	0	0	1	1	6	7	0	0	7	8
222542	6	6	1	2	4	2	0	0	11	10
222543	0	0	0	2	7	6	0	0	7	8
222545	4	6	4	4	17	16	0	0	25	26
222546	0	0	0	0	4	6	0	0	4	6
222548	0	0	0	0	0	0	0	0	0	0
222549	5	5	9	13	49	44	0	0	63	62
222550	8	6	0	1	6	3	0	0	14	10
222551	0	0	0	0	3	4	0	0	3	4
222552	0	0	6	7	29	34	0	0	35	41
222553	0	0	4	1	4	6	0	0	8	7
222556	0	0	6	7	7	8	0	0	13	15
222557	0	0	0	0	0	0	0	0	0	0
222559	0	0	0	0	0	0	0	0	0	0
222560	0	0	0	0	1	1	0	0	1	1
222561	1	0	0	1	1	1	0	0	2	2
222562	0	0	1	1	4	3	0	0	5	4
222564	11	9	1	0	26	30	0	0	38	39
222565	4	4	3	3	4	4	0	0	11	11
222567	0	0	0	0	3	3	0	0	3	3
222568	0	0	0	0	0	0	0	0	0	0
222570	2	1	1	1	5	4	0	0	8	6
222571	0	2	1	0	16	24	0	0	17	26
222572	1	0	0	0	3	0	0	0	4	0
222573	2	1	1	1	3	2	0	0	6	4
222574	0	0	0	0	3	5	0	0	3	5

Table 3: Dialysis Patients Modality and Setting - In Home (continued)

For Survey Years 2013 and 2014

Massachusetts (continued)

Facility CCN	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
222575#	0	0	0	0	0	0	0	0	0	0
222576	0	0	0	0	0	0	0	0	0	0
222577	0	0	0	0	1	3	0	0	1	3
222578	0	0	0	0	0	0	0	0	0	0
222579	9	6	0	3	0	2	0	0	9	11
222580	0	0	0	0	0	0	0	0	0	0
222581^	0	0	0	0	0	0	0	0	0	0
222582	0	0	0	0	0	0	0	0	0	0
222583	0	0	1	0	7	10	0	0	8	10
222584^	0	0	0	0	0	0	0	0	0	0
223302	0	0	0	0	11	9	0	0	11	9
223504	0	0	0	0	0	0	0	0	0	0
MA Total	92	88	103	109	458	462	0	0	653	659

Maine

Facility CCN	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
200018	0	0	0	0	0	0	0	0	0	0
20003F	0	0	0	0	0	0	0	0	0	0
202500	5	6	1	2	4	13	0	0	10	21
202501	0	0	0	0	0	0	0	0	0	0
202502	0	1	0	0	1	2	0	0	1	3
202503	0	0	0	0	10	10	0	0	10	10
202504	2	2	0	0	0	1	0	1	2	4
202505	0	0	0	0	1	2	0	0	1	2
202506	3	2	1	2	4	7	0	0	8	11
202507	1	1	1	0	0	1	0	0	2	2
202508	1	1	0	0	4	2	0	0	5	3
202509	0	0	0	0	0	0	0	0	0	0
202510	0	0	0	1	3	2	0	0	3	3
202511	0	0	2	1	3	3	0	0	5	4
202512	1	1	8	11	16	11	0	0	25	23
202513	0	0	0	0	0	0	0	0	0	0
202514	0	0	0	0	0	0	0	0	0	0
202515	3	3	0	0	3	3	0	0	6	6
ME Total	16	17	13	17	49	57	0	1	78	92

Table 3: Dialysis Patients Modality and Setting - In Home (continued)
For Survey Years 2013 and 2014

New Hampshire

Facility CCN	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
302500	7	10	1	1	3	4	0	0	11	15
302501	1	0	1	0	17	22	0	0	19	22
302502	1	0	4	1	10	13	0	0	15	14
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	6	6	2	1	18	19	0	0	26	26
302508	0	0	0	0	0	0	0	0	0	0
302509	5	6	2	3	5	4	0	0	12	13
302510	0	0	0	0	0	0	0	0	0	0
302511	0	0	0	0	6	5	0	0	6	5
302512	0	0	1	0	1	0	0	0	2	0
302513	0	0	0	0	3	6	0	0	3	6
302514	0	0	0	0	0	0	0	0	0	0
302515	1	1	0	0	0	0	0	0	1	1
302516^	0	0	0	0	0	3	0	0	0	3
302517^	0	0	0	0	0	0	0	0	0	0
NH Total	21	23	11	6	63	76	0	0	95	105

Rhode Island

Facility CCN	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
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	4	5	0	0	3	4	0	0	7	9
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	0	4	2	0	0	4	2
412506	0	0	3	0	8	5	0	0	11	5
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	1	0	14	15	0	0	15	15
412514	0	0	0	0	0	0	0	0	0	0
413500	0	0	0	0	6	16	0	0	6	16
413501	0	0	0	0	0	0	0	0	0	0
RI Total	4	5	4	0	35	42	0	0	43	47

Table 3: Dialysis Patients Modality and Setting - In Home (continued)

For Survey Years 2013 and 2014

Vermont

Facility CCN	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
470003	0	0	0	0	0	0	0	0	0	0
472500	0	0	0	0	0	0	0	0	0	0
472501	0	0	0	0	0	0	0	0	0	0
473500	0	0	0	0	0	0	0	0	0	0
473501	0	0	0	0	0	0	0	0	0	0
473502	0	0	0	0	0	0	0	0	0	0
473503	15	14	6	5	7	14	0	0	28	33
473504	0	0	0	0	0	0	0	1	0	1
VT Total	15	14	6	5	7	14	0	1	28	34

	Hemo		CAPD		CCPD		Other		Total	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
Network Total	216	221	263	242	1,047	1,102	1	2	1,527	1,567

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

Date of Preparation: May 2015

This table includes 1 Veterans Affairs Facility patients for 2013 and 0 Veterans Affairs Facility patients for 2014.

