



End-Stage Renal Disease Network of New York

ANNUAL REPORT 2009

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Prepared by:
IPRO ESRD Network of New York



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1—Preface

Statement from the Chairman

Since 2006 IPRO has worked diligently to improve the lives of Medicare beneficiaries in New York as the ESRD Network and Medicare Quality Improvement Organization. In 2009, almost 25,000 patients with ESRD received treatments in the 239 dialysis centers and 16 transplant centers in New York State. Our professional staff and many volunteers from the provider and patient communities feel privileged to participate in the process by which New York patients can receive compassionate, high-quality care.

As in the past, the Network's efforts include quality improvement initiatives, the collection and management of data, community education, and to serve as a resource to the provider and regulatory communities. The revised Conditions for Coverage (CfC) and the anticipated rollout of the CROWNWeb system have added to the usual challenges faced by our organization.

Quality Improvement

The Network's quality improvement activities continue with a major focus on improving the percentage of arterial venous fistulas in prevalent hemodialysis patients. During the calendar year, the Network's prevalent fistula rate improved from 55.6% to 57.6%. The Network collaborated with providers likely to have the greatest opportunity for improvement and utilized a multi-model approach, providing educational workshops and on-site visits.

Network 2 also pursued other quality improvement projects, including the Influenza Vaccination Project, aimed at ensuring the vaccination of all eligible patients; the Involuntary Discharge (IVD) project, which focused on adherence to prescribed process and conflict resolution; revitalization of the Patient Advisory Committee; Phosphorous Management; Forms Submission Compliance; and the Medication Reconciliation Project.

New York State Department of Health Collaboration

Given the shared interest and complementary responsibilities that New York State and Network 2 have with respect to the ESRD community, we have built upon our previous experience in collaborating with the New York State Department of Health (NYSDOH) Survey and Certification Agency. The Network provides resources and technical assistance to facilities in support of their compliance with the CfC. In particular, the Network helps facilities that the NYSDOH identifies as requiring guidance in the development and maintenance of a Quality Assessment and Performance Improvement program.



Bundled Prospective Payment System

Looking to future challenges, the ESRD Bundling Proposed Rule, mandated under the Medicare Improvements for Patients and Providers Act will mark the first time in 30 years that CMS will make major adjustments to the financing of its system for care of patients with ESRD. This will likely have a monumental effect on the care of our patients, and we anticipate that regulatory agencies will be looking at access to dialysis care for different groups of beneficiaries and at the effects of bundling on quality of care.

Special Projects

Network 2 continues its work with two ESRD Special Projects—Network Information Technology Support (NWITS) and Network Coordinating Center (NCC).

The principal role of NWITS is the creation of the CROWN Help Desk to support the ESRD end-user community. CROWN Help Desk provides support to an expanded customer base of more than 15,000 customers.

The NCC provides centralized coordination and support for the operation of the ESRD Network Program with projects that include the new patient mailing packet process, the ESRD Directory, and website maintenance and preparation of the Summary Annual Report.

Closing Thoughts

On behalf of the IPRO ESRD Network of New York, I am pleased to present the 2009 Network 2 Annual Report, which covers the period January 1–December 31, 2009. We are proud of the progress we have made and hope to achieve even greater accomplishments in the months ahead. On behalf of our organization, I express my gratitude for the commitment of our volunteers—patients, nurses, social workers, physicians, dietitians, and administrators—and for the talented team at IPRO that supports us.

A handwritten signature in black ink, appearing to read 'John Wagner', with a long horizontal flourish extending to the right.

John Wagner, MD
Chairperson, Network Council
IPRO End-Stage Renal Disease Network of New York



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The Mission of the End-Stage Renal Disease Network of New York is to promote healthcare for all ESRD patients that is safe, effective, efficient, patient-centered, timely, and equitable.



2—Introduction

Network Description

The End-Stage Renal Disease (ESRD) Network of New York (Network 2) is operated by IPRO, an independent, not-for-profit corporation, and the Medicare Quality Improvement Organization (QIO) for New York State. Network 2 is the fifth largest Network in the ESRD Network Program, serving 24,932 patients who are receiving treatment for ESRD during 2009.

Network 2 is dedicated to assisting dialysis and renal transplantation centers in establishing and maintaining high standards of care for ESRD patients. The organization is 1 of 18 ESRD Network Organizations under contract to the Centers for Medicare & Medicaid Services (CMS). IPRO is fully committed to promoting and achieving the goals and vision of the ESRD Network Program, as well as providing support to the patients and providers within the Network 2 area.

As specified in the CMS Statement of Work (SOW), each Network is responsible for conducting activities in the following areas:

- Quality Improvement
- Community Information and Resources
- Administration
- Information Management

Network activities, which are framed by the national program goals of improving the quality of healthcare services and quality of life for ESRD beneficiaries, are tailored to meet local needs and include:

- Assuring the effective and efficient administration of benefits
- Improving quality of care for ESRD patients
- Collecting data to measure quality of care
- Providing assistance to ESRD patients and providers
- Evaluating and resolving patient grievances

In calendar year (CY) 2009, 7,234 patients began treatment for ESRD in New York, 0.04% fewer than in CY 2008. Of new patients, 58.3% were male, 61% were white, and

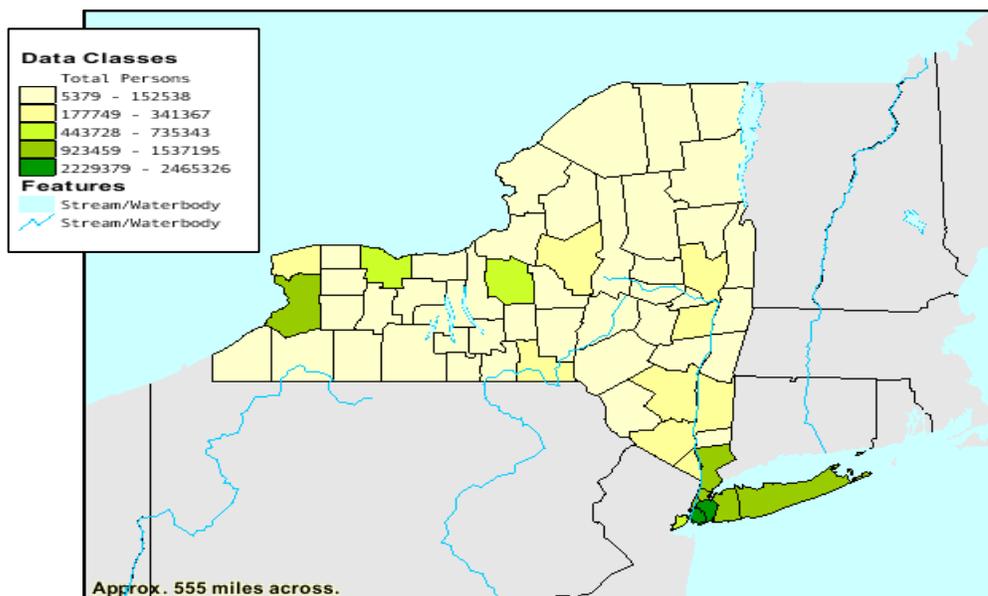
31% were African American. The primary cause of renal failure was attributed to diabetes (40.7%), whereas 24.9% was attributed to hypertension. By the end of CY 2009, 24,941 patients were receiving dialysis treatment for ESRD.

1. Geography and General Population

The ESRD population in the Network 2 area is the fifth largest in the country. Fifty-one percent of these patients reside within the five boroughs of New York City; the remainder lives in both rural and urban settings. This high concentration of patients in the metropolitan area presents challenges relative to ESRD education, preparedness, and treatment modalities.

New York is 54,471 square miles, with 47,234 square miles of land and 7,247 square 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. The boundaries of the Network 2 area coincide with those of New York State, which comprises 62 counties and 12 Standard Metropolitan Statistical Areas. New York State is the third most populated state in the country, with more than 19 million residents and a population density of more than 400 persons per square mile. Forty-two percent of the general population resides in New York City, and nearly two-thirds are concentrated in the City and its immediate suburbs of Long Island and the Hudson Valley. The US Census map above illustrates the variation in general population density across the state (Figure 1).

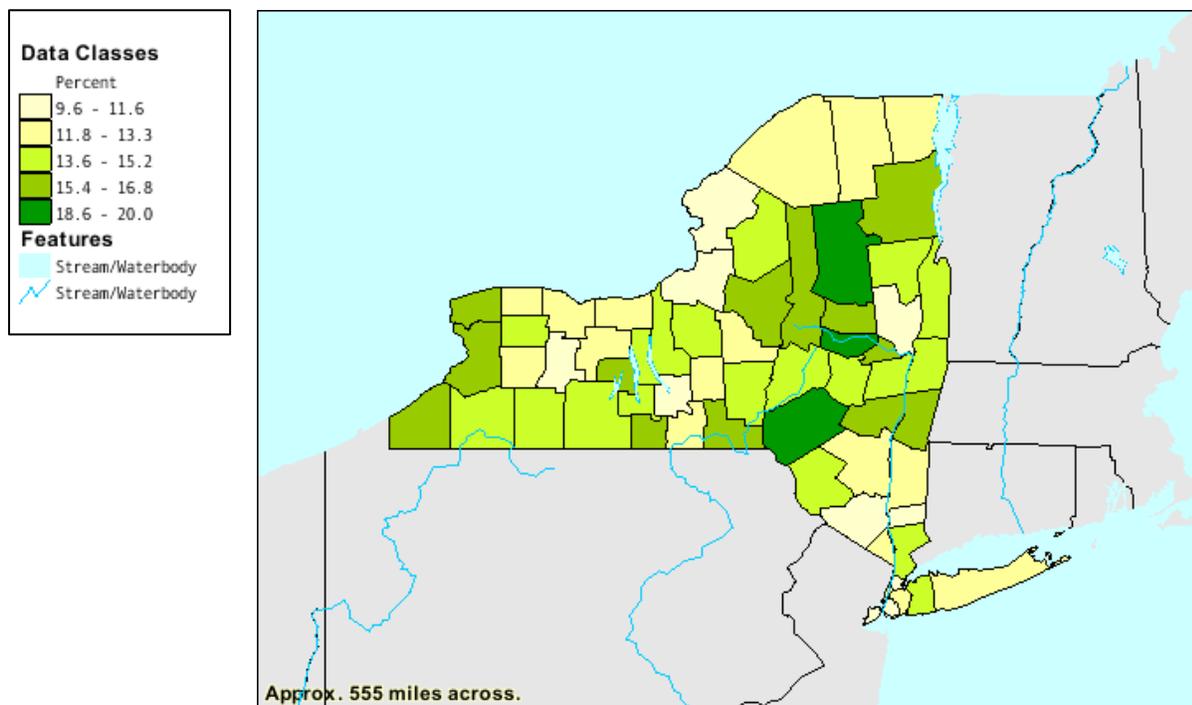
Figure1. Total Population by County in New York state in CY 2000*



Source: US Census Bureau, Census 2000 Summary File 1, Matrices P1 and P30.

Forty-eight percent of New York State’s residents are male, and 52% are female. As shown in Figure 2, approximately 12.7% is aged 65 and older; based on the 2000 US Census, 16% of the population is between 35 and 44 years of age. New York has seen a recent increase in the population ages 45–54 from the 1990 and the 2000 US Censuses, consistent with the 49% increase in the national population of residents in this age group. Both New York State and the nation saw a slower rate of increase in patient population ages 65 and over.

Figure 2. Percent of Persons 65 Years and Over in CY 2000*



*Source: US Census Bureau, Census 2000 Summary File 1, Matrices P1 and P30

New York’s demographic structure reflects some of the same major demographic forces that have shaped the nation’s population; for example, New York’s large baby boomer population is aging. The increasing number of elderly in the general population contributes to a rising number of chronic kidney disease (CKD) patients. In addition, older patients are at greater risk of developing serious illnesses that can lead to chronic kidney disease.

New York’s population size, distribution, and composition have been shaped by other forces such as foreign immigration, high levels of domestic migration, and the high fertility rates of the State’s large and expanding ethnic populations.

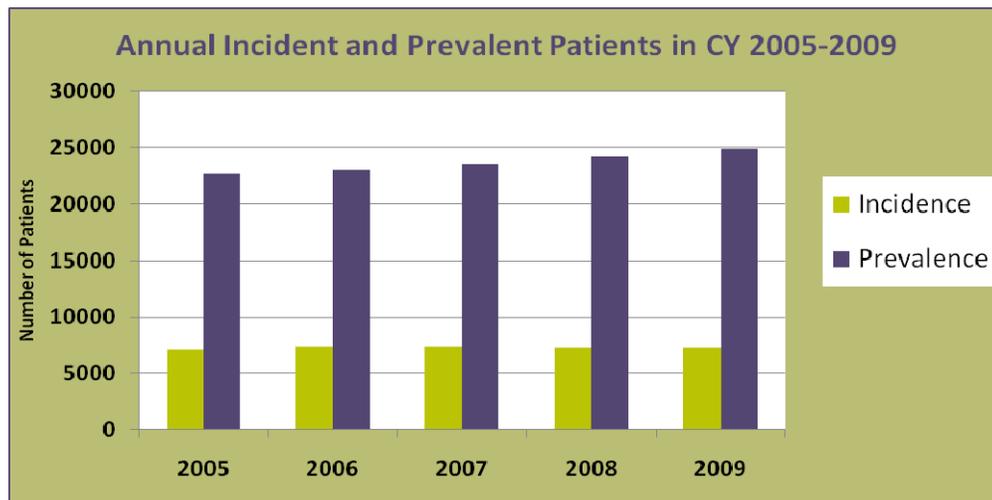
New York’s population of over 19 million individuals is rich in ethnic, racial, religious/spiritual, cultural and life-style diversity. New York’s population is 34% non-white—12% African American, 15% Latino, and 7% Asian. New York is known for its status as a finance, transportation, and manufacturing center, as well as for its history as a gateway for immigration to the United States. According to a 2004 estimate, over 20 percent of the population is foreign-born, with 28 percent of the population speaking a language other than English at home. This diversity must be considered as we move forward with health promotion and education strategies in the ESRD program.

2. ESRD Population

Both the ESRD incident (newly diagnosed) and prevalent (chronic) patient populations in the Network 2 area have grown steadily since CY 2000. In planning for the continued growth, Network 2 works collaboratively with the New York renal community and key stakeholders to assure the quality and adequacy of care. From CY 2008 to CY 2009, the patient prevalent census increased by 3% to 24,941 (Figure 3). Of this number, 56.7% was male, 51.7% was white, and 40.1% was African American. The primary causes of renal failure were diabetes (40.4%) and hypertension (24.9%).

In 2007, the most recent year of available data, 17,513 kidney transplants were performed in the United States — 3 percent fewer than in the previous year, marking the first time in nearly 20 years that transplant counts declined. This decline was seen in both deceased donor transplants (down 130 transplants, or 1 percent, from the prior year) and living donor transplants (down 391, or 6 percent).

