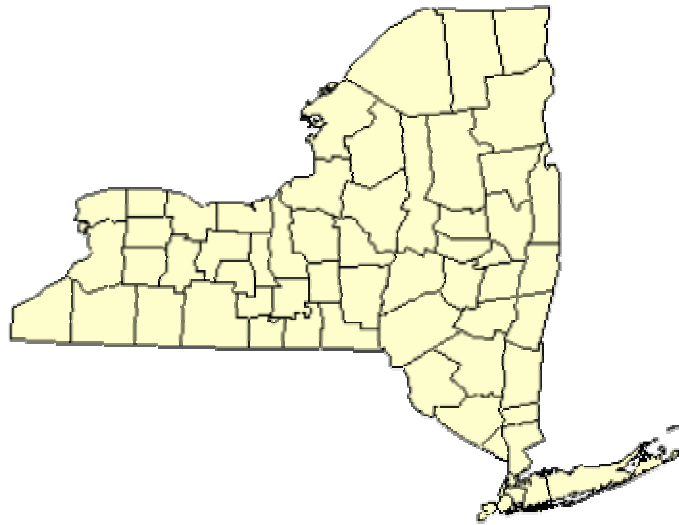


**END STAGE RENAL DISEASE
NETWORK OF NEW YORK, INC.
Contract # 500-03-NW02**

2005 Annual Report



**Submitted to: Centers for Medicare & Medicaid Services (CMS)
Sponsoring Agency, June 2006**

I. PREFACE

MESSAGE FROM THE CHAIR

We are pleased to present the 2005 Annual Report of activities conducted to meet ESRD national goals of the Centers for Medicare and Medicaid Services (CMS).

The Health Care Quality Improvement Program, developed by CMS and the 18 ESRD Networks, provides the methodology to accomplish our mission to monitor and enhance the care of people with ESRD by promoting quality improvement in outcomes of care and offering education and technical support to providers and patients. The National Vascular Access Improvement Initiative (Fistula First), which was announced early in 2003, continued to be a major focus for 2005. Our Network currently ranks second of the 18 Networks in percentage of fistulas in our prevalent dialysis patients.

Professional education in 2005 included on-site sensitivity training for dialysis facilities, and meetings of the Network Council, with facility participation, in both the spring and fall. The spring meeting provided and active dialog with the New York State Department of Health. The fall meeting hosted national speakers. It was entitled Nephrology in the 21st Century: Patients, Staffing and Treatment Options. Attendance at both meeting was excellent.

Our initiatives with the Department of Health, begun with our spring Council meeting in May, continued with meetings in Troy, New York, with both the DOH and with CMS. The Network has a role in assisting the New York State surveyors with technical assistance, which might arise during individual facility surveys. Network 2 has participated in a series of meetings, sponsored by the State DOH, and attended by the Department of Education in the clarification of the roles and responsibilities of LPN's and technicians in the dialysis setting.

Due to problems with Internal Quality Controls at our home office, as well as training and implementation of VISION, an outside consultant, the ESRD Network of New England was retained. In November we contracted ESRD Network of New England to administer Network 2 functions. Thanks to Jenny Kitsen, the Executive Director of ESRD Network of New England, and the dedication of the staffs at both the New York and New England offices, we have made significant progress in correcting these deficits.

We are grateful to New York State's dialysis and transplant centers for the data in this report and to the members of the Network Council and its committees for their guidance, loyalty and support.



Robert I. Lynn, MD
President

TABLE OF CONTENTS

I.	PREFACE	
	1. MESSAGE FROM THE CHAIR	
	2. TABLE OF CONTENTS	
II.	INTRODUCTION	1
	A. NETWORK DESCRIPTION	1
	➤ Geographic and General Population	1
	➤ ESRD Patients and Providers	2
	B. NETWORK STRUCTURE	5
	1. NETWORK STAFF	5
	2. COMMITTEE FUNCTION & ACTIVITY	6
	- Network Council	6
	- Executive Committee	7
	- Medical Review Board	8
	- Finance Committee	9
	- Rehabilitation Committee	9
	3. PATIENT ADVISORY COMMITTEE (PAC)	9
III.	CMS NATIONAL GOALS AND NETWORK ACTIVITIES	10
	A. IMPROVING THE QUALITY OF HEALTH CARE SERVICES AND QUALITY OF LIFE FOR ESRD BENEFICIARIES	10
	➤ National Vascular Access Improvement Initiative (NVAII) “Fistula First”	10
	➤ Clinical Performance Measures (CPM)	19
	➤ Crisis Management Training	28
	➤ Sensitivity Training for Dialysis Staff	29
	➤ Crisis Prevention in a Healthcare Setting	29
	➤ Completing the Continuum of Quality Patient Care: Renal Palliative Care	29
	➤ Spring Network Council Meeting/Provider Session	30
	➤ Fall Annual Network Meeting Scientific Program	30
	➤ Achieving Goals in Quality of Care	31
	B. IMPROVING DATA RELIABILITY, VALIDITY, AND REPORTING AMONG ESRD PROVIDERS/FACILITIES, NETWORKS, AND CMS (OR OTHER APPROPRIATE AGENCY)	32
	➤ Information Management	32
	- Patient Registry	32
	- CMS Forms Processed	32

- Patient Events Entered into SIMS	33
- Provider and Personnel Database	33
- Quality Assurance of Patient Data	33
- # of Facilities Meeting Compliance Rate	34
-	
➤ Other Data Management Activities	34
- Data Requests	34
- Business Continuity and Contingency Plan (BCCP)	35
- New Patient Information Packets	35
- Changes in the Workflow Process	35
- Data Library	35
➤ Achieving Goals in Data Management	36
C. SUPPORT THE MARKETING, DEPLOYMENT, AND MAINTENANCE OF CMS APPROVED SOFTWARE (I.E., CROWN - CONSOLIDATED RENAL OPERATIONS IN A WEB-ENABLED NETWORK)	37
➤ VISION	37
➤ Achieving Network Goals in Promoting CROWN	38
D. ESTABLISHING AND IMPROVING PARTNERSHIP AND COOPERATIVE ACTIVITIES. THESE ACTIVITIES MAY INCLUDE ESRD NETWORKS, QUALITY IMPROVEMENT ORGANIZATIONS (QIOs), STATE SURVEY AGENCIES, ESRD PROVIDERS/FACILITIES, MEDICARE + CHOICE (M+C) ORGANIZATIONS, ESRD FACILITY OWNERS, PROFESSIONAL GROUPS, AND PATIENT ORGANIZATIONS	
➤ Cooperative Activity with ANNA	39
➤ Cooperative Activity with NYS DOH – Site Visit Evaluation Survey Tool	39
➤ Cooperative Activity with State Survey Agencies – Clinical Scope of Practice Issues	39
➤ Cooperative Activity with NYC Office of Emergency Management (OEM)	40
➤ Cooperative Activity with National Coalition for Disaster Preparedness	40
➤ Patient Advisory Committee (PAC) Activities	40
➤ Patient Safety Awareness	41
➤ Newsletters	42
➤ Website	44
➤ Forum of ESRD Networks	44
➤ Council of Nephrology Social Workers	44

➤ Vocational Rehabilitation (VR) Specialist Activities	44
➤ Achieving Goals in Collaborations	49
E. EVALUATING AND RESOLVING PATIENT GRIEVANCES AS CATEGORIZED IN THE STANDARD INFORMATION MANAGEMENT SYSTEMS (SIMS)	
➤ Dealing with the Challenging Patient	50
➤ Technical Assistance	51
➤ Decreasing Dialysis Patient-Provider Conflict (DPC)	51
➤ Information Packet on Depression	52
➤ Achieving Goals to Address Patient Grievances	52
IV. SANCTION RECOMMENDATIONS	53
V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES	54
VI. DATA TABLES	55
Table 1: ESRD Incidence	56
Table 2: ESRD Dialysis Prevalence	58
Table 3: Dialysis Modality by Self-Care Settings - Home	60
Table 4: Dialysis Modality by In-Center Settings	72
Table 5: Renal Transplants by State	84
Table 6: Renal Transplants by Transplant Type, Age, Race, Gender and Primary Diagnosis	85
Table 7: Dialysis Deaths	87
Table 8: Vocational Rehabilitation	89

II. INTRODUCTION

A. Network Description

➤ Geography and General Population

The boundaries of Network 2 coincide with those of New York State, which is comprised of 62 counties and 12 Standard Metropolitan Statistical Areas. Its territory is 54,471 sq. miles, with 47,234 sq. miles of land, and 7,247 sq. miles of inland water. The state includes one of the most highly populated cities in the nation, New York City, and the nation's largest state forest preserve, the Adirondacks.

New York State ranked third in population in the 2000 Census, with a total of 18,976,457 people. This is a 5.5% increase from 1990, less than the nation's 13% increase. New York's population density is approximately 402 persons per square mile. 42% of the state resides in New York City, and nearly two thirds of the state population is concentrated in the City and its immediate suburbs in Long Island and the Hudson Valley. The greatest increases in population from 1990 to 2000 occurred in the Bronx, Queens, and Staten Island, as well as Orange, Putnam, and Saratoga Counties. Much of the state remains rural, such as the Adirondacks, the Catskills, and the western tier.

Forty-eight percent (48%) of New York State is male and 52% female, paralleling the same shrinking gender disparity in the United States. 16% of the population is between 35 and 44 years of age. New York also saw an increase in the population ages 45-54, reflective of the 49% increase in the national population of residents ages 45-54. Both New York State and the nation saw a slower rate of increase in population ages 65 and over.

The state is 32% nonwhite, with African-Americans comprising 16% and Latinos 15% of the population. This has grown from 1990, when only 26% of the state was nonwhite. While nonwhites constitute a greater proportion of the New York City population than other regions, the 2000 census shows a growing nonwhite population in other metropolitan areas such as Albany, Buffalo, Rochester and Syracuse.

The 2004 population estimate for New York State is 19,227,088, representing a 1.3% population increase since the 2000 census.

Sources: Empire State Development. <http://www.empire.state.ny.us> 25 May 2001.
 U.S. Census Bureau. <http://www.census.gov/> 25 May 2001
 U.S. Census Bureau: *State and County Quick Facts*.
<http://www.quickfacts.census.gov> 12 Jan. 2006

➤ ESRD Patients and Providers

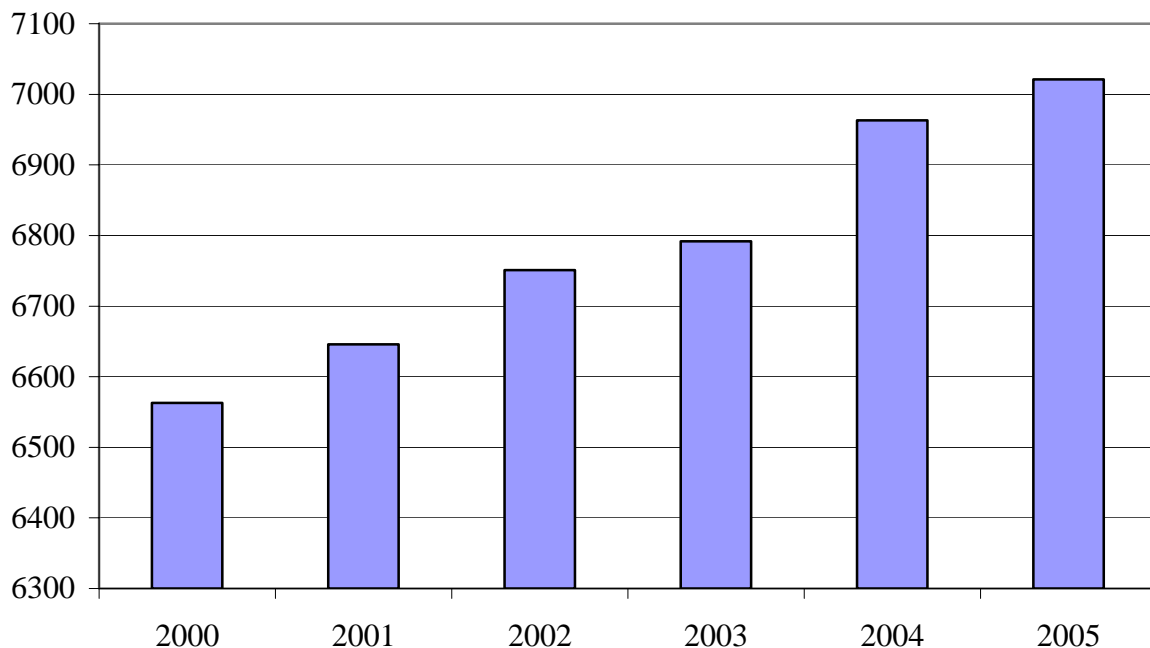
v Incidence Patient Population

The ESRD incidence of patients is the number of patients newly diagnosed with chronic ESRD. In the year 2005, the Network of New York had 7,033 patients begin treatment for ESRD. This included patients starting dialysis, as well as 65 patients with transplants as their initial treatment and 115 patients that received dialysis at VA Facilities. This number continues to grow each year. Of the new patients, 56.7% were males, 59% were white, 29.9% were black or African, and for primary cause of diagnosis 39.5% was diabetes and 22% was hypertension.

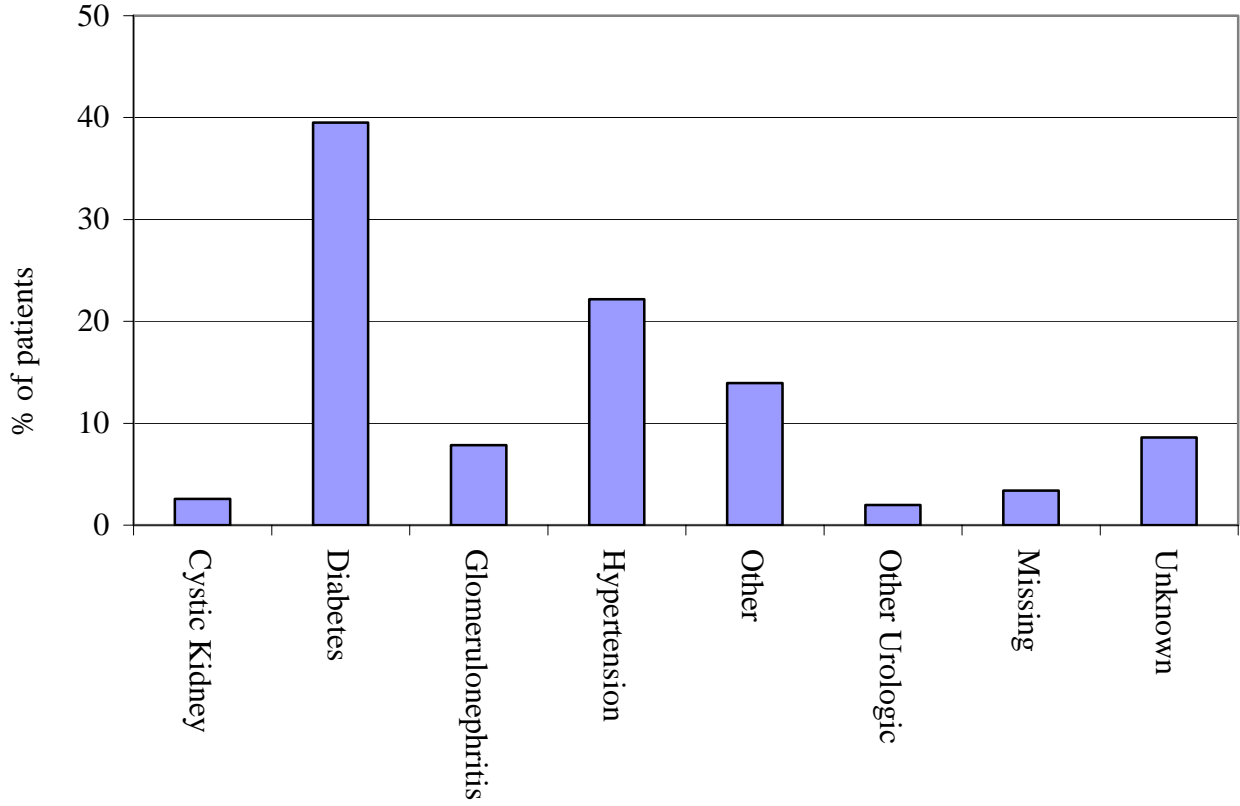
The United States Renal Data Services (USRDS) is a national data system that collects, analyzes, and distributes information on end stage renal disease in the United States. One of its goals is to describe the incident and prevalent ESRD population. The data in the 2005 USRDS Annual Report is based on 2003 or prior statistics. In 2003 the number of incident patients in the US were 102,567 and the mean age was 64.8. This was a 2 percent growth from 2002. Of the new patients, 54.2% were males, 66% were white, 30% were blacks or African, and for primary cause of diagnosis 44.8% were diabetic and 27.6% were hypertension.

Comparing the Network of New York's statistics to the National data, New York State had 6.8% of the US incident patients. There was more of a disparity between males and females in NY (13.4%) than there is nationally (8.4%).

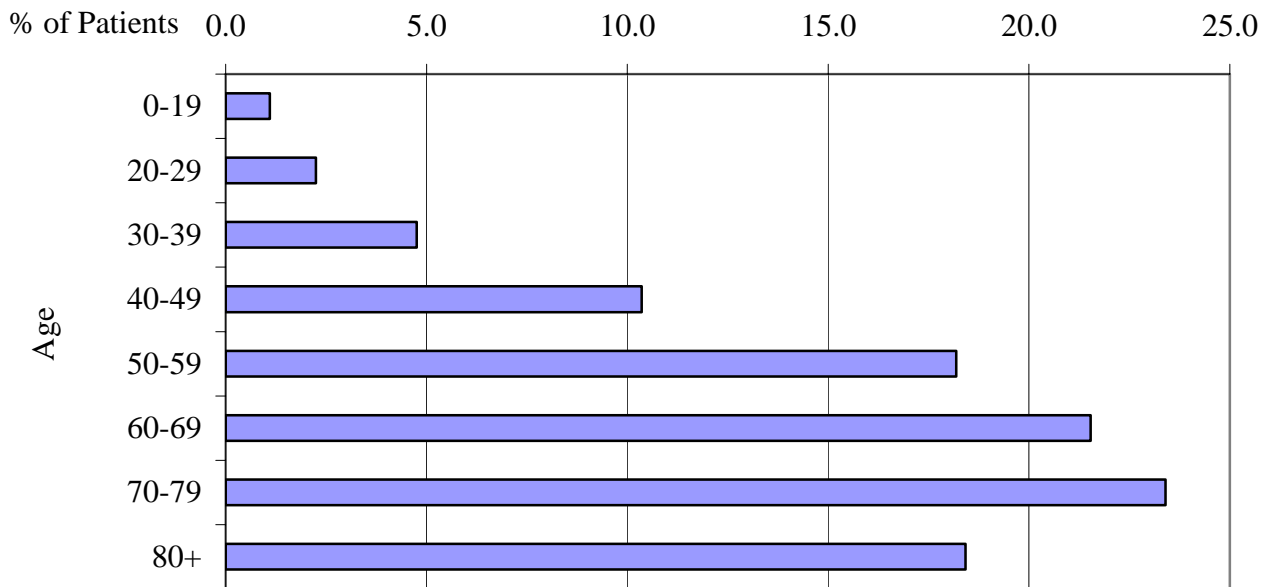
Annual ESRD Incidence Patients in New York



2005 Primary Diagnosis for Incident Patients in New York



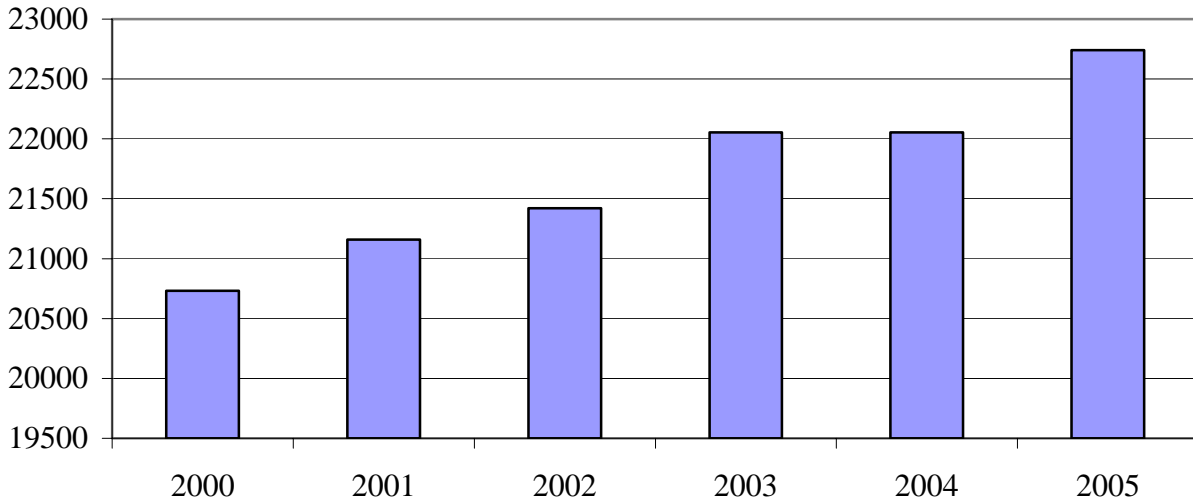
Age of Incidence Patients in 2005 in New York



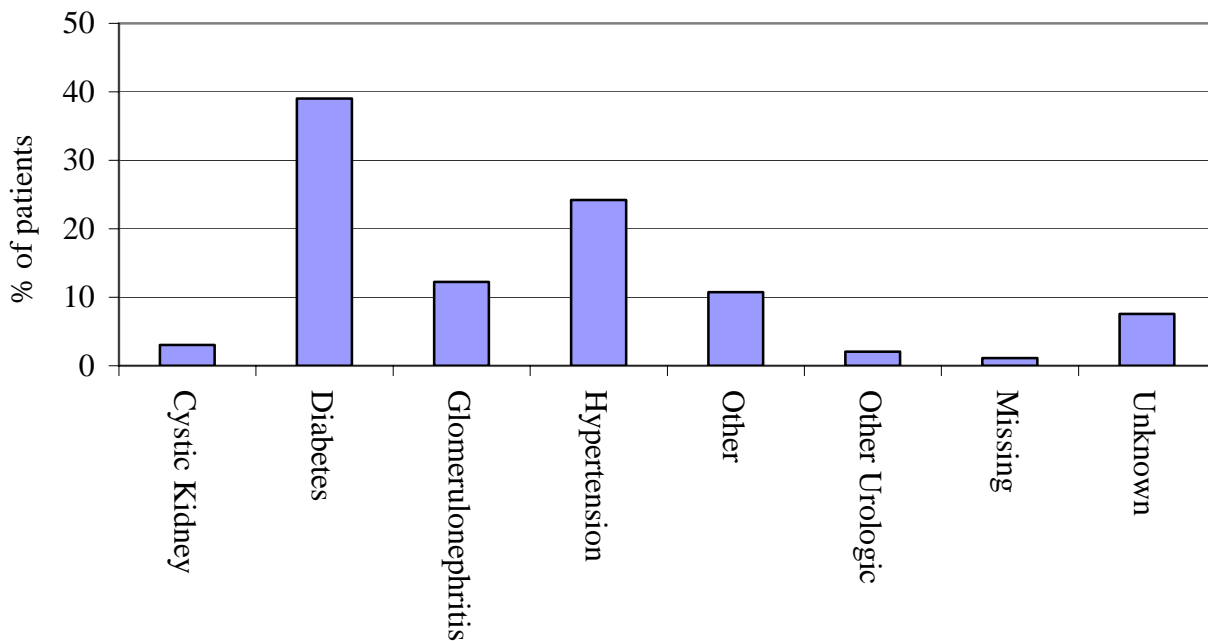
v Prevalence Dialysis Patient Population

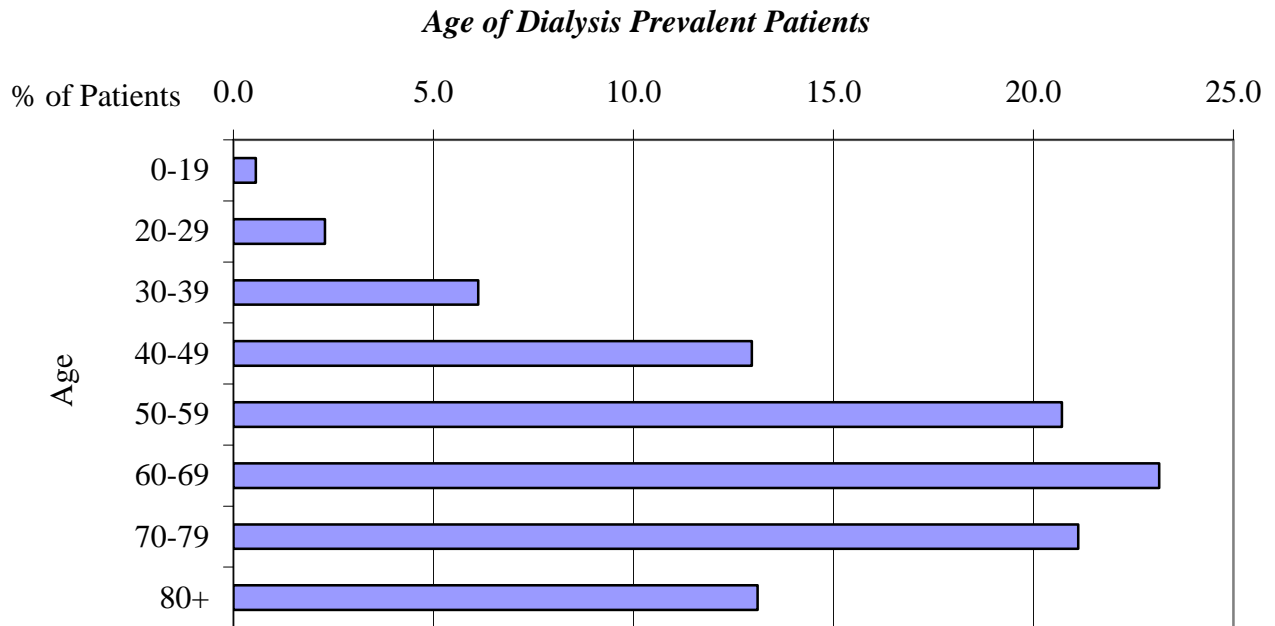
The ESRD prevalence of patients is the number of patients living with chronic ESRD. In the year 2005, the Network of New York had 22,769 patients receiving dialysis treatment for ESRD. This number continues to grow each year. Of the prevalent patients, 56% are males, 48.5% are white, 39.8% are black or African, and for primary cause of diagnosis 39% have diabetes and 24% have hypertension.

Dialysis Prevalent Patients in New York



Primary Diagnosis of Dialysis Prevalent Patients





B. Network Structure

The Network is a non-profit corporation with its offices located in New York City. The governance of the corporation is under the direction of a Board of Directors (Network Council). The only contract held by this corporation is from Centers for Medicare & Medicaid Services (CMS) for the Network ESRD Program. Geographic area of the ESRD responsibility is the state of New York.

1. Network Staff

Geraldine Rasmussen, Executive Director

(Manages administrative and program activities.)