^ Facility not operational in 2013

Facility not operational in 2014

* Facility does not have a generated 2744 in 2014

Data Table 4: Dialysis Patients Modality and Setting - In Center

For Survey Years 2013 and 2014

Connecticut

Facility CCN	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
070025	175	167	0	0	175	167	182	175
07003F	35	38	0	0	35	38	36	38
070035	101	98	0	0	101	98	119	111
072501	240	237	0	0	240	237	312	308
072503	0	0	0	0	0	0	61	62
072504	155	150	0	0	155	150	183	178
072505	51	49	0	0	51	49	60	56
072506	58	50	0	0	58	50	58	50
072507	107	97	2	0	109	97	177	163
072508	45	41	0	0	45	41	50	45
072509	74	81	0	0	74	81	90	99
072510	87	85	0	0	87	85	87	85
072511	135	118	0	0	135	118	187	166
072512	178	180	0	0	178	180	186	188
072513#	0	0	0	0	0	0	0	0
072514	80	84	0	0	80	84	80	84
072515	94	96	0	0	94	96	108	112
072516	130	124	0	0	130	124	155	149
072517	54	59	0	0	54	59	54	59
072518	52	49	0	0	52	49	74	72
072519	68	67	0	0	68	67	83	87
072520	70	81	0	0	70	81	83	101
072521	115	123	0	0	115	123	131	137
072522	71	61	0	0	71	61	71	61
072523	55	58	0	0	55	58	78	78
072524	78	80	0	0	78	80	88	89
072527	48	54	0	0	48	54	60	59
072528	62	56	0	0	62	56	72	77
072529	73	67	0	0	73	67	91	84
072530	30	36	0	0	30	36	30	36
072531	51	46	0	1	51	47	57	51
072532	54	56	0	0	54	56	54	56
072533	64	64	0	0	64	64	88	88
072534	40	38	0	0	40	38	43	42
072535	56	63	0	0	56	63	56	63
072536	26	31	0	0	26	31	26	32
072537	71	76	0	0	71	76	71	76
072538	62	53	0	0	62	53	74	65
072539	56	69	0	0	56	69	73	90

Table 4: Dialysis Patients Modality and Setting - In Center (continued)
For Survey Years 2013 and 2014

Connecticut (continued)

Facility CCN	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
072540	43	40	0	0	43	40	55	55
072541	22	25	0	0	22	25	24	26
072542	38	52	0	1	38	53	47	63
072543	27	44	0	0	27	44	27	44
072544	118	129	0	0	118	129	138	144
072545	11	13	0	0	11	13	12	13
072546^	0	15	0	0	0	15	0	15
CT Total	3,270	3,300	2	2	3,272	3,302	3,902	3,932

Massachusetts

Facility CCN	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
220028	64	61	0	0	64	61	82	80
220036	94	90	0	1	94	91	96	95
220046	99	100	0	0	99	100	110	113
220071	5	3	0	0	5	3	27	22
220081	4	3	0	0	4	3	4	3
22010F	21	21	0	0	21	21	21	21
220110	1	2	0	0	1	2	1	2
220123	8	6	0	0	8	6	8	6
220163	3	3	0	0	3	3	3	3
221302	21	21	0	0	21	21	21	21
222006	13	13	0	0	13	13	13	13
222500	88	97	0	0	88	97	103	107
222501	76	80	0	0	76	80	90	90
222502	131	133	0	0	131	133	131	133
222503	117	125	0	1	117	126	127	132
222504	93	91	0	0	93	91	95	97
222505	64	64	0	0	64	64	64	64
222506	84	89	0	0	84	89	84	89
222507	92	102	0	0	92	102	95	106
222508	102	92	0	0	102	92	102	92
222511	74	79	0	0	74	79	74	79
222512	112	107	0	0	112	107	114	111
222513	67	63	0	0	67	63	86	79
222515	79	82	0	0	79	82	84	86
222516	123	130	0	0	123	130	137	141
222517	119	117	1	0	120	117	131	132
222519	77	67	0	0	77	67	77	67
222520	59	55	0	0	59	55	70	68
222521	71	81	0	0	71	81	81	94

Table 4: Dialysis Patients Modality and Setting - In Center (continued)
For Survey Years 2013 and 2014

Massachusetts (continued)

Facility CCN	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
222523	115	111	0	0	115	111	129	123
222524	70	71	0	0	70	71	70	71
222525	104	112	0	0	104	112	104	112
222526	164	175	2	2	166	177	225	236
222529	136	139	0	0	136	139	174	178
222530	75	78	0	0	75	78	86	90
222532	33	23	0	0	33	23	33	23
222533	63	66	0	0	63	66	73	75
222534	57	66	0	0	57	66	65	77
222535	52	54	0	0	52	54	52	54
222536	88	100	1	2	89	102	107	114
222537	52	51	0	0	52	51	52	51
222538	115	119	0	0	115	119	124	126
222539	50	45	0	0	50	45	57	53
222542	87	87	0	0	87	87	98	97
222543	90	89	0	0	90	89	97	97
222545	89	87	0	0	89	87	114	113
222546	83	87	0	0	83	87	87	93
222548	22	18	0	0	22	18	22	18
222549	79	84	0	0	79	84	142	146
222550	102	100	0	0	102	100	116	110
222551	83	87	0	0	83	87	86	91
222552	131	124	0	0	131	124	166	165
222553	54	53	1	0	55	53	63	60
222556	83	74	0	0	83	74	96	89
222557	44	46	0	0	44	46	44	46
222559	42	46	0	0	42	46	42	46
222560	86	80	0	0	86	80	87	81
222561	77	80	1	0	78	80	80	82
222562	46	43	0	0	46	43	51	47
222564	124	120	1	0	125	120	163	159
222565	109	108	0	0	109	108	120	119
222567	77	64	0	0	77	64	80	67
222568	44	48	0	0	44	48	44	48
222570	57	58	0	0	57	58	65	64
222571	84	79	0	1	84	80	101	106
222572	57	64	0	0	57	64	61	64
222573	106	97	0	0	106	97	112	101
222574	77	88	0	0	77	88	80	93