Figure 3. Annual Incident and Prevalent Patients in CY 2005–2009*



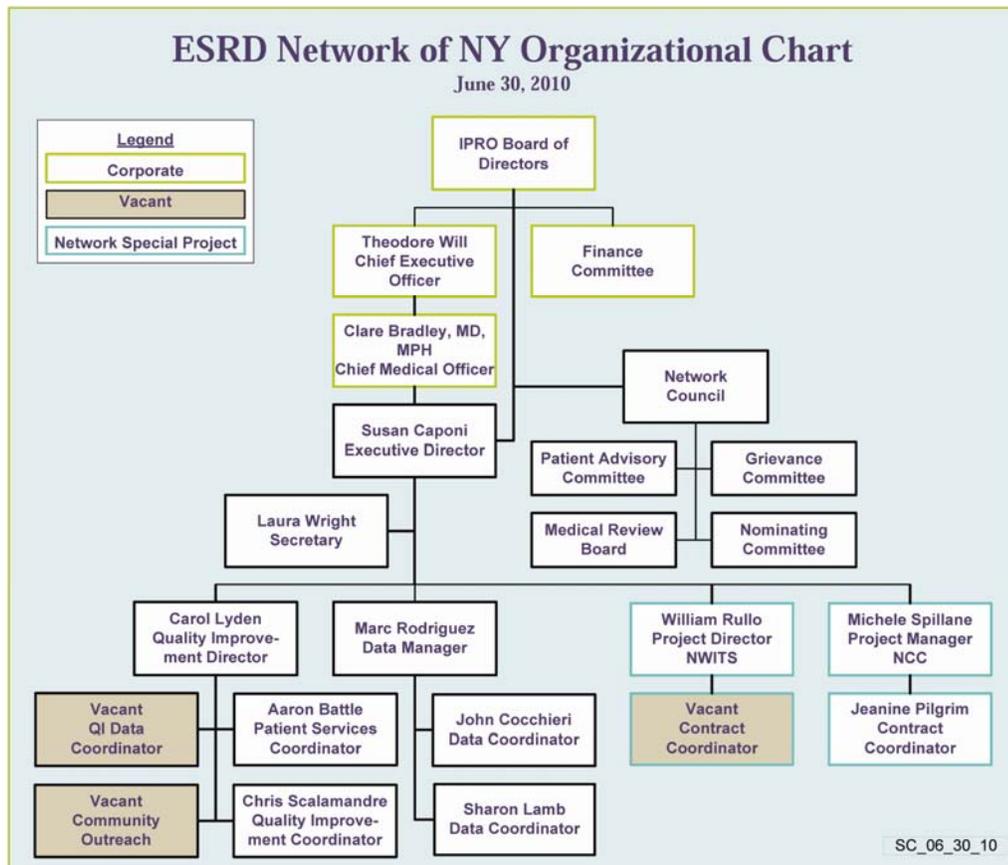
*Source: Standard Information Management System CY 2005–2009.

In CY 2009, 1,263 renal transplants were performed at 16 transplant centers in New York, an overall decrease of 3% from 2008. The numbers of deceased donors dropped by 8 % while the number of living donors increased by 2 %. Of the 1,263 transplant recipients, 61.3% were male, 38.7% female, 60.6% white and 29% African American. Although Network transplant rates have decreased, they still exceed national rates, which continue to fall. (See http://www.usrds.org/2009/pdf/V2_07_09.PDF, the USRDS 2009 Annual Data Report).

3. Network Organizational Structure

Network 2 has an efficient and effective organizational structure that meets the needs of the ESRD Network contract requirements and the New York renal community. Network 2 staff includes both qualified employees and volunteers from the renal community who sit on IPRO’s Board of Directors (Board) and Network advisory committees. Network 2 and its Special Projects—Network Information Technology Support (NWITS) and Network Coordinating Center (NCC) organizational structures—are depicted graphically in Figure 4.

Figure 4. ESRD Network of New York Organizational Chart as of June 1, 2010





4. Network 2 Staff

Network 2 is required under contract by CMS to employ an Executive Director and to adequately staff the Network in order to perform the requirements of the SOW. All but 2 of the 14 required staff positions have been filled (13.5 full time equivalent). The names and key responsibilities of Network staff (as of June 30, 2010) are as follows:

Aaron Battle, Patient Services Coordinator

- Leads social services, community information, and resource activities, including the complaint and grievance system
- Provides technical assistance and conducts community outreach to patients and providers
- Supervises all community outreach activities

Susan Caponi, RN, BSN, Executive Director

- Provides expert recommendations to Network 2—governing bodies on goals, objectives, work plans, and operational policies for the ESRD Network Program
- Establishes and maintains relationships with ESRD providers and other organizations
- Manages operational and financial aspects of the program, including all CMS Special Projects under Task 5
- Assures quality and timely completion of contract deliverables
- Manages staff and daily office operations

John Cocchieri, Data Coordinator

- Processes CMS and Network forms for dialysis and transplant providers
- Maintains patient and facility-specific databases

Sharon Lamb, Data Coordinator

- Processes CMS and Network forms for dialysis and transplant providers
- Maintains patient and facility-specific databases



Carol Lyden, RN, BSN, MS, CNN, Assistant Director of Quality Improvement and Patient Services

- Leads and coordinates Network 2 quality improvement activities
- Develops, implements, and evaluates educational content for applicability to program goals, coordinating with staff, the Medical Review Board (MRB), and Network Council
- Promotes quality improvement initiatives

Jeanine Pilgrim, NCC Contract Coordinator

- Supports the NCC through administrative tasks
- Maintains database and coordinates new patient orientation packets for all ESRD patients nationally

Marc Rodriguez, MSW, Assistant Director of Data Management

- Coordinates activities required to fulfill Network 2's data responsibilities
- Ensures the integrity of Network 2 data and continuous operation of the computer network
- Supervises Data Coordinators

William Rullo, NWITS Project Director

- Responsible for all activities of the NWITS Special Project and management of subcontractors
- Supports the information technology needs of all 18 Networks

Chris Scalamandre, RD, CDN, Quality Improvement Coordinator

- Leads and coordinates Network 2 quality improvement activities
- Develops, implements, and evaluates educational content for applicability to program goals, coordinating with staff, the MRB, and Network Council
- Promotes quality improvement initiatives



Michele Spillane, NCC Project Manager

- Responsible for all activities of the NCC Special Projects
- Provides centralized support for the operation of the ESRD Network Program
- Supervises the NCC Contract Coordinator and Editor

Laura Wright, Secretary

- Provides administrative support to the Network contract
- Provides support to the NWITS contract
- Assists in the completion and monitoring of contract deliverables
- Maintains file systems for Network 2 contracts

5. Governance and Committees

The IPRO Board, Network Council, and several committees support and facilitate Network 2 operations. The role and purpose of these committees are periodically reassessed to ensure that they continue to meet current needs. Board and Committee members include representatives from dialysis and transplant facilities, as well as other strategic organizations in the Network 2 area. Each Committee has at least one consumer representative. The involvement of the consumer representatives is vital to the success of Network 2 activities and to improving the quality of care and life for ESRD patients.

IPRO Board of Directors

IPRO's Board, which consists of physicians and community stakeholder representatives, sets corporate policies and assures the orderly and efficient operation of IPRO and Network 2. The Board has fiduciary oversight responsibility for Network 2 and reviews its activities as reported by ESRD Executive Director, Susan Caponi, and the Network Council Chairperson, John Wagner. The Board considers and acts on recommendations from the Network Council. In addition, ESRD beneficiary Larry Wilson serves as a representative of the renal community. The names, primary professional affiliations, and locations of IPRO's Board and Committee members are listed as follows:



President	Title	Location
Thomas J. Sheehy, Jr., MD	Physician	Huntington, NY
Members	Title	Location
Carlos Alvarez	Executive Director	East Meadow, NY
Lois Aronstein	New York State Director of AARP	New York, NY
Warren R. Betty, MD	Physician	Cape May, NJ
Sister Bernadette Devlin	Medicare Beneficiary/ Catholic Charities	Bayside, NY
Deborah Elliott	Deputy Executive Director, NYS Nurses Association	Latham, NY
John Friedman, MD	Physician	Syracuse, NY
Robert G. Lerner, MD	Physician	Eastchester, NY
Sheila H. Nelson	Vice President, Public Policy and Regulatory Affairs, NY Health Plan	Albany, NY
Bruce R. MacDonald, MD	Physician	Cooperstown, NY
Stuart I. Orsher, MD	Physician	New York, NY
Robert J. Panzer, MD	Physician	Rochester, NY
Ronald A. Paynter, MD	Physician	Long Beach, NY
Carol Rodat	New York Policy Director, Paraprofessional Healthcare Institute	Bronx, NY
Paul J. Rowland	Senior Vice President/CEO, Nassau Healthcare Corp.	East Meadow, NY
John Sardelis, Dr. P.H	Associate Professor, Associate Chairperson, St. Joseph's College	Patchogue, NY
Raymond D. Sweeney	Executive Vice President Healthcare Association of NY State	Rensselaer, NY
John Wagner, MD	ESRD Representative/ Nephrologist	New Hyde Park, NY
Michael A. Walsh, MD	Physician	New Rochelle, NY
Larry Wilson	Consumer/ESRD Beneficiary	Bronx, NY
Donald A. Winikoff, MD	Physician	West Nyack, NY



Network Council

The Network Council is a subcommittee of the IPRO Board. This Council serves as an expert panel that analyzes and advises the Board on quality improvement activities, and policies and procedures for the ESRD Network Program. It serves as a liaison between Network 2 and the provider members of the renal community.

Chairperson	Title	Location
John Wagner, MD	Nephrologist	New Hyde Park, NY
Members	Title	Location
Maria Argentina, LCSW	Social Worker	Bronx, NY
Syed Asad, MD	Nephrologist	Huntington Station, NY
Godfrey Burns, MD	Nephrologist	New York, NY
Chaim Charytan, MD	Nephrologist	Flushing, NY
Ellen Demarco, RN	Administrator	Brooklyn, NY
Vilay Jain, MD	Nephrologist	Rochester, NY
Kathe LeBeau	Consumer/ESRD Beneficiary	Albany, NY
Robert Lynn, MD	Nephrologist	Bronx, NY
Brian Murray, MD	Nephrologist	Buffalo, NY
Sriram Nasipar, MD	Nephrologist	Syracuse, NY

Medical Review Board

The Network 2 MRB is an advisory panel to the Network Council and Grievance Committee on the quality and appropriateness of care delivered to ESRD patients. The MRB also advises on quality improvement activities, including analysis of local data such as Clinical Performance Measure (CPM) data, and develops, implements, and evaluates Network 2 quality improvement projects. The MRB consists of prominent and dedicated members of the renal community who volunteer their time. Several MRB members have served on the Board for many years.

Chairperson	Title	Location
Robert Lynn, MD	Nephrologist	Bronx, NY
Members	Title	Location
Maria Argentina, LCSW	Social Worker	Bronx, NY
Syed Asad, MD	Nephrologist	Huntington Station, NY
Chaim Charytan, MD	Nephrologist	Flushing, NY
Elizabeth Credle	Consumer/ESRD Beneficiary	Queens, NY
Ellen Demarco, RN	Administrator	Brooklyn, NY
Stephen Fishbane, MD	Nephrologist	Mineola, NY
Fred Kaskel, MD	Pediatric Nephrologist	Bronx, NY
Brian Murray, MD	Nephrologist	Buffalo, NY
Sriram Nasipar, MD	Pediatric Nephrologist	Syracuse, NY
Amanda Raff, MD	Nephrologist	New York, NY
John Wagner, MD	Nephrologist	New Hyde Park, NY
Yalemzewd Wordekal, MD	Nephrologist	Brooklyn, NY

Patient Advisory Committee

The Patient Advisory Committee (PAC) assists in identifying and addressing barriers to obtaining quality healthcare from the perspective of ESRD beneficiaries. The PAC supports Network 2 activities by assisting with the development of educational materials for patients via websites, newsletters, and teleconferences; reviewing and making recommendations regarding beneficiary-related healthcare messages, materials, and activities; providing feedback on the effectiveness of beneficiary-related activities; and assisting in recruiting other beneficiaries to obtain their perspective.

Chairperson	Title	Location
Larry H. Wilson	Consumer/IPRO Board of Directors Member	New York, NY
Members	Title	Location
Sue Burns	Consumer/ESRD Beneficiary	Syracuse, NY
Elizabeth Credle	Consumer/ESRD Beneficiary	Queens, NY
Vivian Davis	Consumer/ESRD Beneficiary	Bronx, NY
Shane Carmen Dietz	Consumer/ESRD Beneficiary	Buffalo, NY
Warren Edmonds	Consumer/ESRD Beneficiary	Brooklyn, NY
Dawn Edwards	Consumer/ESRD Beneficiary	Jamaica, NY
Frank Ireland	Consumer/ESRD Beneficiary	Buffalo, NY
Lorraine Langdon	Consumer/ESRD Beneficiary	Bronx, NY
Kathe LeBeau	Consumer/ESRD Beneficiary	Albany, NY
Hazel Parker	Consumer/ESRD Beneficiary	Syracuse, NY
Monica Richter	Consumer/ESRD Beneficiary	Queens, NY
Wendy Rivers	Consumer/ESRD Beneficiary	Brooklyn, NY
Peter Savage	Consumer/ESRD Beneficiary	Islip, NY
Michael Young	Consumer/ESRD Beneficiary	Nassau, NY
Network 2 Staff	Title	Location
Aaron Battle	Patient Services Coordinator	Lake Success, NY

Grievance Committee

The Network 2 Grievance Committee, an advisory panel to the Network Council, consists of nephrology physicians, a nurse, a social worker, and consumer representatives. The Committee investigates and resolves patient complaints and grievances in accordance with CMS procedures and Network 2 policies. In 2009, the Grievance Committee was expanded as noted in the table below.

Chairperson	Title	Location
Godfrey Burns, MD	Nephrologist	New York, NY
Members	Title	Location
Lynn Cahill, LCSW	Social Worker	New York, NY
Mayette Casco, RN	Administrator	Elmont, NY
John Donalds, RN	RN Manager	Mineola, NY
Rhonda Halpern, LCSW	Social Worker	Westchester, NY
Ruth Holliday LCSW	RN Manager	Syracuse, NY
Marilyn Galler, MD	Nephrologist	Flushing, NY
Patricia Hansen, RN	Administrator	Bayshore, NY
Victoria Malara, RN	Administrator	Tarrytown, NY
Ira Meisels, MD	Nephrologist	New York, NY
Larry H. Wilson	Consumer/ ESRD Beneficiary/PAC Chairperson	Bronx, NY



Nominating Committee

The Nominating Committee is responsible for nominating a slate of candidates for election to the Network Council, MRB, and Grievance Committee. The Nominating Committee is also called upon in the event of a vacancy in the Network Council, MRB, or Grievance Committee. The Committee will provide recommendations to the Network Council on candidates for membership and may elect Acting Members to serve for a period of less than 1 year. The names, primary professional affiliations, and locations of IPRO's Nominating Committee members are listed as follows:

Chairman	Title	Location
John Wagner, MD	Nephrologist, Chairman of ESRD Network Council	New Hyde Park, NY
Members	Title	Location
Maria Argentina, LCSW	Social Worker	Bronx, NY
Syed Asad, MD	Nephrologist	Huntington Station, NY
Godfrey Burns, MD	Nephrologist	M New York, NY
Chaim Charytan, MD	Nephrologist	Flushing, NY
Ellen Demarco, RN	Administrator	Brooklyn, NY
Robert Lynn, MD	Nephrologist	Bronx, NY



3—CMS National Goals and Network Activities

In accordance with the legislative mandate for the ESRD Network Program, to assist CMS in meeting its goals to ensure the right care for every person every time, and in keeping with sound medical practice, the strategic goals of the ESRD Network Program and Network 2 are to:

- Improve the quality and safety of dialysis-related services provided for individuals with ESRD
- Improve the independence, quality of life, and rehabilitation (to the extent possible) of individuals with ESRD through support for transplantation, use of self-care modalities (e.g., peritoneal dialysis, home hemodialysis), and in-center self-care, as medically appropriate, through the end of life
- Improve the collection, reliability, timeliness, and use of data to measure processes of care and outcomes; to maintain a patient registry; and to support the goals of the ESRD Network Program
- Improve collaboration with providers and facilities to ensure achievement of goals 1–3 through the most efficient and effective means possible, with recognition of the differences among providers (independent, hospital-based, affiliate of an organization, etc.) and associated possibilities/capabilities
- Improve patient perception and experience of care, and resolve patients' complaints and grievances

The following sections of this Report describe the activities that Network 2 has completed in meeting these goals.