Sandra Waring, MSN, CNN, CPHQ, Director, Quality Management

(Coordinates quality improvement activities and responds to beneficiary complaints)

Carol Logan, RN, MS, CNN, Quality Management Coordinator

(Assists with quality improvement activities, beneficiary complaints and crisis management training)

Richard Russo, MSW, LMSW, Coordinator of Consumer Relations/Community Development

(Responsible for Patient Advisory Committee activities, sensitivity and crisis management training, provider assistance, beneficiary complaints, community outreach, and disaster preparedness)

Miriam Greene, CRC, Vocational Rehabilitation Specialist
(Provides information and assistance to patients, social workers and vocational rehabilitation counselors)

Joy Fearon, Finance and Office Manager
(Maintains financial records, personnel file and office inventory)

Flora Martinez, Data Specialist
(Collects, validates and enters data from ESRD facilities, monitors compliance with data reporting requirements and assists with training data staff)

John Cocchieri and Sharon Lamb, Data Assistants
(Collect, validate and enter data from ESRD facilities and monitor compliance with data reporting requirements.)

2. Committee Function & Activity

v Network Council

The Network Council consists of 41 members, meets bi-annually, and is the Board of Directors of the ESRD Network of New York, Inc. Facilities in the State of New York that have an ESRD provider number issued by the Centers for Medicare & Medicaid Services and Veterans Administration ESRD facilities are members of the Network and are invited to send representatives to the Annual Meeting of the Network Council.

Officers of the Network are its President, Vice President, Secretary and Treasurer, and are elected by the Council. Council membership includes physicians working in nephrology, at least two consumers, a nephrology nurse, social worker, and dietitian, and has geographic representation from New York State's ESRD facilities.

<u>Name</u>	<u>Facility</u>	<u>Discipline</u>
Myrna Abesamis, RN	Bronx Dialysis Center	Nephrology Nurse
Syed Asad, MD	Huntington AKC, Long Island	Medical Director
Geraldine Biddle, RN, CNN, CPHQ	Albany, NY	Nephrology Nurse
Roxanna Bologna, MD	Rogosin Institute, NYC	Medical Director
Sonia Borra, MD	Kingsbrook Jewish Med. Ctr., Bklyn	Medical Director
Godfrey C. Burns, MD	Saint Vincent's Hosp. NYC	Medical Director
Brenda Cassidy, CSW	H&L Rubin Dialysis Center	Renal Social Worker
Chaim Charytan, MD	The NY Hospital Med. Ctr. of Queens	Medical Director
David J. Cohen, MD	NY Presbyterian Hospital, NYC	Medical Director, Tx
Helen Danko, MS, RN	Winthrop Univ. Hospital, Mineola	Nurse Manager
Ute Davenport, CSW	Western Queens Dialysis Mgmt. Corp	Renal Social Worker
Dawn Edwards *	Queens, NY	PAC Chairperson
George Eisele, MD	Albany Medical Center	Nephrologist
Robert Feingold, MD	Montefiore Hospital, Bronx	Nephrologist
Paul A. Frymoyer, MD	St. Joseph's Hospital, Syracuse	Medical Director
Andrew Futterman, CSW	Davita Life Care Dialysis Ctr., NYC	Renal Social Worker
Bruce Garrison, MD	LIJ Satellite Dialysis Facility	Nephrologist
Patricia Hansen, RN	Good Samaritan Hosp Bay Shore/West Islip	Administrator

Renee Garrick, MD	Westchester County Med. Ctr., Valhalla	Medical Director
Kim Healy *	Albany/Utica, NY	PAC Chairperson
Theodore Herman, MD	Millard Fillmore Hosp., Buffalo	Nephrologist
Sharon Hill, RN	Buffalo, NY	Administrator
Christopher Hoy, MD	H & L Rubin Dialysis, Troy	Medical Director
Vijay Jain, MD	St. Mary's Hospital, Rochester	Medical Director
Vickie Keidel *	NKF of Western NY, Buffalo	Patient/Consumer
Edward Kowalski, MD	Winthrop Univ. Hospital, Mineola	Nephrologist
Philomena Kennedy, CSW	Montefiore Dialysis Center IV	Renal Social Worker
Robert I. Lynn, MD	Bronx Dialysis Center	Medical Director
Robert Mayo, MD	Strong Health Dialysis, Rochester	Nephrologist
Ira Meisels, MD	Upper Manhattan Dialysis, NYC	Medical Director
Neal Mittman, MD	Long Island College Hospital, Brooklyn	Medical Director
Sri Narsipur, MD	Upstate Medical Center, Syracuse	Medical Director
Martin S. Neff, MD	Elmhurst Hospital Center, Queens	Nephrologist
Hazel Parker	Bronx, NY	PAC Chairperson
Daisy Salort, RD	Our Lady of Mercy Med. Ctr., Bronx	Renal Dietitian
Melissa Schiff, MD	Highland Hospital, Rochester	Medical Director
Denise Speicher *	Rochester, NY	PAC Chairperson
Philip Varughese, BS, CHT	Richmond Kidney Center, Staten Island	Administrator
Rocco C. Venuto, MD	Erie County Med. Ctr., Buffalo	Medical Director
John D. Wagner, MD	Long Island Jewish Medical Center	Medical Director
Sharon Zalemski, MS, RD	Comprehensive Dialysis	Renal Dietitian

* *Patient Representative*

v Executive Committee

The Executive Committee, which includes the officers of the corporation, the Medical Review Board chairman, and six members at large, meets quarterly and is responsible for financial management, policy development, administrative supervision and program planning. The Executive Committee appoints the Executive Director for the Network and determines the tenure of his or her appointment and salary. The Executive Committee reports to the Network Council.

Robert I. Lynn, MD - President
 John D. Wagner, MD - Vice-President
 Helen Danko, MSN, CNN - Secretary
 Chaim Charytan, MD - Treasurer
 Paul A. Frymoyer, MD - MRB Chair
 Rocco C. Venuto - Past President

Members at Large

George Eisele, MD
 Renee Garrick, MD
 Patricia Hansen, RN
 Vijay Jain, MD
 Vickie Keidel
 Melissa Schiff, MD

v Medical Review Board

The Medical Review Board consists of 14 members with representation from nephrology, nursing, social work, nutrition, and Medicare beneficiaries. The Medical Review Board performs the review, evaluation and study functions of the Network, using criteria and standards approved by the Council. No member of the Medical Review Board may review or provide advice on any case in which he or she has or has had any professional involvement, received reimbursement or supplied goods.

<u>Name</u>	<u>Facility</u>	<u>Discipline</u>
Paul A. Frymoyer, MD – Chairperson	St. Joseph’s Hospital, Syracuse	Medical Director
<u>Name</u>	<u>Facility</u>	<u>Discipline</u>
Amy Abbondandolo, RD	Trude Weishaupt Mem. Dialysis Ctr.	Renal Dietitian
Maria Freitas Argentina, CSW	Bronx Dialysis Center	Renal Social Worker
Joan Arslanian, RN	Trude Weishaupt Mem. Dialysis Ctr.	Nurse Manager
Geraldine Biddle, RN, CNN, CPHQ	Albany, NY	Nephrology Nurse
Nina Caplin, MD	Elmhurst Hospital Center	Nephrologist
Stephen Fishbane, MD	Winthrop Univ. Hospital, Mineola	Medical Director
Renee Garrick, MD	Westchester County Medical Center	Medical Director
Kim Healy*	Albany/Utica, NY	PAC Chairperson
Christopher Hoy, MD	H & L Rubin Dialysis, Troy	Medical Director
Frederick Kaskel, MD	Montefiore Med. Ctr., NYC	Pediatric Nephrologist
Romesh K. Kohli, MD	Comprehensive Dialysis of W. NY, Buffalo	Medical Director
Eugene Petra, MD	Richmond Kidney Center, Staten Island	Medical Director
Melissa Schiff, MD	Highland Hospital, Rochester	Medical Director

* Patient Representative

v Grievance Committee

The Grievance Committee includes representatives from nephrology physicians, nurses, social workers, consumers, and CMS Region II. The Grievance Committee investigates and resolves patient complaints and grievances in accordance with CMS procedures and Network policy.

<u>Name</u>	<u>Facility</u>	<u>Discipline</u>
Godfrey C. Burns – Chairperson	St. Vincent’s Hospital, NYC	Medical Director
<u>Name</u>	<u>Facility</u>	<u>Discipline</u>
Lynn Cahill, CSW	New York Presbyterian Hospital	Renal Social Worker
Michael Daniel, RN	CMS Region II, NYC	Dialysis Nurse
Dawn Edwards*	Queens, NY	PAC Chairperson
Marilyn Galler, MD	The NY Hospital Med. Ctr., Queens	Nephrologist
Patricia Hansen, RN	Good Samaritan Hosp Bay Shore/West Islip	Administrator
Ira Meisels, MD	Upper Manhattan Dialysis, NYC	Medical Director

* Patient Representative

v Finance Committee

The Finance Committee is composed of 5 Council members, with the Network Treasurer as chairperson. The Finance Committee oversees financial management of the Corporation and prepares an annual budget for the Executive Committee.

v Rehabilitation Committee

The Rehabilitation Committee includes a nephrologist, social worker, dietitian, patient representative, sociologist and a representative from the State VR agency for the disabled. The committee plans and oversees the Network's rehabilitation activities.

Activities of 2005 include: 1) Monitored activities of Network VR specialist, and made recommendations to improve training program for the state's Vocational and Educational Services for Individuals with Disabilities (VESID) District Office staff. 2) Developed plan and prepared sample toolkit for facilities to promote regular home exercise by their patients. 3) Focused on depression as a barrier to successful vocational rehabilitation.

3. Patient Advisory Committee (PAC)

The Patient Advisory Committee (PAC) provides a link between consumers and the Network through its patient representatives in dialysis units. The PAC is responsible for identifying, introducing, discussing and acting on local issues of patients' concerns and for conducting activities to improve the quality of life of ESRD patients.

The PAC consists of the Patient Services Coordinator (PSC), PAC chairpersons, and patient representatives. Chairpersons are patients who volunteer time to oversee Network PAC regions and assist patient representatives within their region. Several chairpersons have provided bios with photo and contact information that the Network has sent to units within each of the chairperson's specific region to post for patient information. Chairpersons have quarterly conference calls with the PSC, meet annually for a meeting/dinner sponsored by the Network, and are sponsored to attend national educational patient meetings. In addition, chairpersons are asked to conduct an annual regional meeting for representatives in their region. A few chairpersons are members of Network committees. Representatives are patients in dialysis units who volunteer time to assist in communication between patients, staff and unit administrative staff and the Network. At the close of 2005, there were 350 PAC representatives and 10 PAC chairpersons with 114 (49%) of the Network's 233 chronic outpatient facilities having at least one PAC representative.

The deaths of three PAC chairpersons in the Fall greatly impacted the PAC organization as such a loss has created a void that will be difficult to repair. Earlier in 2005, two new PAC chairs were added: Manhattan/Staten Island received a co-chairperson, as did the Bronx since the previous Bronx co-chair became PAC chairperson for the Syracuse area.

III. CMS NATIONAL GOALS AND NETWORK ACTIVITIES

A. IMPROVING THE QUALITY OF HEALTH CARE SERVICES AND QUALITY OF LIFE FOR ESRD BENEFICIARIES

Network Goal

The Network will establish, maintain and oversee a program to ensure quality and appropriate care for ESRD patients.

Objective

The Network will provide quality improvement resources and support to meet educational needs identified by providers, collaborate with CMS and the Forum of ESRD Networks to support a unified approach to quality improvement in the ESRD Program of Medicare and assist providers in meeting national quality improvement goals by using facility specific outcome data to identify opportunities to improve ESRD patient care.

➤ **National Vascular Access Improvement Initiative (NVAII) “Fistula First”**

The Institute for Healthcare Improvement (IHI) was asked by CMS to assist in developing the National Vascular Access Improvement Initiative. The initiative was launched to improve vascular access for dialysis patients, with the specific goal of increasing AV fistula use. In a press release published April 14, 2004, CMS Administrated Mark B. McClellan, M.D., PhD. stated: "The Fistula First Initiative aims at having fistulas placed in at least half of new dialysis patients with a long-range goal of maintaining fistulas in 40 percent of eligible patients who remain on dialysis."

A multi-disciplinary team from CMS, the ESRD Networks and major stakeholder groups was convened to develop a broad understanding of the challenges and successes for fistula placement within the dialysis and surgical communities. A set of improvement recommendations and tools was developed. The “change package” developed consists of 11 changes in practice across the ESRD treatment continuum that have shown results in practice and are supported by the published literature.

<i>Fistula First Change Package</i>	
Routine CQI review of vascular access	Place secondary AVF in patients with <u>AV Graft</u> where indicated
Early referral to nephrologist	AVF placement in <u>catheter</u> patients where indicated

Early referral to surgeon for “AVF only” for timely evaluation and placement.	Cannulation training for AV fistulas
Surgeon selection based on best outcomes and greatest willingness to provide access services	Monitoring and surveillance to ensure adequate access function
Full range of appropriate surgical approaches	Educate care-givers and patients
Use outcomes feedback to guide practice	

IHI conducted change agent training sessions for Network Staff. Network Medical Review Boards reviewed the Change Package and identified change concepts appropriate for intervention in their respective Networks.

Measurement systems were developed to monitor the success of the initiative. The baseline for improvement measurement was data from the CDC annual survey of ESRD facilities. In December 2002 the national average for prevalent patients with an AV fistula was 32.4%. Monthly facility specific aggregate data collection for the initiative began in December 2003.

In March 2005, CMS announced the launch of the Fistula First Breakthrough Initiative to get “breakthrough” improvements in the use of safe vascular access. The Breakthrough Initiative brings together stakeholders from the CMS, ESRD Network, surgical, medical, nursing, dialysis provider and patient communities to provide education and support for the placement of AV fistulas in eligible patients.

v 2005 Fistula First Activities

Education

Workshops: Network staff presented two regional workshops to promote the role of Vascular Access Coordinator. Workshop content included the role of the vascular access coordinator, engaging nephrologists and surgeons, facilitating permanent access placement and tracking and profiling vascular access improvement. Participants were provided with a “toolbox” containing appropriate journal articles, educational brochures for patients and staff, quality improvement tools and a list of additional resources. Facility specific vascular access reports were provided and exercises were conducted to assist participants to begin identifying activities that could be initiated within their facility. Staff from facilities with a high percentage of prevalent patients with AVF shared their methodology and experience with participants.

Surgeon Education Program: The Network collaborated with Networks # 3 and # 4 to sponsor a surgeon education program. Drs. William Jennings and Lawrence Spergel were the guest speakers. The content of the program included using ultrasound for pre- and post- operative venous mapping, constructing transpositional AV fistulas, converting established grafts to AV

fistulas and defining the role of the intervention radiologists in dialysis access. The program was presented in June and was very well received.

DVD Distribution: The Network distributed “Creating AV Fistulas In All Eligible Hemodialysis Patients” to 300 surgeons. The program is a set of five CD/DVDs for surgeons and intervention radiologists. The University of Oklahoma produced the discs and the program has been approved for Continuing Medical Education credit.

The program includes:

- Fistula First Initiative
- Preoperative Evaluation and Introduction to Ultrasound
- Cimino and Brachial AV Fistulas, Technical Considerations
- Proximal Radial Artery AV Fistulas
- Endovascular presentation of Immature and Dysfunctional AVF’s
- Secondary AV Fistulas, Converting Grafts
- Management of Steal Syndrome
- Ultrasound: Overview of AVF Venous Mapping
- Cimino/Distal Radial Artery AVF
- Proximal Radial Artery AVF with Angioscopy
- Staged Transposition AVF
- Proximal Radial Artery AVF, Preoperative Ultrasound Exam

Network Web Page: Fistula First information is maintained on the Network website www.esrdny.org. The Change Package, quality improvement tools and other information for providers and patients are located on a page devoted to Fistula First.

Newsletters: The Spring 2005 issue of **PAC Notes**, the Network’s patient newsletter contained an article addressing vascular access. The article described the three access types (fistula, graft, and catheter), discussed possible complications associated with each access type and encouraged patients to discuss vascular access choices with their nephrologist or surgeon.

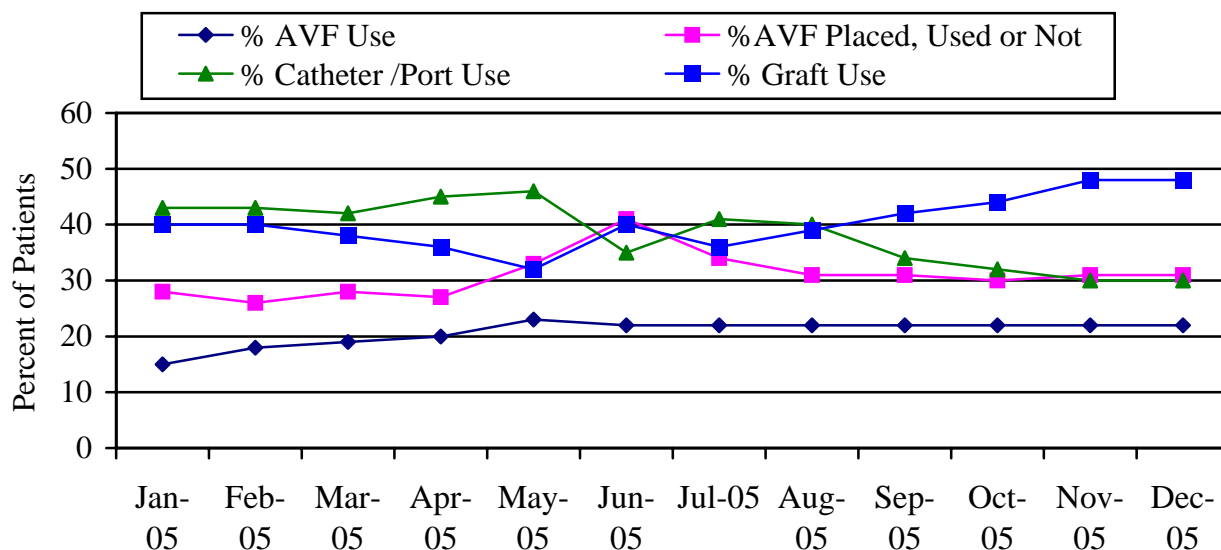
v Feedback Reports

Fistula First Standard Reports: Facility specific data is collected monthly and entered into the CMS Standard Information Management System (SIMS) software. The SIMS Vascular Access Utility produces three Core Standard Reports:

- Network and National comparative data for prevalent AVF use,
- Facility specific vascular access use (all access types), and
- AVF placement in incident patients.

The reports are generated quarterly and sent to medical directors and nurse managers and provided to Fistula First workshop participants as an additional educational tool. Distribution of the reports was suspended in May due to a problem with the utility. Although the utility was repaired in September, the Network did not recommence distribution of the reports until March 2006. A sample of the report is shown below.

**Vascular Access Used in Prevalent Patients
Provider # 33-XXXX**



Surgeon Reports: At the request of the Networks, CMS provided Medicare Part B vascular access data to all Networks. Distribution of reports to surgeons was initially voluntary for Networks. However, the Data Reporting Workgroup of the Fistula First Breakthrough Initiative recommended that there was substantial interest in the surgeon community to receive the reports. A standard report form was designed and all Networks requested to distribute the reports.

The Network participated in the Surgeon specific vascular access project. The Network approached and arranged with IPRO to work with the database. The database provided by CMS was downloaded and sent to IPRO along with the instructions and report template. IPRO had worked with the Network to produce similar reports in 2004. IPRO evaluated the data making sure only surgeons in New York State were included in the analysis. Using the instructions and report template provided by the Network, IPRO refined the database and produced the reports.

CPT codes included in the report are:

Autogenous A-V Fistula: Placement

- 36819: Arteriovenous anastomosis, open; by upper arm basilic vein transposition
 36820: Arteriovenous anastomosis, open; by forearm vein transposition
 36821: Arteriovenous anastomosis, open; direct, any site (e.g., Cimino type) (separate procedure); autogenous graft
 36825: Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft. This is utilized when obtaining vein graft for AVF. Autogenous A-V Fistula: Surgical Intervention / Revision
 36831: Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)

- 36832: Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
- 36833: Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
- 36834: Plastic repair of arteriovenous aneurysm (separate procedure)
- 37607: Ligation or banding of angioaccess arteriovenous fistula

A-V Graft Placement: 36830

The Network distributed 316 surgeon reports by December 16, meeting the CMS deadline for this activity. There were 35 reports returned to the Network office as undeliverable. The Network received calls/e-mails from three surgeons upset with the data in their reports; concerned that their results were grossly under-reported. The reports did not include Medicare Part A, private insurers or uninsured patients. These issues will be considered by CMS prior to future distribution of reports.

v Sample Surgeon Report


Medicare Part B Permanent Vascular Access Claims Data* (January 2004 - December 2004)

Physician : _____
UPIN : _____

Where Do You Stand in AV Fistula Placement Improvement!

Hemodialysis Access Placement Procedures and CPT Codes	Your Numbers	Network 2 (New York)
Total Placement of AVFs and AVGs for 2004	1	2562
Total AVF Placement	0	1463
CPT 36819 - AVF Upper Arm Basilic Transposition	0	252
CPT 36820 - AVF Forearm Vein Transposition	0	125
CPT 36821 - Direct Any Type (e.g., Cimino Type)	0	881
CPT 36825 - AVF by other than Direct	0	205
CPT 36830 - AVG PTFE	1	1099

Your Ratio of AVFs (0) to AVGs (1) is: 0 to 1



FISTULA FIRSTSM
National Vascular Access Improvement Initiative

WHY FISTULAS?
(Benefits of AVF's)

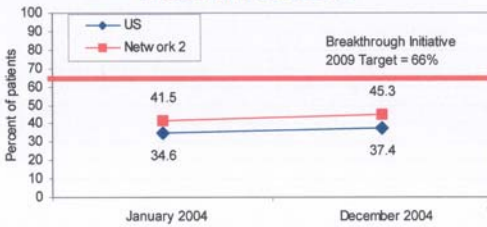
- ▣ Decreased Patient Mortality
- ▣ Fewer Complications than AVG's or Catheters
- ▣ Lower Cost

Are You Satisfied with YOUR AVF Rates and Success?

Help is available towards making fistulas work.

1. CD / DVD Series:
"Creating AV Fistulae in All Eligible Hemodialysis Patients"
<http://cme.ouhsc.edu/5E016webtro pages.htm>
2. Web sites: www.fistulafirst.org
www.esrdny.org
3. Regional Educational Meetings


Percent of AV Fistula Utilization in Prevalent Hemodialysis Patients



Month	US (%)	Network 2 (%)
January 2004	34.6	41.5
December 2004	37.4	45.3

*Data Source and Limitations
This data presents a "snapshot" of hemodialysis only AVF and AVG permanent vascular access placement practices. The data does include all placement (ICD9 585 Chronic Renal Failure) procedures and does not reflect success or functionality. Data for your individual rate, as well as the comparative Network rate, came only from Medicare Part B Outpatient Claims (January 2004 - December 2004). This data is limited as it does not include placements for Medicare Part A, non-Medicare and uninsured patients. Catheter placements are NOT included. It is recognized that surgeon AVF placement rates may be limited by factors such as timing of patient referrals, practice settings and claims processing.

Data for the National and Network comparative graph came from the CMS Dashboard, which is produced monthly as a result of a special aggregate data collection effort at the dialysis facility level. To learn more about the Fistula First Project and/or to contact the ESRD Network in your area for your area go to www.esrdnetworks.org



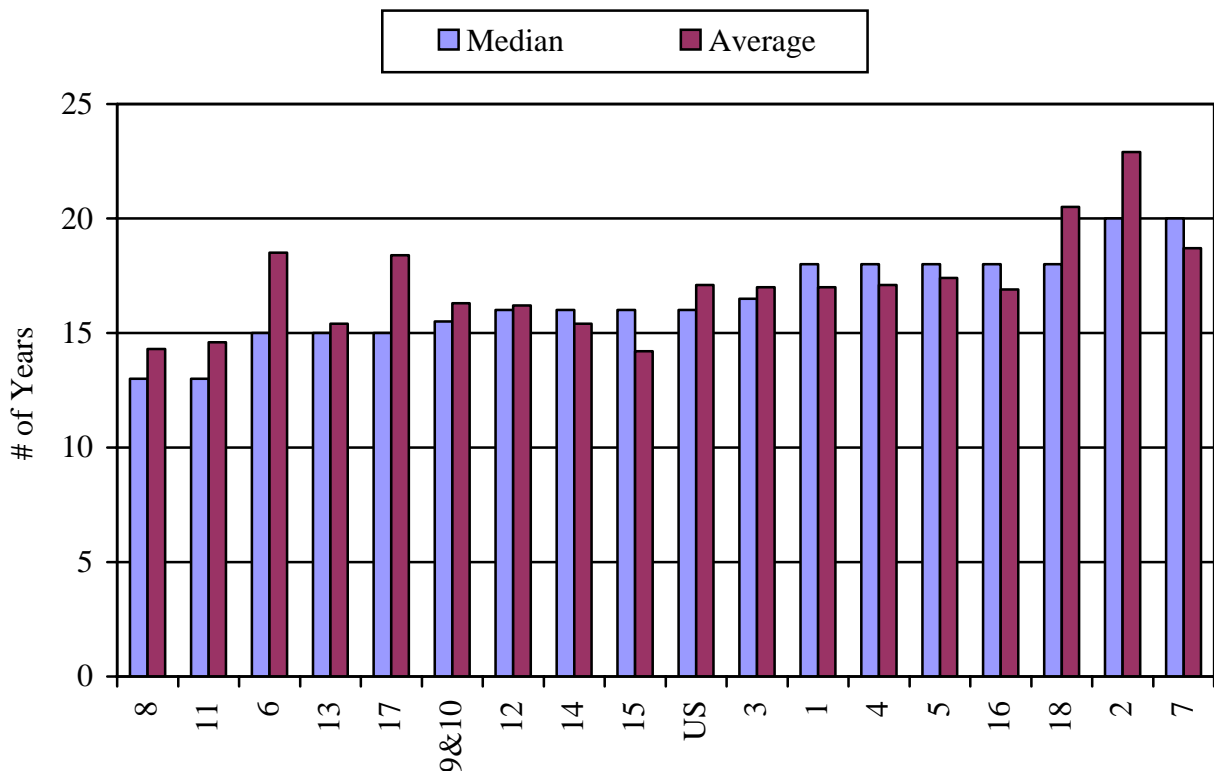
ESRD
End Stage Renal Disease
Network of New York, Inc.

In conjunction with the surgeon’s report, a questionnaire of surgeon practice was distributed to 316 surgeons. Network 2 received 38 completed questionnaires. The data was entered into a database and sent to NW5. NW5 aggregated the data from all 18 Networks and worked with the United States Renal Data System to analyze the information.