Table 4: Dialysis Patients Modality and Setting - In Center (continued)

For Survey Years 2013 and 2014

Massachusetts (continued)

Facility CCN	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
222575#	0	0	0	0	0	0	0	0
222576	40	45	0	0	40	45	40	45
222577	25	28	0	0	25	28	26	31
222578	6	9	0	0	6	9	6	9
222579	14	27	0	0	14	27	23	38
222580	8	36	0	0	8	36	8	36
222581^	0	7	0	0	0	7	0	7
222582	102	97	0	0	102	97	102	97
222583	188	189	2	0	190	189	198	199
222584^	0	37	0	0	0	37	0	37
223302	22	14	0	0	22	14	33	23
223504	3	5	0	0	3	5	3	5
MA Total	5,476	5,592	9	7	5,485	5,599	6,138	6,258

Maine

Facility CCN	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
200018	40	42	0	0	40	42	40	42
20003F	17	14	0	0	17	14	17	14
202500	81	78	0	0	81	78	91	99
202501	53	54	0	0	53	54	53	54
202502	53	52	0	0	53	52	54	55
202503	79	74	0	0	79	74	89	84
202504	50	60	0	0	50	60	52	64
202505	82	80	0	0	82	80	83	82
202506	56	57	0	0	56	57	64	68
202507	24	23	0	0	24	23	26	25
202508	25	25	0	0	25	25	30	28
202509	31	33	0	0	31	33	31	33
202510	15	15	0	0	15	15	18	18
202511	20	26	0	0	20	26	25	30
202512	111	114	0	0	111	114	136	137
202513	34	34	0	0	34	34	34	34
202514	46	55	0	0	46	55	46	55
202515	49	46	0	0	49	46	55	52
ME Total	866	882	0	0	866	882	944	974

Table 4: Dialysis Patients Modality and Setting - In Center (continued)
For Survey Years 2013 and 2014

New Hampshire

Facility CCN	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
302500	68	65	0	0	68	65	79	80
302501	51	50	0	0	51	50	70	72
302502	93	98	0	0	93	98	108	112
302503	42	46	0	0	42	46	42	46
302504	58	54	0	0	58	54	58	54
302505	70	66	0	0	70	66	70	66
302506	50	40	0	0	50	40	50	40
302507	87	90	0	0	87	90	113	116
302508	27	31	0	0	27	31	27	31
302509	68	78	0	0	68	78	80	91
302510	29	37	0	0	29	37	29	37
302511	25	21	0	0	25	21	31	26
302512	18	18	0	0	18	18	20	18
302513	10	14	0	0	10	14	13	20
302514	44	44	0	0	44	44	44	44
302515	15	20	0	0	15	20	16	21
302516^	0	19	0	0	0	19	0	22
302517^	0	6	0	0	0	6	0	6
NH Total	755	797	0	0	755	797	850	902

Rhode Island

Facility CCN	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
410007	2	0	0	0	2	0	2	0
410012	0	0	0	0	0	0	0	0
41002F	33	31	0	0	33	31	33	31
412501	113	108	0	0	113	108	120	117
412502	39	45	0	0	39	45	39	45
412503	70	67	0	0	70	67	70	67
412504	84	90	0	0	84	90	84	90
412505	104	107	0	0	104	107	108	109
412506	69	56	0	0	69	56	80	61
412507	41	44	0	0	41	44	41	44
412508	76	74	0	0	76	74	76	74
412509	75	46	0	0	75	46	75	46
412510	64	65	0	0	64	65	64	65
412511	68	67	0	0	68	67	68	67
412512	71	72	0	0	71	72	86	87
412514	65	62	0	0	65	62	65	62
413500	78	81	0	0	78	81	84	97
413501	22	33	0	0	22	33	22	33
RI Total	1,074	1,048	0	0	1,074	1,048	1,117	1,095

Table 4: Dialysis Patients Modality and Setting - In Center (continued)
For Survey Years 2013 and 2014

Vermont

Facility CCN	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
470003	9	8	0	0	9	8	9	8
472500	40	37	0	0	40	37	40	37
472501	30	29	0	0	30	29	30	29
473500	32	28	0	0	32	28	32	28
473501	49	50	0	0	49	50	49	50
473502	42	39	0	0	42	39	42	39
473503	89	79	0	0	89	79	117	112
473504	18	18	0	0	18	18	18	19
VT Total	309	288	0	0	309	288	337	322

	Hemo		PD		Total		Total In-Center & Home ¹	
	2013	2014	2013	2014	2013	2014	2013	2014
Network Total	11,750	11,907	11	9	11,761	11,916	13,288	13,483

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

This table cannot be compared to Table 2 because the CMS Facility Survey is limited to dialysis patients receiving outpatient services from Medicare approved dialysis facilities.

Date of Preparation: May 2015

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 2013 and 104 Veterans Affairs Facility patients for 2014.