Goal 1: Improve the quality and safety of dialysis-related services provided for individuals with ESRD

The mission of CMS ESRD Health Care Quality Improvement Program, as defined in the ESRD SOW, is to promote the quality, effectiveness, and efficiency of services for Medicare beneficiaries by strengthening the community of those committed to monitoring and improving care. During CY 2009, Network 2 developed quality improvement projects with direct guidance from its MRB and through partnerships with renal providers. The CMS contract for ESRD Networks for the period of July 1, 2006, through June 30, 2010, requires all Networks to assist ESRD providers in assessing and improving care to all ESRD patients. To guide these efforts, Network 2, working closely with the MRB, has developed a comprehensive Quality Improvement Work Plan (QIWP), addressing four major areas:

1. Vascular Access (Fistula First Breakthrough Initiative [FFBI])

- Facility Access Reporting
- Feedback Reports
- Education—Patient, Professional
- Facility Quality Improvement Plans
- Fistula First Steering Committee
- Facility-Specific Goals
- Collaboration with the Chronic Kidney Disease (CKD) Project

2. CPM—Phosphorous Management

3. Network-Specific Quality Improvement

- Influenza Vaccination Project
- Involuntary Discharges (IVDs)
- PAC Revitalization

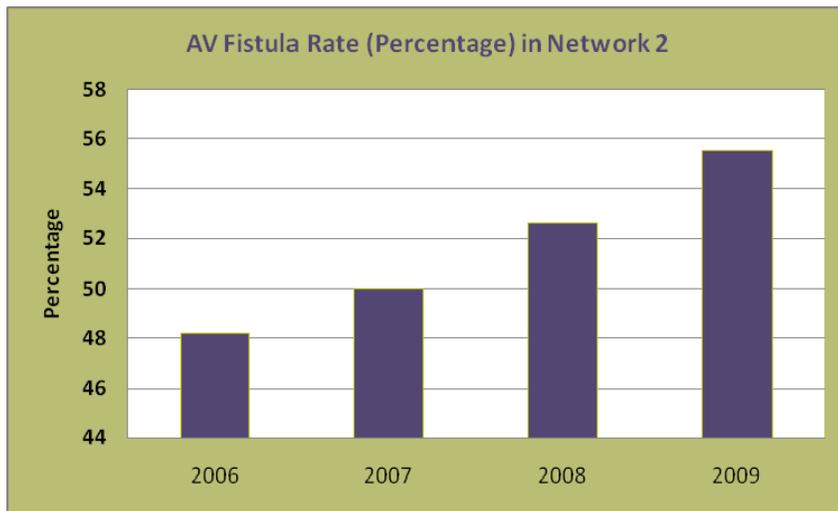
4. Facility-Specific Quality Assessment and Improvement

- Quality Assessment and Performance Improvement Project
- Forms Submission Compliance
- Medication Reconciliation Project

1. Vascular Access (FFBI)

CMS, in collaboration with key stakeholders in the renal community, launched the FFBI to improve vascular access for dialysis patients with the specific goal of increasing arterial venous (AV) fistula use. Figure 5 illustrates the improvement in the rate of AV fistulas used in the Network 2 area from 2006 through 2009.

Figure 5. AV Fistula Rates (Percentage) in Network 2 2006-2009*

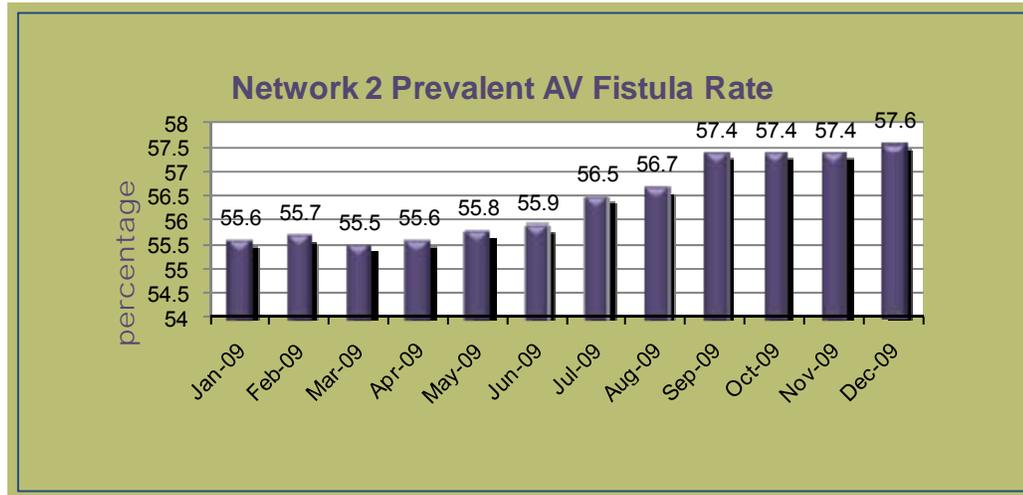


*Source: Fistula First Outcomes Dashboard CY 2006–2009.

For the current contract period, CMS set a new stretch goal of 66% of prevalent hemodialysis patients with AV fistulas. Each Network must demonstrate an annual decrease of 20% in its AV fistula quality deficit.

In this period of performance, the baseline measure for prevalent AV fistula use was 55.5% in March 2009 (Figure 6). The resulting goal of 57.6% was to be achieved by March 31, 2010. This goal was met according to the June 4, 2010 Dashboard. (March 2010 data).

Figure 6. Network 2 AV Fistula Rates (Percentage) in CY 2009*



*Source: Fistula First Outcomes Dashboard CY 2009.

Facility Access Reporting

Network 2 continues to collect facility-specific data and enter it into the CMS Standard Information Management System (SIMS). The data entered are compiled and reported via the Fistula First Outcomes Dashboard, which is available to the public at www.esrdncc.org and shows the prevalent rate of AV fistula use by Network and the percent of eligible facilities reporting. Each generation of the Dashboard includes data entered since the last Dashboard was updated.

The Network’s contractual requirement is to collect aggregate vascular access data from 100% of applicable facilities using the Fistula First Data Collection Tool. Network 2 maintained this reporting at 100% for each month in CY 2009.

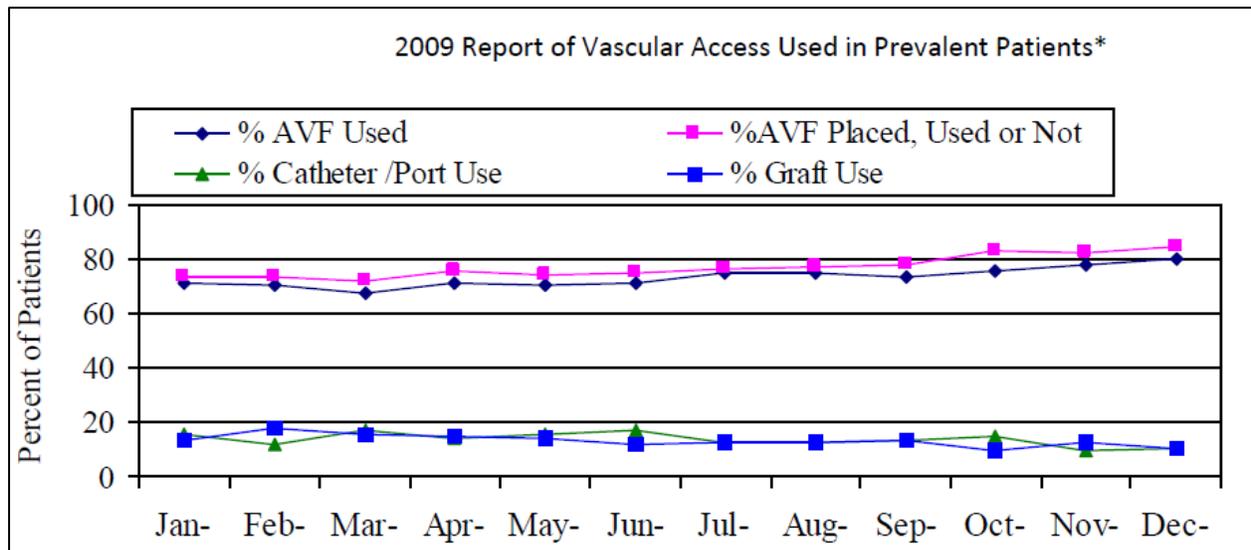
Feedback Reports

The SIMS Vascular Access Utility also produces three Core Standard Reports:

- Network and National comparative data for prevalent AV fistula use
- Facility-specific vascular access use (AV fistulas, grafts, and catheters)
- AV fistula placement in incident patients

These reports, which illustrate the percentages of prevalent patients with AV fistulas in use, catheter use, AV fistulas placed (used or not), and graft use were generated and sent to Network 2 medical directors and nurse managers throughout the months of February, May, and November 2009. A sample report is shown in Figure 7.

Figure 7. Sample Report of Facility-Specific Vascular Access Use in Prevalent Patients



*Source: Fistula First Outcomes Dashboard CY 2009.

Network 2 developed two new reports during CY 2007, which continue to be distributed in CY 2009.

Catheter in Place >90 Days Report—Developed to assist our quality improvement project to decrease catheters in ≥ 90 days in prevalent hemodialysis patients. The data were obtained from the monthly Vascular Access Reports submitted to the Network. The Report identifies the facility’s catheter rate in ≥ 90 days, the facility’s percentile rank in the state, and the state average. This allows each facility to compare its performance to others across the state. This Report was sent to medical directors and nurse managers, along with the aforementioned reports on a quarterly basis in February, May, August, and November 2009.

Physician Report—Developed to make nephrologists aware of the percentage of their patients that began treatment with a catheter and to encourage them to examine their practice patterns to decrease that percentage. The data used for this Report were obtained from Form CMS-2728. The Report identifies the number of incident patients that



began dialysis treatment by the identified nephrologist, the type of access the patient had at the initiation of treatment, and the number of patients seen by the nephrologist prior to the initiation of treatment. The Report was sent to individual nephrologists on a quarterly basis in February, May, August, and November 2009.

Access Patient/Provider Education Activities

Network 2 has offered several programs to disseminate information on FFBI. During CY 2009, eight Vascular Access Workshops were offered, titled, “CE [Continuing Education] Workshop for Dialysis Staff Vascular Access: Infection Control, Surveillance and Maintenance.” They were held in several locations throughout New York State—Brooklyn, Buffalo, Manhattan, Nassau, Queens, Suffolk, Syracuse, and Westchester. The target audiences were small groups of nurses and patient care technicians. The American Nephrology Nurses Association (ANNA) awarded two CE nursing credits for completion of this program. The objectives of this program were to educate staff on the physical assessment of vascular access, identification of potential complications, and improvement of cannulation techniques. A total of 413 participants represented 232 out of 239 Network 2 facilities. The overall evaluation of the program was 4.6, based on a five-point Likert scale.

Network 2 provides FFBI information on the ESRD IPRO website, <http://www.esrd.ipro.org> for patients and professionals. A recording of a WebEx presentation, titled, “Improving the Numbers: Achieving a 66% AV Fistula Rate,” can be viewed by going to the Events page. This program was originally presented on September 17, 2008 and included a vascular surgeon, David Fox, MD, a nephrologist, Eugene Petra, MD, and an interventional radiologist, Gregg Miller, MD. Additionally, a link to the Fistula First WebEx is located on the website.

Additional provider and patient information on the vascular access initiative is provided through Network 2’s newsletters, specifically, *ESRD Network Notes* and *PAC Notes*.

The Spring/Summer 2009 issue of *PAC Notes*, which was published in English and sent to providers for distribution to ESRD patients in September 2009, contained the article, “Caring for Your Hemodialysis Catheter,” as well as a “Fistula First Crossword Puzzle.” The Fall/Winter 2009 issue of *ESRD Network Notes*, which was distributed to Network 2’s renal care professionals in November 2009, included the articles, “AV Fistula Goal for Each Provider” and “The Vascular Surgery Change in Physician Reimbursement Rate,” as well as a list of facilities that have reached the AV fistula goal of 66%.



A patient pamphlet, *Vascular Access for Hemodialysis—A Guide for Patients*, was developed by Network 2 using materials provided by the Southern California Renal Disease Council, Inc. (Network 18), and the Northwest Renal Network (Network 16) in CY 2007. This pamphlet was translated into Spanish in CY 2008. A poster, *A Vascular Access for Hemodialysis*, was developed and printed in English and Spanish. The pamphlets and posters continue to be distributed to patients at regional PAC meetings and hemodialysis facilities, as well as to nephrologists, along with forms for ordering additional copies.

The Network has regional patient meetings in New York State. The goals of these meetings are to encourage patients to be involved members of the healthcare team and to strengthen the PAC by enlisting new members. Network 2 has taken this opportunity to spread the FFBI to patients through an interactive PowerPoint presentation and an open forum for questions and answers.

2. Facility Quality Improvement Plans

The ESRD Networks are responsible for overseeing the quality management of dialysis and transplant facilities. It is the responsibility of each Network to identify low-performing facilities and to assist them in improving outcomes. The data sources used to determine Network 2's vascular access performance are the Fistula First Outcomes Dashboard and the CPM Report. The data source used to determine the facilities' performance levels is the Vascular Access Reports, submitted to the Network by the provider or the provider's management company. Network 2, in conjunction with the MRB, reviews the data and determines the need for focused interventions.

In CY 2009, the MRB determined that each provider be given a vascular access goal based on the 2009–2010 contracts' quality deficit goal. Facilities were given a goal between 1% and 4%. If the quality deficit was less than 1%, the facility's goal was 1%. If the quality deficit was greater than 4%, the facility's goal was 4%. The goal was determined from the March 2009 vascular access data submitted in April 2009.

A request for QIPs was sent out to facilities with a census ≥ 50 patients that did not meet minimum standards as of March 2009 (May 2009 Dashboard) for AV fistula rates and/or catheter rates in ≥ 90 days. There were 20 requests for facilities that had an AV fistula rate less than 46% and 19 requests for facilities that had catheter rates greater than 15% in ≥ 90 days. This request was sent out in June 2009. Ten facilities met both the AV fistula and catheter criteria. There were a total of 29 requests for QIPs, which were all received into the Network. The QIPs were reviewed for completeness and reviewed with facilities that were not showing improvement.



The vascular access data were reviewed monthly. The targeted facilities had a baseline weighted average of 35.4% prevalent patients with AV fistulas and 24.8% prevalent patients with catheters rates ≥ 90 days. As of December 2009, the targeted facilities for AV fistula rates had a weighted average of 37.6%, which was a 2.2 percentage point improvement; targeted facilities for catheter rates ≥ 90 days had a weighted average of 21%, which was a 3.8 percentage point improvement. In October 2009, conference calls were held with the 15 facilities that did not show improvement for AV fistula and/or catheter rates. As of December 2009, 14 facilities showed improvement in AV fistula rates, with 8 facilities meeting the 4% goal; 13 facilities showed improvement in catheter rates ≥ 90 days, with 8 facilities meeting the 4% goal. Facilities that did not show improvement for AV fistula and/or catheter rates ≥ 90 days were reviewed with the MRB in the first quarter of 2010 (Figure 8 and 9).