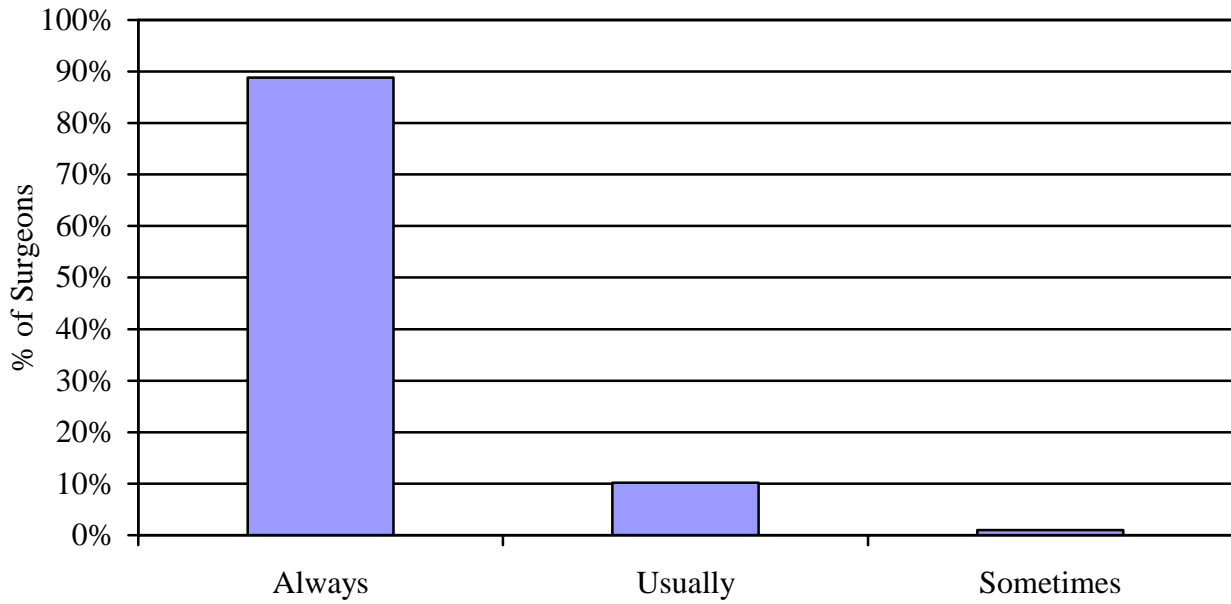
The questionnaire was voluntary and resulted in a small response rate. Caution should be used in interpretation of this information. The respondents were probably interested & already supportive of AVFs, thus a bias exists. The questionnaire was not used for its designed purpose. The questionnaire was intended as a tool for nephrologists to query surgeons providing services to their patients to aid in referral. Its use as a measure of national surgical practices is limited. There are no questions linking AVF procedures with discussions with patients or vessel mapping thus omitting information regarding the integration of the variables of surgical practices.

The following graphs display the national results (N = 717) for some of the questions asked of surgeons. It is of interest that Network 2 has the highest average years of surgeons performing vascular access procedures. Only 50% of the surgeons use vein mapping as a routine part of their assessment for access placement.

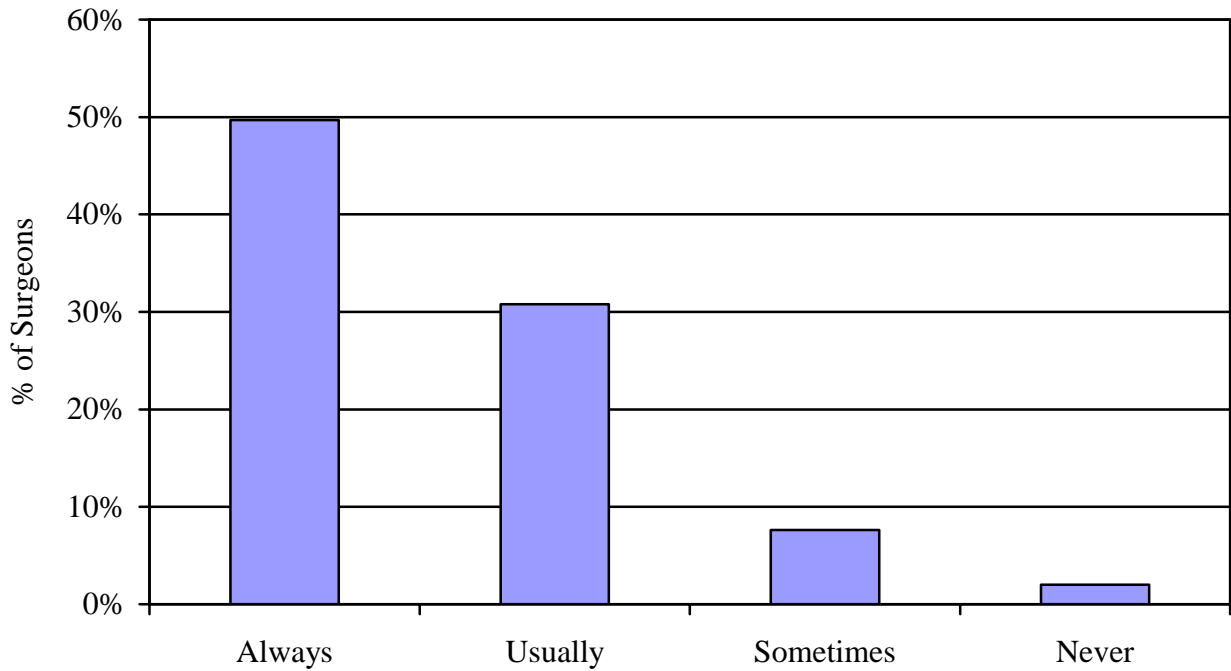
Years Performing HD Vascular Access Procedures by Network



Discussing Vascular Access Options with Patients



Use of Vein Mapping



v Fistula First Progress

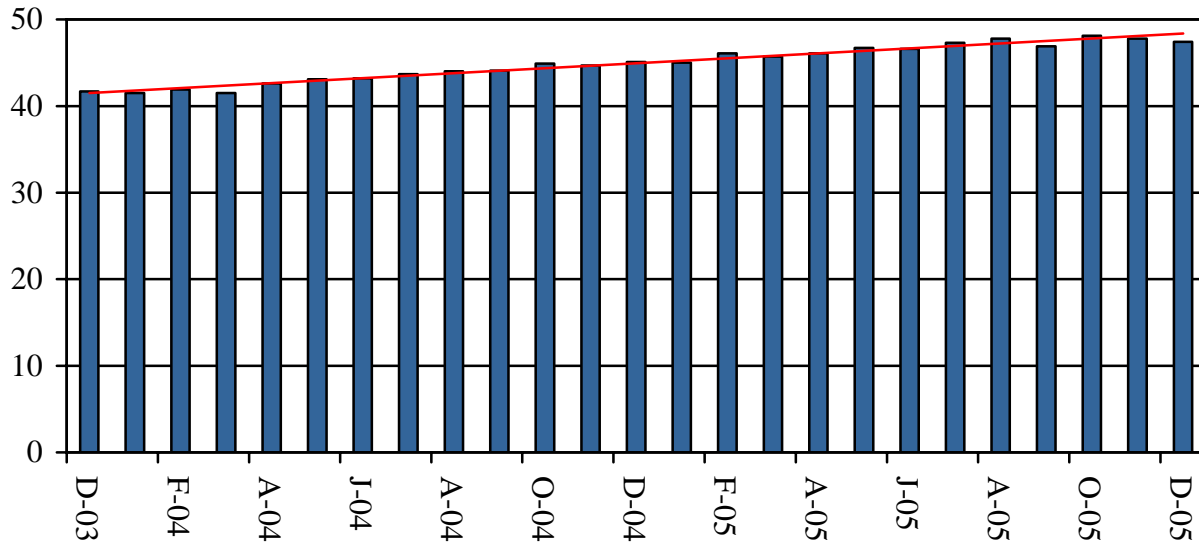
The baseline for improvement measurement is the December 2002 Centers for Disease Control data, that collected data from all facilities on their practices and clinical outcomes. These data showed that 38.9% of patients in New York State were treating with an AVF, as reported by

100% of facilities. The CMS goal for Network 2 required a 3% improvement and was met in February 2004, when 42% of its patients were treating with an AVF. As of December 2005, 47.4% were treating with an AVF, as reported by 80% of 217 eligible facilities (pediatric, PD and acute care providers are excluded). Of the 217 that were eligible, Large Dialysis Organizations (LDOs) managed 79 facilities and 138 were independently owned. LDOs submit electronic data to CMS for their providers and independently owned facilities submit paper forms, which Network staff enters into a SIMS-based vascular access utility. The electronic data submitted by LDOs is merged into the SIMS vascular access database.

Computer Services Center works closely with CMS to develop ESRD software. One of its products is the Fistula First Dashboard. The dashboard is a table showing the prevalent rate of AVF use by Network and the percent of eligible facilities reporting. Each generation of the dashboard includes data entered since the last dashboard was created and thus is a fluid document. The dashboard is a public document and can be found on the Esource website: www.esource.net.

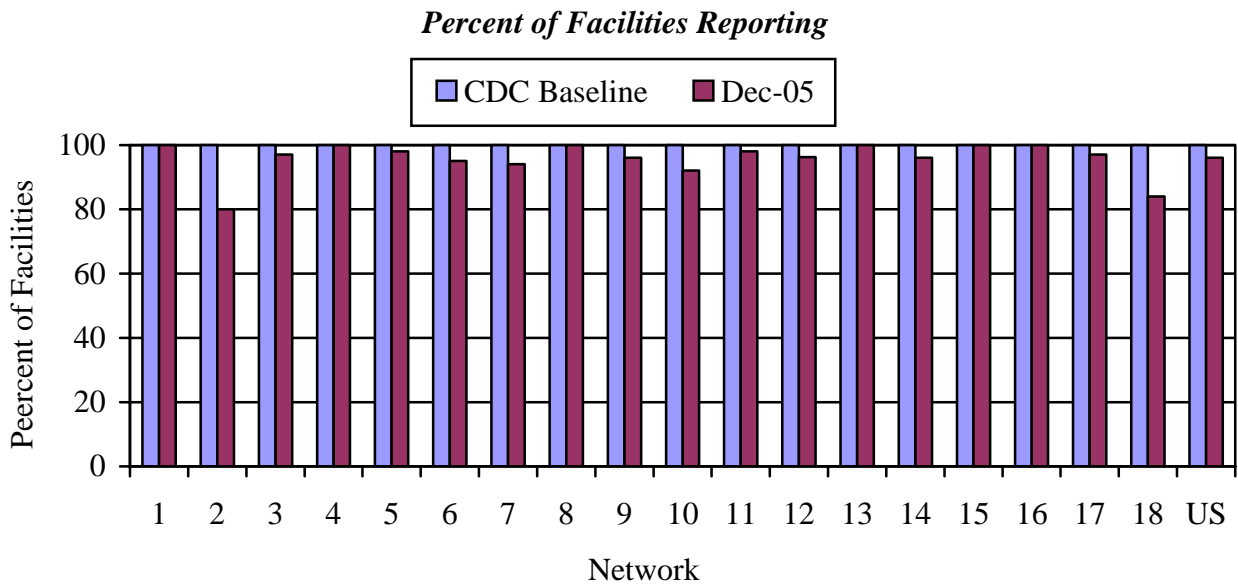
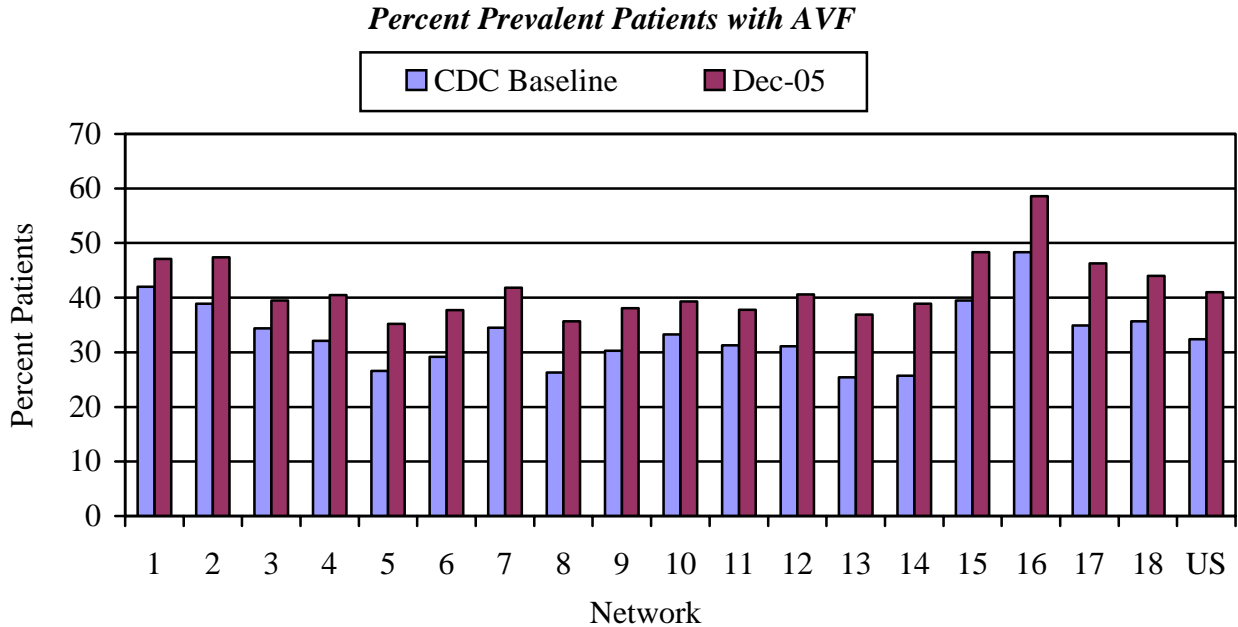
The Network has shown a steady improvement in prevalent patients treating via AVF.

NW2 Percent of Prevalent Patients with AVF



AVF rates have improved in all Networks. The national rate has increased 8.6%, from 32.4% at baseline to 41% in December 2005, which exceeds the CMS projection of 4.1%. CMS has established a goal of 66% of patients with an AVF by 2009.

The following charts show the percent of prevalent patients with an AVF and percent of facilities reporting data for each of the 18 Networks. The data source for the charts is the dashboard generated on March 15, 2006.



This Network experienced a significantly lower percentage of facilities reporting data than the national average; only about 65% of eligible facilities were reporting data. To remedy the situation, a letter from the MRB Chairman was sent to the Medical Director of facilities that were eligible to report data but was not. Network staff followed up with faxes to Nurse Managers of these facilities requesting submission of delinquent reports. The rate of data submission improved from 65% of facilities reporting to 80% in the last quarter of 2005. Efforts to improve reporting improvement are ongoing.

Buffalo Collaborative: In September 2005, a meeting of several Network physicians, local surgeons and the Network Executive Director and Quality Improvement Director (QID) was held to discuss a possible coalition of stakeholders in the Buffalo area to improve AVF rates. In addition to improving AVF rates, the Network planned to develop a template for AVF improvement that could be used in other areas of the Network based on the activities of the Buffalo collaborative. A multi-faceted proposal that surgeons, nephrologists and private payers construct a system of education and financial incentives to improve AVF rates was developed. The lead for this activity is a past-president and current member of the Network Executive Committee. The Network QID is providing Network support as needed.

A second meeting took place on October 26th in Buffalo to launch a focused project to improve AVF rates in the region. Attending were nephrologists, vascular surgeons and a surgeon practice administrator. The participants represented all of the major practice groups in the area. The Network QID introduced the surgeons to the Network and summarized its activities in promoting FF. The QID discussed with the participants the educational resources of the Network. Participants indicated interest and enthusiasm and agreed to move forward with planning a larger meeting that would include representatives from private payers and some fiscal intermediaries, whose support would be needed for any financial incentives that might be established to increase AVF and improve long-term outcomes. The larger meeting took place on December 7, 2005.

The participants discussed the need for development of criteria that might justify financial incentives with private payor groups. The need for education at the surgeon, nephrologist and dialysis unit staff was identified. Issues related to longevity of permanent access post surgical placement was discussed. Representatives of private payers and fiscal intermediaries expressed their interest in exploring incentives for long-term fistula survival.

The Network QID recommended the inclusion of nurses and patients and suggested education and improvement measurement would be significant elements in the success of the plan. Network participation in the collaboration is directed toward assisting in the education of stakeholders. The following subcommittees were formed: Professional Education, Patient/Staff Education, and Payer/Intermediary Education. It was agreed that nurses and patients would be invited to participate in the education subcommittees. More meetings are scheduled for 2006.

➤ **Clinical Performance Measures (CPM)**

The Clinical Performance Measures is a national effort that has existed for twelve years. A random sample of hemodialysis and peritoneal dialysis patients is selected for clinical data profiles. Data is profiled by each Network for comparative reporting and monitoring.

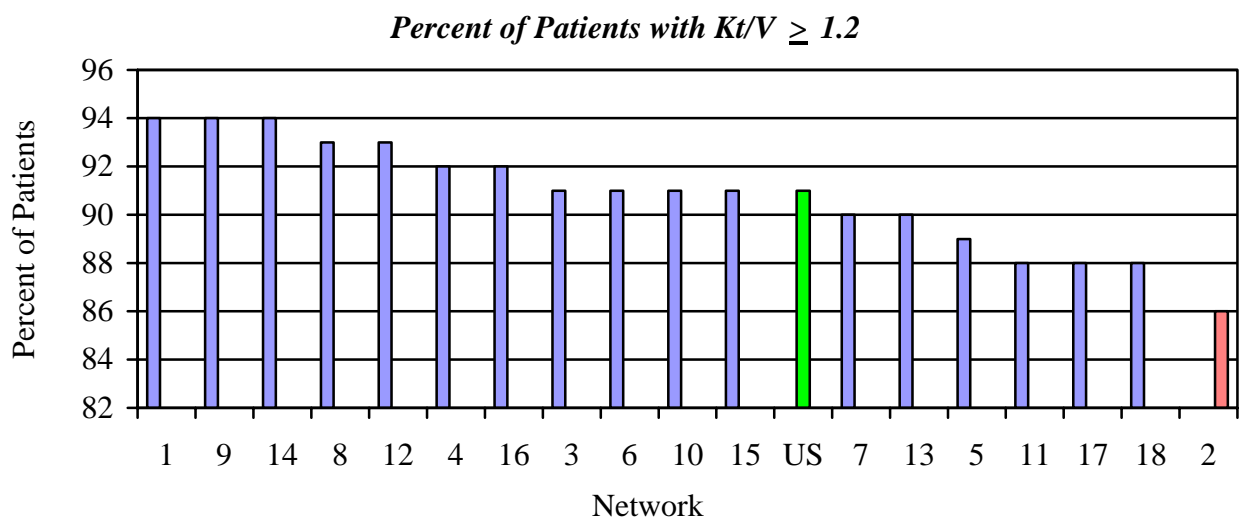
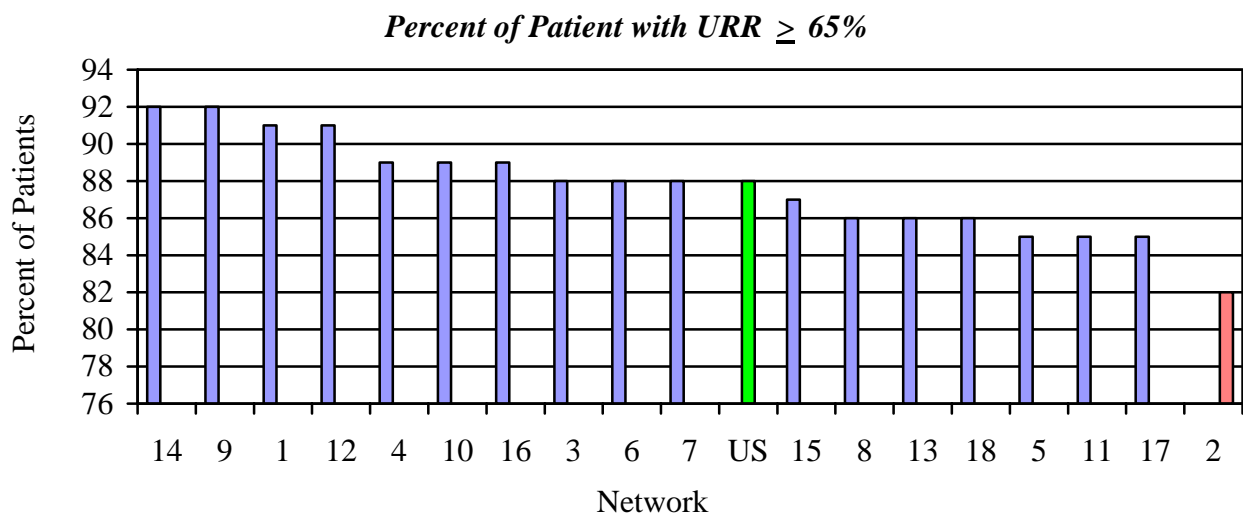
A total of 937 CPM data collection forms were mailed to facilities in August. These included 667 forms to Medicare certified ESRD providers and 270 forms to VA Hospitals. A total of 667 forms were completed and returned from 189 facilities. One facility did not send data, since they had closed and no staff was available to retrieve the data. Forms were reviewed for completeness, facilities were called for missing data and forms were entered into SIMS. Approximately 66% of forms submitted required further follow-up with the facilities for

accuracy and completeness. VA hospitals returned 205 forms, which were forwarded to Network 9/10 the first week of October. Reliability of 17 CPM forms was done by chart review, conducted by Network QI staff, and information was entered into the SIMS database.

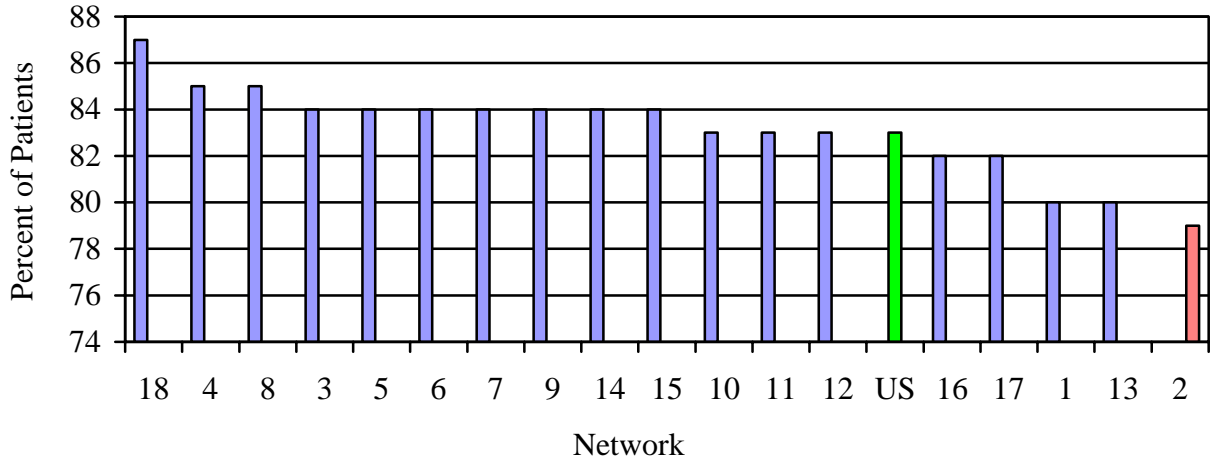
v Results from 2005 CPM Project

Network 2 Compared to Other Networks & the U.S.

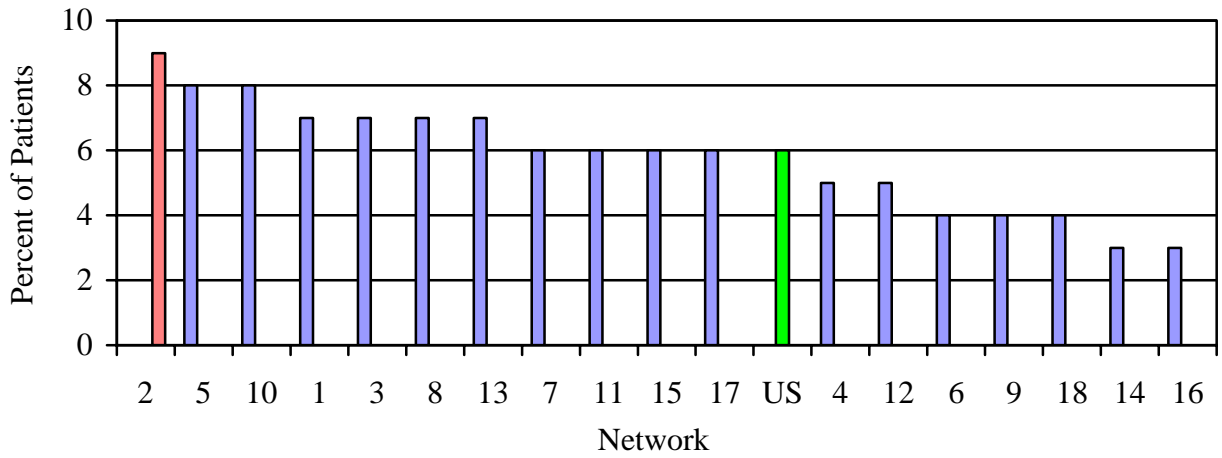
The CPM project represents a 5% statistical sample of patients from each Network. Data is collected for the last quarter of the year (October – December). The CPM Annual Report shows data for the previous year. The 2005 Annual CPM Report, displayed below, shows data from the last quarter of 2004. The following data graphs compare all 18 Networks as a percent of patients meeting the clinical measurement.