^ Facility not operational in 2013

Facility not operational in 2014

* Facility does not have a generated 2744 in 2014

Data Table 5: Renal Transplants by Transplant Center and State

1/1/2014 – 12/31/2014

Transplant Center	Total Transplants Performed		Patients Awaiting Transplant	
	2013	2014	2013	2014
070022	108	101	468	479
070025	43	55	386	389
CT Total	151	156	854	868
220031	32	34	233	169
220071	100	117	139	137
220077	37	22	144	132
220086	68	62	340	342
220110	53	65	84	245
220116	25	37	237	109
220163	51	51	228	229
220171	39	38	161	165
223302	22	36	14	9
MA Total	427	462	1,580	1,537
200009	38	55	99	93
ME Total	38	55	99	93
300003	35	40	128	103
NH Total	35	40	128	103
410007	42	62	345	128
RI Total	42	62	345	128
470003	25	28	103	80
VT Total	25	28	103	80

	Total Transplants Performed		Patients Awaiting Transplant	
	2013	2014	2013	2014
Network Total	718	803	3,109	2,809

Data Table 6: Renal Transplant Recipients

1/1/2014 – 12/31/2014

Age Group	Transplant Type			Total
	Deceased	Living Related	Living Unrelated	
00-04	5	5	0	10
05-09	2	3	1	6
10-14	4	5	3	12
15-19	14	6	0	20
20-24	5	10	3	18
25-29	16	11	5	32
30-34	13	4	7	24
35-39	23	17	14	54
40-44	30	11	10	51
45-49	44	15	23	82
50-54	60	18	22	100
55-59	78	19	21	118
60-64	62	17	13	92
65-69	67	14	19	100
70-74	41	9	7	57
75-79	13	2	3	18
80-84	0	0	0	0
>=85	0	0	0	0
Total	477	166	151	794

Gender	Transplant Type			Total
	Deceased	Living Related	Living Unrelated	
Female	187	53	44	284
Male	290	113	107	510
Total	477	166	151	794

Race	Transplant Type			Total
	Deceased	Living Related	Living Unrelated	
American Indian/Alaska Native	0	0	0	0
Asian	17	4	3	24
Black or African American	84	9	12	105
Multiracial	0	0	1	1
Native Hawaiian or Other Pacific Islander	4	1	1	6
White	372	152	134	658
Not Specified	0	0	0	0
Total	477	166	151	794

Table 6: Renal Transplant Recipients (continued)

1/1/2014 – 12/31/2014

Primary Diagnosis	Transplant Type			Total
	Deceased	Living Related	Living Unrelated	
Acquired obstructive uropathy	6	0	3	9
Acute interstitial nephritis	0	0	0	0
AIDS nephropathy	1	0	0	1
Amyloidosis	0	0	1	1
Analgesic abuse	1	0	0	1
Cholesterol emboli, renal emboli	1	0	0	1
Chronic interstitial nephritis	17	1	2	20
Chronic pyelonephritis, reflux nephropathy	5	3	2	10
Complications of other specified transplanted organ	0	1	0	1
Complications of transplanted bone marrow	0	1	0	1
Complications of transplanted heart	1	0	1	2
Complications of transplanted intestine	0	0	0	0
Complications of transplanted kidney	23	3	6	32
Complications of transplanted liver	2	0	0	2
Complications of transplanted lung	0	0	0	0
Complications of transplanted organ unspecified	2	0	0	2
Complications of transplanted pancreas	0	0	0	0
Congenital nephrotic syndrome	0	1	0	1
Congenital obstruction of ureteropelvic junction	1	0	0	1
Congenital obstruction of ureterovesical junction	0	0	0	0
Cystinosis	0	0	0	0
Dense deposit disease, MPGN type 2	2	0	1	3
Diabetes with renal manifestations Type 1	30	13	10	53
Diabetes with renal manifestations Type 2	98	18	11	127
Drash syndrome, mesangial sclerosis	0	0	0	0
Etiology uncertain	18	8	5	31
Fabry's disease	0	0	0	0
Focal Glomerulonephritis, focal sclerosing GN	30	13	10	53
Glomerulonephritis (GN) (histologically not examined)	22	6	4	32
Goodpasture's syndrome	2	2	0	4
Gouty nephropathy	0	0	0	0
Hemolytic uremic syndrome	2	0	1	3
Henoch-Schonlein syndrome	0	0	0	0
Hepatorenal syndrome	8	0	0	8
Hereditary nephritis, Alport's syndrome	1	0	3	4
Hypertension: Unspecified with renal failure	66	11	14	91
IgA nephropathy, Berger's disease (proven by immunofluorescence)	18	18	11	47
IgM nephropathy (proven by immunofluorescence)	1	0	1	2

Table 6: Renal Transplant Recipients (continued)

1/1/2014 – 12/31/2014

Primary Diagnosis	Transplant Type			Total
	Deceased	Living Related	Living Unrelated	
Lead nephropathy	0	0	0	0
Lupus erythematosus, (SLE nephritis)	8	2	3	13
Lymphoma of kidneys	0	0	0	0
Medullary cystic disease, including nephronophthisis	2	1	1	4
Membranoproliferative GN type 1, diffuse MPGN	4	4	2	10
Membranous nephropathy	7	1	1	9
Multiple myeloma	0	0	1	1
Nephrolithiasis	3	0	0	3
Nephropathy caused by other agents	3	1	0	4
Nephropathy due to heroin abuse and related drugs	0	0	0	0
Other (congenital malformation syndromes)	3	2	4	9
Other Congenital obstructive uropathy	7	3	1	11
Other disorders of calcium metabolism	0	0	0	0
Other immuno proliferative neoplasms (including light chain nephropathy)	0	1	0	1
Other proliferative GN	3	2	1	6
Other renal disorders	6	10	2	18
Other Vasculitis and its derivatives	2	0	0	2
Polyarteritis	2	0	0	2
Polycystic kidneys, adult type (dominant)	48	17	36	101
Polycystic, infantile (recessive)	2	3	0	5
Post infectious GN, SBE	0	1	2	3
Post-partum renal failure	0	0	0	0
Primary oxalosis	0	1	0	1
Prune belly syndrome	0	4	0	4
Radiation nephritis	0	0	0	0
Renal artery occlusion	0	0	0	0
Renal artery stenosis	2	0	0	2
Renal hypoplasia, dysplasia, oligonephronia	8	3	3	14
Renal tumor (benign)	0	0	1	1
Renal tumor (malignant)	2	0	0	2
Renal tumor (unspecified)	0	0	0	0
Scleroderma	0	0	0	0
Secondary GN, other	2	1	1	4
Sickle cell disease/anemia	0	0	0	0
Sickle cell trait and other sickle cell (HbS/Hb other)	0	0	0	0
Traumatic or surgical loss of kidney(s)	0	0	0	0
Tuberous sclerosis	0	0	0	0
Tubular necrosis (no recovery)	1	2	1	4