Figure 8. Percentage of Patients with AV Fistulas in Low-Performing Facilities

Provider	2009									
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	35.2	35.6	35.2	35.9	36.8	33	34.9	34.1	34.1	35.2
2	45.1	41.2	39.6	38.9	41.2	43	42.6	44.2	46	47.1
3	35.7	37.4	36.2	39.5	35.7	35.9	42.4	40.4	40.6	40.4
4	36.1	39.7	40.4	42.1	42.6	41.7	45.9	46.9	42.6	40.6
5	40.6	40.7	39.1	36.6	37.7	36.6	36.2	35.8	35.8	35.2
6	35.8	38.9	38.6	36.1	38	38.2	36.8	36.4	38.3	40.3
7	37.5	35.6	32.3	36.4	36.9	32.8	35.1	35.6	43.5	40.6
8	38.9	41.2	44.9	44.3	47	42.9	41.4	35.3	33.3	33.3
9	37	36.4	34.6	36.8	35.9	35.8	46.3	46.6	44.2	44.2
10	28.1	25.4	25.6	31.4	33	38.5	41.7	40.9	40.4	39.8
11	24.3	22.4	23.8	25	26.1	27	27.8	28.3	27.4	26.8
12	43.4	43.6	40	41.7	44.8	42.6	42.6	46.8	45.8	46.7
13	37.1	41.1	39.6	42.5	40.7	42.3	39.6	41.8	44.8	47.1
14	28.7	31	30	30.3	35	37.2	40.9	43.6	40.6	41.8
15	34.1	32.5	32.7	31.3	31.5	31.6	33.5	34.1	44.9	32.8
16	38.6	36.5	37	40.3	33.3	28.6	29.7	29.4	31.4	34.2
17	32.1	27.3	28.2	28.6	25.3	19.8	21.1	19.2	18.9	18.4
18	43.9	43.9	49.2	48.4	49.2	48.4	47.6	50	47.3	46.3
19	36.8	38.5	38.5	32.9	30.9	34.4	33.3	32.9	30.7	28.0
20	42.6	44.8	44.8	44.1	42.3	41.6	40.3	42.7	41.6	48.6

Figure 9. Percentage of Patients with Catheters ≥90 Days in Low-Performing Facilities

Provider	2009									
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1	31.6	29.3	32.1	30.8	30.8	27.3	25	25.5	27.5	26.8
2	26.5	27.9	29.7	29.9	16.9	15.9	13	14.5	12.7	9.9
3	19.6	19.6	13.7	10.3	12.8	14.3	11.3	9.8	8.1	8.1
4	22.9	22.1	19.4	15.7	17	13	14.3	14.3	12.5	12.1
5	25.4	25	24.1	22.6	17.5	15	16.2	15.6	17	15.9
6	24.5	25.9	24.3	25.5	14.4	15.1	17.4	15.1	15.9	15.0
7	20.3	24.8	27.6	28.9	28.6	27.4	24.3	21.9	22.1	20.7
8	27.8	28.1	28.7	28.7	31.5	30.1	28.5	29.1	27.6	24.3
9	20.7	20.2	20.5	17.1	16.7	15.2	12.9	13.7	15.4	15.1
10	31.9	31.9	28.7	32.3	40.8	38.7	37	37.7	36.3	36.8
11	20.8	18.2	16.7	11.7	12.1	13.1	13.1	11.3	32.2	23.3
12	15.2	23.2	25.2	23.9	23.9	25.2	27	25.5	23.8	23.5
13	28.7	23.3	22.3	18.9	19.7	19.7	17.5	16.5	14.3	13.5
14	21	20.7	21.6	21.9	22	21.8	20.2	21.4	20.9	22.6
15	34.3	35.1	38.4	37.3	38.7	36.4	31.1	36.8	32.9	32.9
16	25	25	24.7	25	26.5	27.2	25	20.5	23	23.7
17	24.6	28.1	26.2	21	20.6	21	27	26.7	27.3	27.8
18	46	46.2	38.5	42.4	27.7	20	22.6	31.8	36.4	34.4
19	29.1	20.9	44.8	16.2	16.9	15.6	13	12	18.2	17.6

Fistula First Steering Committee

Network 2 has established a Fistula First Steering Committee to advise and guide the Network on improving fistula rates and to assist the Network in identifying areas of opportunity in the community to spread FFBI. The Committee met in June and September 2008 and comprises interdisciplinary members (nephrologists, vascular surgeons, an interventional radiologist, a primary care physician, an administrator, and a registered nurse). An achievement of this Committee is the presentation of a WebEx in September 2009, titled “Improving the Numbers: Achieving a 66% AV Fistula Rate.” This presentation was recorded and placed on the Network’s website. The Committee also developed a vascular surgeon database. Each facility was asked to send contact information for the vascular surgeons to whom they refer most frequently. The Network has used this database, consisting of 373 vascular surgeons, to send information on the FFBI and to ask these surgeons to share their knowledge on the facilitating factors and barriers to AV fistula placement.

CKD Prevention Project

The Network is currently collaborating with the CKD Prevention Project (CKD group). Both the Network and the CKD group are contracted by CMS. The Network focuses its activities on quality improvement activities for ESRD patients who are receiving treatment for kidney failure. The CKD group focuses on the early identification and care of the CKD patient prior to treatment requirements. Both groups have contractual obligations to improve AV fistula rates. Their collaborative efforts are as follows:

- The two groups have developed a joint calendar of both of their activities;
- The CKD group attended the vascular access program in Nassau County;
- The CKD group has provided a list of nephrologists and dialysis units to the Network, and the Network has shared data on the identified low-performing facilities with the CKD group;
- Vascular data by nephrologist and dialysis unit have been shared with the CKD group;
- The CKD senior director has joined the Fistula First Steering Committee;
- The Network's Executive Director and Assistant Director are members of the IPRO CKD Coalition;
- A collaborative project on the accuracy of the CMS-2728 form vascular access data compared to the vascular access billing data has been initiated. The goal of this project is to achieve accurate vascular access data for incident patients; and
- Monthly collaborative meetings have been instituted.

3. Clinical Performance Measures

Network 2 participates in the national CMS ESRD CPM Project, under which clinical information on dialysis patients is collected to measure and track the quality of care received by these patients in dialysis facilities. These Measures are based on the National Kidney Foundation's (NKF's) Kidney Disease Outcomes Quality Initiative (KDOQI) Clinical Practice Guidelines. A statistically significant sample of hemodialysis and peritoneal dialysis patients across Networks is selected for clinical data profiling. For hemodialysis patients, the data are collected during the last quarter of each year; for peritoneal dialysis patients, the data are collected during the last quarter of each year and the first quarter of the following year. The CPM Project was replaced with the Elab Data

Project in 2009. Although facility-specific data are not available, Networks receive reports on their performance compared to other Networks and the nation as a whole (Figure 10).

The Networks are required to review the CPM data and develop a quality improvement project related to the data. Based on the 2008 CPM Report (data last quarter of 2007), received in February 2009, phosphate management was chosen by the MRB to be the focused intervention for the Network.

Performance on the Mean Phosphorous CPM data improved by 3 percentage points from CY 2007 to CY 2008, bringing it 4% above the national average. Other measures such as Mean URR > 65%, Mean Kt/V > 1.2, Mean Serum Albumin % $\geq 4.0/3.7$ g/dL, and Percent of Patients with Adjusted Calcium 8.4–10.2 mg/dL all remained consistent with the national average, with no statistically significant changes from CY 2007 to CY 2008.

The Network’s Mean Hb ≥ 11 g/dL dropped 7 percentage points from CY 2007 to CY 2008 and is 5% below the national average, but the Network’s Mean Hb 11–12 g/dL improved by 5 percentage points in the same time frame, bringing the Network 1% above the national average. The national Mean Serum Albumin $\geq 4.0/3.7$ g/dL dropped from CY 2007 to CY 2008 by 37%, and the Network-wide rate by 4%; the Mean Tsat % dropped 2 percentage points, and the Mean Serum Ferritin percentage was unchanged and remains 4% below the national average. Network 2’s MRB will continue monitoring to determine whether future interventions will be necessary.

Figure 10. CPM Results CY 2006–2008*

CPM	National Results			Network 2 Results		
	2006	2007	2008	2006	2007	2008
Mean URR $\geq 65\%$	88%	88%	89%	89%	88%	88%
Mean Kt/V ≥ 1.2	91%	90%	91%	93%	91%	90%
Mean Hb ≥ 11.0 g/dL	84%	84%	82%	82%	84%	77%
Mean Hb 11–12 g/dL	33%	35%	39%	32%	35%	40%
Mean Tsat % ≥ 20	78%	80%	80%	79%	80%	78%
Mean Serum Ferritin % ≥ 100 ng/mL	95%	95%	95%	92%	91%	91%



CPM	National Results			Network 2 Results		
	2006	2007	2008	2006	2007	2008
Mean Serum Albumin \geq 4.0/3.7 g/dL	33%	37%	34%	31%	37%	33%
Mean Serum Albumin \geq 3.5/3.2 g/dL	80%	82%	82%	80%	79%	81%
Prevalent Patients Catheters \geq 90 Days	21%	22%	21%	21%	20%	23%
Prevalent Patients AV Fistulas	44%	46%	49%	48%	47%	51%
Incident Patients AV Fistulas	54%	42%	42%	53%	43%	40%
Adjusted Calcium 8.4–10.2 mg/dL	83%	85%	85%	84%	85	84%
Mean Phosphorous 3.5–5.5 mg/dL	na	53%	52%	na	53%	56%

*Source: ESRD CPM Project.

To support the Project, Network 2 sent a total of 914 CPM data collection forms to 192 facilities on June 13, 2008. All forms were completed and returned. The Network 2 quality improvement staff conducted a reliability study of 22 forms by chart review; information was entered into the SIMS database.

Network 2 also participates in the National Elab Data Collection Project, which provides patient-level data for those cared for in large dialysis organizations (LDOs), managed/owned facilities, and independently owned facilities. Participation in the Project is voluntary. With these facility-level data, the MRB and Network 2 identified and developed interventions for the facilities that demonstrated opportunities for improvement.

During CY 2009, preliminary 2008 CPM data (based on care provided during the fourth quarter of 2007) was reviewed with the MRB and it was determined that Network 2 would focus on phosphorous management. Although the phosphorous levels in Network 2 are 4 percentage points above the national average, the MRB selected this Project because an elevated serum phosphorous increases risk of death in the ESRD patient. Additionally,



the management of bone disease is required by the Conditions for Coverage (CfC) and recommended by the KDOQI Clinical Practice Guidelines.

Phosphorous Management

The goal of this Project is to increase the percent of patients in targeted facilities who have phosphorous levels between 3.5 and 5.5 mg/dL by 5 percentage points. Facilities were selected to participate in this Project from the 2007 and 2008 Elab data collection. The selection criteria for this Project was a census >50 patients and <50% of patients with serum phosphorous levels 3.5–5.5 mg/dL for 2 years. These facilities were matched by percentage of patients with serum phosphorous levels 3.5–5.5 mg/dL and placed in one of two groups, an intervention group and a non-intervention group. The purpose of the non-intervention group is to compare it to the intervention group to determine the effectiveness of the interventions.

The Network received phosphorous data from the Elab Data Collection Project, which were reviewed and analyzed. The baseline data were collected from the last quarter of 2008. The intervention group had a baseline weighted average of 44.2% of patients meeting the target value of 3.5–5.5 mg/dL, and they ranged from 36.3% to 47.4%. The non-intervention group had a weighted average of 43.4% of patients meeting the target value of 3.5–5.5 mg/dL and ranged from 36.3% to 48.8%. The remeasure was collected from the Elab data from the last quarter of 2009. The intervention group had a weighted average of 58% of patients meeting the target value of 3.5–5.5 mg/dL. This was an improvement of 13.8%. All facilities showed improvements ranging from 11.3% to 20.3%. The final remeasure ranged from 56.1% to 67.6% of patients meeting the target value of 3.5–5.5 mg/dL. The overall Project, as well as each targeted facility, met its goal. All of the intervention group facilities were above the Network average of 56%. The non-intervention group showed a 9.2% improvement in patients meeting the target value of 3.5–5.5 mg/dL. Their weighted average was 52.6%. All facilities showed improvement ranging from 5.3% to 14.9%. The final remeasure ranged from 45.4% to 59.3% of patients meeting the target value of 3.5–5.5 mg/dL. Of the non-intervention group, only two facilities were above the Network average of 56%.

Figure 11: Comparison of Intervention Group and Non Intervention Group

	Baseline		Re-measure		Improvement	
	Weight Average	Range	Weight Average	Range	Weight Average	Range
Intervention	44.2%	36.3-47.4%	58%	56.1-67.6%	13.8%	11.3-20.3%
Non-Intervention	43.4%	36.3-48.8%	52.6%	45.4-59.3%	9.2%	5.3-14.9%

The intervention group had a 4.6% higher weighted average than the non-intervention group, demonstrating that interventions (monthly conference calls and monthly data collection) done by facilities with the intervention group alone had a positive impact on these facilities' outcomes. The non-intervention group also showed improvement but not as much as the intervention group. The reason for the non-intervention group's improvement was due to the interventions offered to all facilities in the Network. The interventions included a dietitian conference call, a WebEx on phosphorous management, articles in *Network Notes* and *PAC Notes*, and presentations at regional patient meetings. In addition, the best practice group, the intervention group, and the non-intervention group were asked to complete an environmental scan. All activities had an impact on the non-intervention group to improve its phosphorous outcomes.

4. Network-Specific Quality Improvement Project

Influenza, commonly called "the flu," is a contagious respiratory disease that can be spread from person to person prior to and after the onset of symptoms through droplet contamination. According to the Centers for Disease Control and Prevention (CDC), most people who get the flu recover completely in 1–2 weeks; however, more than 200,000 people develop serious and potentially life-threatening complications requiring hospitalization, and another 36,000 die each year.¹

People of any age group can get the flu, but rates of infection are highest among children. Serious illness and death are highest among persons 65 and older, children under 2, and persons with medical conditions that put them at higher risk for complications. Ninety percent of deaths attributed to influenza occur in adults over 65 years of age.² ESRD patients are at a high risk for developing complications from influenza. In CY 2008, this population comprised 43.3% of patients over the age of 65 nationally. Of this ESRD population, 43.7% had diabetes, 27.7% had hypertension, and

¹ Center for Disease Control and Prevention, "Key Facts About Seasonal Influenza (Flu)," March 12, 2009, <<http://www.cdc.gov/flu/keyfacts.htm>>, June 26, 2009.



patients had an average of 4.1 co-morbidities each. In Network 2, this population comprised 47.4% of patients over the age of 65; 40.8% had diabetes, 24.7% had hypertension, and patients had an average of 4.6 co-morbidities each.²

Annual influenza vaccination is the most effective method for preventing the flu and its complications. The Healthy People 2010 goal is to increase the number of influenza immunizations given. The vaccine should be provided to all persons who want to reduce the risk of getting the flu, but emphasis on high-risk groups include children 6 months to 18 years, persons >50 years, and adults at risk for medical complications from the flu. The CDC states that 83% of the United States is in one or more of the targeted groups, but <40% of the US population received the influenza vaccine during 2007–2008. The ESRD patient population is considered a high-risk population, and it is recommended that every patient be vaccinated. In 2006, US Renal Data System (USRDS) reported that 56.5% of ESRD patients received flu vaccines nationally.³

On April 15, 2008, the final rule for the CfC for ESRD facilities was published. The CfC states that a patient's assessment must include an immunization history, and the quality assessment and performance improvement program must include recommendations and action plans to promote immunizations. The influenza vaccination project was selected by the MRB in CY 2008 to support the requirements of the CfC, the goal of the Healthy People 2010, and the low vaccination rate reported by the USRDS. This Project increased the number of ESRD patients who received the influenza vaccination by 14%. During the 2007–2008 influenza season, 65.4% of patients received the vaccine. The interventions of this Project resulted in an increased rate of vaccination in the 2008–2009 influenza season to 79.4%. The Network will continue to work on this Project until it meets the 90% goal of CMS.⁴

As part of the Quality Improvement Work Plan, Network 2 developed an Influenza Project. The Influenza Project was developed to improve the percentage of patients who received the influenza vaccination from the 2008–2009 flu season to that of 2009–2010 by 5 percentage points. An environmental scan was developed in 2008 to measure the improvement in influenza vaccination rates between the CY 2007–2008 flu season and that of 2008–2009. This scan was used again this year for the re-measure. A random sample of statistically significant patients was selected. During the 2008–2009 flu season, 79.4% of patients received the influenza vaccination; the re-measure was 81.2% of patients who received the seasonal influenza vaccination for 2009–2010, an

² US Renal Data System, USRDS 2007 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2007, p.5.