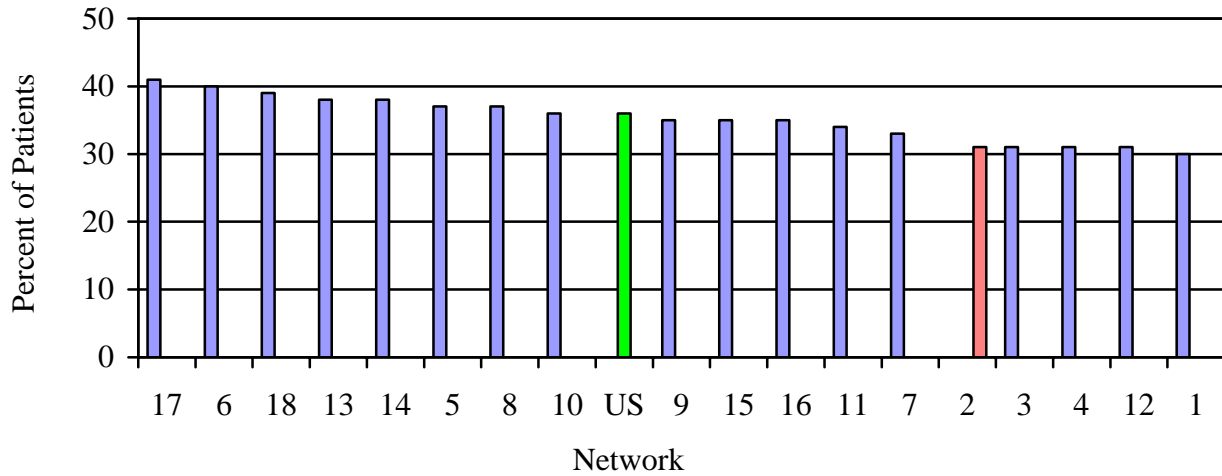
Percent of Patients with HGB ≥ 11

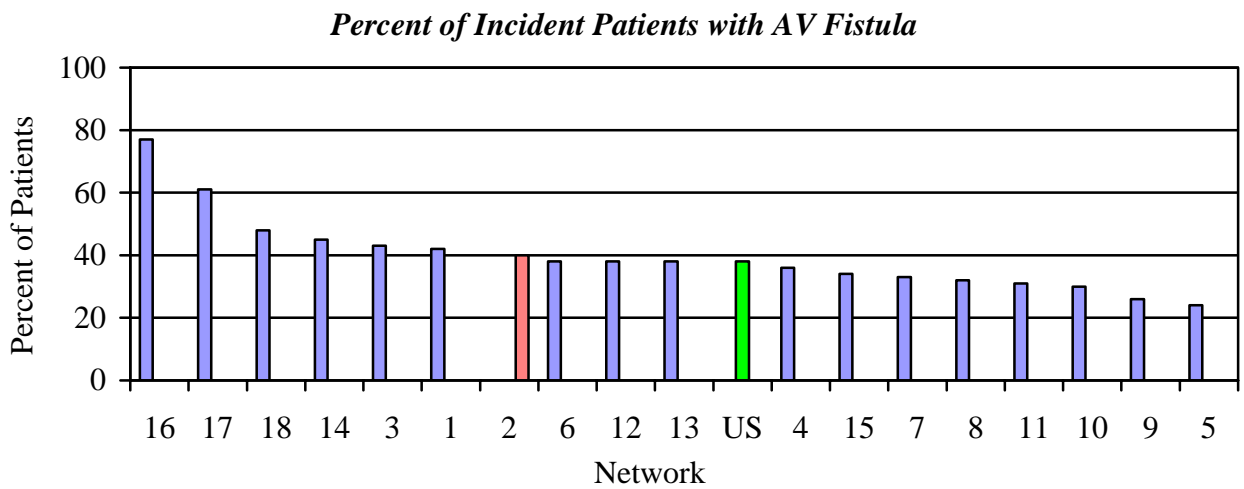
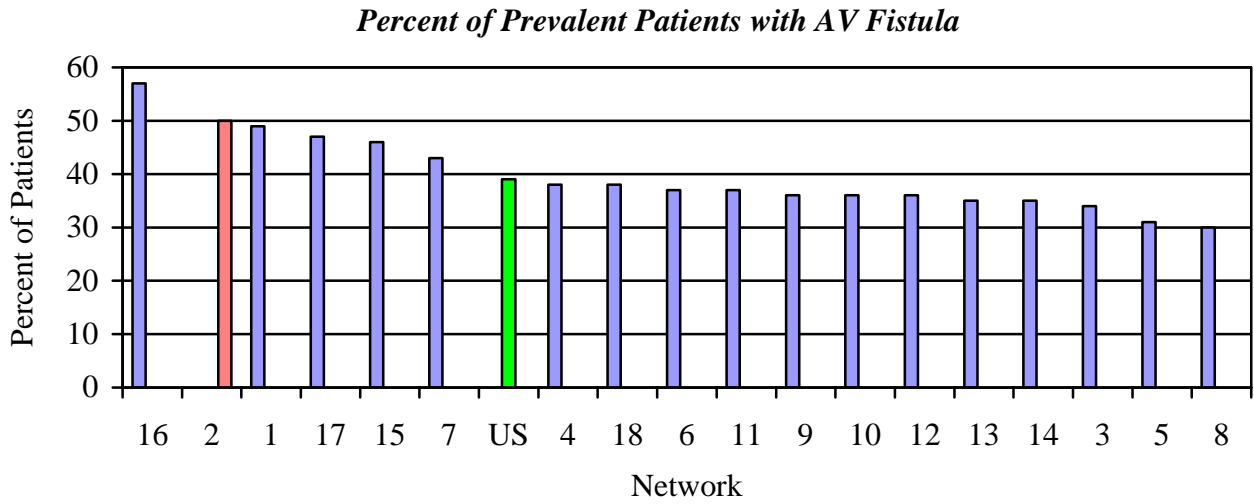
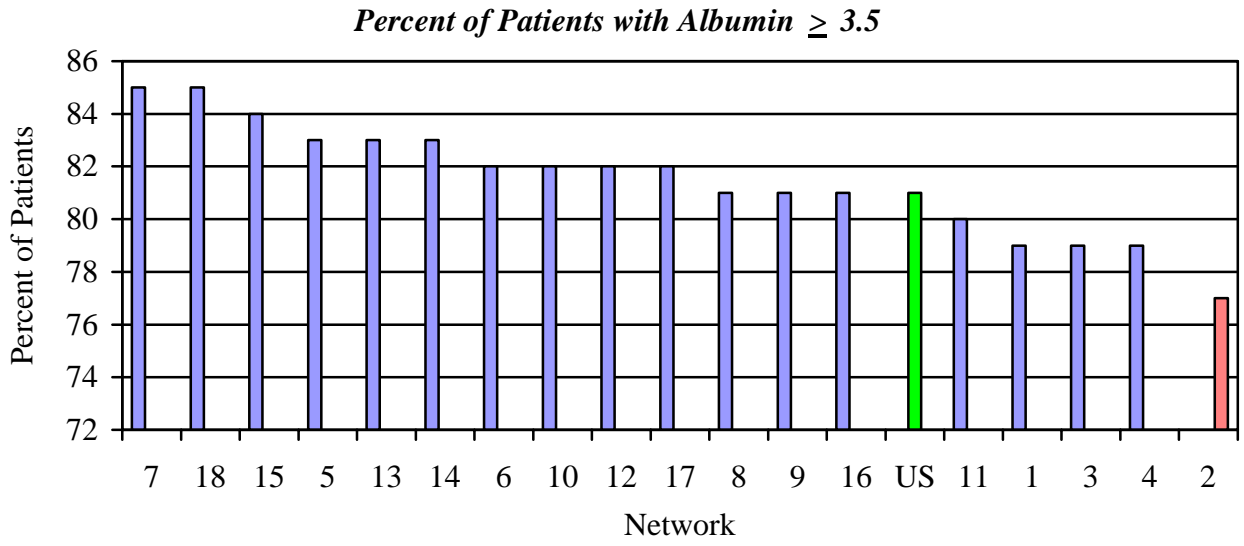


Percent of Patients with HGB < 10

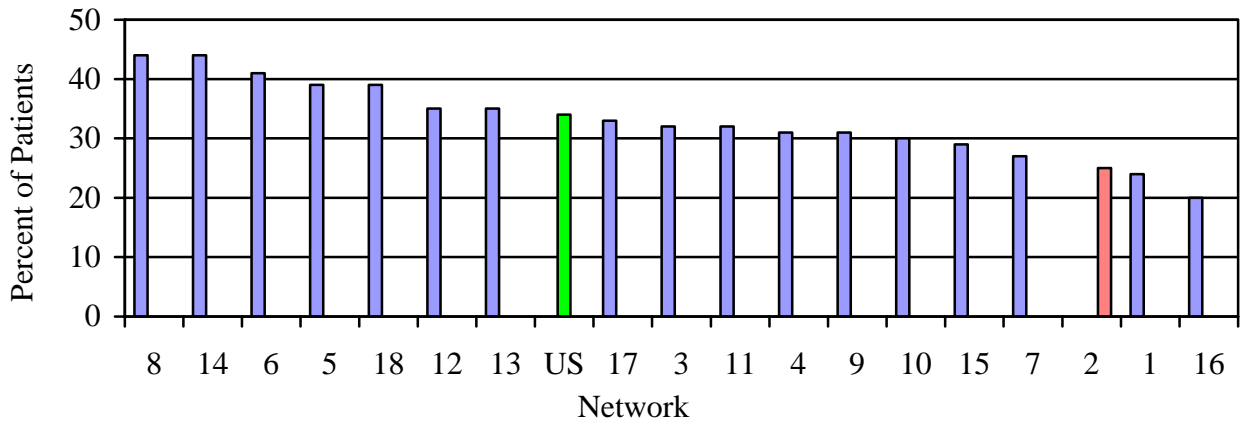


Percent of Patients with Albumin ≥ 4.0

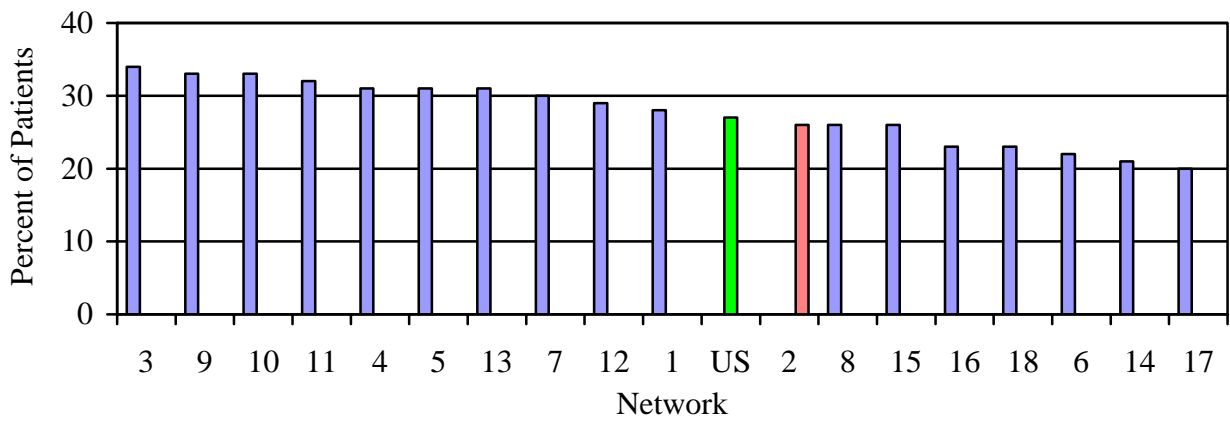




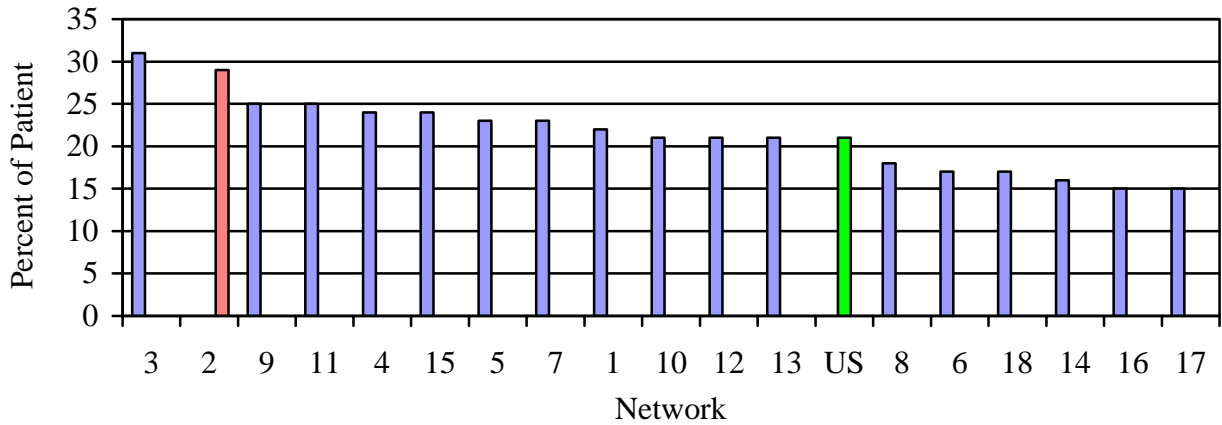
Percent of Prevalent Patients with AV Graft



Percent of Prevalent Patients with Catheter



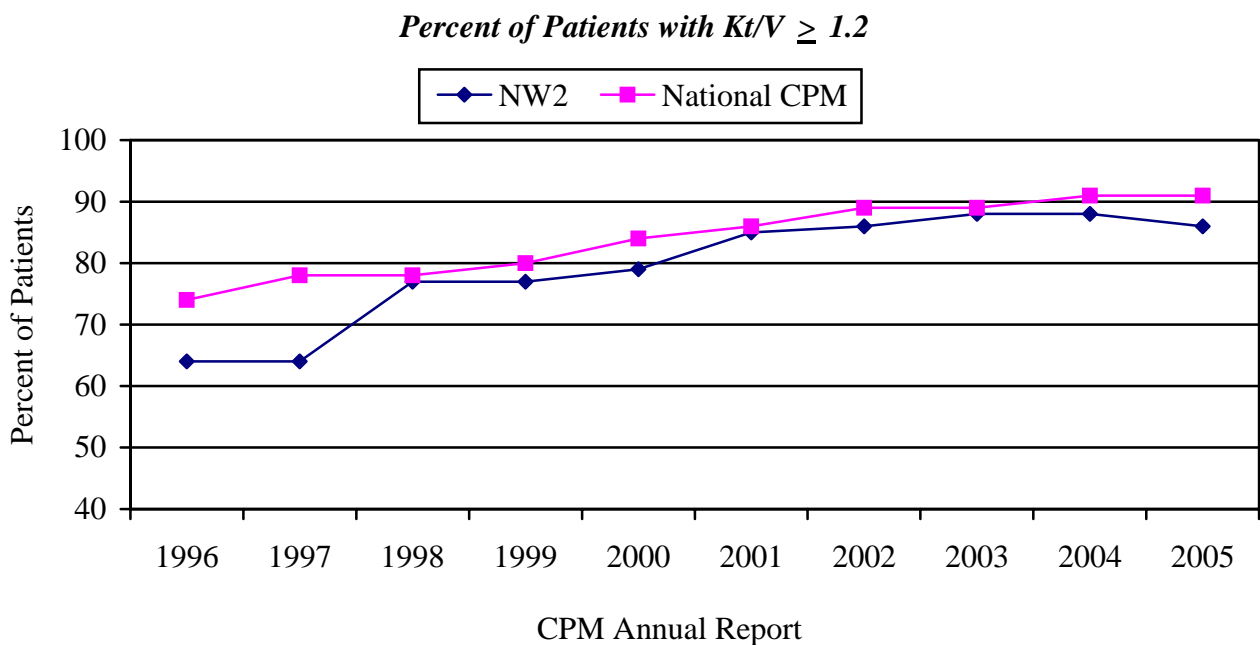
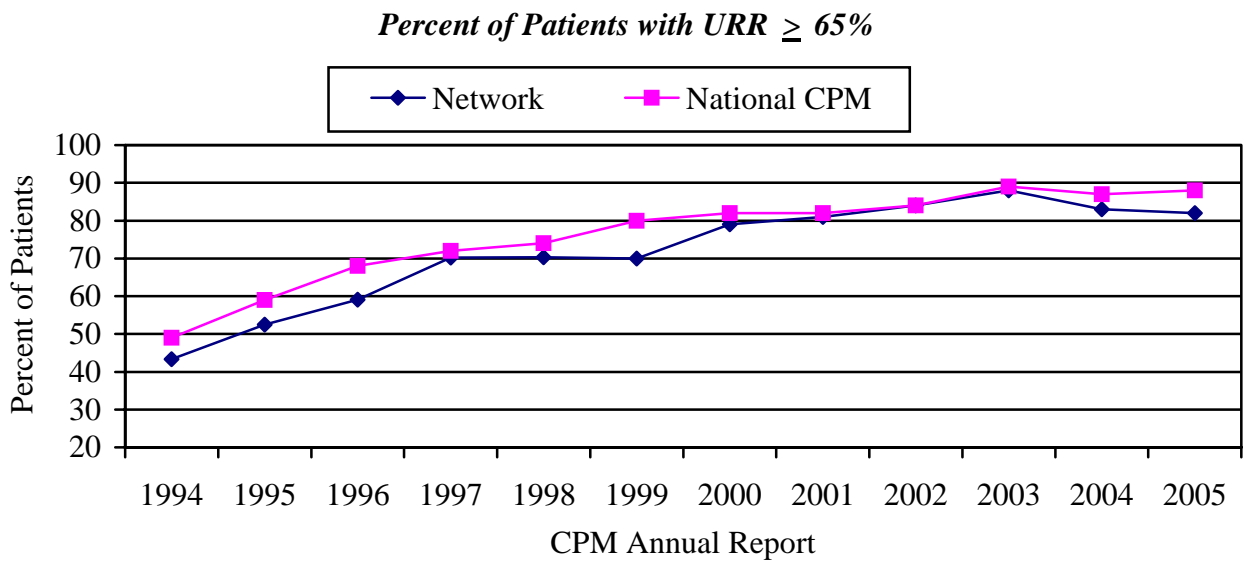
Percent of Prevalent Patients with Catheter \geq 90 Days

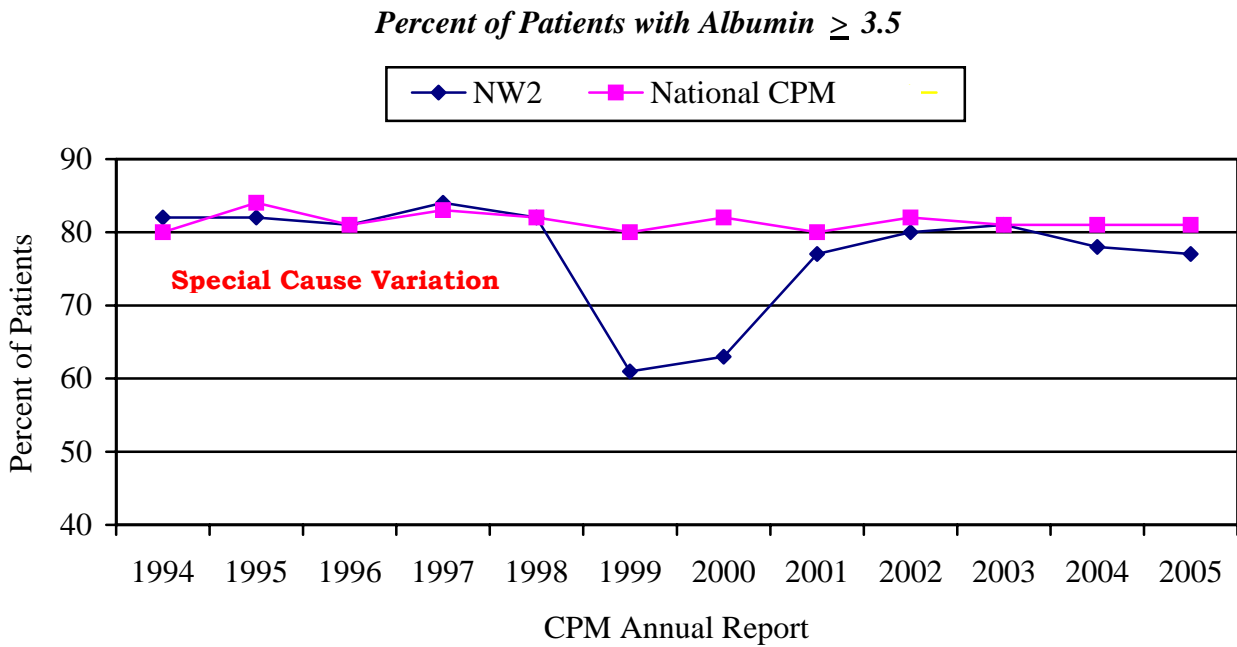
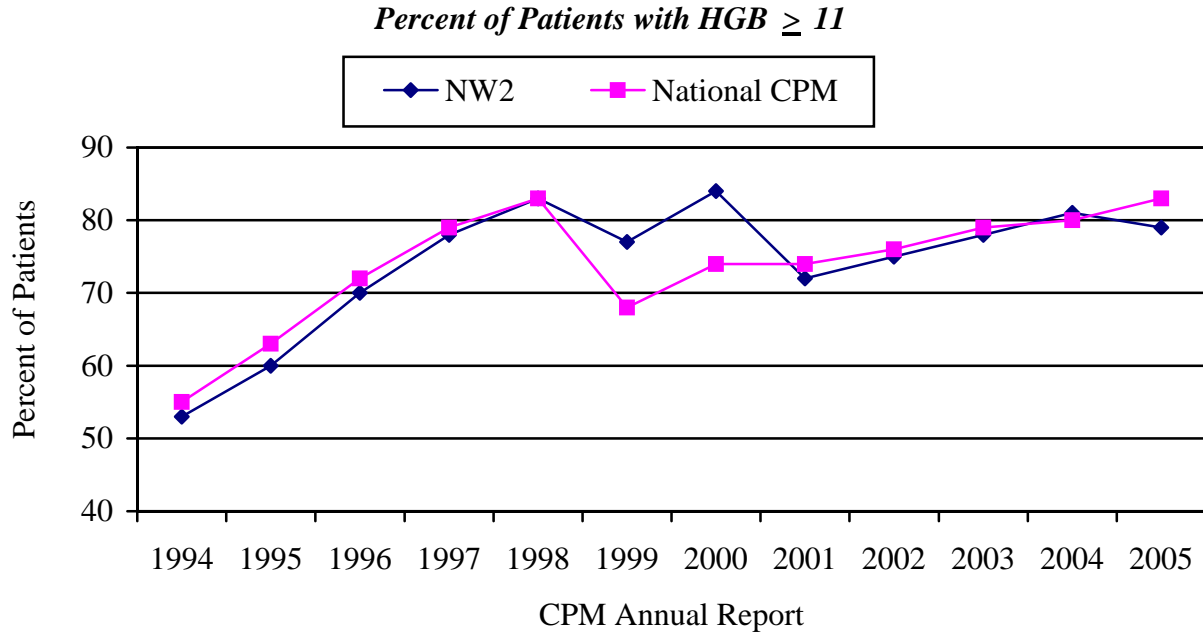


From the data it would appear that Network # 2 performs poorly in all CPM areas with the exception of vascular access. A close examination of the data shows a small percentage in variation from the lowest performing Network to the highest performing Network. However, the Network Medical Review Board is concerned with these results and will focus on anemia management in 2006. The charts below show that this Network has made improvements in all areas of the CPMs often exceeding CMS or KDOQI guidelines.

v Network 2 Progress on CPMs

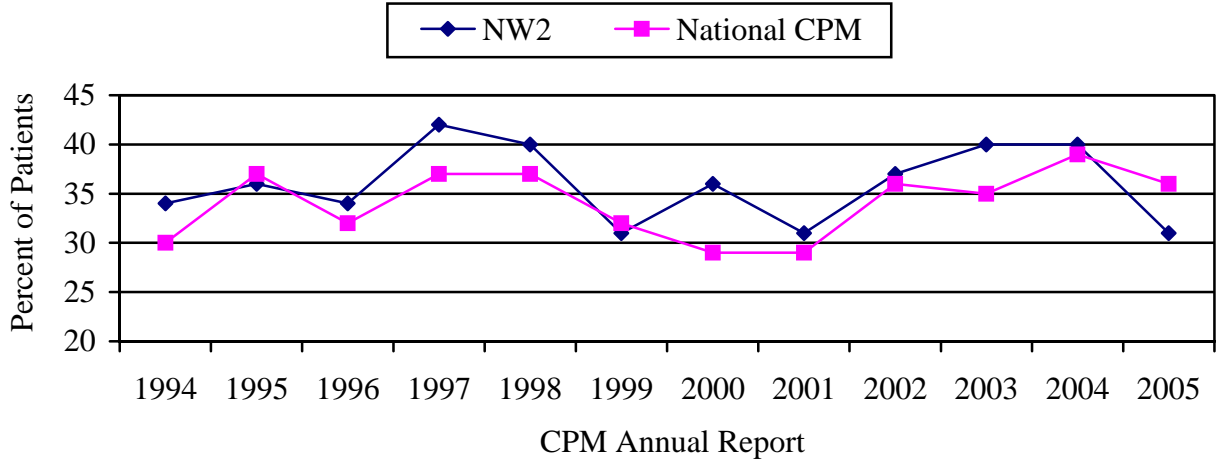
(Source 2005 CPM Annual Report)



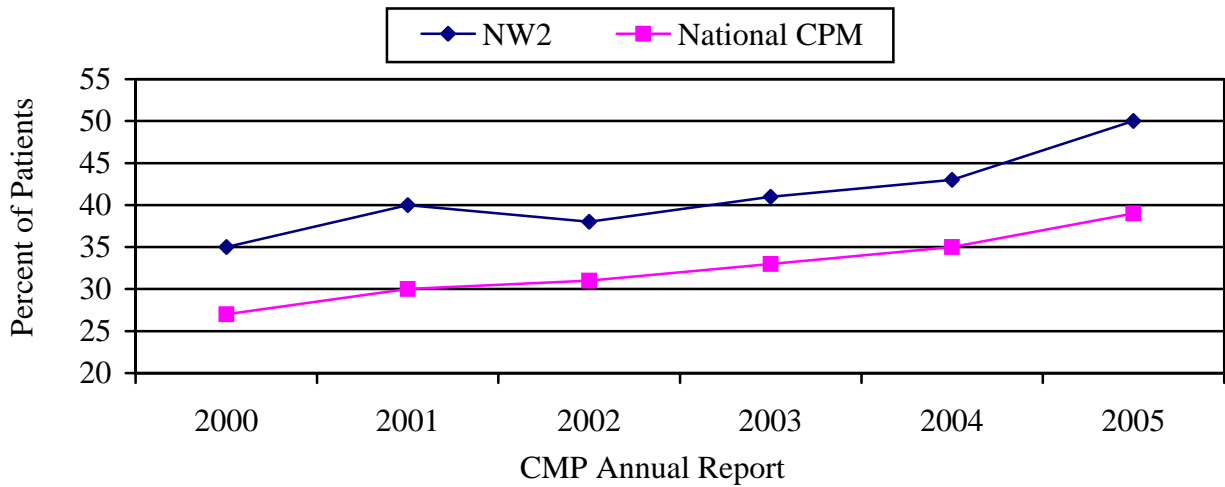


Special Cause Variation: Local laboratories changed the assay methodology. When the variation from National means was discovered, the laboratories resumed using the previous methodology.