Table 6: Renal Transplant Recipients (continued)
1/1/2014 – 12/31/2014

Primary Diagnosis	Transplant Type			Total
	Deceased	Living Related	Living Unrelated	
Urinary tract tumor (benign)	0	0	0	0
Urinary tract tumor (malignant)	0	0	0	0
Urinary tract tumor (unspecified)	0	0	0	0
Urolithiasis	1	0	0	1
Wegener's granulomatosis	1	3	0	4
With lesion of rapidly progressive GN	0	0	0	0
Not Specified	2	5	5	12
Total	477	166	151	794

This table cannot be compared to Table 5 as this table excludes patients that do not have a 2728 form submitted (i.e., international patients).

Data Table 7: Dialysis Deaths

1/1/2014 – 12/31/2014

Age Group	CT	MA	ME	NH	RI	VT	Other	Total
00-04	0	1	0	0	0	0	0	1
05-09	0	0	0	0	0	0	0	0
10-14	0	0	0	0	0	0	0	0
15-19	0	1	0	0	0	0	0	1
20-24	0	0	0	0	0	0	0	0
25-29	2	7	1	0	1	1	0	12
30-34	2	6	0	1	1	1	0	11
35-39	6	8	0	2	1	2	0	19
40-44	8	13	2	1	1	1	0	26
45-49	20	24	3	4	8	3	0	62
50-54	45	52	8	10	12	1	0	128
55-59	55	65	12	9	11	4	1	157
60-64	58	86	22	11	20	14	1	212
65-69	84	150	31	18	21	18	2	324
70-74	110	164	40	21	33	12	2	382
75-79	116	174	32	33	32	6	5	398
80-84	97	162	26	34	41	9	5	374
>=85	126	252	27	21	44	11	3	484
Total	729	1,165	204	165	226	83	19	2,591

Gender	CT	MA	ME	NH	RI	VT	Other	Total
Female	297	479	86	64	99	42	5	1,072
Male	432	686	118	101	127	41	14	1,519
Total	729	1,165	204	165	226	83	19	2,591

Race	CT	MA	ME	NH	RI	VT	Other	Total
American Indian/Alaska Native	1	1	1	0	0	0	0	3
Asian	8	36	0	1	2	0	0	47
Black or African American	165	133	3	3	24	3	1	332
Multiracial	0	2	0	0	1	0	0	3
Native Hawaiian or Other Pacific Islander	1	2	0	0	1	0	0	4
White	554	991	200	161	198	80	18	2,202
Total	729	1,165	204	165	226	83	19	2,591

Table 7: Dialysis Deaths (continued)

1/1/2014 – 12/31/2014

Primary Diagnosis	CT	MA	ME	NH	RI	VT	Other	Total
Cystic/Hereditary/Congenital Diseases	15	28	4	4	7	4	1	63
Diabetes	326	525	98	71	90	40	8	1,158
Glomerulonephritis	51	86	12	14	15	7	1	186
Hypertension/Large Vessel Disease	179	272	49	44	57	12	7	620
Interstitial Nephritis/Pyelonephritis	19	44	5	6	16	7	1	98
Miscellaneous Conditions	86	128	20	13	24	3	1	275
Neoplasms/Tumors	31	52	13	5	14	5	0	120
Secondary GN/Vasculitis	18	20	3	4	3	5	0	53
Not Specified	4	10	0	4	0	0	0	18
Total	729	1,165	204	165	226	83	19	2,591

Primary Cause of Death	CT	MA	ME	NH	RI	VT	Other	Total
Cardiac	251	385	56	48	92	22	1	855
Endocrine	0	0	0	0	0	0	0	0
Gastro-Intestinal	9	11	1	2	3	0	0	26
Infection	107	138	17	14	24	3	3	306
Liver Disease	11	12	2	0	1	0	0	26
Metabolic	3	3	1	1	0	1	0	9
Other	297	537	109	81	95	50	14	1,183
Vascular	37	50	15	6	9	4	0	121
Not Specified	14	29	3	13	2	3	1	65
Total	729	1,165	204	165	226	83	19	2,591

Source of Information: CROWNWeb

Race: The categories are from the CMS-2728 Form

Diagnosis: The categories are from the CMS 2728 Form

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 25 patients receiving treatment at VA facilities.