³ University of Michigan Kidney Epidemiology and Cost Center, 2008 Dialysis Facility Report Documentation Network 2, July 2008

⁴ Prevention and Control of Influenza—Recommendations of the Advisory Committee on Immunization Practices (ACIP) 2008. *MMWR Morb Mortal Wkly Rep*, 2008; 57(RR07):1–60

improvement of 1.8 percentage points. This program was successful in that 36% ($n = 83$) of facilities reported that >90% of their patients received the flu vaccine.

Although Network 2 did not meet its improvement goal of 5 percentage points, patients who received the influenza vaccination are above the national average. It is believed that the main reason Network 2 fell short of its goal is because the seasonal flu vaccine was reported to be on back order by several facilities, resulting in their inability to vaccinate patients. The Network did try to assist the facilities in getting their patients vaccinated by suggesting that patients be referred to their primary care physicians, local pharmacies, or the New York State Department of Health (NYSDOH). The Network sent out emails and faxes addressing this issue. Another reason why the Network did not reach its goal was because the goal was set too high, especially after the 14% increase last year. Regarding the success rate of >90%, more patients who did not receive the vaccination refused it than were willing to take it.

Network 2's activities to achieve this goal included (1) providing facilities with updated information from the CDC and NYSDOH, (2) development of a poster and pocket guides to be used to encourage patients to receive the vaccine, (3) asking facilities to track and submit vaccination rates for their patients, and (4) awarding certificates of achievement to facilities with a 90% vaccination rate.

5. Facility-Specific Quality Assessment and Improvement Project

The Network assists providers/facilities in the development and implementation of Quality Assessment and Performance Improvement (QAPI) Projects to improve patient care processes and outcomes. Through collaboration with the MRB, it was established that two projects would be developed and implemented: Medication Reconciliation and QAPI.

Medication Reconciliation Project

Medication errors are one of the most common patient safety issues. The Joint Commission and the Institute for Healthcare Improvement (IHI) cite that lack of medication reconciliation at care transitions is the main reason for medication errors. Transition of care can include admission to the hospital, changes from one unit to another, discharge from the hospital, transfer to long-term care facilities, and discharge to dialysis facilities. In 2005, the Joint Commission made the accurate and complete reconciliation of medications across the continuum of care the eighth National Patient Safety Goal; and in 2006, it mandated all accredited organizations to implement a medication reconciliation process. The underlying principle of this goal is that patients are at high risk for harm from adverse drug events when communication about medications is not clear, and the chance for errors increases whenever individuals involved in a patient's

care change. For this reason, communication about the medication list, ensuring that it is accurate, and reconciliation of any discrepancies are essential.

Lack of reconciling medications has been cited by IHI as being the cause of 50% of all medication errors and the cause of 20% of all adverse drug errors.⁵ In its sentinel database, the Joint Commission maintains that more than 350 medication errors have resulted in death or major injury.⁶ Of those, 63% were caused by a breakdown in communications, and half could have been prevented if medication reconciliation was done. Types of reconciliation errors include improper dose, omission error, prescribing error, wrong drug, and wrong frequency.

Although many dialysis facilities are not accredited, the CfCs require ESRD facilities to have an ongoing program that measures improvement of health outcomes and a reduction in medical errors. Medication errors might be a common problem in dialysis units due to the many transitions of care in which the patient may be involved. Some of these transitions are due to the patient seeing several physicians, such as a nephrologist, a primary care physician, a vascular surgeon, and an interventional radiologist. The patient may be hospitalized frequently, or admitted to a long-term facility or rehabilitation facility; therefore, it is important that a complete and accurate list of medications is reconciled during each transition of care to prevent medication errors.

Although there are many transitions of care, the Network Project focuses on the transition of the patient discharged from the hospital and returning to the dialysis facility. The goal of the Project is to improve the medication reconciliation process in facilities that have been identified as having no process or a limited process. In the last quarter of 2008, an environmental scan was sent to facilities with high numbers of patient admissions to the hospital, determined from the 2008 Dialysis Facility Report. The answers on the environmental scan were assigned a point value. Higher points indicated a more complete reconciliation process. Three groups (best practice, intervention, and non-intervention) were selected based on their points. The 10 facilities with the lowest points (0–13) were selected for random placement into one of the two groups (intervention or non-intervention). As of January 2009, the Network has been working with the intervention group to assist in the development and implementation of a formal medication reconciliation process. The non-intervention group has been made aware that the Network is working on a Medication Reconciliation Project, but the Network has not worked with the group to develop or implement such a process. To evaluate the effectiveness of this Project, the environmental scan was sent out to both the intervention

⁵ 5 Million Lives Campaign. *Getting Started Kit: Prevent Adverse Drug Events (Medication Reconciliation) How-to Guide*. Cambridge, MA: Institute for Healthcare Improvement; 2008. (Available at www.ihc.org)

⁶ The Joint Commission, "Sentinel Event Alert – Issue 35," January 25, 2006, <http://www.jointcommission.org/SentinelEvents/SentineleventAlert/sea_35.htm>, June 26, 2009.



group and the non-intervention group in June 2009. The re-measure showed that the intervention group improved its point value from 0–13 to 18–25 while the non-intervention group point value improved from 0–13 to 9–17. Although the non-intervention group showed improvement, the intervention group showed greater improvement. The change in scores between the intervention group and the non-intervention group shows that the interventions were effective in improving the medication reconciliation process in the intervention groups.

The interventions used to improve the medication reconciliation process were a WebEx, interviews with best practice providers, and conference calls with the intervention group. The WebEx, titled “Medication Reconciliation in the Outpatient Dialysis Setting,” was offered to all providers. Interviews with the best practice providers were used to identify successful medication reconciliation systems in place and to share this information with the intervention group. Conference calls were held monthly with each provider in the intervention group. The topics included development of a policy on medication reconciliation, staff and patient education, and quality improvement processes to maintain and sustain the medication reconciliation process. After each conference call, the providers were required to submit to the Network documents such as a written policy, an education plan, and a quality improvement tool.

Under the direction of the MRB, it was determined that this Project be extended to identify its sustainability and to make it available to all facilities in the Network. The facilities in the intervention group were requested to do chart reviews for 6 months to identify whether improvements in medication reconciliation were sustained. From July through December 2009, the facilities averaged 75% medication reconciliation. The information to develop an effective medication reconciliation process has been posted to the ESRD website: www.esrd.ipro.org, and a letter informing facilities of this information was sent out via email and fax.

Quality Assessment and Performance Improvement (QAPI)

In the CfC, it states a facility’s QAPI program must develop, implement, maintain, and evaluate an effective data-driven program. The QAPI program must comprise an interdisciplinary team led by the Medical Director, and it should focus on patient outcomes and prevention of medical errors. The CfC specifies that the program should have achievable outcomes that are measured by indicators or performance measures. The facility must maintain ongoing monitoring of these measures to identify, correct, and sustain improvement and prioritize its improvement effects with immediate correction to any identified problem that threatens the health and safety of patients. The QAPI program as stated in the CfC must include, but is not limited to, adequacy of dialysis, nutritional status, mineral metabolism and renal bone disease, anemia management, vascular



access, medical injury and medical error identification, hemodialysis reuse (if the facility reuses dialyzers), patient satisfaction and grievances, and infection control.

The Survey and Certification Providing Data Quickly (S&C PDQ) website, <http://pdq.cms.hhs.gov/index.jsp> retains a citation frequency report. In CY 2009 (January–July), QAPI was the most frequently cited condition level, followed by infection control and medical directors' responsibilities. Of the 236 facilities in New York State, as indicated on this website, this condition level was cited in 1.3% ($n = 3$) of all facilities. Upon closer inspection, one of the facilities that were identified as having a condition level QAPI is not listed on this website. If this fourth facility were included, the condition level for QAPI would have been cited in 1.7% of all facilities. This website indicated that 33 surveys were done during CY 2009, which indicates that condition level QAPI was cited 9% ($n = 3$).

On February 1, 2009, the State Survey Agency (SSA) for New York State and Network 2 signed an agreement to exchange information prior to and after a facility recertification survey. The Network is contacted prior to a facility survey and supplies the SSA with information relating to Network goals. After the survey, the SSA notifies the Network if there are any condition levels cited for the facility and sends the Network a copy of the Statement of Deficiencies (SODs). Between February 1 and July 31, 2009, the Network sent information to the SSA for 33 facilities: Seven facilities or 21% of surveyed facilities were cited for any condition level, and four facilities or 12 % of surveyed facilities were cited for QAPI. The specific areas in which QAPI was cited were for lack of monitoring data and/or implementing a corrective plan related to patient outcomes (adequacy, albumin, mineral metabolism, anemia, vascular access, mortality, infection control, rehabilitation, patient satisfaction, home hemodialysis, and peritoneal dialysis) and threats to patient safety (reuse, physical environment, infection control, and hospitalization rates). With this information, the MRB, along with the Network, has decided to assist facilities that are struggling with the development and implementation of their QAPI program.

The goal of the QAPI Project is to have the facility develop, implement, and sustain an effective QAPI process. Facilities that are cited with a condition level must submit a plan of correction that is acceptable to the SSA; but often they do not fully implement the plan of correction and are cited again with the same condition level. The focus of the Network is to ensure that the plan of correction is fully implemented. Facilities that are cited with a condition level for QAPI after August 2009 will be placed in this Project. As of December 31, 2009, there are two facilities in the Project. Both facilities have developed an effective QAPI program, and the Network is reviewing monthly QAPI minutes and data to ensure sustained implementation.



The interventions used to improve the identified facilities include site visits, PowerPoint presentation, collection and review of QAPI minutes and data, and Network suggestions to improve the QAPI process. The SSA notifies the Network of any facility that has received a condition level for QAPI. The Network contacts the facility to offer assistance in the development of a plan of correction, to request QAPI minutes and data, and to set up a date for the site visit. At the site visit, the Network presents a PowerPoint presentation on the development of a QAPI, reviews the current QAPI minutes and data, and identifies areas in the QAPI process that need change.

6. Quality Improvement Work Plan

The QIWP is the primary framework for defining and implementing the Network's quality improvement program goals. Network 2 is required to develop a QIWP annually in conjunction with the MRB, which guides and directs the actions that Network 2 will implement to improve patient outcomes.

The QIWP, which was submitted on August 27, 2009, was designed to allow for rapid cycle improvement. The Plan was developed based on Network-specific needs identified from data sources, including national reports, public use files, historical data, and complaints and grievances. It includes processes to monitor Network resources through the Network's internal quality improvement program, fostering continuous quality improvement.

The Network reports on the status of its QIWP to CMS in the Quarterly Progress and Status Report, and Plan activities are reflected in the Annual Report.

Goal 2: Improve the independence, quality of life, and rehabilitation (to the extent possible) of individuals with ESRD through transplantation, use of self-care modalities, and in-center self-care, as medically appropriate, through the end of life

Network 2 continues to promote independence, quality of life, and rehabilitation through various activities, as outlined below. The Network has encouraged participation in vocational rehabilitation and has instituted the community service outreach position to champion vocational rehabilitation by visiting facilities and attending work programs. Some of the many ways in which Network 2 promotes this goal is by hosting patient education meetings in each of the state’s 11 regions, attending renal community events and patient meetings, and providing education via the Network’s newsletters, website, and various provider meetings throughout the year.

1. Newsletters

Network 2 produces two newsletters: one for patients, *PAC Notes*, and one for renal care professionals, *ESRD Network Notes*. Included in The Spring/Summer 2009 issue of *PAC Notes* were articles about: caring for your vascular access; disaster preparedness; IVDs; a question and answer section with responses provided by a CMS New York Regional Office Medicare specialist; the “How Are We Doing?” evaluation form; medication reconciliation; information regarding phosphorous, vocational rehabilitation information; and “Ask Dawn,” a section in which the Network 2 Community Outreach Coordinator provides a response to a question submitted by a patient. Questions are reprinted in this section; however, the patient’s identity is kept anonymous.

Each issue of *PAC Notes* contains a vascular access article, a word search puzzle, a Consumer Activity Report, ESRD-related websites, a dialysis-friendly recipe, consumer education information, and Network 2 contact information. *PAC Notes* is published in both English and Spanish, and is distributed to all facilities.





Network Notes, which is directed to renal professionals, was produced and distributed in Fall/Winter 2009 and featured information on the decreasing Dialysis Patient-Provider Conflict (DPC), IVD, FFBI Project update, an article on Advance Care Planning, getting help using the CROWN customer portal and the implementation of Consolidated Renal Operations in a Web-Enabled Network (CROWNWeb) Phase 2; information was also provided on common condition infractions that pose a serious threat to patients and if left uncorrected, would place facilities in immediate jeopardy of being closed. Congratulations were offered to facilities meeting the CMS goal of 66% of prevalent patients with an AV fistula.

2. Website

The Network 2 website provides information about Network 2, as well as educational and resource materials in both English and Spanish. The website was developed to serve patients and their families, dialysis and transplant providers, and the community at large. The website, www.esrd.ipro.org, includes information on:

- Emergency Planning,
- Grievance Procedures,
- Information for Patients,
- Patient Safety,
- Resources, and
- News and Events.

Also included are:

- A link to Dialysis Facility Compare,
- Information for Professionals,
- Archived Patient and Provider Newsletters, and
- Network Annual Reports.

The website has a “search” feature that allows the viewer to search within the site itself or across the Internet. The site meets federal accessibility requirements and is updated with new content on a regular basis. The “Contact Us” feature allows the viewer to contact a Network 2 staff member with questions or requests for additional information.



The Network 2 website will undergo redevelopment in 2010. This update will be aimed at making the website easier to use and more visibly appealing to the provider and consumer communities.

3. Vocational Rehabilitation

Network 2 provided information regarding vocational rehabilitation in CY 2009. Patients received individualized vocational counseling on issues such as problems on the job, new career options, how to obtain training, concerns about loss of benefits, how to make the “return to work” transition, and job-seeking skills (e.g., preparing resumes, interviews, and disclosure of disability). For patients not able to work, suggestions on places to volunteer were offered and the benefits of regular exercise were emphasized. The Community Outreach Coordinator also dedicates a segment of the regional patient meetings to vocational rehabilitation as well as volunteerism and exercise.

Facility social workers were given information to help their patients deal with vocational concerns. Patient inquiries included requests for advice on working with Vocational and Educational Services for Individuals with Disabilities, the Americans with Disabilities Act, Social Security work incentives and income allowances, trial work periods, and available medical coverage.