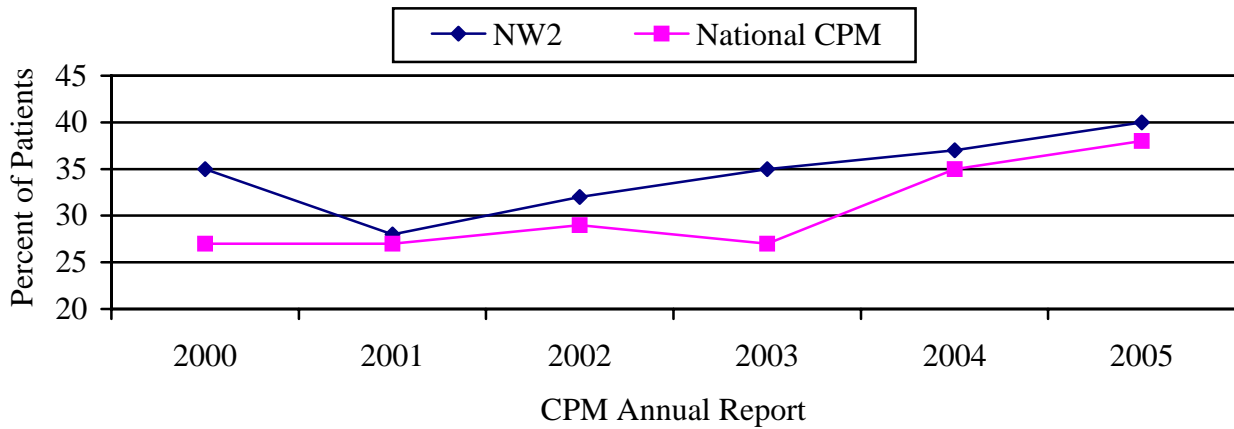
Percent of Patients with Albumin ≥ 4.0

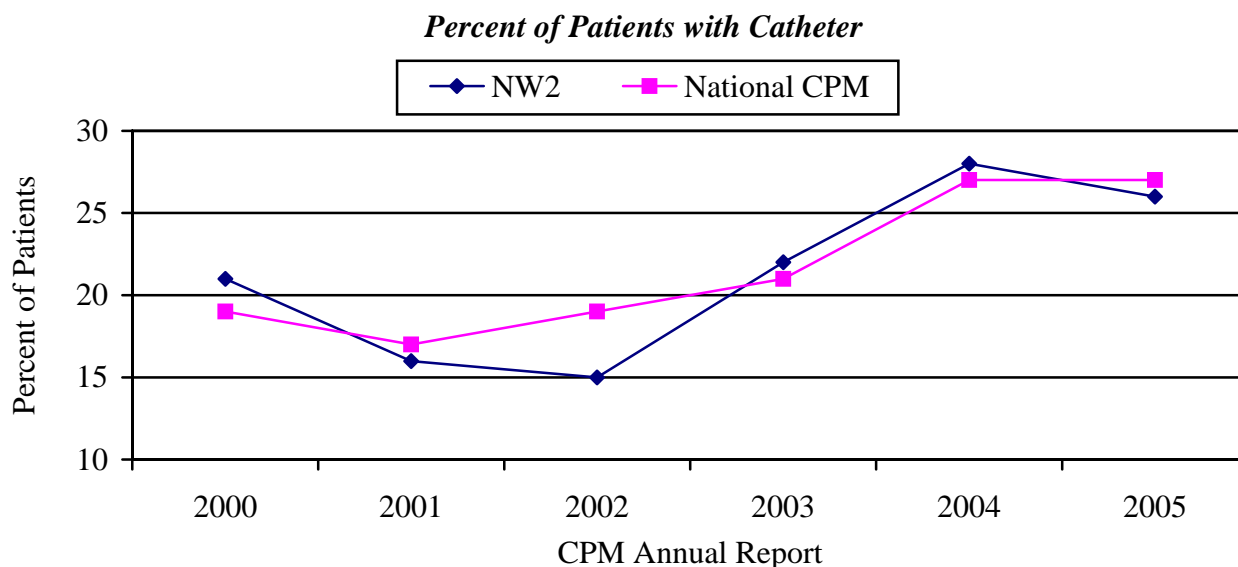


Percent of Prevalent Patients with AV Fistula



Percent of Incident Patients with AV Fistula





Summary: Network Clinical Performance Measures

CPM	Quality Indicator	Network Goal	Network Performance
Adequacy of Dialysis	% of Pts with URR ≥ 65	80%	82%
Adequacy of Dialysis	% of Pts with Kt/V ≥ 1.2	84%	86%
Anemia Management	% of Pts with Hgb ≥ 11	85%	79%
Iron Management			
Ferritin	% of Pts with Ferritin ≥ 100	-	93%
TSAT	% of Pts with TSAT ≥ 20	-	77%
IV Iron	% of Pts receiving IV iron	-	65%
Nutrition	% of Pts with Alb $\geq 3.7/4.0$	45%	31%
	% of Pts with Alb $\geq 3.2/3.5$	-	77%
Vascular Access	% of Pts with AVF	50%	50%

CMS provides the Networks with aggregated CPM data for each data collection period. The Network Medical Review Board reviews the data and develops a plan of interventions to respond to changes in CPM performance beyond normal variation. The CPM data collection represents a random sample of 5% of the Network's patients. Therefore, facility specific data is not available. However, the Network is participating in the National CPM Laboratory Data Collection project. The project will provide patient level data for patients cared for in Large Dialysis Organization managed/owned facilities and some independently owned facilities (participation in the project is voluntary). With facility level data, the MRB will be able to focus interventions in areas, and with facilities, that demonstrate opportunities for improvement.

Network resources will be devoted primarily to the National Vascular Access Improvement Initiative (Fistula First). The Network Medical Review Board has identified two areas for focused intervention: Anemia Management and Central Venous Catheter use beyond 90 days.

Seventy-nine percent of the Network's patients have a hemoglobin of 11% or better. The National performance level is 83% and ten Networks exceed the National level. The Network is participating in the current CPM laboratory data collection project. Using the data collected, the Network plans to identify groups of providers or providers in the same geographic area with significant numbers of patients with Hgb less than 11% for focused intervention.

Identified facilities will be provided with educational material (appropriate scientific articles, tracking and profiling tools) and technical assistance. Network will request that facilities provide periodic information documenting their progress toward improving Anemia outcomes (data, reports or telephone communication of outcome progress). The Network will provide technical assistance in specific areas as requested. Upon request, and within the limits of Network resources, the Network will provide on-site technical assistance.

The Network Medical Review Board is concerned with the increasing number of patients with catheters for more than 90 days, which is currently at 29%. The National average is 21%. The Network will petition CMS for patient specific vascular access data. The data will be used to identify patients with catheters in use more than 90 days.

The Network will use the data to develop a pareto chart to determine priorities for interventions. The Network will then develop focused interventions to improve outcomes in the identified areas.

➤ **Crisis Management Training**

The Network continued its series of one-day regional workshops for facility staff in 2005 with presentations in Albany (April) and New York City (November) entitled "Help! Nonviolent Crisis Intervention in the Dialysis Unit." The Network Patient Services Coordinator (PSC) who is certified as a trainer by the Crisis Prevention Institute, demonstrated methods for defusing disruptive and threatening situations. Twenty-five participants from 17 facilities practiced techniques for de-escalating verbal threats, maintaining personal safety and gaining adherence from challenging individuals. Attendees included a nurse practitioner, nurses, social workers and a technician. Continuing Education Credits from the National Kidney Foundation (NKF) for 8.4 contact hours are provided for this program. Evaluations completed at the two workshops provided an overall rating of 4.61 on a scale of 1-5. Since its inception in April 2002, 195 staff members have attended the Network's crisis management training workshops from 135 (58%) of 233 of New York State's dialysis outpatient facilities with an overall score of 4.2. In addition, the Decreasing Dialysis Patient-Provider Conflict (DPC) Toolkit contents were reviewed and the necessity for facility-level staff training utilizing the toolkit was discussed.

➤ **Sensitivity Training for Dialysis Staff**

Entitled “Mental Health in Dialysis – a chronic treatment,” these onsite, interactive sessions scheduled at the request of the provider, include group self-exploration and discussion that promote better understanding of how one’s life changes as a dialysis patient, and ways in which professional boundaries can assist in improving quality of patient care and staff-patient relationships. In addition, review of the Patient Functioning Chart demonstrates how symptomatic behaviors develop from mental states due to common dialysis patient experiences. This allows staff to have a better understanding of some of the challenging patient behavior staff encounters. All levels of staff attend, including clerical and maintenance workers. Attendance at 15 sessions presented during the year included 195 staff members from 9 dialysis units. Evaluations showed an overall rating of 3.64 on a scale of 1 to 4 (1:poor; 2:fair; 3: good; 4:excellent) as compared to 3.65 in 2004. Continuing Education Credits from the National Kidney Foundation (NKF) for 1.8 contact hours are provided for this program to professional participants. Written comments provide valuable feedback on how the Network can be of greater assistance to providers. These include requests for repeat and additional in-services, information on personality disorders, coping with staff-patient and staff-staff conflict, dealing with patient depression and management of abusive patients. Since its inception in April 2001, 1,277 staff members have received this training in 117 sessions at 69 outpatient facilities (30%) with an overall score of 3.59 on a 1 to 4 scale.

➤ **Crisis Prevention in a Healthcare Setting**

Since the first sensitivity training in April 2001, Network staff received requests for a follow-up in-service. In addition to a regional 1-day workshop on crisis prevention, provided at least twice a year, Network staff developed a follow-up in-service based on the program. Required to be scheduled within 6 weeks of the sensitivity training for the same staff, this training began in April 2005. The session reviews the crisis development model, non-verbal behaviors, paraverbal communication, precipitating factors, rational detachment, verbal tips & techniques and involves participants in discussion concerning the importance of maintaining unit policies universally. The Decreasing Dialysis Patient-Provider Conflict (DPC) Toolkit, its purpose and necessity for its use are also discussed. Evaluation scores and staff comments suggest this training should continue as a follow-up in-service to the sensitivity training. Attendance at 12 sessions presented during the year included 131 staff members from 8 dialysis units. Evaluations showed an overall rating of 3.71 on a scale of 1 to 4 (1:poor; 2:fair; 3: good; 4:excellent).

➤ **“Completing the Continuum of Quality Patient Care: Renal Palliative Care”**

The Network presented a workshop for professionals in 2004 to provide information on palliative care as an option for ESRD patients and ways to incorporate palliative care into the continuum of care. In 2005, a videotape of the speakers and copies of their PowerPoint presentations are available as a web-based tutorial for viewing and download of PowerPoint handouts and may be viewed at www.esrdny.org. Its objective is to increase awareness of options for end of life care decisions and help staff with the aftermath of patient deaths. Presentations include: “Why the Nephrology Community Should Care about Palliative Care” and

“Incorporating Palliative Care into Your Dialysis Unit,” by Alvin Moss, MD; a video of a dialysis unit memorial service, followed by discussion; “Hospice: Optimizing Palliative Care for Patients with ESRD,” by Judith Skretny; and “Aftermath of an Unexpected Death: Procedures for Staff,” by Sandra Waring and Richard Russo. Dr. Moss concludes the program with a discussion of case histories that presented difficult end of life issues.

➤ **Spring Network Council Meeting/Provider Session**

In an outreach to providers, the Network invited medical directors, unit administrators, and other facility professional staff to attend the May Council Meeting that took place at a hotel near LaGuardia Airport, New York City on May 20, 2005. Guest speakers from the NYS DOH and CMS Region II gave presentations on state survey procedures, opening and closing of dialysis units and issues of governance. The Network Vocational Rehabilitation Specialist presented six employer recognition awards for their support in assisting ESRD patients in their workplace. The Network’s Fistula First exhibit was on display at the meeting and the Kidney and Urology Foundation of America and National Kidney Foundation of Greater New York co-sponsored the luncheon and displayed education materials.

➤ **Fall Annual Network Meeting Scientific Program**

Facility providers and other renal community members attended the Network Annual Meeting on September 9, 2005. “Nephrology in the 21st Century: Patients, Staffing, Treatment Options” was the theme of the teaching day presented in Rochester, NY, and attended by 200 physicians, nurses, social workers, dietitians and patient representatives. Goals of the workshop were to:

- i. Provide an overview of ESRD Program changing demographics
- ii. Present Buffalo’s experience in Population-wide GFR (glomerular filtration rate) screening
- iii. Improve understanding of issues involved in end of life care for CRF patients
- iv. Describe latest developments in Daily Nocturnal Hemodialysis and its economic considerations
- v. Explain strategies for developing a culture of staff retention in dialysis units
- vi. Identify changing roles of renal social workers and dietitians.

The keynote speaker, Allan Collins, MD, gave a statistical overview with future projections titled “Chronic Kidney Disease and ESRD: High-Risk Populations.”

Lewis M. Cohen, MD, discussed issues surrounding end of life, including hospice and palliative care and showed a film of a memorial service in a dialysis unit.

Presentations during the luncheon included an overview of the MMA Prescription Drug Plan by Paul Winter from CMS and the Dialysis Patient/Provider Conflict Resolution educational initiative, by Richard Russo, the Network’s Patient Services Coordinator (PSC).

Concurrent sessions included a joint presentation by Brian Murray, MD and Bruce Boissonnault, MBA, titled “Primary Care: Chipping Away at the Iceberg of CKD,” on the Buffalo program to

screen for GFRs in primary care patients. Debbie Benner, MA, RD, spoke on “Renal Nutrition: Past, Present and Into the Future.” Mary Beth Callahan, LMSW, spoke on the “Changing Role of Renal Social Workers” and Carolyn Quinn, MSN, described the culture of nursing staff retention in place at the Schneider Children’s Hospital on Long Island.

Andreas Pierratos, MD and Christopher Hoy, MD, who have pioneered successful nocturnal home hemodialysis programs in Toronto and Troy, NY, respectively, presented clinical outcomes and an overview of financial considerations.

Melissa Schiff, MD, chair of the Network’s Program Committee was the moderator. The program was CEU approved by the Rochester Academy of Medicine and ANNA Long Island Chapter.

➤ **Achieving Goals in Quality of Care**

The Network of New York has achieved the KDOQI targets for adequacy of treatment, but has not met anemia target, which will be an area of focus in 2006.

The fistula First CMS performance goal was met by this Network. However, this measurement is based on 80% of providers submitting monthly fistula data. As the fistula rates rise, the catheter rates are also increasing. This experience is happening to most Networks, and will require focused work with vascular surgeons and hospitals.

During 2005, this Network faced many challenges and did not complete all contract deliverables in a timely manner. Reorganization of internal workflow and the hiring of new professional staff is improving Network performance.

B. IMPROVING DATA RELIABILITY, VALIDITY, AND REPORTING AMONG ESRD PROVIDERS/FACILITIES, NETWORKS, AND CMS (OR OTHER APPROPRIATE AGENCY)

➤ **Information Management**

v Patient Registry

The Network of New York collects, maintains, validates and analyzes the End Stage Renal Disease (ESRD) patient data for individuals receiving ESRD services in New York State as mandated by the Social Security Act and required by the contract's Statement of Work (SOW). The Network maintains patient information in the "Standard Information Management System" (SIMS) database. The patient information is replicated to the central SIMS database repository. Central SIMS receives similar data from 18 Network organizations located in different geographical areas and this constitutes the national ESRD patient registry. Renal Management Information Systems (REMIS) is a database that contains information on providers billing for ESRD services and Medicare entitlement data and has an operational interface to the SIMS Central Repository. REMIS serves as the primary mechanism to store and access ESRD patient and facility information in the ESRD Program Management and Medical Information System Database to enable the determination of the Medicare coverage periods for ESRD patients.

The purpose of maintaining the Network patient registry is to ensure a patient's renal medical condition has reached end stage and to register all ESRD patients (Medicare and Non-Medicare) with the United States Renal Data System (USRDS) as mandated by law. In order to register a patient as ESRD, the dialysis or transplant facility that initiates the patient's first outpatient ESRD treatment submits a Medical Evidence form (CMS Form 2728-U-4). A new 2728 was developed and sent to providers for use in June 2005. This form must be submitted to the Network within 45 days of the initiation of chronic treatment. This data is entered into SIMS to determine if the patient meets the criteria for ESRD. Providers with more than 10% of patients not meeting the criteria are profiled and are reviewed by the Network's Medical Review Board for appropriateness of treatment. Upon the death of a patient, the provider must submit a death notification form (CMS Form 2746) within 30 days. The Network of New York has seen an increase in the number of forms processed each year. In 2005, the total number of new patients starting treatment (incident) was 7,021 and the total number of all patients receiving treatment (prevalent) was 22,740.

v CMS Forms Processed

	Medical Evidence (Form 2728)	Death Notification (Form 2746)
2004	6910	4761
2005	7262	5173

In addition to documenting incident and prevalent patients, the Network also tracks patient events. On a monthly basis, the provider submits a monthly activity form. Changes in patient

treatment modality status are listed on this form and include events such as transfer-in or transfer-out of the facility. At the end of the 2005 year, the 245 facilities (230 dialysis and 15 transplant facilities) in the ESRD Network of New York are requested to reconcile the patients in their facility. The CMS Facility Survey Form (CMS 2744) is printed out and sent to the facility in January 2005 along with the patient beginning and ending census and patient events for the year. The facilities verified the patient census, made changes to the 2744 and submitted any omitted forms and events for the year. The Network entered these corrections in SIMS.

v Patient Events Entered into SIMS

2005	30,128
------	--------

v Provider and Personnel Database

The Network of New York maintains a provider database in SIMS, which includes the facilities name, demographic information, treatment modalities offered, shifts, and key personnel. The Network staff updates this information in SIMS when they become aware of provider related changes. There are several ways the Network becomes aware of these events: the Department of Health notifies the Network of facilities that are newly approved, have changed their name, owner, or provider number, or have closed; facilities are requested to notify the Network of changes to the facility information and personnel; and annually the facilities are sent a facility roster to review, update and return to the Network.

Centers for Medicare and Medicaid Services (CMS) maintains a website, Dialysis Facility Compare (DFC), located on the CMS website. This is a national listing of all Medicare-certified dialysis facilities. The information included on this website is dialysis facility characteristics such as: name, address, telephone number, date of Medicare certification, shifts starting at or later than 5 PM, the number of treatment stations, types of dialysis offered, and ownership type. Quality measures, adequacy of dialysis, treatment of anemia, and patient survival, are also included on the website. The SIMS provider database is uploaded to the DFC on a monthly basis to maintain accurate information.

v Quality Assurance of Patient Data

The Network is required to monitor the submission of accurate and timely data from the ESRD facilities in the State of New York. The forms submitted to the Network are monitored for accuracy, completeness, and timeliness. The Network communicates with the providers to obtain this goal. Two reports, reject and missing forms, are printed and sent to the providers on a monthly bases. Reject reports notify the provider of missing or inaccurate information on a form submitted. Missing forms reports notify the provider of forms that have not been submitted to the Network. The 2728 forms with missing patient and/or physician signatures are also included on the missing forms report. Facilities are requested to send in the corrected data and/or missing forms when they receive these reports. The facilities are notified semi-annually and annually of their accuracy and timeliness of forms by way of a compliance report. This gives the facility their compliance rate for timeliness and accuracy for both 2728 and 2746 forms and compares

them to the Network compliance rate. The CMS goal for semi-annual compliance is 80% and the goal for annual compliance is 90%. Facilities that did not meet the compliance rate were asked to submit a performance improvement plan to the Network. The CMS Project Officer is sent the list of providers who do not meet the compliance rate. Of the seventy-four facilities that did not meet the semiannual compliance rate, twenty-one submitted an improvement plan. Sixty-two percent of those facilities had an improvement in their compliance rate. A second request for an improvement plan was sent to those facilities that did not respond, had a compliance rate of less than seventy percent, and submitted more than twenty forms in the six-month period.

v # of Facilities Meeting Compliance Rate

Semi-annual above 80%	Annual above 90%
175	85

The accuracy and completeness of the Network's databases are verified in several ways. This includes SIMS accretions and notifications and REMIS alerts. Accretions are patients that are not in SIMS but are known to CMS through other renal databases. Notifications are discrepancies in the data elements between SIMS and other renal databases. REMIS alerts are related to patient entitlement status and serve as a method of communicating information about patient status among all REMIS users. The Network staff investigates these data discrepancies daily. Accretions and notifications are accepted or rejected in SIMS and alerts are corrected in SIMS by Network data staff or CMS.

The United Network for Organ Sharing (UNOS) and CMS developed a process of reporting kidney transplantation events to the National Renal Registry in 1994. Every month UNOS supplies the Network of New York with updates on kidney transplants from their website. The data staff verifies the kidney transplant information in SIMS with the transplant data received from UNOS. Quarterly the Network notifies transplant centers of any delinquent forms they have for UNOS.

➤ Other Data Management Activities

v Data Requests

In the State of New York, prior to opening a new dialysis facility or increasing the number of treatment stations, an application for the Certificate of Need must be approved by the Department of Health. This application is reviewed for public need, financial feasibility, character and competence of the applicant, and meeting the building regulations. The Network receives requests from both applicants and the DOH for the number of patients within the zip codes of the community the facility will be located. The Network refers these requests to the report of patients by zip code located on the Network's website. To maintain patient privacy, when there are less than 10 patients in a zip code, the number of patients in that zip code cannot be reported. If this affects most of the area requested, the Network will report the total number of patients located in the health services area.

v Business Continuity and Contingency Plan (BCCP)

CMS required each Network to develop a written BCCP that would outline the roles and responsibilities of staff, CMS, CSC, and Network vendors in the case of a disaster. The plan will provide documented procedures for making backup copies of software, operating data, and user processes for recovering data and returning all systems to an operational level in the event they are lost, destroyed, or otherwise inoperable. The plan includes prevention strategies, assessment of disaster, recovery operations, and list of contact information for staff, CMS, CSC, and vendors. A copy of the plan is kept both on and offsite. All staff will be trained on the BCCP early in 2006.

v New Patient Information Packets

The Forum of ESRD Networks mails informational materials to all new ESRD patients. The new patients along with their addresses are obtained from the SIMS patient database. The Network is notified by the Forum of any packets that are not deliverable and of any address corrections. The Network staff investigates the reason for the returned packets and makes the address changes in SIMS. The Forum is notified when this is complete so they can send the packet to the patient. The Network of New York has an average return rate below 6% return rate.

v Changes in the Workflow Process

CMS forms (2728 & 2746) must be entered into SIMS with complete and accurate information no later than 15 working days of receipt into the Network. Events on the monthly patient activity report must be entered into SIMS within 10 working days of receipt into the Network. With these recent changes in work requirements, the data staff had to develop work processes to improve efficiency. Originally, the data staff had their own facilities and was responsible for handling all forms received, patient events, and all problems from those facilities. Since all of their work was decentralized, it was difficult to determine their performance and if they required assistance. The work process was changed to a centralized organization of forms and monthly activity reports. Each data staff member was given tasks they were responsible for such as 2728, 2746, monthly activity reports, notification, accretions, etc. When a staff member is off, another person is responsible to complete their tasks. This redesign in processes has increased the department's ability to meet the contractual requirements.

v Data Library

Many of the procedures that are done in the data department have references to several sources, online manuals, Statement of Work, Medicare End Stage Renal Disease Network Organizations Manual and CROWN memos. The decision was made to develop a data library. Online manuals would be printed out and a hard copy would be placed in the data department as a resource. In addition, the Network is in the process of developing a data department policy and procedure manual. This would combine all data references to a task into a single policy and procedure central location.

➤ **Achieving Goals in Data Management**

In 2004 and part of 2005, some contract deliverables were not completed or timely in submission. A major redesign of workflow and staff responsibilities, along with assistance from Network # 1 in retraining of staff were completed. All the data staff are to be commended for their hard work and long hours, which has resulted in completing several important data deadlines by the end of 2005. A new Data Manager is to be hired in early 2006.

C. SUPPORT THE MARKETING, DEPLOYMENT, AND MAINTENANCE OF CMS APPROVED SOFTWARE (I.E., CROWN - CONSOLIDATED RENAL OPERATIONS IN A WEB-ENABLED NETWORK)

CMS and the ESRD Networks are working together to build an integrated ESRD information system known as CROWN. This information system will facilitate the collection and maintenance of information about the Medicare ESRD program, individuals with ESRD, and the services provided to them. CROWN implementation began in June 2002 and includes the Vital Information System to Improve Outcomes in Nephrology (VISION) software, SIMS, Central SIMS and REMIS. VISION allows data entry at the facility level which is sent to the Network via the QualityNet Exchange (QNet), a secure Internet website. The Networks import the VISION data received through QNet into SIMS. This data is replicated to the Central SIMS every night. Once the data is imported into the Network data system, it is reviewed by the CMS data system (REMIS) to determine if the patient is Medicare Eligible.

➤ VISION

The Network is responsible for determining which facilities are eligible to use the VISION software, to offer training, register them in QNet, and to assist facilities in the implementation of VISION. Large Dialysis Organizations submit data electronically to CMS and do not require the use of this software. VISION is to be used by independent or hospital owned ESRD providers that meet the specific IT requirements. A survey went out in the spring of 2005 to determine the VISION eligible providers and training classes were held in April and May.

CMS has set a goal by June 2006, 50% of VISION eligible facilities will be trained and 50% of the trained facilities will be transmitting data via VISION. The Network of New York has 141 facilities that are VISION eligible. The contractual goal for the Network is to have 70 facilities trained and 35 facilities reporting through VISION. At the end of 2005 there were 33 facilities trained and 3 facilities reporting via VISION.

v Status of VISION Goals

VISION Eligible Facilities	CMS Goal for Training as of June 30, 2006	CMS Goal for Data transmission as of June 30, 2006	# of Facilities trained as of December 31, 2005	# of Facilities transmitting data as of December 31, 2005
141	70	35	33	3

The electronically submitted forms are to be printed out by the facility to have the patient and physician sign the form in blue ink. The original printed form with signature is sent to the Social Security Office and a copy is put in the patient's records. The Network does not get a hard copy of this form. To validate signatures, annually the Network requests 3 percent of the forms submitted electronically be sent in to the Network to verify both the patient and physician signatures.

v VISION Signature Verification

a. Number of forms imported from VISION 2005	5
b. Total number of forms selected	1
c. Total number of forms received	5
d. Total percent of forms validated	100%

The electronic submission of data will improve the accuracy of the information, allow for prompt beneficiary coverage and will allow for better utilization of staff at both the Network and provider of level.

➤ Achieving Network Goals in Promoting CROWN

The Network of New York has had delays in meeting this goal due to technical difficulties in the early stages of the VISION software and due to the lack of a Data Manager in the 2nd half of 2005. To meet the June 2006 goal, a performance improvement plan was submitted to the CMS project officer for approval. This plan was accepted with retraining of providers that have expressed an interest to return to using VISION. A new Data Manager is to be hired in early 2006 will focus his responsibilities, with assistance from Network # 1, on training and implementation of VISION.

D. ESTABLISHING AND IMPROVING PARTNERSHIP AND COOPERATIVE ACTIVITIES. THESE ACTIVITIES MAY INCLUDE ESRD NETWORKS, QUALITY IMPROVEMENT ORGANIZATIONS (QIOs), STATE SURVEY AGENCIES, ESRD PROVIDERS/FACILITIES, MEDICARE + CHOICE (M+C) ORGANIZATIONS, ESRD FACILITY OWNERS, PROFESSIONAL GROUPS, AND PATIENT ORGANIZATIONS

➤ **Cooperative Activity with ANNA**

The Network Quality Improvement Coordinator (QIC) is the current chapter treasurer. She attends monthly educational committee meetings, now represents the Network in the Long Island Chapter. The committee developed a full day conference that was presented in November and included a one-hour presentation by the QIC titled “What To Do with the Challenging Patient.” The chapter also participates in planning the Network’s annual meeting scientific program and in processing its application for CEU’s.

➤ **Cooperative Activity with NYS DOH – Site Visit Evaluation Survey Tool**

The Network invited representatives of the NYS DOH to attend a MRB meeting in 2004 to discuss the State Survey Agency (SSA) survey process. As a result of the meeting, the DOH and Network agreed to develop a survey tool that would allow facilities to evaluate the site visit they just experienced. A draft of the tool was developed and reviewed by the MRB. The tool was approved as submitted. Plans are underway to distribute the tool to Medical Directors for review and comment in early 2006. State Surveyors will leave the tool with the facility after a site visit. Completed surveys will be returned to the Network office. Semiannually, the Network will provide the SSA with aggregate summary data. The SSA will use the data to identify educational opportunities for surveyors.

➤ **Cooperative Activity with State Survey Agencies – Clinical Scope of Practice Issues**

The first meeting of this coalition was held on December 15th in Troy, New York. Representatives from the Department of Health, State Education Department, ESRD Network, New York State Nurse’s Association, Union 1199, DaVita, and Fresenius were there. The group’s main focus was to review the Renal Dialysis Center Staffing Task Comparison Data. This was an in depth list of dialysis tasks prepared by the New York State Department of Health Bureau of Hospital and Primary Care Services in conjunction with the New York State Department of Education Office of the Professions, State Board for Nursing. The list identified what staff members could perform each task when they have received the appropriate training. The remainder of the meeting included discussion of a timeline for future activities and forming a Work Group to complete this work.

➤ **Cooperative Activity with NYC Office of Emergency Management (OEM)**

The Network PSC initiated contact with the NYC OEM to communicate the special needs of dialysis patients in city planning for response to the Asian Bird Flu Pandemic. A meeting with the NYC agencies involved in an emergency response, including the ESRD Network PSC, was conducted in January 2006.