Data Table 8: Vocational Rehabilitation

1/1/2014 – 12/31/2014

Connecticut

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	71	0	10	0
07003F	2	0	1	0
070035	20	0	5	0
072501	110	0	12	0
072503	21	0	8	0
072504	36	0	10	0
072505	16	0	4	0
072506	11	0	3	0
072507	68	1	4	1
072508	19	0	2	0
072509	30	0	4	0
072510	9	0	4	0
072511	47	0	5	0
072512	56	1	8	1
072514	20	0	5	0
072515	25	0	5	0
072516	38	1	15	1
072517	19	0	0	0
072518	23	0	3	0
072519	28	1	5	1
072520	28	1	11	0
072521	26	0	4	0
072522	7	0	1	0
072523	22	3	2	0
072524	14	0	7	0
072527	16	0	0	0
072528	16	1	4	1
072529	21	1	9	0
072530	8	0	1	0
072531	15	0	1	0
072532	9	0	1	0
072533	28	1	7	1
072534	7	0	0	0
072535	14	0	3	0
072536	12	0	2	0
072537	13	1	6	1
072538	21	1	4	1
072539	23	0	9	0

Table 8: Vocational Rehabilitation (continued)

1/1/2014 – 12/31/2014

Connecticut (continued)

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
072540	10	0	3	0
072541	6	0	2	0
072542	13	0	4	0
072543	14	0	0	0
072544	28	3	12	0
072545	6	1	0	1
072546	0	0	0	0
CT Total	1,046	17	206	9

Massachusetts

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	17	0	5	0
220036	17	0	3	0
220046	27	0	10	0
220071	12	0	3	0
220081	1	0	1	0
22010F	0	0	0	0
220110	2	0	0	0
220116	0	0	0	0
220123	1	0	0	0
220163	1	0	1	0
221302	2	0	1	0
222006	6	0	0	0
222500	43	1	5	0
222501	17	0	4	0
222502	45	0	1	0
222503	29	0	8	0
222504	23	0	7	0
222505	21	0	1	0
222506	17	0	1	0
222507	41	0	7	0
222508	23	2	9	1
222511	19	0	5	0
222512	28	0	6	0
222513	20	0	5	0
222515	16	0	1	0
222516	37	1	9	1
222517	19	0	4	0

Table 8: Vocational Rehabilitation (continued)

1/1/2014 – 12/31/2014

Massachusetts (continued)

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
222519	15	0	2	0
222520	9	0	3	0
222521	36	0	4	0
222523	27	1	8	1
222524	17	0	2	0
222525	28	0	1	0
222526	98	0	7	0
222529	61	2	17	0
222530	30	1	1	1
222532	2	0	0	0
222533	11	0	0	0
222534	13	0	4	0
222535	17	1	1	1
222536	39	0	3	0
222537	5	0	0	0
222538	46	3	10	3
222539	12	0	2	0
222542	23	0	5	0
222543	19	1	2	0
222545	28	0	5	0
222546	20	0	5	0
222548	1	0	0	0
222549	40	2	12	0
222550	12	0	3	0
222551	16	1	3	1
222552	49	0	11	1
222553	9	0	2	0
222556	9	0	2	0
222557	5	0	1	0
222559	5	0	1	0
222560	16	1	0	1
222561	17	1	2	1
222562	10	0	1	0
222564	43	1	13	1
222565	41	0	5	0
222567	10	0	1	0
222568	6	0	1	0
222570	20	0	6	0

Table 8: Vocational Rehabilitation (continued)

1/1/2014 – 12/31/2014

Massachusetts (continued)

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
222571	26	1	4	1
222572	7	0	1	0
222573	33	0	9	0
222574	25	1	5	1
222576	12	0	1	0
222577	6	0	2	0
222578	2	0	0	0
222579	12	0	3	0
222580	7	0	3	0
222581	3	0	0	0
222582	23	1	4	1
222583	41	0	11	0
222584	6	0	1	0
223302	8	1	0	1
223504	1	0	1	0
MA Total	1,561	23	288	17

Maine

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
200018	10	1	0	0
20003F	3	0	0	0
202500	31	3	10	3
202501	13	1	2	0
202502	10	0	3	0
202503	14	1	2	0
202504	20	0	3	0
202505	15	0	5	0
202506	16	0	3	0
202507	3	0	0	0
202508	5	0	1	0
202509	6	0	1	0
202510	4	0	0	0
202511	5	0	2	0
202512	34	0	6	0
202513	12	0	0	0
202514	13	0	3	0
202515	9	0	2	0
ME Total	223	6	43	3

Table 8: Vocational Rehabilitation (continued)

1/1/2014 – 12/31/2014

New Hampshire

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
302500	21	0	3	0
302501	17	0	4	0
302502	33	0	7	0
302503	17	0	3	0
302504	13	0	4	0
302505	16	2	2	1
302506	9	0	0	0
302507	31	0	4	0
302508	11	0	0	0
302509	24	0	4	0
302510	6	0	1	0
302511	7	0	5	0
302512	5	0	0	0
302513	4	0	1	0
302514	7	0	1	0
302515	4	0	0	0
302516	1	0	0	0
302517	0	0	0	0
NH Total	226	2	39	1

Rhode Island

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
410012	0	0	0	0
41002F	0	0	0	0
412501	38	1	8	0
412502	6	1	1	0
412503	16	1	0	1
412504	16	0	4	0
412505	24	0	4	0
412506	23	0	2	0
412507	8	0	0	0
412508	8	1	1	0
412509	8	0	3	0
412510	21	1	1	1
412511	22	0	6	0
412512	19	1	4	0

Table 8: Vocational Rehabilitation (continued)

1/1/2014 – 12/31/2014

Rhode Island

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
412514	8	1	4	0
413500	47	1	4	1
413501	8	0	2	0
RI Total	272	8	44	3

Vermont

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	0	0	0	0
472500	8	0	0	0
472501	7	0	0	0
473500	3	0	1	0
473501	5	0	1	0
473502	11	0	1	0
473503	19	0	5	0
473504	7	0	0	0
VT Total	60	0	8	0

	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
Network Total	3,388	56	628	33

APPENDIX. NETWORK STAFFING AND STRUCTURE

The management staff of IPRO ESRD Network of New England consists of:

- **Executive Director: Danielle Daley, MBA**

Danielle Daley is a healthcare program executive with more than 16 years' experience in end stage renal disease. She holds a Master of Business Administration. In addition to her work for the Network, Ms. Daley is an active advocate for promoting organ and tissue donation awareness as a director on the board of Donate Life Connecticut and task member of the New England Donor Collaborative. She also serves and a member of the Medical Advisory Committee for the Connecticut-Western Massachusetts Chapter of the National Kidney Foundation. In her role at the Network Ms. Daley:

- Maintains contract compliance by ensuring timeliness and accuracy of deliverables.
- Works closely with governing bodies, i.e., IPRO Board of Directors, ESRD Divisional Board, Network Council and Medical Review Board, to develop program goals and objectives.
- Manages daily office operations, including supervising Network staff.
- Supports ESRD community, state agency, and stakeholder partnerships.
- Safeguards financial health through oversight and management.

- **Patient Services Director: Lisa M. Shea, LMSW**

Lisa Shea is a licensed social worker with extensive experience working with diverse and vulnerable populations, including those with complex medical and mental health needs. Prior to coming to the Network, Ms. Shea provided education and consultation to medically compromised patients in the nursing home setting, including coordination of complex discharge plans for ensuring patients safely return to the community. She holds a Master of Social Work degree. In her role at the Network Ms. Shea:

- Evaluates and resolves patient grievances; provides technical or general assistance with the coordination of at risk patients, involuntary patient discharges and patient placement.
- Facilitates all activities of the Patient and Family Engagement Learning and Action Network (PFE LAN).
- Develops and implements patient-centered educational campaigns and quality improvement activities.
- Develops regional disaster plan, coordinates response and recovery efforts for ESRD provider related emergencies; editor of Network newsletters.

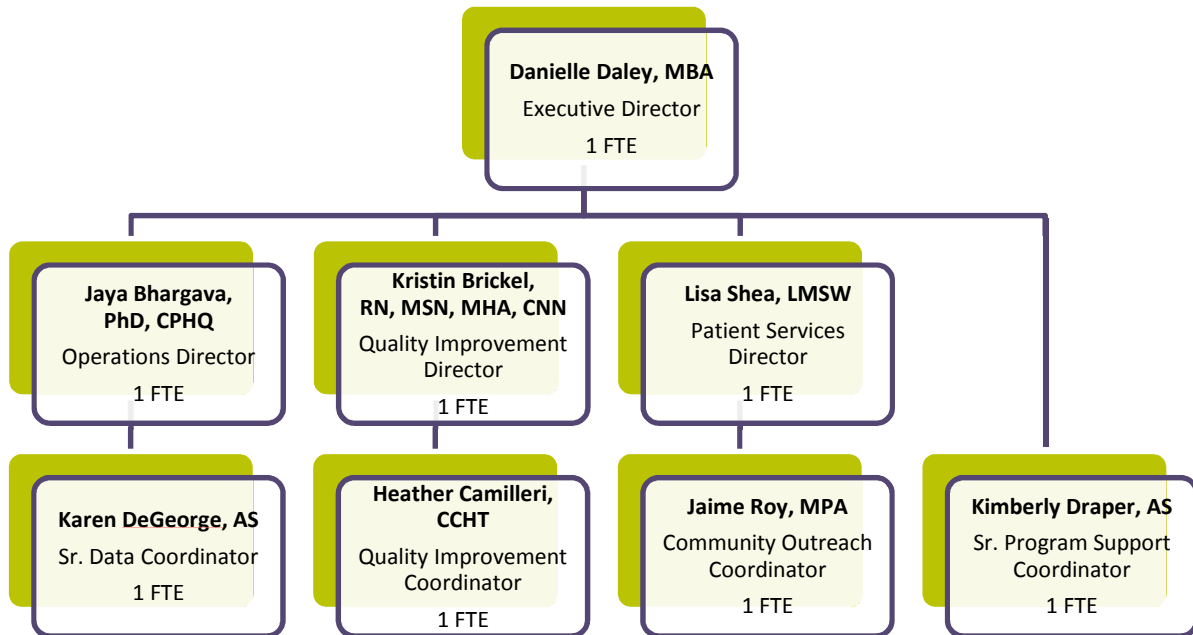
- **Quality Improvement Director: Kristin Brickel, RN, MSN, MHA, CNN**

Kristin Brickel is a registered nurse with more than 18 years of combined experience in administrative and clinical aspects of end stage renal disease. In addition to her work for the Network, Ms. Brickel works as an adjunct instructor for the University of Connecticut School of Nursing, as a nurse planner for the Forum of ESRD Networks, and as a member of the Medical Advisory Committee for the Connecticut-Western Massachusetts Chapter of the National Kidney Foundation. In her role at the Network Ms. Brickel:

- Directs all quality improvement initiatives, including developing work plans, trends analysis, and statistical reporting

- Leads and guides vascular access and Healthcare Associated Infections (HAI) activities at the facility-level
 - Reports status of quality improvement activities to Medical Review Board for implementing actions plans based on outcomes
 - Responds to all clinical inquiries and regulation related to nephrology nursing
 - Provides consultation to professional community on ESRD clinical policies and procedures
- **Data Manager and Security Point of Contact: Jaya Bhargava, PhD, CPHQ**
 Jaya Bhargava is a Certified Professional in Healthcare Quality and has a doctorate degree in Biochemistry. She has 15 years' experience in end stage renal disease data systems management, is an expert in National Healthcare Safety Network (NHSN) data systems, and data submission requirements. In her role at the Network Ms. Bhargava:
 - Provides support to facility staff in enrolling in QIMS \ CROWNWeb
 - Ensures technical assistance for Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN)
 - Educates ESRD community on Dialysis Facility Reports and Quality Incentive Program (QIP)
 - Responds to questions related to data entry and access to different data systems

IPRO ESRD Network of New England Staff Structure



Overall, the Network employed eight full-time staff and no part-time staff in 2014.