Goal 3: Improve the collection, reliability, timeliness, and use of data to measure processes of ESRD care and outcomes, maintain the ESRD patient registry, and support national ESRD Network Program data reporting, reliability, and validity

Network 2 collects, maintains, validates, and analyzes patient data for individuals receiving ESRD services in New York State, as mandated by the Social Security Act and as required by contract. Network 2 maintains patient information in the SIMS database and replicates it to the central SIMS database repository on a daily basis.

The central repository receives similar data from the 18 Network organizations across the country, constituting the national ESRD patient registry. Renal Management Information Systems (REMIS) is a database that contains information on provider billing for ESRD services, as well as 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 Network 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 that a patient’s renal medical condition has reached end stage and to register all ESRD patients (Medicare and non-Medicare) with the USRDS, as mandated by law.

1. CMS Forms Processed

To register an ESRD patient, the treating dialysis or transplant facility must submit a Medical Evidence form (CMS-2728 form) to the Network within 45 days of initiation of chronic treatment. Network 2 enters the data into SIMS to determine if the patient meets the criteria for ESRD. Upon the death of a patient, the provider must submit a Death Notification form (CMS-2746 form) within 30 days.

As shown in Figure 11, from CY 2008 to CY 2009, Network 2 experienced a 1.5 percentage point decrease in the number of forms processed. In CY 2009, the total number of new patients starting treatment (incident patients) was 7,234, representing an increase of 12 patients over CY 2008. The total number of all patients receiving treatment (prevalent patients) as of December 31, 2009 was 24,941, representing an increase of 727 patients over CY 2008.

Figure 11. CMS Forms Processed CY 2001–2009*

Year	Medical Evidence (CMS-2728 form)	Death Notification (CMS-2746 form)
2001	6,030	4,554
2002	7,443	4,635
2003	7,591	5,884
2004	6,790	4,950
2005	7,158	5,160
2006	8,195	5,461
2007	8,135	5,559
2008	7,647	4,976
2009	7,409	5,046

*Source: Standard Information Management System CY 2001–2009.

2. Patient Events

In addition to documenting incident and prevalent patients, Network 2 tracks patient events.

On a monthly basis, providers submit Patient Activity Reports (PARs), which indicate changes in patient treatment modality status and events, such as transfers in or out of a facility. There was a slight increase in the number of patient events reported in CY 2009, as compared to CY 2008 (Figure 12). Two hundred sixty-four facilities (239 dialysis and 16 transplant facilities) in the Network 2 area were requested to verify the patient census and reconcile any discrepancies on a quarterly basis throughout CY 2009. The CMS Facility Survey form (CMS-2744B), along with the patient beginning and ending census and patient events for the year, was printed and sent to providers on February 12, 2010. Facility staff verified the patient census, made changes to the form, and submitted any previously omitted forms and events for the year to Network 2, where corrections were entered in the SIMS database.

Figure 12. Number of Patient Events CY 2001–2009*

Calendar Year	# of Events Entered
2001	27,920
2002	29,815
2003	34,651
2004	31,630
2005	30,081
2006	35,685
2007	30,901
2008	28,167
2009	28,291

*Source: Standard Information Management System CY 2001–2009.

3. Provider and Personnel Database

Network 2 maintains a provider database in SIMS that contains facility names, demographic information, treatment modalities offered, shifts, and key personnel. The CMS Northeast Consortium/Division of Survey & Certification notifies Network 2 of facilities that are newly approved, have undergone a change of name, owner, or provider number, or have closed. Providers also notify the Network of changes to facility



information and personnel as they occur, and update their facility roster semi-annually. Network 2 staff updates the information in SIMS when changes are received.

The updated SIMS provider database is uploaded to the CMS Dialysis Facility Compare website monthly. This website, which is accessible via www.medicare.gov lists all Medicare-certified dialysis facilities nationally and provides dialysis facility characteristics such as name, address, telephone number, date of Medicare certification, shifts starting at or later than 5 p.m., number of treatment stations, types of dialysis offered, and ownership type. Quality measures, adequacy of dialysis, treatment of anemia, and patient survival are also reported.

4. Quality Assurance of Patient Data

Network 2 is required to monitor the submission of accurate and timely data from ESRD providers within New York State. Network 2 data staff monitors submitted forms for accuracy, completeness, and timeliness, communicating with providers using various reports, such as the Reject Report and Missing Forms Report, which are printed and sent to providers each month. The Reject Report notifies the provider of missing or inaccurate information on a form that was submitted. The Missing Forms Report notifies the provider of forms that were not received. Corrected data must be submitted within 3 days, whereas missing forms must be provided within 7 days of receipt of the Report.

The accuracy and completeness of the Network's databases are verified in several ways—SIMS accretions and notifications and REMIS alerts. Accretions are defined as patient records 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. Network 2 staff investigates these data discrepancies weekly. 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 Network 2 with updates on kidney transplants from its website. Within 30 days, data staff reconciles the kidney transplant information in SIMS with the transplant data received from UNOS. Quarterly, the Network notifies transplant centers of any forms that they are delinquent in sending to UNOS.

5. Annual Compliance Reports

The facilities are notified semi-annually of their accuracy and timeliness of form submission by way of a Compliance Report, which allows the facility to compare timeliness and accuracy for both CMS-2728 and CMS-2746 forms to determine the Network compliance rate. The CMS goal for semi-annual and annual compliance is 90%. Facilities that do not meet the compliance rate are asked to submit a performance improvement plan to the Network. The CMS Project Officer is sent a list of providers and their compliance rates. Of the 237 dialysis facilities in operation in CY 2009, 44 (18.6%) did not meet the semi-annual compliance goal (Figure 13). This represents a decrease of 70 facilities since CY 2008. All 44 facilities submitted performance improvement plans.

By the end of CY 2009, 239 dialysis facilities were in operation. Of the 239 facilities, 47 (19.7%) did not reach the annual compliance goal of 90%. Despite the slight rise in the number of facilities that did not meet the goal during CY 2009, this number represented a decrease of 50 facilities compared to the end of CY2008. For the Annual Compliance Report, providers that failed to meet the annual goal of 90% were instructed to complete a performance improvement plan that incorporated, at a minimum: (1) Identification of the obstacles preventing the provider from achieving its compliance goals; (2) a detailed description of steps the facility planned to take to improve future performance; and (3) identification of the facility personnel who were responsible for implementing steps to be taken. In addition, the providers were required to have the performance improvement plan signed by the facility Medical Director, Administrator, and the Data Contact to ensure that key personnel at the facility were involved in improving the facility’s compliance.

Figure 13. Number of Facilities Failing to Meet Compliance Rate in CY 2009*

Semi-Annual Below 90%	Annual Below 90%
44	47

*Source: Standard Information Management System CY 2009.

The biggest challenge for ESRD providers submitting data in New York State is forms compliance, i.e., the accurate and timely completion of CMS-2728 and -2746 forms. The CMS goal for ESRD forms submission compliance rates is 90% combined accuracy and timeliness for all ESRD providers. Although the majority of Network 2 providers are currently meeting this goal, a significant number of facilities are not; this affects the overall compliance of Network 2 as a whole. The total forms compliance rate for Network 2 was 88.5% as of the 2008 Annual Compliance Report, just shy of the 90% CMS goal.



In July of 2009, Network 2 implemented a Quality Improvement Project in an effort to raise and maintain the overall Network compliance rate above 90%. A concurrent goal was to assist the lowest-performing dialysis providers in achieving and maintaining an overall compliance rate increase of 5 or more percentage points by the end of December 2009.

The baseline measure to determine the lowest-performing providers, as well as the Network baseline rate, is determined from the compliance rates reported on the 2008 Annual Forms Compliance Report. Among the providers identified as poor performers in 2008, the baseline measurement ranged from 50% compliance to 64%. The poorest-performing providers in 2008 were then tracked in the first and second quarters of 2009 to identify facilities that continued to have low compliance rates. Although most of the providers improved, the compliance rates for the poorest performers in the first half of 2009 ranged from 50% to 80%. As a result of evaluating the first and second quarters of 2009, two facilities were removed from the group of poor performers because of their progress and were replaced by two other facilities—one that is new to the Network and another that dropped in compliance significantly.

The Network Data Manager conducted site visits at each of the eight targeted facilities. Prior to each visit, the Data Manager reviewed the facility's Compliance Report to identify the primary areas that needed improvement, i.e., accuracy of the 2728 form, timeliness of the 2746 form, etc. The Data Manager also reviewed the facility's most recent Performance Improvement Plan, ran a Missing Forms Report and a Reject Report for the facility, and determined if the facility was up to date with its submission of monthly patient activity.

The Facility Administrator and Data Contact were required to meet with the Network Data Manager. Attendance for all other facility staff was optional. During this meeting, the Data Manager provided an in-depth review of the above documentation with the facility staff and provided recommendations for areas of improvement. The Data Manager also interviewed the facility staff in an effort to gain insight into its business operations and to explore other areas where improvement is needed. Based on this information, the Data Manager assisted the facility in developing an updated Performance Improvement Plan.

During the final phase of this project, the facilities in the intervention group experienced an increase in the overall weighted average compliance rate of 11.2%. This helped the intervention group to reach a weighted compliance score of 79.5% for the Annual Compliance Report. This represents an increase of 21.2% from fiscal year 2008. All eight facilities in the intervention group met their goal of a 5 percentage point increase in



compliance with the highest increase being 37% and the smallest, 8.3%. The overall Network compliance rate increased to 93.8%.

The Data Manager concluded the project by conducting a PowerPoint presentation for the eight facilities involved via WebEx on March 26, 2010. The purpose of the presentation was to recap lessons learned during the scope of the project.

6. Other Data Management Activities

Data Requests

To open a new dialysis facility in the State of New York or to increase the number of treatment stations, an application for the Certificate of Need must be approved by the NYSDOH and reviewed for New York State-specific requirements. The Network receives requests from both the applicants and the NYSDOH for the number of patients within the ZIP Code of the community where the facility will be located. The Network then refers these requestors to reports of patients by ZIP Code, located on the Network 2 website.

Network 2 continues to have a close working relationship with the NYSDOH regarding needs analysis throughout New York State. The majority of requests in CY 2009 were for the number of stations and the number of patients in various facilities. The NYSDOH uses these data to conduct utilization reviews to assess the need for opening new dialysis facilities within a given region. Other requests were for updated lists of providers with ESRD Medicare provider numbers, updated reports of patient counts by ZIP Code of residence, and verification of facility openings and closings.

The Network also responded to select inquiries from Medicare Advantage organizations regarding the status of CMS-2728 forms and the transplant status of ESRD Medicare beneficiaries who were members of Medicare Advantage organizations. In CY 2009, Network 2 processed 388 requests for such information. The information given included the first date of dialysis or transplant date, as well as the date that the CMS-2728 forms were submitted to CMS.

Business Continuity and Contingency Plan

CMS requires each Network to develop a written Business Continuity and Contingency Plan that outlines the roles and responsibilities of staff, CMS, and Network vendors and subcontractors in the case of a disaster. The Plan provides documented procedures for making backup copies of software, databases, and user processes for recovering data and returning all systems to an operational level in the event data are lost, destroyed, or



otherwise inoperable. The Plan, which has been approved by the CMS Project Officer, includes prevention strategies, assessment of damages, recovery of business operations, and lists of contact information for staff, CMS, and vendors.

New ESRD Patient Orientation Packets (NEPOPs)

The NCC mails informational materials to all new ESRD patients. The names of new patients, along with their addresses, are obtained from the SIMS patient database. The NCC sends Network 2 an electronic file of any packets that are not deliverable and any address corrections. Network 2 staff investigates the reason for the returned packet and makes the address changes in SIMS, as well as in the electronic file. The NCC is notified when Network 2 uploads the electronic file so that NCC staff can resend the packet to the patient. In CY 2009, Network 2 had an average return rate of approximately 4%. This is a decrease of 1.3 percentage points from CY 2008 due to the streamlined electronic process implemented by the NCC.

Changes in the Workflow Process

CMS-2728 and CMS-2746 forms must be entered into SIMS with complete and accurate information no later than 15 working days of receipt. Events on the monthly PAR must be entered into SIMS within 10 working days of receipt. In CY 2007, Network 2 data staff developed work process strategies to improve efficiency and continued to follow the same strategies in CY 2009. As a result, all forms are entered into SIMS within 5 days of receipt, on average.

Data Library

Many of the procedures that are done in the data department reference several sources, such as online manuals, the SOW, and the Medicare ESRD Network Organizations Manual. In addition, Network 2 has updated and redeveloped the Network 2 policy manual.



The data procedures in the policy manual are as follows:

- Local Server Backup and Offsite Storage
- Semi-Annual and Annual Compliance Reports
- Change Reporting Process
- CROWN Memo Processing
- Control of ESRD Records
- Collection, Validation, Submission, and Maintenance of ESRD Forms
- Missing Forms
- REMIS Alerts
- Routine Database Updates
- Reject Reports

All of these policies and procedures are based on CMS contract deliverables and have been developed to ensure that the data maintained by SIMS are accurate and up to date.

CMS Software Support

Implementation of the CROWN environment began in June 2002 and includes 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 subsequently sent to the Network via QualityNet (QNet) Exchange, a secure Web-based environment.

The Network imports VISION data received through QNet into the local SIMS database. These data are replicated to the SIMS Central Repository every night. Upon successful replication, the data are consolidated by the CMS billing data system (REMIS) to determine Medicare eligibility. These systems will eventually be replaced by an integrated Web-based ESRD information system known as CROWNWeb (Please see *below* for more information on the CROWNWeb system).

VISION

Although Network 2 continues to support and maintain those trained to submit data through VISION, CMS is not recruiting or training new facilities to use VISION at this time. As of CY 2009, there are 21 facilities using VISION in the Network 2 area.

VISION Signature Verification

Each electronically submitted CMS-2728 and CMS-2746 form is printed out by the facility and signed by the patient and physician in blue ink. The printed form with original signatures is then sent to the Social Security Administration, and a copy is placed in the patient's record. Network 2 verifies a 3% sample of patient and physician signatures on these forms annually (Figure 14). For CY 2009, this task was completed in the third contract quarter. Of the 513 forms submitted via VISION during the contract period, 15 (3%) were chosen at random for verification. All forms requested were received within 7 days of the Network's request and all had signatures.

Figure 14. CMS-2728 and -2746 forms Validated in CY 2009*

CMS-2728 and -2746 forms	Amount
a. Number of forms imported from VISION in CY 2009	513
b. Total number of forms selected	15
c. Total number of forms received	15
d. Total percent of forms validated	100%

*Source: Standard Information Management System CY 2009.

CROWNWeb

CMS and the ESRD Networks are working together to build the business requirements for the integrated ESRD information system known as CROWNWeb. This Web-based system will facilitate the electronic collection and maintenance of information for the ESRD Network Program, ESRD patients, and the services that they receive. The initial release date for CROWNWeb was February 1, 2009. In preparation for CROWNWeb implementation, Network staff attended CROWNWeb training sessions in December of CY 2008. CMS has since modified CROWNWeb implementation to be a phased-in approach. The initial phase consisted of 4 Networks and 12 providers. Network 2 was not a part of the initial phase but has been actively participating in Phase II of CROWNWeb implementation, which began in July 2009.

Phase II consists of all 18 participating Networks, with 10 dialysis providers from each Network. Network data staff and representatives of the 10 Phase II facilities in Network 2 attend monthly conference calls conducted by CMS addressing CROWNWeb issues.



During this year, Network data staff also attended face-to-face CROWNWeb training that was provided to New York State facilities from November 10–12, 2009. Each day, a Network 2 staff member was present and actively participated in the training by answering and asking questions. The Network provides its CMS Project Officer with a weekly summary report of all Phase II activities.