➤ **Cooperative Activity with National Coalition for Disaster Preparedness**

The Network PSC communicated with Network 7 of Florida that this Network would participate in the national effort for disaster preparedness. A national meeting was conducted in Washington DC in January 2006.

➤ **Patient Advisory Committee (PAC) Activities**

Regional PAC representative meetings conducted by the PAC chairperson usually have a 30 to 50% turnout of all representatives in the region. The Network Patient Services Coordinator (PSC) and Vocational Rehabilitation Specialist (VRS) attend these meetings.

Review of the ESRD Network organization, its goals and purpose, and relationships with the Centers for Medicare & Medicaid Services (CMS), State Agency (SA), our dialysis facilities and transplant centers, and the importance of the Conditions for Participation provides insightful information to the representatives as does discussion and handouts of the Network Patient Referral, Transfer or Discharge Policy. There is a PAC manual that delineates roles, responsibilities and boundaries representatives are to follow that is sent to social workers at facilities that have representatives registered with the Network office, PAC chairpersons, and is mailed as part of the introductory packet for new representatives. Relevant sections of this manual are also reviewed at regional meetings with questions and answers that assist in clarifying representative activities. The Vocational Rehabilitation Specialist (VRS) presents current information and handouts on back-to-work incentives and tips and techniques in working with the state vocational rehabilitation program, Vocational and Educational Services for Individuals with Disabilities (VESID), and answers questions.

Often additional topics are part of a regional meeting such as Patient Safety Awareness. At the December Manhattan/Staten Island regional meeting, the chairs presented an idea for a Dialysis Day. Action plans were developed that carried into 2006.

PAC chairpersons provide ongoing support to their representatives to work on Goals for Representatives created by the chairs. These are:

- ▼ Educate consumers about treatment options but refrain from giving medical advice.
- ▼ Empower consumers to be involved in their healthcare emphasizing to KNOW YOUR NUMBERS!
- ▼ Promote exercise emphasizing to “check with your doctor first.”
- ▼ Encourage patients to seek counsel from their social workers.

- ▼ Integrate socializing with information pertinent to dialysis and chronic renal failure.
- ▼ Organize social events to promote a sense of community.

PAC chairpersons created their own goals as follow:

- ▼ Attend: quarterly conference calls and annual dinner.
- ▼ Patient Safety Initiative: Educate and involve representatives on patient safety awareness.
- ▼ PAC chairpersons' bios for units: Provide a photo and short bio with contact information to the Network for display in their units.
- ▼ Adopt-A-Unit: Encourage reps from near-by units to work together to improve resources for both units in education, recreation, and support keeping in mind respect for ownership differences between the units.
- ▼ Visiting units to recruit or initiate PAC representation: Chairs are to initiate contact through the Network office for the unit they would like to visit.

Events of 2005 PAC activities include:

- ▼ PAC efforts to enhance awareness of Patient Safety among consumers as discussed under the Patient Safety Awareness section of this report.
- ▼ PAC chairperson regional meetings of PAC representatives took place in the Bronx and Manhattan
- ▼ The Queens PAC chairperson responded to requests from two facilities to provide information on the ESRD Network and the PAC organization to patients
- ▼ Bronx PAC chairpersons and the Queens, Albany and Rochester chairs visited units without PAC representation to encourage and educate the social workers of the benefits of having a PAC and assisted in patient recruitment at some units
- ▼ Chairpersons held quarterly conference calls and an Annual Meeting to plan activities and discuss issues identified that concern them, their representatives, and patients.
- ▼ Two chairpersons were sponsored by the Network for one chair to attend the American Association of Kidney Patients (AAKP) and one chair to attend the Renal Support Network (RSN) patient educational conferences

➤ **Patient Safety Awareness**

A Bronx Patient Advisory Committee (PAC) chair wrote an article on the importance of patient awareness concerning patient safety that was the Profile article in the Winter 2005 issue of PAC Notes. This newsletter issue continues to be used as a handout as part of the educational campaign to promote patient safety awareness. Early in the year during PAC chair conference calls, chairs were encouraged to schedule regional meetings with their representatives to promote patient awareness and safety. Two unit meetings were conducted in Queens and regional meetings were held in the Bronx and Manhattan. The NW PSC and VRS attended the regional meetings. Discussions included the importance of knowing your lab values and being involved in your healthcare, not being afraid to ask questions, and reporting anything of concern to the nurse manager, social worker, or a PAC rep for assistance. In December, the Manhattan/Staten

Island chairs conducted their representatives meeting in which discussions on patient safety included concern that the annual emergency take-off procedure lesson should be taught to patients more often, especially in today's political-terrorist-disaster environment. Attendees stated they would communicate to their respective administrative teams this concern.

➤ Newsletters

The August 2005 issue of the Network professional newsletter, Network Notes, contained information promoting Medicare Prescription Drug Coverage, Employer Recognition Awards, the NKF of Greater New York Kidney Walk, a Downstate Medical Center in Brooklyn educational conference "Inner-City Nephrology" held in September, Fistula First website, Network 2005 Annual Meeting, Nonviolent Crisis Intervention one-day workshop, and the Home Dialysis Central website.

Articles included "Team Work Saves Accesses," written by a nephrology nurse from one of our upstate units and an introduction to Mount Sinai's Transplant Liaison who holds this new position at the Medical Center's kidney/pancreas transplant program. A list of Network technical assistance items available and a list of where to find Spanish Versions of informational brochures on several topics were included. Results from the Vocational Survey were reported as was the new address and contact information for the new Network offices the Network staff occupied in May.

The patient newsletter was produced and distributed in Winter-Spring and Fall 2005. Each issue contains legislative news from the National Kidney Foundation (NKF) Office of Scientific and Public Policy, a section called PAC News that reports on Patient Advisory Committee activities, the Poet's Corner: A Place for Prose where patients contribute content and Munchies Madness that contains renal recipes submitted by readers, or, renal nutritional information from the NKF or National Institute of Health (NIH). Each issue has a Profile (first page) article, Consumer Activity Report, ESRD related website listings, Consumer Information – for the savvy renal patient in the know, Advice for Patients As Consumers, and contact information for the Network Vocational Rehabilitation Specialist.

v Winter-Spring 2005

The Bronx PAC co-chairperson wrote the first quarter issue's Profile article on Patient Safety, which listed appropriate lab values for Phosphorous, Potassium, Albumin, Calcium, Parathyroid hormone (P.T.H), Kt/V and URR, and cholesterol with reasons why each is so important.

The Consumer Activity Report announced a PAC Notes reader Fistula Award contest for the patient with the oldest working fistula and information on the NKF of Greater New York emergency grant program and free medical identification jewelry program.

The Consumer Information section contained an article written by the Network Quality Improvement Director (QID) entitled, "'Fistula First – What's It All About And Why Should You Care?" This article contained the 5 good reasons to consider an A-V Fistula, definitions

with graphics of a fistula, graft, and catheter, and information on venous stenosis, clotting, infection, pseudo-aneurysm, large vessel stenosis and access life expectancy.

An article written by a patient entitled, “Kidney Transplant – An Experience,” was about the experiences of a patient who was diagnosed at age 11 with Lupus. Since the age of 17, she had been on peritoneal dialysis, hemodialysis and was now on her third transplant. Her story is uplifting and encouraging for all patients.

An article about a patient on Nocturnal Home Hemodialysis and his experiences provided insight on aspects of this relatively new treatment modality.

Advice for Patients As Consumers provided suggestions on coping with sodium amounts in food and ways to maintain low sodium dietary intake.

Munchies Madness announced the recipe contest winner from the contest announced in the precious issue of PAC Notes. Her recipe submission, from the American Diabetes Association, was included.

Additionally, a transplant center’s contact information to complete a listing of statewide transplant centers was provided. Contact information was also provided for the Renegel REACH Program sponsored by Genzyme Corporation, which is a drug card discount program for Renegel that helps control phosphorous levels.

v Fall 2005

The Profile article for this issue reported on “What is a PAC Rep?” and answered this question by describing a PAC representative to be a patient who is adherent to treatment, has a cooperative attitude, and has a concern for quality of care issues. A report on PAC roles and responsibilities and examples of PAC representative activities was included.

The PAC News section in this issue presented the Network’s PAC chairpersons with a paragraph about each one’s focus on improving quality of patient care.

The Consumer Activity Report presented the winner of the PAC Notes reader “Do you think you have had a fistula longer than anyone else in the Network?” contest. The patient has a working fistula since August 1974. Information on the NKF of Greater New York and the Kidney & Urology Foundation of America Support Walks was provided.

The Consumer Information section provided information on Medicare’s new prescription drug benefit and contact information for beneficiaries with questions and an article about “African Americans and Kidney Disease,” based on an educational initiative of the National Institute of Health (NIH).

The Munchies Madness section of this issue provided information from an NKF pamphlet on getting the right amount of calories while the Advice for Patients As Consumers feature

encouraged readers to seek their dialysis center's dietitian for answers to their renal dietary questions.

➤ **Website**

The Network maintains a website, www.esrdny.org, with sections on Information for Professionals, a special section on Fistula First, Information for Patients, Vocational Rehabilitation, Grievance Procedures, Patient Safety, the Network Annual Report, an archive of newsletters, and a Contact Us link. Included is a search engine that provides a choice of searching the site or the World Wide Web. Direct links predominately displayed on the homepage include topics on Fistula First, Influenza Pandemic Information, and Katrina: Emergency Dialysis Information.

➤ **Forum of ESRD Networks**

The Forum of ESRD Networks is a national non-profit organization that represents all 18 Networks regarding QI ESRD activities at the national level, and policy issues. Dr. Martin Neff, from this Network, serves on the Forum Board.

➤ **Council of Nephrology Social Workers**

Network Patient Services Coordinator (PSC) and the Quality Improvement Director (QID) provided a 90-minute presentation to 54 social workers at the November meeting. The PowerPoint presentation and printed materials included a brief history of the ESRD Networks and the relationship with Centers for Medicare & Medicaid Services (CMS), State Agency (SA), our facilities and the importance of the Conditions for Participation, following Network goals, information on the Network committees with special emphasis on the PAC and the CMS goal of patient-centered care. Review of the DPC toolkit to encourage social workers to assist in staff training and of case studies of Network response to provider calls in an effort to improve awareness in addressing challenging patient situations was a part of the presentation. Included was information on Network in-services and the one-day workshop offered to assist staff in addressing conflict. Handouts included the Network function in disaster preparedness, a directory of New York nursing homes that accept dialysis patients, a Patient Pocket Guide to ESRD Resources, a PAC representative registration form, the facility complaint/grievance procedure, and the Network's patient referral, transfer or discharge policy.

➤ **Vocational Rehabilitation (VR) Specialist Activities**

Two hundred sixteen (216) patients contacted the VR Specialist in 2005 and received individualized vocational counseling on work related issues, such as problems on the job, new career options, how to obtain training, concerns about loss of benefits, returning to work, job seeking skills, such as preparing resumes, job interviews, and disclosure of disability.

Seventy-four (74) social workers were given information to help their patients deal with vocational concerns. Their inquiries included requests for advice on working with VESID, on

the Americans with Disabilities Act, Social Security work incentives and income allowances, trial work period, available medical coverage and other patient concerns.

One hundred eighty-three (183) packets of relevant material were mailed to individuals who had called requesting specific information.

Seventeen (17) site visits and group presentations attended by 292 professional staff and patients increased awareness of the services provided by the VR Specialist and encouraged staff to assess the vocational potential of their patients.

The VR Specialist arranged 4 training programs on the special needs of ESRD patients to District Offices of VESID, New York State's VR agency for people with disabilities. Training was provided to 142 professional staff members at the Manhattan, Albany, Rochester and Buffalo District Offices

Follow-up surveys completed by patients six months after they received information and assistance showed the following results:

- ▼ 23% applied for VR training
- ▼ 18% began a VR training program
- ▼ 18% retained their job
- ▼ 5% found a new job
- ▼ 22% decided not to pursue VR goals at this time

▼ Patient Characteristics and Utilization of Rehabilitative Services

In a series of five graphs, we present key characteristics of the dialysis and transplant patients that have contacted the VR Specialist since November 2000; the date shortly after Network 2 began this vocational rehabilitation project. In all, 802* patients contacted the VR Specialist between November 2000 and September 2005.

As the reader will see, the composition of the 802 patients is similar over time. Men have been slightly more likely than women to have contacted the VR Specialist; 80% of the patients are on dialysis, 17% are transplants and the remainder are pre-ESRD patients; most live in one of the five boroughs of New York City; they have worked in the past; and they are interested in becoming employed again (or retaining their present job) or beginning a job training program.

* The total number of 802 fluctuates slightly from graph to graph because of missing data on one or another variable.

Figure 1. Men and Women Are about Equally Likely to Contact the VR Specialist. (Nov 2000 – Sept 2005)

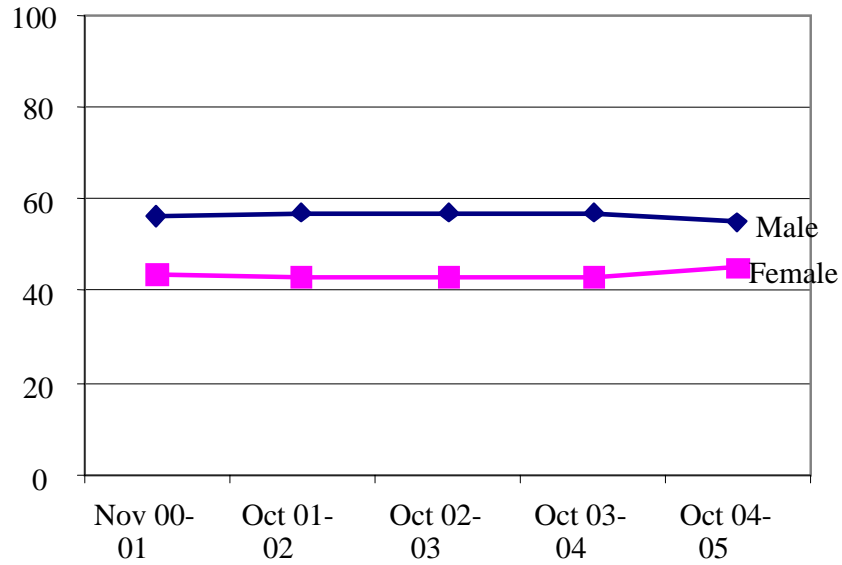


Figure 2. Most Patients Live in One of the Five Boroughs of New York City. (Nov 2000 – Sept 2005)

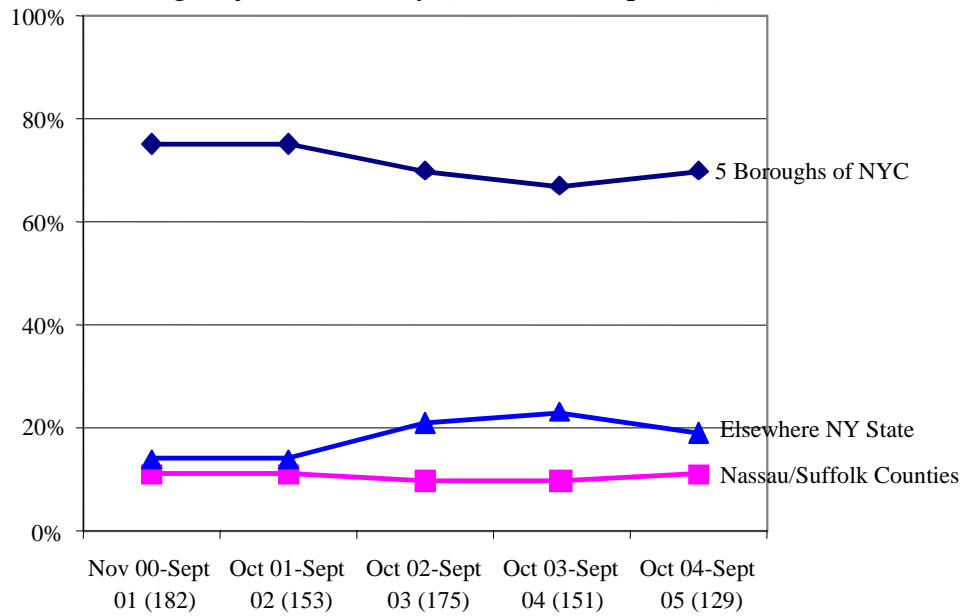


Figure 3. Most Patients Are Not Working When They Contact the VR Specialist, but They Have in the Past. (Nov 2000 – Sept 2005)

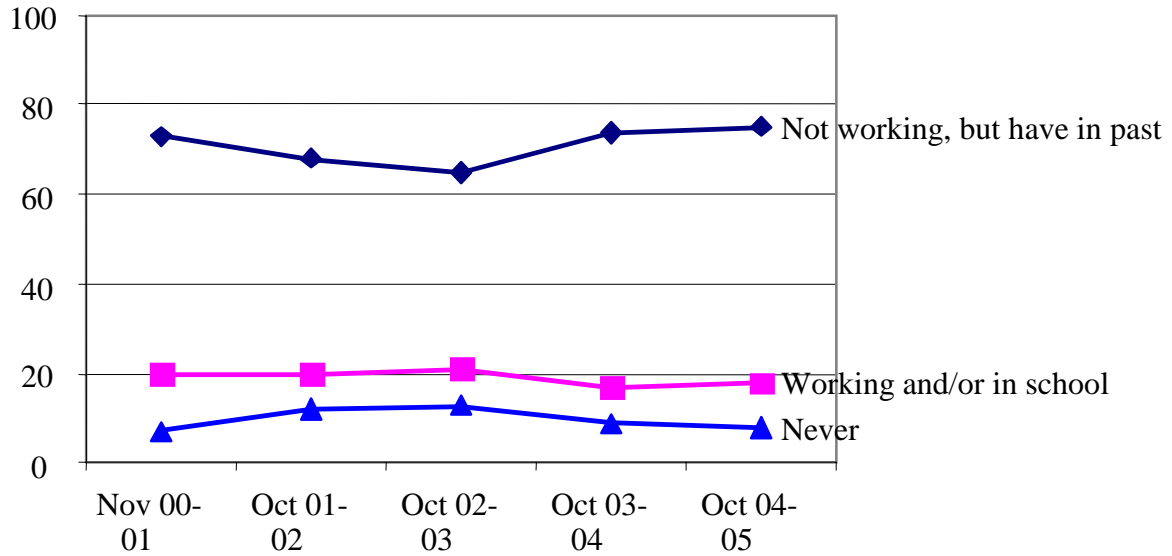


Figure 4. The Work Category for Most Patients Is Semi-Professional/Skilled or Professional/Executive. (Nov 2000 – Sept 2005)

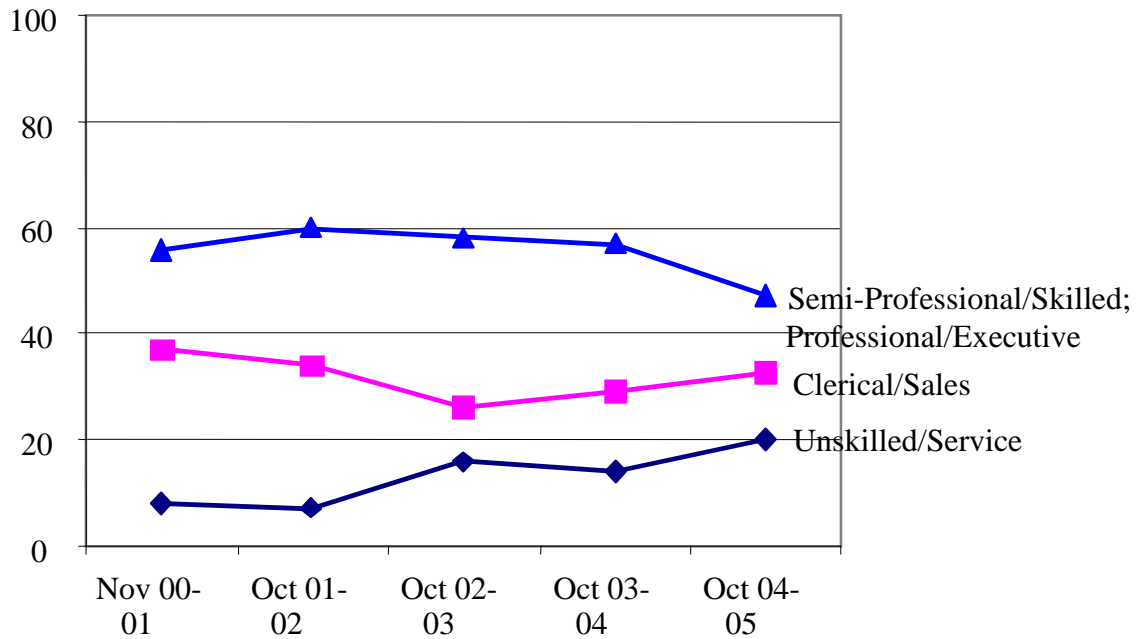
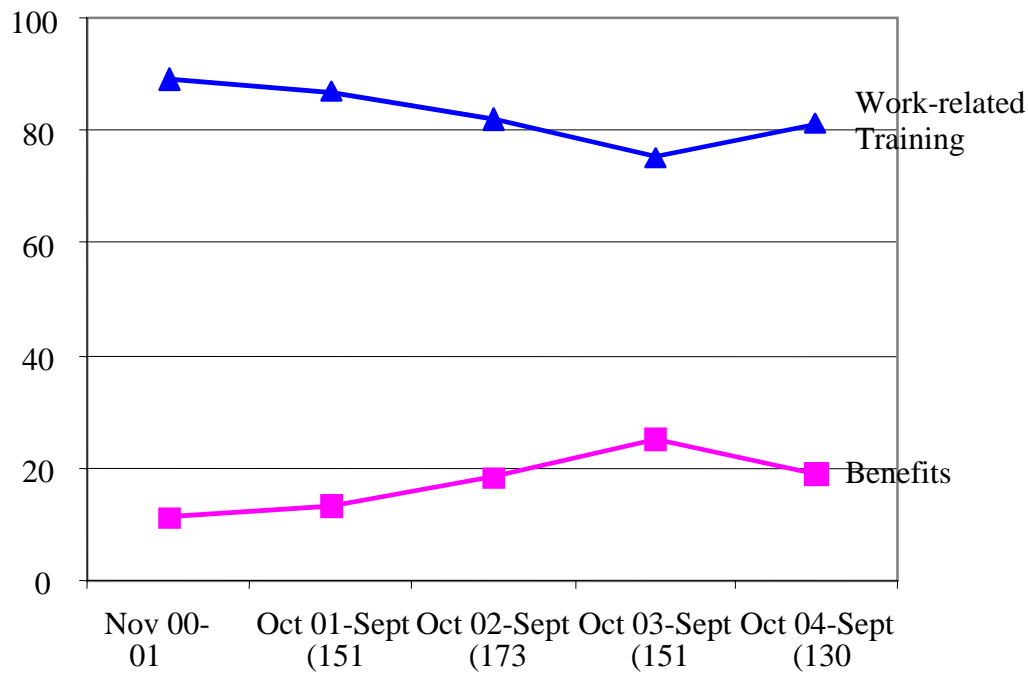


Figure 5. Main Reason Patients Contact the VR Specialist to Talk about Work or Job Training. (Nov 2000 – Sept 2005)



v Employer Recognition Awards

A program to honor employers who hire and offer support to workers with chronic kidney disease was established in 2003. Information on the program is at www.esrdny.org and included in Network newsletters for patients and professionals. Letters and posters describing the program were sent to dialysis and transplant units.

Nominations have been received from workers in unskilled occupations as well as those in professional capacities. A total of 8 employers were honored at Network Council meetings during the year.

v Rehabilitation Committee Activities

The committee met in March and September. Agenda items included review and approval of Network goals for rehabilitation, discussion of VR Specialist activity reports and ways to improve service delivery, facility specific employment rates and interventions to improve low employment rates and ways to increase the number of ESRD patients who exercise on a regular basis. Representatives from VESID attended the meetings and offered their recommendations for educating counselors in VESID district offices.

v Facility Specific Employment Data

The Network sent facility specific reports to medical directors in August comparing their patient employment rates with that of the Network, other units in the same region and other units of similar size. Medical Directors with low employment rates were asked to review their rates with their quality improvement team.

➤ Achieving Goals in Collaborations

The Network's cooperative activities have strengthened the Network relationships with organizations within and without our renal community. Ongoing efforts to strengthen the renal community response to disasters have helped to increase awareness of these issues within facilities. Other cooperative activities have addressed improving the quality of care delivered to our beneficiaries.

The educational programs and materials provided to facilities through these Network programs and the Patient Advisory Committee activities have assisted facilities to better understand and more effectively respond to patient behavior providing an improved patient experience in the dialysis environment. The Patient Advisory Committee (PAC) chairpersons and representatives educational materials has assisted in increasing patient focus on the consumers need to be a partner in maintaining their health and maximizing the safety of their care through their awareness and involvement.

CMS's goal of improving quality of life was met by improving patient access to vocational rehabilitation, providing examples of how employers helped patients maintain their employment, and encouraging providers to use a QI approach to improve employment rates. The impact on the ESRD population was to promote vocational rehabilitation to enhance quality of life for dialysis patients.

E. EVALUATING AND RESOLVING PATIENT GRIEVANCES AS CATEGORIZED IN THE STANDARD INFORMATION MANAGEMENT SYSTEMS (SIMS)

In 2005, the Network established written procedures and policies to clearly define Network processing of complaints and grievances. The intake of complaints/grievances is processed as informal, formal or referral. The Network staff works with involved parties to achieve a workable solution for an informal intake. This process does not require a formal written report by the complainant/grievant. A formal grievance involves a CMS-specific investigation process, a grievance determination, due process for involved parties, and a final written report. Medical Review Board or Grievance Committee determinations may be required. Specific steps to achieve these determinations are documented in the written policy. Referral occurs when the appropriate agency or entity's authority would be more appropriately handled by that entity for the issue involved. In addition, the filing and handling of documentation has written procedures to delineate secure processing and storage to maintain anonymity.

There were 24 beneficiary complaints that were resolved informally. Three beneficiary complaints were referred to agencies or entities with authority to appropriately address the issue. One was referred to CMS Region 2 office and two were referred to State Agency (SA). One formal grievance was received by the Network and was referred to SA who has authority to respond to the issue. There were no complaints or grievances that remained open or unresolved and none left under investigation.

➤ Dealing with the Challenging Patient

After the shooting in 2005 of a staff member in a dialysis center, the Long Island Chapter of ANNA asked the Network to give a presentation on dealing with the disruptive/abusive patient. The shooting emphasized the need in the community to train and empower staff in handling patients whose disruptive behavior can escalate to violent behavior.

The presentation included recommended techniques for dealing with such patients, including behavior modification, interdisciplinary meetings, and behavior agreements. Also reviewed was the need to document each episode and to include the Network in the process for discharging those patients whose violent behavior is out of control. Network resources (DPC tool kit, In-services, Policy Statement on Patient Referral, Transfer or Discharge, and web site) were reviewed.

The 1-hour presentation was part of an all day CEU approved conference attended by 138 nurses at the Long Island Marriot in Uniondale. Overall evaluation for this presentation was 4.77 based on 5 point Likert scale (5=excellent).

➤ **Technical Assistance**

A notable trend in the type of calls received by the Network are from facility staff for technical assistance on topics that include abusive, disruptive and threatening behaviors from their patients, discharge procedures and if discharge is applicable, and non-payment issues.

Complaints to the Network from beneficiaries have declined significantly.