The IPRO ESRD Network of New England has an efficient and effective organizational structure that meets the requirements of the ESRD Network contract and the New England renal community. The Network staff includes qualified employees and volunteers from the renal community who sit on IPRO's Board of Directors and Network advisory committees.

The activities of the Network are overseen by an executive director, who ensures that the Network is adequately staffed to perform the requirements of the statement of work. All staff positions have been filled.

Network Boards and Committees

The IPRO Board of Directors, ESRD Divisional Board, Network Council, Medical Review Board, and several committees support and facilitate Network operations. The roles and purpose of these committees are periodically reassessed to ensure that they continue to meet current needs. Board and committee members include representatives from dialysis and transplant facilities, as well as other strategic organizations in the Network's service area. Each committee has at least two consumer representatives. The involvement of consumer representatives is vital to the success of Network activities and to improving the quality of care and life for ESRD patients as we move toward the vision of patient-centered care.

IPRO Board of Directors

IPRO's Board of Directors, which consists of physicians and community stakeholder representatives, sets corporate policies and assures the orderly and efficient operation of IPRO and the Network. The Board has fiduciary oversight responsibility for the Network, and reviews its activities as reported by the CEO, ESRD Program, the Network's Executive Director, and ESRD Divisional Board Co-Chairpersons (comprised of one ESRD professional and one ESRD beneficiary). The Board considers and acts on recommendations from the ESRD Divisional Board.

ESRD Divisional Board

The ESRD Divisional Board is responsible for oversight and management of the IPRO ESRD Network of New England, the IPRO ESRD Network of New York, and any other ESRD Networks that may be operated by IPRO. The ESRD Divisional Board is elected by the IPRO Board pursuant to IPRO's bylaws and includes the following representatives from each Network: at least one individual representative of ESRD providers, and at least two representatives of ESRD patients. The Network Council provides recommendations for the ESRD Divisional Board representatives.

Network Council

The Network Council (NC) is a subcommittee of the ESRD Divisional Board. The Council serves as an expert panel that analyzes and advises the ESRD Divisional Board on educational campaigns, quality improvement activities and policies and procedures for the ESRD Network Program. The members of the Council represent the diverse geographic areas and the multiple professional disciplines of the New England renal community. This includes nephrologists, nurses, social workers, dietitians, technicians, and ESRD beneficiaries. At a minimum, the Network Council shall perform the following functions in regard to the delivery of ESRD care in New England:

- Review and recommend to the IPRO ESRD Divisional Board policies and procedures
- Interface with CMS and other regulatory agencies
- Encourage vocational rehabilitation programs
- Develop criteria and standards relating to the quality and appropriateness of patient care and Network goals
- Implement procedures for evaluation and resolution of patient grievances by the Medical Review Board

- Identify facilities consistently not meeting Network goals, assisting facilities in developing appropriate plans for correction, and submitting recommendations to the Medical Review Board regarding facilities and providers that are not providing appropriate medical care
- Support activities of the Medical Review Board and the Patient Advisory Committee

Medical Review Board

The Medical Review Board (MRB) is an advisory panel to the Network Council and the Grievance Committee, comprised of professionals who are qualified to evaluate the quality and appropriateness of care delivered to ESRD patients. The MRB also advises on quality improvement activities, including analysis of local data, and develops, implements, and evaluates Network quality improvement projects. At a minimum, the Medical Review Board shall perform the following functions in regard to the delivery of ESRD care in New England:

- Advise the Network Council and Network Staff on the care and appropriate placement of ESRD
- Advise the Network Council and Network staff on all Network quality improvement activities
- Assist Network staff in the development, implementation and evaluation of quality improvement projects
- Make recommendations to the Network regarding sanctions for facilities or providers that do not comply with Network goals or standards
- Evaluate whether Network projects require Institutional Review Board approval or involvement pursuant to Office of Human Research Protection regulations

Patient Advisory Committee

2014 marked the 16th anniversary of the Network's PAC, serving as advisors to governing bodies, Network staff, and the New England ESRD community.

The PAC assists in identifying and addressing barriers to, and best practices for, obtaining quality healthcare, from the perspective of Medicare beneficiaries with ESRD. PAC members collaborate with their peers, facility staff, and the Network. The Committee reviews and makes recommendations regarding beneficiary-related healthcare messages, materials and activities; provides feedback on the effectiveness of beneficiary-related activities; and assists in recruiting other beneficiaries to obtain their perspectives, with a focus on empowerment and patient-centered care. Other activities of the PAC include:

- Promoting communication between patients and staff
- Informing patients about services provided by the ESRD Network
- Enabling fellow patients to resolve issues themselves
- Informing appropriate unit staff members of patient concerns
- Encouraging patients to be involved in their healthcare
- Empowering patients to seek counsel from their healthcare team
- Gathering and noting ideas and suggestions from other patients
- Helping patients understand information provided by their facilities and the ESRD Network

Grievance Committee

The Grievance Committee is an advisory panel to the Network Council that includes a nephrology physician, a nurse, a social worker, and a consumer representative. The Committee investigates and resolves patient grievances in accordance with CMS procedures and Network policies.

Nominating Committee

The Nominating Committee is responsible for nominating a slate of candidates for election to the Network Council, Medical Review Board, and Grievance Committee. The Nominating Committee is also called upon in the event of a vacancy on the Network Council, Medical Review Board, or Grievance Committee. The Committee provides recommendations to the Network Council on candidates for membership and may elect acting members to serve for a period of less than one year.