In preparation of full CROWNWeb implementation, the Network data staff provides technical assistance to providers attempting to register users for access to the CROWNWeb system through the QualityNet Identity Provisioning System (QIPS). During CY 2009, the Network has made great strides regarding QIPS enrollment. The Network began the year with approximately 60 facilities not registered in QIPS. By the end of the year, all but 4 dialysis facilities had at least one user registered in QIPS. As a result of this progress, Network 2 was asked to give a brief presentation on a CMS-sponsored conference call in March of 2010, offering tips to the Network community on how to overcome some of the obstacles in getting facilities to register users for QIPS.

Goal 4: Improve collaboration with providers and facilities to ensure achievement of goals 1–3 through the most efficient and effective means possible, with recognition of the differences among providers (independent, hospital-based, member of a group, affiliate of an organization, etc.) and associated possibilities/capabilities

Developing and maintaining cooperative relationships within the renal community, including facilities, is key to quality improvement and to meeting Network goals. Through ongoing collaboration, these new relationships are developing or becoming reengaged. In the following sections, the Network describes its performance and activities, which were conducted to meet the goals listed above.

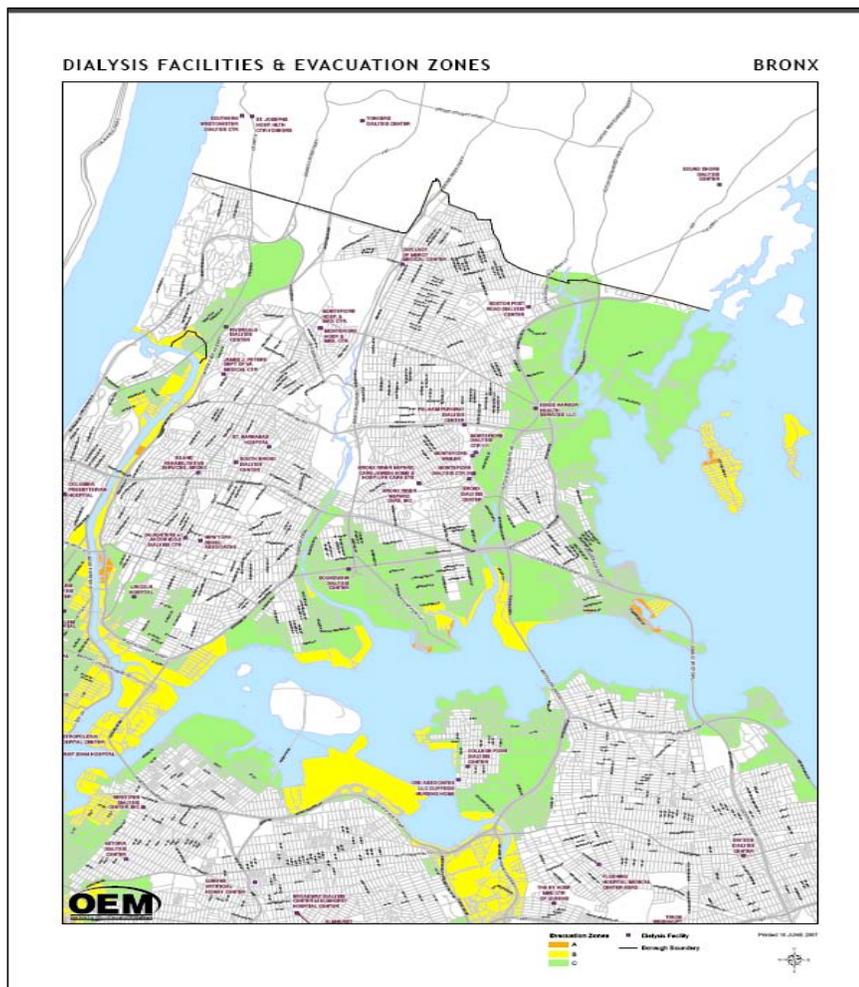
Coalition and Network Disaster Preparedness

Due to Network 2's vulnerability to terrorist attacks, inclement weather, and the constant threat of pandemic flu and other possible emergencies, the Network has continued its work in the ESRD Network Coalition for Disaster Preparedness. The mission of this coalition is "To ensure that providers and patients are prepared to respond in an efficient, effective, and safe manner during an emergency allowing for continuity of life-sustaining dialysis care."

When it originated in 2007, the Coalition for Disaster Preparedness consisted of 70 members, who made great strides in developing internal emergency preparedness processes for Network 2 and worked to structure the role of Network facility support. Work groups were formed, ideas were shared, and reports were made on the progress and the successes of these combined efforts. Through the Coalition’s work, the Network partnered with the NYC Office of Emergency Management (OEM) and was able to bring ESRD patients and facilities to the forefront on the topic of emergency preparedness.

Network 2 was integrated into the OEM Special Needs Advanced Warning System (AWS). This was the first time that New York dialysis patients and providers were represented in the event of an emergency to the OEM. The Network and the OEM collaborated on the inclusion of dialysis facilities to New York Sea, Lake, and Overland Surge from Hurricanes maps (Figure 15).

Figure 15. OEM Map of Dialysis Facilities and Evacuation Zones





These maps provide details of facilities that may be affected by a flood or hurricane. The AWS engages agencies in preparedness, and provides information and problem solving by having all special needs groups engaged. The agencies represented on AWS calls include the Department of Health, Department of Transportation, Emergency Medical Services, National Weather Service, and City Hall, Office of the Mayor.

In CY 2009, a coalition of providers and renal community partners was established to work on patient influenza vaccination compliance. The goal of the project is to encourage facilities to immunize as many patients as possible with the seasonal flu vaccine. The goal is to have $\geq 90\%$ of patients vaccinated. The Network provided Influenza Toolkits to every facility to track vaccinations and reasons why patients refuse them. These totals will be submitted to the Network and will be used in future influenza projects.

The best-performing facilities and/or facilities reaching the 90% goal would receive certificates from the Network.

A flu poster was developed and distributed to all New York State facilities. A handout was also distributed to nurses in the facility, which addresses the reasons why patients should be vaccinated and give flu facts to patients who refuse the flu vaccine.

The Influenza Toolkit, which stresses the importance of hand-washing and staff immunization, as well as other information and resources related to seasonal and H1N1 (Swine Flu), was created for staff and mailed to every facility medical director and administrator in New York State. The information in the Toolkit was made available on the Network website. The Network also participated in AWS calls regarding H1N1. These calls provided additional information and updates on vaccination distribution, information and resources, and the implementation of free immunization clinics in New York City, as well as offering an opportunity to address any issues of ESRD patients or providers.

The Critical Asset Survey (CAS), which was developed by the Coalition in 2008, was sent to all Network 2 facilities in October 2009. The CAS creates a single repository of important facility resource information (such as communications, equipment, and staffing), which will help the Network better serve facilities if they are unable to get the assistance that they need or should require additional resources.

This CAS is a Web-based program developed through the expertise of the IPRO Information Technology team. Facilities are asked to submit completed surveys in a timely manner, and any facilities outstanding after the specified deadline are urged to comply.



Network 2 also participates in the Kidney Community Emergency Response (KCER) Coalition efforts. KCER is a CMS Special Project managed by Network 7, whose goal is to minimize disruption to life-sustaining dialysis and transplant services in the event of any type of emergency or disaster. The Coalition includes patient and professional organizations; practitioners; providers, including independent dialysis facilities, LDOs, and transplant facilities; hospitals; suppliers; ESRD Networks; state emergency and survey representatives; and federal agencies. The Network continues to work with KCER through participation in conference calls and forwarding alerts to patients and providers.

2. Quality Improvement Organization

In 2009, IPRO continues its 9th Scope of Work quality initiatives under contract with CMS, with New York being 1 of only 10 states awarded the Chronic Kidney Disease (CKD) Project. This statewide initiative is focused in New York City, along with its suburban communities of Southern New York State and Long Island's Nassau and Suffolk counties—the focal point being interventions in Medicare-underserved communities. There is also an additional focus in Medicare-underserved communities in Erie, Syracuse, and Albany.

One of the focus areas of the CKD Project is AV fistula placement and maturation as the first choice for vascular access when medically appropriate. With this common goal, the Network works with the CKD Project team by serving on the IPRO CMS CKD New York State Coalition in conjunction with the New York State Task Force, attending facility visits, and supporting system level changes that will increase AV fistula rates.

3. New York State Department of Health

Survey and Certification Agency

Medicare pays for services provided by ESRD facilities that voluntarily seek and are approved for certification by the US Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS). CMS contracts with the NYSDOH to evaluate compliance with the federal ESRD regulations by periodically conducting surveys of these facilities.

Network 2 began a collaborative effort with the NYSDOH to improve communication with regard to ESRD facilities in New York State. The meetings follow a formal agenda, and issues such as complaints, IVDs, and facility survey concerns are discussed. Attendees include the CMS Boston Regional Office Project Officer, CMS New York Region II Office, ESRD Coordinator, NYSDOH State Surveyors from each region, Network 2 Executive



Director, Network Quality Improvement Director, and the Network Patient Services Coordinator (PSC).

This collaboration led to the development of a QAPI Project. As part of the Network's QIWP, the Network is notified and intervenes with surveyed facilities cited with a QAPI condition level. The Network reviews the SOD, contacts the facility, reviews its current QAPI program, and offers support to the facility in developing the improved QAPI. The support can include a site visit to the facility, providing education on the analysis of data, benchmarking, setting goals and developing an action plan.

Also through collaboration, a surveyor tool was developed to standardize the process and the information provided to the surveyors from the Network. Included in the tool are the following:

- Facility fistula rate,
- Network's fistula goal,
- Network's current fistula rate,
- Number of complaints in last 12 months,
- Number of IVDs,
- Number of involuntary transfers,
- Facility compliance rate, and
- Facility quality of care concerns.

This collaboration has benefited all agencies, as all strive from different directions to improve the care of ESRD patients.

4. Other ESRD Networks

The following text outlines some of the ways that Network 2 works collaboratively with the ESRD Network community.

Network 2 is a member of the Forum of ESRD Networks, which is a not-for-profit organization that advocates on behalf of its membership and coordinates projects and



activities of mutual interest to ESRD Networks. Network 2 participates in Forum activities and contributes to Forum projects. This work is independent of the Network 2 contract.

In August 2009, the Network 2 Executive Director and Assistant Director attended "Quality Improvement Redesign: Demonstrating Success in Network Quality Initiatives" in Baltimore, Maryland. This conference was developed by the Forum of ESRD Networks.

5. Professional Organizations

The Network conducted activities in cooperation with the American Nephrology Nurses Association (ANNA) in CY 2009. The Network 2 Quality Improvement Coordinator, who serves as the treasurer of the Long Island Chapter of ANNA, attends monthly educational committee meetings. The Network is collaborating with ANNA on a Vascular Access Program. The Program, which began in April 2009, offers education on vascular access infection control, maintenance, and monitoring. The Network provided a presentation on CROWNWeb at the ANNA all-day seminar in November 2009.

The Network continues its work with the Kidney and Urology Foundation when the opportunity presents itself, as well as participating annually in the Kidney Walk. The Network also worked with the National Kidney Foundation's New York Chapter on its Annual World Kidney Day and the annual Kidney Walk, which raises awareness of kidney disease and the need for early detection. The Network collaborates with other chapters of the NKF in the state as well. Upstate chapters provide space for regional patient education meetings. In CY 2009, the Network reached out to the NKF of Syracuse. In this collaborative meeting, a new regional PAC Chairperson was identified and recruited.

The Network participates in quarterly meetings with the Council of Nephrology Social Workers New York Metropolitan Chapter. The Network provides updates and information regarding Network 2. In CY 2009, the PSC provided a presentation on the ESRD CfC regulations regarding IVD.

6. Centers for Medicare & Medicaid Services

In April 2009, CMS completed an annual onsite review of Network 2. The primary focus for this visit was to evaluate the performance of the ESRD contract. Several best practices were identified by CMS, including the PAC and the complaint system in place.

Network 2 also reports its activities and challenges via monthly conference calls with the CMS Project Officer and also in the Quarterly Progress and Status Report.



Goal 5: To improve patients' perceptions of care and experience of care, and resolve patients' complaints and grievances regarding ESRD facilities and providers

Network 2 maintained consistent efforts throughout CY 2009 to assist and educate staff at ESRD facilities in resolving beneficiary complaints and grievances. Complaints and grievances are classified as informal, formal, or referral on intake. Examination of a formal grievance involves CMS-specific investigation criteria, a grievance determination, due process for involved parties, and a final written report. The Network Grievance Committee encourages resolution of patient and staff complaints and grievances in the local dialysis unit. However, there are instances when patients are not comfortable approaching facility staff, or have tried unsuccessfully to resolve their issues at the facility level and need to request Network assistance. When necessary, the Network will take action on all complaints and grievances.

Except in cases deemed to pose immediate life-threatening situations, the Network consults with the Grievance Committee on all complaints and grievances prior to referring them to the MRB. The Network reports complaint and grievance activity to CMS on a quarterly basis.

There were no formal grievances in CY 2009. A total of 101 beneficiary complaints were resolved informally in CY 2009, an increase of 12% over the previous year. Fourteen referrals were made to the agencies deemed appropriate by Network 2 staff, the Grievance Committee, and the MRB. There were 17 IVDs in 2009, a decrease of 1 in 2008. The causes of these IVDs or transfers are noted as follows.

- Behavioral Issues (14)
- Non-Adherence (1)
- Non-Payment (2)

The issue of involuntarily discharged patients in Network 2 is a concern to the Network staff, Grievance Committee, MRB, Network Council, and the Board. Network 2 is committed to assisting with conflict and patient discharge situations when it is made aware of them through patient complaints, facility contacts, or data reporting.

As stated in the CfC, a patient is considered involuntarily discharged if he/she has received written or verbal notice that he/she will no longer be allowed to receive dialysis at a center. If the patient transfers to another facility without interruption to service, the matter must still be reported as an involuntary patient discharge.



In the event that the decision to involuntarily discharge a patient is made, the Network requests the facility to carry out the following as required by the CMS CfC:

- Notify the Network of the decision to involuntarily discharge a patient prior to the actual discharge. In the case of immediate discharge due to violence or threats of violence, contact the PSC as soon as possible.
- The facility is required to provide the Network copies of the 30-day notice of discharge, reassessment of patient to determine the root cause of the problem, and provide documentation related to the events leading to the decision to involuntarily discharge to the Network. The documentation should include but is not limited to doctor's progress, nursing, social work notes, patient plan of care, and a written physician's order, signed by both the Medical Director and the patient's attending physician. The facility is required to make an effort to place the patient at another out-patient facility and document those efforts. The facility should also notify the SSA regarding the IVD.
- Report the IVD on the monthly PAR under event "6C" (Transfer Out—Category C) in the losses column and indicate the reason for the discharge in the last column of the PAR.

1. Patient Advisory Committee Activities

The PAC is a statewide organization of patients or family members who volunteer to represent the Network to their facility and their facility to the Network. The PAC is led by the Network PSC and the Network Community Outreach Coordinator.

The PAC Chairpersons are responsible for overseeing the activities of the PAC Representatives and the PAC Representatives are the liaisons in the facility who promote communication between patients and staff. Both the PAC Chairpersons and the PAC Representatives report to the Network.

In 2009, the PAC developed the PAC Revitalization Campaign. This campaign includes recruiting two regional chairpersons for each of the 11 regions of New York State. These chairpersons oversee the activities of the facility patient representatives in their region. In CY 2009, the membership increased to 13 from 8 in 2008.