The Network staff observes this trend as being attributed to the development of the Network Patient Referral Policy, which was revised in 2003 to clarify and strengthen transfer/discharge procedures, distributed to providers and presented at Network Council meetings with resultant increasing adherence by providers. One of the intents of the updated policy was to hold accountable providers who discharge patients without due process and to protect patient rights.

In addition, NW staff provides facility onsite in-services in which facility staff group exploration of the patient experience of the dialysis lifestyle is reviewed along with professional behavior expectations and a chart that links typical dialysis patient experiences to mental states and related behaviors. A follow-up in-service on crisis prevention techniques was launched in April. A 1-day crisis prevention workshop is offered twice a year for facilities to send their staff for training. The transfer/discharge policy is frequently faxed to providers as a reference tool to guide their obligations to their patients and is reviewed at Network and other professional meetings that include Network staff presentations. It is believed the totality of these proactive efforts have impacted the type of calls received by NW staff by minimizing patient complaints and maximizing awareness and adherence to the Network transfer/discharge policy lessening involuntary discharges.

In cases where facilities are requesting guidance in discharging a pt when it was not warranted, Network staff provided detailed assistance to the unit in addressing issues that led to considering such action. This Network intervention based on Network policy, federal regulations and professional experience has prevented patient involuntary discharge from maintenance treatment in most cases.

The year has also shown an increase in facility calls requesting technical assistance with managing patients with mental health issues or illnesses, which the facility has great difficulty in attempting to resolve due to lack of resources and adequately trained personnel. NW professional staff has assisted facility staff in appropriately addressing these issues.

➤ **Decreasing Dialysis Patient-Provider Conflict (DPC)**

An additional tool to the Network educational programs to assist facility staff to understand and respond more effectively to patient challenging behavior is the Centers for Medicare & Medicaid Services (CMS) and The ESRD Networks Forum sponsored “Decreasing Dialysis Patient-Provider Conflict” (DPC) toolkit. Supplied to all Networks, this facility level toolkit to assist unit administration in training their staff was distributed to Nurse Managers in August. Review of the toolkit contents and the importance and benefit of utilizing it was conducted at Network providers, nurses, and social workers meetings, and in the Network’s crisis prevention trainings

and notices in the professional newsletter. Network efforts to establish the DPC toolkit as part of facility-level staff training is on going.

➤ **Information Packet on Depression**

The Network distributed to all social workers depression assessment materials. Reports from Rochester area social workers who utilized the depression resource packet mailed to providers in November of 2004 have shown patient improvement in assessment scores after intervention provided by the social workers. This topic on depression management will be explored further by the Network in 2006.

➤ **Achieving Goals to Address Patient Grievances**

Extensive work has been done this year in the area of prevention of discharges, due to abusive behavior. Training sessions, the DPC toolkit, provider level sensitivity training about diverse cultures, and presentations on the impact of chronic disease (depression) have been well received by the provider community.

This year the entire internal Network process for intake and documentation of grievances was rewritten to allow for better assessment and follow-ups.

IV. SANCTION RECOMMENDATIONS

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

No sanctions were recommended to CMS regarding any ESRD provider in this Network in 2005.

V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES

The Network of New York has a high proportion of hospital based and independent, freestanding providers. This is due in part to existing licensure requirements by the state of New York, and the Certificate of Need review criteria. The Health Department has informed the Network of their interest in revisiting these requirements in light of the changes that are taking place throughout the healthcare delivery systems. They are eager to have Network advice.

There is a growing concern of coordination of care for dialysis patients in nursing homes. In 2006, this Network will conduct a needs assessment on this topic, and will utilize the recommendations offered in the report submitted to CMS by Network 9/10.

VI. DATA TABLES

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

Table 1: ESRD Incidence

Table 2: ESRD Dialysis Prevalence

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

Table 4: Dialysis Modality by In-Center Settings

Table 5: Renal Transplants by State

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

Table 7: Dialysis Deaths

Table 8: Vocational Rehabilitation

TABLE 1: ESRD INCIDENCE

NEWLY DIAGNOSED CHRONIC ESRD PATIENTS (ESRD INCIDENCE)

NEWLY DIAGNOSED CHRONIC ESRD PATIENTS BY STATE OF RESIDENCE,
AGE, RACE, GENDER, AND PRIMARY DIAGNOSIS FOR CALENDAR YEAR 2005

AGE	NY	OTHER*	TOTAL
00-04	17	1	18
05-09	2	0	2
10-14	12	0	12
15-19	43	2	45
20-24	49	2	51
25-29	103	3	106
30-34	130	3	133
35-39	196	4	200
40-44	293	3	296
45-49	423	10	433
50-54	532	6	538
55-59	732	12	744
60-64	759	8	767
65-69	738	10	748
70-74	793	11	804
75-79	832	9	841
80-84	712	10	722
>=85	569	4	573
Missing	0	0	0
Total	6,935	98	7,033

TABLE 1 CONTINUED

NEWLY DIAGNOSED CHRONIC ESRD PATIENTS (ESRD INCIDENCE)

NEWLY DIAGNOSED CHRONIC ESRD PATIENTS BY STATE OF RESIDENCE,
AGE, RACE, GENDER, AND PRIMARY DIAGNOSIS FOR CALENDAR YEAR 2005

RACE	NY	OTHER*	TOTAL
American Indian/ Alaska Native	30	0	30
Asian	284	4	288
Black or African American	2,139	20	2,159
More than one race selected	26	0	26
Native Hawaiian or Other Pacific Islander	26	0	26
White	4,175	64	4,239
Missing	255	10	265
Total	6,935	98	7,033

GENDER	NY	OTHER*	TOTAL
Female	3,001	30	3,031
Male	3,934	68	4,002
Missing	0	0	0
Total	6,935	98	7,033

DIAGNOSIS	NY	OTHER*	TOTAL
Cystic Kidney	173	4	177
Diabetes	2,782	21	2,803
Glomerulonephritis	542	13	555
Hypertension	1,562	18	1,580
Other	969	23	992
Other Urologic	138	2	140
Missing	143	7	150
Unknown	626	10	636
Total	6,935	98	7,033

Source of information: Network SIMS Database

Date of Preparation: June 2006

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

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

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

This table includes 65 patients with transplant therapy as an initial treatment.

This table includes 115 patients receiving treatment at VA facilities.

TABLE 2: ESRD DIALYSIS PREVALENCE

LIVING ESRD DIALYSIS PATIENTS

ALL ACTIVE ESRD DIALYSIS PATIENTS BY STATE OF RESIDENCE, AGE, RACE, GENDER,
AND PRIMARY DIAGNOSIS AS OF DECEMBER 31, 2005

AGE	NY	OTHER*	TOTAL
00-04	17	1	18
05-09	12	0	12
10-14	18	0	18
15-19	79	0	79
20-24	171	1	172
25-29	345	2	347
30-34	513	10	523
35-39	857	16	873
40-44	1,245	14	1,259
45-49	1,660	33	1,693
50-54	2,135	24	2,159
55-59	2,531	26	2,557
60-64	2,566	25	2,591
65-69	2,660	20	2,680
70-74	2,481	32	2,513
75-79	2,271	21	2,292
80-84	1,767	18	1,785
>=85	1,182	16	1,198
Missing	0	0	0
Total	22,510	259	22,769

TABLE 2 CONTINUED

LIVING ESRD DIALYSIS PATIENTS

ALL ACTIVE ESRD DIALYSIS PATIENTS BY STATE OF RESIDENCE, AGE, RACE, GENDER,
AND PRIMARY DIAGNOSIS AS OF DECEMBER 31, 2005

RACE	NY	OTHER*	TOTAL
American Indian/ Alaska Native	289	0	289
Asian	1,094	19	1,113
Black or African American	9,230	78	9,308
More than one race selected	59	10	69
Native Hawaiian or Other Pacific Islander	77	0	77
White	11,663	150	11,813
Missing	98	2	100
Total	22,510	259	22,769

GENDER	NY	OTHER*	TOTAL
Female	9,874	93	9,967
Male	12,636	166	12,802
Missing	0	0	0
Total	22,510	259	22,769

DIAGNOSIS	NY	OTHER*	TOTAL
Cystic Kidney	679	13	692
Diabetes	8,834	95	8,929
Glomerulonephritis	2,766	36	2,802
Hypertension	5,490	61	5,551
Other	2,440	30	2,470
Other Urologic	464	1	465
Missing	71	2	73
Unknown	1,766	21	1,787
Total	22,510	259	22,769

Source of information: Network SIMS Database

Date of Preparation: June 2006

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

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

* Patients residing outside Network area or of unknown residence, however, patients received dialysis in this Network.

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

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

TABLE 3: DIALYSIS MODALITY - HOME

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
 SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
ALBANY	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
330013	0	0	2	0	2	2	0	0	4	2
330079	0	0	0	0	0	0	0	0	0	0
33009F	0	0	0	0	0	0	0	0	0	0
330191	0	0	5	4	7	5	0	0	12	9
330250	0	0	7	9	0	0	0	0	7	9
332523	0	0	1	2	5	3	0	0	6	5
332532	0	0	1	1	11	7	0	0	12	8
332544	0	0	0	0	0	0	0	0	0	0
332557	32	31	3	3	5	7	0	0	40	41
332562	0	0	0	4	0	0	0	0	0	4
332569	1	0	5	5	14	18	0	0	20	23
332586	0	0	0	1	11	6	0	0	11	7
332632	0	0	2	3	2	7	0	0	4	10
332641	0	0	0	0	0	0	0	0	0	0
333512^	0	0	0	0	0	0	0	0	0	0
333518	0	0	0	0	0	0	0	0	0	0
333523	0	0	0	0	0	0	0	0	0	0
333531	0	2	0	0	0	0	0	0	0	2
TOTAL	33	33	26	32	57	55	0	0	116	120

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
BRONX	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
330009^	0	0	0	0	0	0	0	0	0	0
330059	0	0	2	2	4	3	0	0	6	5
330072	0	0	0	0	0	0	0	0	0	0
330080	0	0	0	0	0	0	0	0	0	0
33016F	0	1	3	0	4	4	0	0	7	5
332009	0	0	7	7	5	5	0	0	12	12
332506	0	0	0	0	0	0	0	0	0	0
332563	0	0	0	0	0	0	0	0	0	0
332565	0	0	0	0	0	0	0	0	0	0
332576	0	0	0	0	0	0	0	0	0	0
332582	0	0	0	0	3	0	0	0	3	0
332588	0	0	9	15	2	3	0	0	11	18
332590	0	0	0	0	0	0	0	0	0	0
332611^	0	0	0	0	0	0	0	0	0	0
332612	0	0	7	7	3	3	0	0	10	10
332613	0	0	11	10	6	6	0	0	17	16
332619	0	0	0	0	0	0	0	0	0	0
332624	0	0	0	0	0	0	0	0	0	0
332640	0	0	0	0	0	0	0	0	0	0
332642	0	0	0	0	0	0	0	1	0	1
332645	0	0	0	0	0	0	0	0	0	0
332648#	0	0	0	0	0	0	0	0	0	0
TOTAL	0	1	39	41	27	24	0	1	66	67

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
BUFFALO	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
330005	1	1	6	7	5	9	0	0	12	17
330053	0	0	0	0	0	0	0	0	0	0
330103	0	0	0	0	0	0	0	0	0	0
33012F	0	0	1	2	1	0	0	0	2	2
330219	0	0	0	0	0	0	0	0	0	0
330229	0	0	2	1	0	0	0	0	2	1
330239	0	0	3	1	25	25	0	0	28	26
332510	0	0	0	0	0	0	0	0	0	0
332537	0	0	0	0	0	0	0	0	0	0
332548	0	0	0	0	0	0	0	0	0	0
332549	1	3	2	1	1	0	0	0	4	4
332551	0	0	24	28	1	3	0	0	25	31
332554	0	0	0	0	0	0	0	0	0	0
332597	0	0	0	0	0	0	0	0	0	0
332600	0	0	9	9	7	6	0	0	16	15
332608	0	0	2	6	4	5	0	0	6	11
332649#	0	0	0	2	0	9	0	0	0	11
333300	0	0	0	0	6	4	0	0	6	4
333516	0	0	1	0	12	0	0	0	13	0
333526	0	0	0	0	0	0	0	0	0	0
TOTAL	2	4	50	57	62	61	0	0	114	122

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
HUDSON VALLEY										
330004	0	0	4	0	3	5	0	0	7	5
330006	0	0	2	1	4	3	0	0	6	4
330158	0	0	4	3	6	1	0	0	10	4
330209	0	0	28	24	4	6	0	0	32	30
330273	0	0	0	0	0	0	0	0	0	0
332504	0	0	0	0	0	0	0	0	0	0
332538	0	0	0	0	0	0	0	0	0	0
332539	0	0	0	0	0	0	0	0	0	0
332546	0	0	0	0	0	0	0	0	0	0
332559	0	0	0	0	0	0	0	0	0	0
332571	0	0	0	0	0	0	0	0	0	0
332572	0	0	1	1	0	0	0	0	1	1
332574	0	0	0	0	0	0	0	0	0	0
332599	0	0	0	0	0	0	0	0	0	0
332601	0	0	0	0	0	0	0	0	0	0
332602	0	0	0	0	0	0	0	0	0	0
332606	0	0	0	0	0	0	0	0	0	0
332609	0	0	0	0	0	0	0	0	0	0
332614	0	0	0	0	0	0	0	0	0	0
332616	0	0	0	0	0	0	0	0	0	0
332617	2	2	6	3	8	11	0	0	16	16
332633	0	0	9	6	23	25	0	0	32	31
332651#	0	0	0	0	0	0	0	0	0	0
333534	0	0	0	0	2	2	0	0	2	2
TOTAL	2	2	54	38	50	53	0	0	106	93

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
KINGS	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
330056	0	0	4	1	4	6	0	0	8	7
330152	0	0	0	0	0	0	0	0	0	0
330194	0	0	0	0	0	0	0	0	0	0
330196	0	0	0	0	0	0	0	0	0	0
330201	0	0	0	0	0	0	0	0	0	0
330202	0	0	0	0	0	0	0	0	0	0
33020F	0	0	0	0	0	0	0	0	0	0
330233	0	0	0	0	0	0	0	0	0	0
330306^	0	0	0	0	0	0	0	0	0	0
330396	0	0	0	0	0	0	0	0	0	0
330397	0	0	0	0	0	0	0	0	0	0
332512	0	0	0	0	0	0	0	0	0	0
332516	0	0	1	2	2	1	0	0	3	3
332522	0	0	1	2	3	5	0	0	4	7
332533	4	0	0	0	0	0	0	0	4	0
332534	0	0	0	0	0	0	0	0	0	0
332535	0	0	0	0	0	0	0	0	0	0
332556	0	0	0	0	0	0	0	0	0	0
332560	0	0	7	3	0	0	0	0	7	3
332561	0	0	0	0	0	0	0	0	0	0
332566	0	0	0	0	0	0	0	0	0	0
332577	0	0	0	0	0	0	0	0	0	0
332578	0	0	0	0	0	0	0	0	0	0
332579	0	0	13	9	16	13	0	0	29	22
332581	0	0	3	3	0	0	0	0	3	3
332596	0	0	0	0	0	0	0	0	0	0
332598	0	0	0	0	0	0	0	0	0	0
332604	0	0	0	0	0	0	0	0	0	0

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
KINGS	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
332622	0	0	0	0	0	0	0	0	0	0
332635	0	0	0	0	0	0	0	0	0	0
332636	0	0	0	0	0	0	0	0	0	0
332637	0	0	0	0	0	0	0	0	0	0
332644	0	0	0	0	0	0	0	0	0	0
332646#	0	0	0	0	0	0	0	0	0	0
333515	0	0	0	0	0	0	0	0	0	0
333544	6	6	9	6	5	13	0	0	20	25
TOTAL	10	6	38	26	30	38	0	0	78	70

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
NASSAU	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
330027	0	0	1	1	10	8	0	0	11	9
330106	3	3	6	8	18	18	0	0	27	29
330167	0	0	15	17	4	0	0	0	19	17
330195	0	0	0	0	0	0	0	0	0	0
330198	0	0	0	0	0	0	0	0	0	0
332521	0	0	0	0	0	0	0	0	0	0
332529	0	0	0	0	0	0	0	0	0	0
332552	0	0	0	0	0	0	0	0	0	0
332558	0	0	0	0	1	0	0	0	1	0
332591	0	0	0	0	0	0	0	0	0	0
332592	0	0	0	0	0	0	0	0	0	0
332605	0	0	0	0	0	0	0	0	0	0
332607	0	0	0	0	0	0	0	0	0	0
332610	0	0	0	0	0	0	0	0	0	0
332620	0	0	3	3	0	0	0	0	3	3
332634	0	0	0	0	0	0	0	0	0	0
333522	0	0	0	0	0	0	0	0	0	0
333535	0	0	0	0	0	0	0	0	0	0

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
NASSAU	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
333538	0	0	0	0	0	0	0	0	0	0
333543	0	1	0	0	0	0	0	0	0	1
TOTAL	3	4	25	29	33	26	0	0	61	59

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
NEW YORK	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
330012	0	0	0	0	0	0	0	0	0	0
330024	1	0	16	13	17	18	0	0	34	31
330046	0	0	0	0	0	0	0	0	0	0
330064	0	0	0	0	0	0	0	0	0	0
330101	0	0	0	0	0	0	0	0	0	0
330119	0	0	0	0	0	0	0	0	0	0
330169	0	0	0	0	0	0	0	0	0	0
33017F	0	0	1	0	0	0	0	0	1	0
330199	0	0	2	0	6	2	0	0	8	2
330204	0	0	9	9	12	11	1	1	22	21
330214	0	0	0	0	0	0	0	0	0	0
330230	0	0	0	0	0	0	0	0	0	0
330240	0	0	0	0	0	0	0	0	0	0
330290	0	0	0	0	0	0	0	0	0	0
332514	0	0	0	0	0	0	0	0	0	0
332520	25	28	22	24	25	14	0	0	72	66
332524	0	0	0	0	0	0	0	0	0	0
332528	0	0	6	4	5	6	0	0	11	10
332530	0	0	0	0	0	0	0	0	0	0
332542	0	0	1	2	3	3	0	0	4	5

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
NEW YORK										
332543	0	0	0	0	0	0	0	0	0	0
332564	0	0	0	0	0	0	0	0	0	0
332593	0	0	5	4	4	2	0	0	9	6
332621	0	0	14	12	20	15	0	0	34	27
332623	0	0	0	0	0	0	0	0	0	0
333506	0	0	0	0	0	0	0	0	0	0
333511	0	0	0	0	0	0	0	0	0	0
333524	0	0	1	1	6	4	0	0	7	5
333539	0	0	5	5	1	0	0	0	6	5
TOTAL	26	28	82	74	99	75	1	1	208	178

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
QUEENS										
330055	0	0	0	0	0	0	0	0	0	0
330128	0	0	3	0	1	0	0	0	4	0
330193	0	0	2	3	1	2	0	0	3	5
330231	0	0	0	0	0	0	0	0	0	0
330357	0	0	15	14	4	4	0	0	19	18
330395	0	0	0	0	0	0	0	0	0	0
332508	0	0	31	31	16	12	0	0	47	43
332517	0	0	0	0	0	0	0	0	0	0
332519	0	0	0	0	0	0	0	0	0	0
332531	0	0	0	0	0	0	0	0	0	0
332541	0	0	6	1	0	0	0	0	6	1
332547	0	0	0	0	0	0	0	0	0	0
332568	0	0	0	0	0	0	0	0	0	0

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
QUEENS	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
332583	0	0	0	0	0	0	0	0	0	0
332589	0	0	1	2	0	1	0	0	1	3
332594	1	1	1	0	0	0	0	0	2	1
332595	0	0	0	0	0	0	0	0	0	0
332603	0	0	0	0	0	0	0	0	0	0
332618	0	0	0	0	0	0	0	0	0	0
332639	0	0	0	0	0	0	0	0	0	0
332647#	0	0	0	0	0	0	0	0	0	0
332650#	0	0	0	0	0	0	0	0	0	0
333503	10	9	1	0	0	0	0	0	11	9
TOTAL	11	10	60	51	22	19	0	0	93	80

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
RICHMOND	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
332511	0	0	5	2	4	5	0	0	9	7
332525	0	0	5	4	0	0	0	0	5	4
332567	0	0	0	0	1	0	0	0	1	0
332625	1	1	0	0	0	0	0	0	1	1
332638	0	0	0	0	0	0	0	0	0	0
TOTAL	1	1	10	6	5	5	0	0	16	12

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
330058	0	0	1	2	5	4	0	0	6	6
330090	0	0	2	2	23	28	0	0	25	30
330125	0	0	12	5	49	52	0	0	61	57
330151	0	0	0	0	5	9	0	0	5	9
330226	0	0	9	12	10	9	0	0	19	21
330275	0	0	0	0	0	0	0	0	0	0
332585	2	0	0	0	0	0	0	0	2	0
332626	0	0	0	0	0	0	0	0	0	0
332627	1	0	19	19	31	31	0	0	51	50
332628	0	0	0	0	0	0	0	0	0	0
332629	0	0	0	0	1	1	0	0	1	1
332630	0	0	0	0	0	0	0	0	0	0
332631	0	0	0	0	0	0	0	0	0	0
333532	0	0	0	0	0	0	0	0	0	0
TOTAL	3	0	43	40	124	134	0	0	170	174

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
SUFFOLK	0	0	0	1	0	0	0	0	0	1
330045	0	0	0	1	0	0	0	0	0	1
330107	0	0	2	1	9	10	0	0	11	11
330141	0	0	0	0	0	0	0	0	0	0
33019F	0	0	0	1	0	0	0	0	0	1
330286	0	0	0	0	0	0	0	0	0	0
330401	1	0	4	2	4	6	0	0	9	8
332513	0	0	4	3	16	14	0	0	20	17
332518	0	0	5	2	4	3	0	0	9	5
332555	0	0	0	0	0	0	0	0	0	0
332570	1	1	3	1	15	14	0	0	19	16
333504	8	10	6	5	2	3	0	0	16	18
333527	0	1	10	8	5	6	0	0	15	15
333533	0	0	0	0	0	0	0	0	0	0
333537	0	0	0	0	0	0	0	0	0	0
333541	0	0	0	0	0	0	0	0	0	0
TOTAL	10	12	34	24	55	56	0	0	99	92

TABLE 3 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
SELF-CARE SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

SELF-CARE SETTINGS – HOME

PROVIDER	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
330044	0	0	12	14	11	12	0	0	23	26
330136	0	0	6	8	16	12	0	0	22	20
330140	0	0	0	0	12	21	0	0	12	21
330211	0	0	0	0	0	0	0	0	0	0
330394	0	1	11	3	28	15	0	0	39	19
332536	0	0	2	1	16	11	0	0	18	12
332540	0	0	3	4	5	6	0	0	8	10
332545	1	1	5	6	23	20	0	0	29	27
332580	0	0	0	0	0	0	0	0	0	0
332584	0	0	0	0	0	0	0	0	0	0
332615	0	0	7	5	64	56	0	0	71	61
332643^	0	0	0	0	0	0	0	0	0	0
333510	0	0	0	0	0	0	0	0	0	0
333517	0	0	0	0	0	0	0	0	0	0
333525	0	0	0	0	0	0	0	0	0	0
333529	0	0	0	0	0	0	0	0	0	0
333536	0	0	9	9	0	0	0	0	9	9
333542	0	0	0	0	0	0	0	0	0	0
333545	0	0	0	0	0	0	0	0	0	0
333546#	0	0	0	5	0	22	0	0	0	27
TOTAL	1	2	55	55	175	175	0	0	231	232
NY Total	102	103	516	473	739	721	1	2	1,358	1,299

Source of Information: Facility Survey (CMS 2744) and Network SIMS Database

Date of Preparation: June 2006

This table includes 10 Veterans Affairs Facility patients for 2004 and 9 Veterans Affairs Facility patients for 2005 # Provider not operational in 2004, ^ Provider not operational in 2005

TABLE 4: DIALYSIS MODALITY - IN-CENTER

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
ALBANY								
330013	6	10	0	0	6	10	10	12
330079	25	22	0	0	25	22	25	22
33009F	2	6	0	0	2	6	2	6
330191	99	100	0	0	99	100	111	109
330250	69	66	0	0	69	66	76	75
332523	127	131	0	0	127	131	133	136
332532	90	88	0	0	90	88	102	96
332544	131	127	0	0	131	127	131	127
332557	60	58	0	0	60	58	100	99
332562	63	61	0	0	63	61	63	65
332569	132	138	0	0	132	138	152	161
332586	70	74	0	0	70	74	81	81
332632	74	81	0	0	74	81	78	91
332641	48	52	0	0	48	52	48	52
333512^	0	0	0	0	0	0	0	0
333518	51	42	0	0	51	42	51	42
333523	15	18	0	0	15	18	15	18
333531	67	70	0	0	67	70	67	72
TOTAL	1,129	1,144	0	0	1,129	1,144	1,245	1,264

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
BRONX	2004	2005	2004	2005	2004	2005	2004	2005
330009^	0	0	0	0	0	0	0	0
330059	47	32	0	0	47	32	53	37
330072	62	65	0	0	62	65	62	65
330080	75	65	0	0	75	65	75	65
33016F	72	76	0	0	72	76	79	81
332009	191	185	0	0	191	185	203	197
332506	117	112	0	0	117	112	117	112
332563	148	149	0	0	148	149	148	149
332565	130	119	0	0	130	119	130	119
332576	177	173	0	0	177	173	177	173
332582	153	147	0	0	153	147	156	147
332588	123	120	0	0	123	120	134	138
332590	108	120	0	0	108	120	108	120
332611^	0	0	0	0	0	0	0	0
332612	184	185	0	0	184	185	194	195
332613	201	182	0	0	201	182	218	198
332619	142	129	0	0	142	129	142	129
332624	36	5	0	0	36	5	36	5
332640	33	35	0	0	33	35	33	35
332642	96	132	0	0	96	132	96	133
332645	27	44	0	0	27	44	27	44
332648#	0	46	0	0	0	46	0	46
TOTAL	2,122	2,121	0	0	2,122	2,121	2,188	2,188

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
BUFFALO	2004	2005	2004	2005	2004	2005	2004	2005
330005	116	124	0	0	116	124	128	141
330053	34	34	0	0	34	34	34	34
330103	60	62	0	0	60	62	60	62
33012F	55	64	0	0	55	64	57	66
330219	36	39	0	0	36	39	36	39
330229	50	59	0	0	50	59	52	60
330239	70	74	0	0	70	74	98	100
332510	65	61	0	0	65	61	65	61
332537	56	56	0	0	56	56	56	56
332548	121	111	0	0	121	111	121	111
332549	86	87	0	0	86	87	90	91
332551	137	142	0	0	137	142	162	173
332554	76	81	0	0	76	81	76	81
332597	48	52	0	0	48	52	48	52
332600	98	98	0	0	98	98	114	113
332608	94	95	0	0	94	95	100	106
332649#	0	101	0	0	0	101	0	112
333300	9	8	0	0	9	8	15	12
333516	100	0	0	0	100	0	113	0
333526	61	64	0	0	61	64	61	64
TOTAL	1,372	1,412	0	0	1,372	1,412	1,486	1,534

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
HUDSON VALLEY								
330004	108	113	0	0	108	113	115	118
330006	25	35	0	0	25	35	31	39
330158	122	118	0	0	122	118	132	122
330209	106	113	0	0	106	113	138	143
330273	64	0	0	0	64	0	64	0
332504	67	91	0	0	67	91	67	91
332538	114	111	0	0	114	111	114	111
332539	179	187	0	0	179	187	179	187
332546	70	76	0	0	70	76	70	76
332559	46	56	0	0	46	56	46	56
332571	81	94	0	0	81	94	81	94
332572	85	90	0	0	85	90	86	91
332574	73	78	0	0	73	78	73	78
332599	66	63	0	0	66	63	66	63
332601	4	0	0	0	4	0	4	0
332602	139	140	0	0	139	140	139	140
332606	138	127	0	0	138	127	138	127
332609	22	0	0	0	22	0	22	0
332614	34	34	0	0	34	34	34	34
332616	13	12	0	0	13	12	13	12
332617	86	92	0	0	86	92	102	108
332633	152	158	0	0	152	158	184	189
332651#	0	75	0	0	0	75	0	75
333534	49	46	0	0	49	46	51	48
TOTAL	1,843	1,909	0	0	1,843	1,909	1,949	2,002

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
KINGS	2004	2005	2004	2005	2004	2005	2004	2005
330056	18	12	0	0	18	12	26	19
330152	1	3	0	0	1	3	1	3
330194	7	9	0	0	7	9	7	9
330196	1	3	0	0	1	3	1	3
330201	84	83	0	0	84	83	84	83
330202	110	111	0	0	110	111	110	111
330233	28	35	0	0	28	35	28	35
330306^	0	0	0	0	0	0	0	0
330350	8	10	0	0	8	10	10	10
330396	4	0	0	0	4	0	4	0
330397	25	25	0	0	25	25	25	25
332512	125	120	0	0	125	120	125	120
332516	193	184	0	0	193	184	196	187
332522	170	190	0	0	170	190	174	197
332533	75	0	0	0	75	0	79	0
332534	63	62	0	0	63	62	63	62
332535	165	167	0	0	165	167	165	167
332550	108	102	0	0	108	102	108	102
332556	160	131	0	0	160	131	160	131
332560	117	124	0	0	117	124	124	127
332561	137	116	0	0	137	116	137	116
332566	153	155	0	0	153	155	153	155

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
KINGS	200	199	0	0	200	199	200	199
332577	200	199	0	0	200	199	200	199
332578	132	126	0	0	132	126	132	126
332579	0	0	0	0	0	0	29	22
332581	182	172	0	0	182	172	185	175
332596	89	90	0	0	89	90	89	90
332598	115	88	0	0	115	88	115	88
332604	64	58	0	0	64	58	64	58
332622	90	123	0	0	90	123	90	123
332635	125	145	0	0	125	145	125	145
332636	38	35	0	0	38	35	38	35
332637	66	71	0	0	66	71	66	71
332644	28	67	0	0	28	67	28	67
332646#	0	101	0	0	0	101	0	101
333515	183	176	0	0	183	176	183	176
333544	154	155	0	0	154	155	174	180
33020F	65	57	0	0	65	57	65	57
TOTAL	3,283	3,305	0	0	3,283	3,305	3,363	3,375

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
NASSAU	200	199	0	0	200	199	200	199
330027	92	84	0	0	92	84	103	93
330106	175	183	0	0	175	183	202	212
330167	193	204	0	0	193	204	212	221
330195	8	3	0	0	8	3	8	3
330198	1	2	0	0	1	2	1	2
332521	87	95	0	0	87	95	87	95
332529	69	65	0	0	69	65	69	65
332552	77	82	0	0	77	82	77	82

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
NASSAU	2004	2005	2004	2005	2004	2005	2004	2005
332558	134	147	0	0	134	147	135	147
332591	45	43	0	0	45	43	45	43
332592	81	78	0	0	81	78	81	78
332605	79	86	0	0	79	86	79	86
332610	113	120	0	0	113	120	113	120
332620	121	132	0	0	121	132	124	135
332634	35	43	0	0	35	43	35	43
333522	96	93	0	0	96	93	96	93
333535	85	95	0	0	85	95	85	95
333538	25	30	0	0	25	30	25	30
333543	8	10	0	0	8	10	8	11
TOTAL	1,524	1,595	0	0	1,524	1,595	1,585	1,654

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
NEW YORK	2004	2005	2004	2005	2004	2005	2004	2005
330012	31	33	0	0	31	33	31	33
330024	36	44	0	0	36	44	70	75
330046	1	5	0	0	1	5	1	5
330064	53	45	0	0	53	45	53	45
330101	23	22	0	0	23	22	23	22
330119	5	12	0	0	5	12	5	12
330169	4	1	0	0	4	1	4	1
33017F	39	42	0	0	39	42	40	42
330199	48	49	0	0	48	49	56	51
330204	62	61	0	0	68	66	90	87

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
NEW YORK								
330214	9	6	0	0	9	6	9	6
330230	29	31	0	0	29	31	29	31
330240	79	84	0	0	79	84	79	84
330290	14	8	0	0	14	8	14	8
332514	181	192	0	0	181	192	181	192
332520	248	241	0	0	248	241	320	307
332524	105	106	0	0	105	106	105	106
332528	160	147	0	0	160	147	171	157
332530	157	163	0	0	157	163	157	163
332542	176	174	0	0	176	174	180	179
332543	59	63	0	0	59	63	59	63
332564	116	105	0	0	116	105	116	105
332593	170	168	0	0	170	168	179	174
332607	148	150	0	0	148	150	148	150
332621	126	132	0	0	126	132	160	159
332623	0	0	0	0	0	0	0	0
333506	157	152	0	0	157	152	157	152
333511	163	182	0	0	163	182	163	182
333524	179	178	0	0	179	178	186	183
333539	179	179	0	0	179	179	185	184
TOTAL	2,757	2,775	0	0	2,763	2,780	2,971	2,958

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
QUEENS	2004	2005	2004	2005	2004	2005	2004	2005
330055	28	25	0	0	28	25	28	25
330128	37	39	0	0	37	39	41	39
330193	96	111	0	0	96	111	99	116
330231	1	2	0	0	1	2	1	2
330357	52	6	0	0	52	6	71	24
330395	100	64	0	0	100	64	100	64
332508	218	223	0	0	218	223	265	266
332517	338	330	0	0	338	330	338	330
332519	99	102	0	0	99	102	99	102
332531	216	212	0	0	216	212	216	212
332541	273	265	0	0	273	265	279	266
332547	135	182	0	0	135	182	135	182
332568	112	90	0	0	112	90	112	90
332583	112	106	0	0	112	106	112	106
332587	60	40	0	0	60	40	60	40
332589	230	230	0	0	230	230	231	233
332594	91	97	0	0	91	97	93	98
332595	138	143	0	0	138	143	138	143
332603	94	114	0	0	94	114	94	114
332618	75	79	0	0	75	79	75	79
332639	47	67	0	0	47	67	47	67
332647#	0	27	0	0	0	27	0	27
332650#	0	5	0	0	0	5	0	5
333503	173	182	0	0	173	182	184	191
TOTAL	2,725	2,741	0	0	2,725	2,741	2,818	2,821

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
RICHMOND								
332511	163	172	0	0	163	172	172	179
332525	137	138	0	0	137	138	142	142
332567	112	101	0	0	112	101	113	101
332625	74	87	0	0	74	87	75	88
332638	26	25	0	0	26	25	26	25
TOTAL	512	523	0	0	512	523	528	535

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
ROCHESTER								
330058	66	67	0	0	66	67	72	73
330090	108	105	0	0	108	105	133	135
330125	238	252	0	0	238	252	299	309
330151	40	55	0	0	40	55	45	64
330226	178	169	0	0	178	169	197	190
330275	74	97	0	0	74	97	74	97
332585	71	89	0	0	71	89	73	89
332626	10	7	0	0	10	7	10	7
332627	99	74	0	0	99	74	150	124
332628	76	92	0	0	76	92	76	92
332629	165	175	0	0	165	175	166	176
332630	8	12	0	0	8	12	8	12
332631	62	60	0	0	62	60	62	60
333532	30	28	0	0	30	28	30	28
TOTAL	1,225	1,282	0	0	1,225	1,282	1,395	1,456

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
SUFFOLK	2004	2005	2004	2005	2004	2005	2004	2005
330045	14	20	0	0	14	20	14	21
330107	74	72	0	0	74	72	85	83
330141	16	15	0	0	16	15	16	15
33019F	27	25	0	0	27	25	27	26
330286	27	24	0	0	27	24	27	24
330401	95	98	0	0	95	98	104	106
332513	98	94	0	0	98	94	118	111
332518	90	98	0	0	90	98	99	103
332555	45	49	0	0	45	49	45	49
332570	121	125	0	0	121	125	140	141
333504	159	180	0	0	159	180	175	198
333527	153	136	0	0	153	136	168	151
333533	59	57	0	0	59	57	59	57
333537	4	0	0	0	4	0	4	0
333541	123	128	0	0	123	128	123	128
TOTAL	1,105	1,121	0	0	1,105	1,121	1,204	1,213

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
SYRACUSE	2004	2005	2004	2005	2004	2005	2004	2005
330044	187	206	0	0	187	206	210	232
330136	34	37	0	0	34	37	56	57
330140	164	138	0	0	164	138	176	159
330211	1	2	0	0	1	2	1	2
330394	179	127	0	0	179	127	218	146
332536	39	39	0	0	39	39	57	51
332540	99	103	0	0	99	103	107	113
332545	137	133	0	0	137	133	166	160

TABLE 4 CONTINUED

NUMBER OF LIVING PATIENTS BY MODALITY BY DIALYSIS FACILITY
IN-CENTER SETTINGS AS OF DECEMBER 31, 2004 AND DECEMBER 31, 2005

IN-CENTER SETTINGS

PROVIDER	HEMO		PD		TOTAL		TOTAL HOME * & INCENTER	
	2004	2005	2004	2005	2004	2005	2004	2005
SYRACUSE	2004	2005	2004	2005	2004	2005	2004	2005
332580	42	50	0	0	42	50	42	50
332584	48	48	0	0	48	48	48	48
332615	156	172	0	0	156	172	227	233
332643^	12	0	0	0	12	0	12	0
333510	55	61	0	0	55	61	55	61
333517	51	61	0	0	51	61	51	61
333520	24	24	0	0	24	24	24	24
333525	43	46	0	0	43	46	43	46
333529	32	32	0	0	32	32	32	32
333536	62	60	0	0	62	60	71	69
333542	31	32	0	0	31	32	31	32
333545	13	23	0	0	13	23	13	23
333546#	0	88	0	0	0	88	0	115
TOTAL	1,409	1,482	0	0	1,409	1,482	1,640	1,714
Network Total	21,006	21,410	0	0	21,012	21,415	22,372	22,714

Source of Information: Facility Survey (CMS 2744) and Network SIMS Database

*Total from Table 3 plus total from Table 4 (for last column of report year)

Date of Preparation: June 2006

This table includes 260 Veterans Affairs Facility patients for 2004 and 267 Veterans Affairs Facility patients for 2005.

Provider not operational in 2004

^ Provider not operational in 2005

TABLE 5: RENAL TRANSPLANTS BY STATE

NUMBER OF RENAL TRANSPLANTS PERFORMED BY TRANSPLANT CENTERS WITHIN THE
NETWORK AREA
CALENDAR YEAR 2004 AND CALENDAR YEAR 2005

TX CENTER	TOTAL TRANSPLANTS PERFORMED		PATIENTS WAITING FOR TRANSPLANT	
	2004	2005	2004	2005
NY				
330005	54	43	0	261
330012	139	199	69	214
330013	52	60	108	120
330024	131	177	0	916
330046	8	18	111	184
330059	84	94	791	854
330101	99	170	17	0
330214	35	33	304	283
330219	40	44	78	68
330234	140	110	238	40
330241	41	42	161	143
330285	76	73	203	250
330350	76	95	629	506
330393	53	70	348	359
333300	0	3	8	7
NY TOTAL	1028	1231	3065	4205
NETWORK TOTAL	1028	1231	3065	4205

Source of information: Network SIMS Database/CMS-2744

Date of Preparation: June 2006

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

Provider not operational in 2004

^ Provider not operational in 2005

TABLE 6: RENAL TRANSPLANTS BY TRANSPLANT TYPE

RENAL TRANSPLANT RECIPIENTS FOR TRANSPLANT CENTERS
WITHIN THE NETWORK AREA
BY TRANSPLANT TYPE; AGE, RACE, GENDER AND PRIMARY DIAGNOSIS
CALENDAR YEAR 2005

AGE	CADAVERIC	LIVING RELATED	LIVING UNRELATED	TOTAL
00-04	1	2	0	3
05-09	3	2	1	6
10-14	11	7	0	18
15-19	29	16	4	49
20-24	8	20	4	32
25-29	20	26	9	55
30-34	23	31	11	65
35-39	54	27	14	95
40-44	72	33	21	126
45-49	77	36	21	134
50-54	97	32	33	162
55-59	101	42	22	165
60-64	73	23	16	112
65-69	84	20	13	117
70-74	51	11	7	69
75-79	13	3	2	18
80-84	5	0	0	5
>=85	0	0	0	0
Missing	0	0	0	0
Total	722	331	178	1,231

TABLE 6 CONTINUED

RENAL TRANSPLANT RECIPIENTS FOR TRANSPLANT CENTERS
WITHIN THE NETWORK AREA
BY TRANSPLANT TYPE; AGE, RACE, GENDER AND PRIMARY DIAGNOSIS
CALENDAR YEAR 2005

RACE	CADAVERIC	LIVING RELATED	LIVING UNRELATED	TOTAL
American Indian/ Alaska Native	1	3	0	4
Asian	43	15	3	61
Black or African American	240	72	25	337
More Than One Race Selected	2	3	1	6
Native Hawaiian or Other Pacific Islander	3	1	0	4
White	383	207	111	701
Missing	50	30	38	118
Total	722	331	178	1,231

GENDER	CADAVERIC	LIVING RELATED	LIVING UNRELATED	TOTAL
Female	280	139	64	483
Male	442	191	114	747
Missing	0	1	0	1
Total	722	331	178	1,231

DIAGNOSIS	CADAVERIC	LIVING RELATED	LIVING UNRELATED	TOTAL
Cystic Kidney	65	23	16	104
Diabetes	171	69	44	284
Glomerulonephritis	154	87	35	276
Hypertension	146	55	21	222
Other	89	53	16	158
Other Urologic	14	8	4	26
Missing	24	16	28	68
Unknown	59	20	14	93
Total	722	331	178	1,231

Source of Information: Network SIMS Database

Date of Preparation: June 2006

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

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

This table includes 0 patients receiving treatment at VA facilities.

TABLE 7: DIALYSIS DEATHS

DEATHS OF DIALYSIS PATIENTS BY STATE OF RESIDENCE, AGE, RACE, GENDER,
PRIMARY DIAGNOSIS AND CAUSE OF DEATH
CALENDAR YEAR 2005

AGE	NY	OTHER*	TOTAL
00-04	2	0	2
05-09	1	0	1
10-14	0	0	0
15-19	6	0	6
20-24	7	0	7
25-29	21	1	22
30-34	29	0	29
35-39	49	0	49
40-44	107	1	108
45-49	194	1	195
50-54	287	4	291
55-59	382	5	387
60-64	478	1	479
65-69	599	7	606
70-74	728	11	739
75-79	814	4	818
80-84	777	9	786
>=85	688	11	699
Missing	0	0	0
Total	5,169	55	5,224

RACE	NY	OTHER*	TOTAL
American Indian/ Alaska Native	17	0	17
Asian	174	1	175
Black or African American	1,650	13	1,663
More Than One Race Selected	5	0	5
Native Hawaiian or Other Pacific Islander	6	0	6
White	3,055	40	3,095
Missing	262	1	263
Total	5,169	55	5,224

TABLE 7 CONTINUED

DEATHS OF DIALYSIS PATIENTS BY STATE OF RESIDENCE, AGE, RACE, GENDER,
PRIMARY DIAGNOSIS AND CAUSE OF DEATH
CALENDAR YEAR 2005

GENDER	NY	OTHER*	TOTAL
Female	2,470	23	2,493
Male	2,699	32	2,731
Missing	0	0	0
Total	5,169	55	5,224

DIAGNOSIS	NY	OTHER*	TOTAL
Cystic Kidney	83	1	84
Diabetes	2,220	15	2,235
Glomerulonephritis	349	8	357
Hypertension	1,262	12	1,274
Other	693	14	707
Other Urologic	110	0	110
Missing	41	0	41
Unknown	411	5	416
Total	5,169	55	5,224

CAUSE OF DEATH	NY	OTHER*	TOTAL
Cardiac	2,203	14	2,217
Gastro Intestinal	52	0	52
Infection	1,017	15	1,032
Liver Disease	37	0	37
Vascular	269	4	273
Missing	301	8	309
Other	820	8	828
Unknown	470	6	476
Total	5,169	55	5,224

Source of Information: Network SIMS Database

Date of Preparation: June 2006

Race: The categories are from the CMS-2728 Form

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

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

TABLE 8: VOCATIONAL REHABILITATION

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER ALBANY	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330013	1	0	0	0		N
330079	4	0	1	1		N
33009F	2	0	0	0		N
330191	27	2	8	0	Y	
330250	23	0	8	0		N
332523	57	0	13	1		N
332532	24	0	7	0		N
332544	36	3	7	1		N
332557	27	1	10	0		N
332562	24	0	6	0		N
332569	59	4	13	6	Y	
332586	23	1	5	1	Y	
332632	22	0	7	0		N
332641	24	0	6	0		N
333518	14	0	1	0		N
333523	4	0	0	0		N
333531	12	0	3	0	Y	
TOTAL	383	11	95	10	4	13

TABLE 8: VOCATIONAL REHABILITATION

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER BRONX	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330059	17	0	0	0		N
330072	19	5	4	0		N
330080	28	0	11	0	Y	
33016F	18	0	0	0		N
332009	73	0	8	2	Y	
332506	54	1	4	1		N
332563	48	2	19	0		N
332565	39	0	4	0		N
332576	67	0	9	1		N
332582	56	0	10	1		N
332588	49	0	13	1		N
332590	66	2	2	0		N
332612	84	2	20	2	Y	
332613	96	3	25	7	Y	
332619	69	4	5	1		N
332624	1	0	0	0		N
332640	1	0	0	0		N
332642	51	1	3	1		N
332645	2	0	0	0		N
332648	10	0	0	0		N
TOTAL	848	20	137	17	4	16

TABLE 8: VOCATIONAL REHABILITATION

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER BUFFALO	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330005	62	0	8	0	Y	
330053	10	1	0	0		N
330103	13	0	2	0		N
33012F	13	0	2	0		N
330219	21	0	4	1		N
330229	15	1	1	1		N
330239	25	0	2	0		N
332510	23	0	6	0	Y	
332537	14	1	1	0		N
332548	33	0	7	0	Y	
332549	12	1	2	0	Y	
332551	51	0	22	0		N
332554	21	0	3	0		N
332597	11	0	1	0		N
332600	14	0	4	1	Y	
332608	23	0	5	1	Y	
332649	39	0	6	2	Y	
333300	5	0	0	1		N
333516	0	0	0	0	Y	
333526	16	0	3	0		N
TOTAL	421	4	79	7	8	12

TABLE 8: VOCATIONAL REHABILITATION

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER HUDSON VALLEY	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330004	28	1	9	2		N
330006	9	0	0	0	Y	
330158	30	0	6	1	Y	
330209	43	4	14	1	Y	
330273	0	0	0	0		N
332504	34	1	14	1	Y	
332538	43	2	12	1		N
332539	65	2	15	2	Y	
332546	25	0	7	0		N
332559	14	0	5	0	Y	
332571	20	0	11	0		N
332572	20	9	9	0		N
332574	14	0	4	1		N
332599	9	0	4	0		N
332601	0	0	0	0		N
332602	33	1	12	0		N
332606	30	0	10	0	Y	
332609	0	0	0	0		N
332614	4	0	0	0		N
332616	0	0	0	0		N
332617	39	0	12	3	Y	
332633	58	1	25	0	Y	
332651	11	1	3	0		N
333534	12	0	3	2	Y	
TOTAL	541	22	175	14	10	14

TABLE 8: VOCATIONAL REHABILITATION

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER KINGS	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330056	10	0	2	1		N
330152	1	0	0	0		N
330194	2	1	1	0	Y	
330196	2	0	0	0		N
330201	14	0	0	0	Y	
330202	64	2	26	4	Y	
33020F	13	0	0	0		N
330233	8	0	0	0	Y	
330350	4	0	0	0		N
330396	0	0	0	0	Y	
330397	9	0	3	0		N
332512	57	3	12	2	Y	
332516	48	2	3	1		N
332522	56	0	21	0	Y	
332533	0	0	0	0	Y	
332534	26	0	1	1	Y	
332535	76	3	19	4	Y	
332550	33	0	0	3	Y	
332556	46	7	13	1	Y	
332560	32	0	5	0		N
332561	20	0	4	1	Y	
332566	50	3	10	4	Y	

TABLE 8: VOCATIONAL REHABILITATION

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
 PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER KINGS	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
332577	70	0	21	0	Y	
332578	65	2	24	1	Y	
332579	12	0	6	0		N
332581	65	0	14	0		N
332596	15	1	2	1	Y	
332598	46	0	2	0	Y	
332604	15	0	1	0		N
332622	23	1	6	1		N
332635	32	0	7	0	Y	
332636	4	0	0	0		N
332637	15	8	5	0		N
332644	15	0	2	0	Y	
332646	26	0	1	0		N
333515	55	0	17	4	Y	
333544	73	0	12	0	Y	
TOTAL	1,102	33	240	29	22	15

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER NASSAU	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330027	51	1	15	0	Y	
330106	81	4	28	16		N
330167	56	1	25	4	Y	
330195	1	0	0	0	Y	
330198	1	0	0	0		N
332521	30	0	10	0	Y	
332529	13	0	0	0		N
332552	11	0	7	0	Y	
332558	30	1	10	1	Y	
332591	2	0	0	0		N
332592	17	0	6	2	Y	
332605	34	4	11	1		N
332610	22	0	9	1		N
332620	20	0	9	0		N
332634	3	0	0	0		N
333522	15	0	3	0	Y	
333535	15	0	4	0	Y	
333538	5	0	1	0		N
333543	1	0	0	0		N
TOTAL	408	11	138	25	9	10

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER NEW YORK	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330012	14	0	2	0	Y	
330024	30	2	11	15	Y	
330046	2	0	0	0		N
330064	11	1	1	1	Y	
330101	12	0	5	1	Y	
330119	2	0	0	0		N
330169	0	0	0	0		N
33017F	11	0	0	1		N
330199	32	0	1	0		N
330204	53	0	22	2		N
330214	2	0	0	0		N
330230	11	0	4	1		N
330240	45	0	3	1		N
330290	1	0	0	0		N
332514	68	0	2	1	Y	
332520	142	5	28	10	Y	
332524	39	0	8	0		N
332528	64	1	25	3	Y	
332530	64	1	16	0	Y	
332542	69	0	12	0		N
332543	20	0	4	0		N

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER NEW YORK	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
332564	30	0	0	0	Y	
332593	55	0	16	1	Y	
332607	28	0	11	1	Y	
332621	42	3	6	3		N
333506	30	1	8	1	Y	
333511	90	2	19	3	Y	
333524	62	1	16	2	Y	
333539	59	1	13	1		N
TOTAL	1,088	18	233	48	14	15

PROVIDER QUEENS	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330055	7	0	2	0	Y	
330128	21	0	4	0	Y	
330193	35	0	9	4		N
330231	2	1	0	0		N

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER QUEENS	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330357	8	0	3	0		N
330395	24	0	0	0		N
332508	56	0	27	0	Y	
332517	129	2	34	3	Y	
332519	25	0	3	0	Y	
332531	72	0	10	4	Y	
332541	84	3	0	0	Y	
332547	55	0	13	1	Y	
332568	23	0	5	1		N
332583	41	0	9	2	Y	
332587	17	0	4	0		N
332589	69	3	16	2	Y	
332594	24	0	1	0		N
332595	52	1	17	0		N
332603	21	0	8	0		N
332618	23	0	5	1		N
332639	18	0	10	0		N
332647	12	1	0	0		N
332650	0	0	0	0		N
333503	58	0	11	1	Y	
TOTAL	876	11	191	19	11	13

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER RICHMOND	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
332511	59	10	16	2	Y	
332525	36	1	15	1	Y	
332567	22	0	5	0		N
332625	37	0	16	1		N
332638	1	0	0	0		N
TOTAL	155	11	52	4	2	10

PROVIDER ROCHESTER	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
3330058	14	3	4	0		N
330090	50	1	7	0		N
330125	79	3	13	3	Y	
330151	15	0	1	1		N
330226	36	2	7	0	Y	
330275	36	0	7	1	Y	
332585	17	2	4	0		N
332626	3	0	0	0	Y	

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER ROCHESTER	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
332627	57	3	16	1	Y	
332628	49	5	11	3	Y	
332629	70	0	4	2	Y	
332630	0	0	0	0		N
332631	15	0	5	0	Y	
333532	4	0	0	0		N
TOTAL	445	19	79	11	8	6

PROVIDER SUFFOLK	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330045	4	0	0	0		N
330107	26	0	7	0		N
330141	3	0	1	0	Y	
33019F	4	0	0	0		N
330286	3	0	0	0	Y	
330393	0	0	0	0		N
330401	16	0	3	1	Y	

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER SUFFOLK	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
332513	12	0	5	1	Y	
332518	23	0	9	1		N
332555	13	0	0	0		N
332570	56	1	16	3		N
333504	68	0	11	1	Y	
333527	37	0	9	1	Y	
333533	13	5	3	1		N
333537	0	0	0	0		N
333541	36	3	8	1	Y	
TOTAL	314	9	72	10	7	9

TABLE 8 CONTINUED

VOCATIONAL REHABILITATION BY DIALYSIS FACILITY
PATIENTS AGED 18 - 55 AS OF DECEMBER 31, 2005

PROVIDER SYRACUSE	NUMBER OF DIALYSIS PATIENTS AGED 18 -54 (NETWORK LIST)	NUMBER OF DIALYSIS PATIENTS RECEIVING SERVICES FROM VOC REHAB AND OTHER VOC REHAB RELATED SERVICE PROVIDERS (PUBLIC OR PRIVATE)	NUMBER OF DIALYSIS PATIENTS EMPLOYED FULL-TIME OR PART- TIME	NUMBER OF DIALYSIS PATIENTS ATTENDING SCHOOL FULL- TIME OR PART- TIME	OFFERS DIALYSIS SHIFT STARTING AT 5 PM OR LATER	
					Yes	No
330044	58	9	19	0		N
330136	19	1	3	0		N
330140	54	2	10	1	Y	
330211	0	0	0	0		N
330241	0	0	0	0		N
330394	36	0	6	0	Y	
332536	16	0	6	1	Y	
332540	31	0	6	1		N
332545	67	1	6	1	Y	
332580	11	0	1	0		N
332584	9	0	4	0		N
332615	58	0	21	0		N
333510	17	0	6	1	Y	
333517	7	0	1	0	Y	
333520	3	0	0	0		N
333525	9	0	1	0		N
333529	6	0	2	0		N
333536	22	0	3	0		N
333542	4	0	1	0		N
333545	5	0	1	0		N
333546	32	0	0	0		N
TOTAL	464	13	97	5	6	15
Network Total	7,045	182	1,588	199	105	148

Source of Information: Network SIMS Database/CMS-2744

Date of Preparation: May 2006