Facilities are encouraged to recruit patients to serve as patient representatives; the Network goal for each facility is to have at least one patient representative. Chairpersons



have regularly scheduled conference calls with Network coordinators and at least two face-to-face meetings per year. At the 2009 Annual PAC Meeting, chairpersons were educated on professionalism, presentation skills, and methods of properly addressing problems at a facility. The PAC will also be working with the quality improvement department to help educate patients and achieve Network goals. Chairpersons will also be encouraged to visit facilities' patient meetings to educate patients about the PAC and Network activities.

The PAC goals in CY 2009 were:

- To increase the chairperson membership to at least 1 chairperson in each of the 11 regions
- To recruit PAC representation in facilities without PAC representatives
- To help improve patient/staff communication
- To ensure that patients are receiving copies of the *PAC Notes* newsletter
- To encourage patients to attend regional patient meetings
- To empower patients to be part of the healthcare team

2. Dealing with the Challenging Patient

As stated previously, an increase in disruptive/abusive patients was reported by facilities in CY 2008. Reporting facilities are referred to all available Network 2 resources, i.e., CfC, the DPC toolkit, and the Network website, www.esrd.ipro.org. Network 2 received 89 calls related to patient transfer/discharge in CY 2009.

At the core of the DPC toolkit is the staff-training component, which is designed for all levels of staff, particularly dialysis staff that provides direct patient care but might not have received training in professionalism or conflict resolution. The training aims to build the staff's conflict resolution and communication skills, and improve understanding of how the staff's interactions with patients, their families, friends, and other staff might trigger or escalate conflict in the dialysis setting.

The DPC training toolkit contains:

- A Provider Manual
- DPC Brochures
- DPC Pocket Guides



- CD-ROM (DPC CONFLICT Interactive Training Tool)
- CD-ROM (DPC Conflict Resolution Resources for Dialysis Professional Program Documents)

In 2009, as part of the QIWP, a project was developed to decrease IVDs by 10 %. The ESRD Network of New York will track and monitor IVDs in Network 2. The Network worked with facilities by reviewing their IVD policies to ensure that facilities met the requirements as stated in the CMS CfC for ESRD facilities. The Network educated facilities on the use and benefit of the DPC toolkit, interdisciplinary meetings, behavioral agreements, and other interventions to avoid IVDs.

The Network developed a WebEx training presentation and subsequent conference calls, and encouraged the participation of all Network 2 facilities. Any facility that had an IVD during the contract year was required to attend the WebEx and participate in the conference calls. Articles were published in *Network Notes* on the DPC toolkit and IVDs. The WebEx was also made available on the Network website.

3. Technical Assistance

Network 2 has continued to receive calls for technical assistance from facility staff. These calls include requests for data; educational resources; help with insurance issues; support services and requests for help on issues of abusive, disruptive, and threatening behaviors from patients; discharge procedures, if discharge is applicable; and non-payment.

In response to requests of assistance on issues of behavior and discharge, Network 2 referred facility staff to the CMS CfC and the Interpretive Guidance for ESRD Facilities, located on the Network 2 website. Some callers requested assistance in resolving issues and preventing patient discharge. In cases of aggressive and/or disruptive behavior without physical assault or serious threat of physical assault, detailed steps for behavior modification and intervention strategies were provided. In most cases, Network 2 staff recommended use of the DPC toolkit to train staff on conflict prevention and resolution.

Most beneficiary complaints were resolved by Network 2 staff, interacting with dialysis unit staff on behalf of the patient, i.e., providing suggestions for intervention and encouraging increased education and communication with the patient.



In addition to the Network's proactive efforts in addressing complaints and grievances, Network 2 developed a WebEx training presentation with subsequent conference calls for the DPC toolkit, produced articles in *Network Notes* on IVD and CfC.

In CY 2009, Network 2 provided assistance regarding vascular access data, forms completion, and referrals to patients and providers regarding insurance issues. Educational materials are sent to patient and facilities upon request and links to websites are available on the Network's website.

4. Regional Patient Meetings

Network 2 holds Regional Patient Education Meetings for its 11 regions in New York State. The meetings provide an opportunity to educate patients regarding the Network, what it is, what it does, and how to file a complaint/grievance.

Patients learn about the Network's quality improvement projects, such as the Fistula First Initiative, phosphorous, medication reconciliation, and the importance of influenza vaccination. The roles and responsibilities of PAC Representatives are reviewed, and patients have the opportunity to meet Network staff, their PAC Chairperson(s), and other patients in their regions. Patients are also encouraged to volunteer as PAC Representatives and participate in other patient organizations in the renal community.

4—Special Projects

1. Network Coordinating Center (NCC)

Network 2 continues to serve as the NCC, providing centralized coordination and support for the operation of the ESRD Network Program. The NCC provides ESRD Networks with several hallmark deliverables, such as:

- The End-Stage Renal Disease Network Organization Program Summary Annual Report (SAR)
- The Directory of ESRD Network Organizations
- CMS/ESRD Networks' Annual Meeting
- NCC website
- New ESRD Patient Orientation Packet (NEPOP)

ESRD Network Organization Program Summary Annual Report

The 2007 ESRD Network Program SAR was submitted April 2009 and was approved January 2010. The SAR is a compilation of information gathered from the 18 Network Annual Reports and typically requires abstraction of data and information from various sections of the reports. To streamline the data collection process and to ensure data quality, the 2008 Development Team provided each Network Executive Director with a Data Overview Form for completion. Network 2 completed this form and assisted the NCC in developing the SAR and confirmed data accuracy. The 2008 SAR was submitted April 2010 and is pending CMS approval.

Directory of ESRD Network Organizations

The NCC also publishes an annual Directory of ESRD Network Organizations, which contains contact information for professionals in all 18 Networks, renal community organizations, and CMS. The updating process for this Directory is through an online uplink available annually. This tool allows the Networks to update their Network-specific information via the NCC website in a timely manner. The Directory was published on January 12, 2010, containing a new Index section in the Appendix.



Annual Meeting/Conferences

After review of its available funding, CMS determined that a separate CMS/ESRD Networks' Annual Meeting would not take place. In lieu of the Annual Meeting, the NCC was asked by CMS Central Office leadership to assist with the QNet Conference. The NCC assisted in securing speakers for select ESRD sessions, confirmed their participation, and provided support throughout the Meeting. The QNet Conference was held December 1–3, 2009, in Baltimore, Maryland, with over 800 attendees from across the 18 ESRD Networks, QIOs, as well as the renal community.

New ESRD Patient Orientation Packet

The timely distribution of the NEPOPs remains a priority to the Networks and the NCC. The automated New ESRD Patient Mailing Organizer (NEMO), which was piloted in the Spring of 2008 and released nationally on September 11, 2008, has since shown a 2% decrease in annual returns. The NCC continues to work with the Networks to develop efficiencies within the NEMO program and the NEPOP process. The NCC processed 107,439 NEPOPs in 2009.

The Network community may contact the NCC in the following ways:

- Phone (516)-209-5365
- E-mail: ncc@ncc.esrd.net
- Website: www.esrdncc.org

2. Network Information Technology Support

Network 2 is pleased to be serving its third year as the contractor for the NWITS Special Project. This contract primarily supports the development of CROWNWeb. The Network's principal role is the creation of the CROWN Help Desk to support the ESRD end-user community.

Traditionally, CROWN Help Desk support consisted of supporting the 18 ESRD Networks, but now the CROWN Help Desk provides support to an expanded customer base of more than 15,000 customers comprising Networks, Dialysis Centers, LDOs, CMS staff, and CMS Contractors and Researchers. NWITS is the primary point of contact for ESRD CROWN Help Desk calls/service requests related to ESRD data and software developed or maintained by NWITS and/or other CROWN contractors.



The CROWN Help Desk is responsible for processing the QIPS Account Form. ESRD Networks and dialysis facility staff must register for a QIPS account in order to access CROWNWeb. Upon activating each QIPS account, the Help Desk provides a QIPS User ID to the applicant, which is needed for logging into CROWNWeb. As of December 31, 2009, the CROWN Help Desk has processed approximately 8,623 accounts.

In addition to processing QIPS Account Forms, the CROWN Help Desk also processes CMS-10268 (Batch Delegation of Authority Form). Dialysis facilities that submit patient data electronically are required to submit CMS-10268 forms for participation in the electronic data submission feature of the CROWNWeb Application. As of December 31, 2008, the CROWN Help Desk had processed approximately 3,715 CMS-10268 forms.

In 2009, NWITS launched self-help Internet-based Customer Portal. The Customer Portal allows users to access information about alerts, search the knowledge base for ESRD Program-supported applications, access popular links to other ESRD sites, submit service requests to the CROWN Help Desk, and view the status of submitted service requests.

NWITS also introduced the concept of “Problem Management” to CROWN Help Desk service delivery. The goal of Problem Management is to identify the incidents that impact business operations, discover the root cause, and provide knowledge concerning the solution and/or workaround as timely as possible. The ability to centrally manage many incidents and mass communicate via email to all incident owners associated with a problem allows for quick disbursement of critical information. In addition, critical decision-making statistics are provided to CMS management regarding the impact and urgency of issues affecting the CROWNWeb user community.

The NWITS team is responsible for addressing issues related to Fistula First Outcomes Dashboard Errors, Ad Hoc Data Extracts, Special Help Desk Support Issues, and more than 75 other contract deliverables.

The Network community and end-user community may contact the CROWN Help Desk in the following ways:

- Phone: (888) ESRDHD1 (888-377-3431)
- E-mail: support@crownhelpdesk.com
- CROWN Help Desk Customer Portal on the Internet at www.crownhelpdesk.com.



5—Sanction Recommendations

Section (§)1881(c)(2)(G) of the Social Security Act requires Networks to identify facilities and providers that are not cooperating toward meeting the Network goals and assist such facilities/providers in developing appropriate plans for correction. Network 2 reports to CMS the facilities that continue to be non-compliant and those that are not providing appropriate medical care.

No sanctions were recommended to CMS regarding any ESRD provider in Network 2 during CY 2009.



6—Recommendations for Additional Facilities

No specific recommendations for additional facilities were made during CY 2009.



7—Data Tables*

The following data tables are supplied, using the SIMS template, at the end of this document.

Table 1. Newly Diagnosed Chronic ESRD Patients

Table 2. Living ESRD Dialysis Patients

Table 3. Dialysis Modality—Self-Care Settings—Home

Table 4. Dialysis Modality—In-Center

Table 5. Renal Transplant by Transplant Center

Table 6. Renal Transplant Recipients

Table 7. Dialysis Deaths

Table 8. Vocational Rehabilitation

*A complete list of Network 2 providers is available from the Network website at www.esrd.ipro.org. This list contains contact information, Medicare provider number, ownership type, and ESRD services provided.

Newly Diagnosed Chronic ESRD Patients (ESRD Incidence)

Newly diagnosed chronic ESRD patients by state of residence, age, gender, race, and primary diagnosis for CY 2009

Age Group	NY	OTHER	TOTAL
00-04	12	2	14
05-09	10	1	11
10-14	13	1	14
15-19	26	2	28
20-24	75	1	76
25-29	96	0	96
30-34	137	2	139
35-39	178	5	183
40-44	301	5	306
45-49	421	5	426
50-54	568	11	579
55-59	686	8	694
60-64	819	8	827
65-69	801	7	808
70-74	797	8	805
75-79	812	6	818
80-84	747	6	753
>=85	656	1	657
Missing	0	0	0
Total	7155	79	7234
Gender			
Female	2981	31	3012
Male	4174	48	4222
Missing	0	0	0
Total	7155	79	7234
Race			
American Indian/Alaska Native	24	0	24
Asian	344	3	347
Black or African American	2238	7	2245
More than one race selected	100	3	103
Native Hawaiian or Other Pacific Islander	31	0	31
White	4361	54	4415
Missing	57	12	69
Total	7155	79	7234
Primary Diagnosis			
Cystic Kidney	175	6	181
Diabetes	2930	14	2944
Glomerulonephritis	522	9	531
Hypertension	1785	16	1801
Other	1021	12	1033
Other Urologic	125	0	125
Missing	86	13	99
Unknown	511	9	520
Total	7155	79	7234

Source of information: Network SIMS Database

Date of Preparation: May 2010

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

Diagnosis: Categories are from the CMS-2728. A diagnosis of 'Other' is ICD-9 code 59389. A diagnosis of 'Unknown' is ICD-9 code 7999.

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

This table includes 229 patients with transplant therapy as an initial treatment.

This table includes 97 patients receiving treatment at VA facilities.

Living ESRD Dialysis Patients (ESRD Dialysis Prevalence)

All active Dialysis Patients by state of residence, age, race, gender and primary diagnosis as of 12/31/09

Age Group	NY	OTHER	TOTAL
00-04	14	0	14
05-09	12	0	12
10-14	20	0	20
15-19	56	0	56
20-24	208	4	212
25-29	322	6	328
30-34	554	2	556
35-39	769	15	784
40-44	1257	8	1265
45-49	1758	21	1779
50-54	2235	37	2272
55-59	2736	18	2754
60-64	3086	33	3119
65-69	2909	30	2939
70-74	2727	30	2757
75-79	2412	15	2427
80-84	2051	24	2075
>=85	1555	17	1572
Missing	0	0	0
Total	24681	260	24941
Gender			
Female	10695	93	10788
Male	13986	167	14153
Missing	0	0	0
Total	24681	260	24941
Race			
American Indian/Alaska Native	182	0	182
Asian	1249	12	1261
Black or African American	9947	76	10023
More than one race selected	303	7	310
Native Hawaiian or Other Pacific Islander	113	0	113
White	12737	158	12895
Missing	150	7	157
Total	24681	260	24941
Primary Diagnosis			
Cystic Kidney	679	10	689
Diabetes	10003	92	10095
Glomerulonephritis	2616	25	2641
Hypertension	6134	82	6216
Other	2962	23	2985
Other Urologic	463	1	464
Missing	191	5	196
Unknown	1633	22	1655
Total	24681	260	24941

Source of information: Network SIMS Database

Date of Preparation: May 2010

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

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

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

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

This table includes 343 patients receiving treatment at VA facilities.

ESRD Network 2
Table #3 — Part 1

Dialysis Modality

Number of living patients by modality by dialysis facility self-care settings as of December 31, 2008 and December 31, 2009
Self-Care Settings – Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
330005	0	0	10	8	2	2	0	0	12	10
330006	0	0	1	1	0	0	0	0	1	1
330012	0	0	0	0	0	0	0	0	0	0
330013	0	0	0	0	0	1	0	0	0	1
330024	0	0	13	12	33	30	0	0	46	42
330027	0	0	2	1	7	13	0	0	9	14
330044	2	8	6	8	19	23	0	0	27	39
330045	0	0	0	0	0	0	0	0	0	0
330046	0	0	0	0	0	0	0	0	0	0
330053	0	0	0	0	0	0	0	0	0	0
330055	0	0	0	0	0	0	0	0	0	0
330056	1	2	3	4	7	6	0	0	11	12
330058	0	0	3	4	0	0	0	0	3	4
330059	0	0	0	0	9	2	0	0	9	2
330064	0	0	0	0	0	0	0	0	0	0
330065#	0	0	0	0	0	0	0	0	0	0
330072	0	0	0	0	0	0	0	0	0	0
330079	0	0	0	0	0	0	0	0	0	0
330080	0	0	0	0	0	0	0	0	0	0
330090	0	0	1	1	17	14	0	0	18	15
33009F	0	0	0	0	0	0	0	0	0	0
330101	0	0	0	0	0	0	0	0	0	0
330103^	0	0	0	0	0	0	0	0	0	0
330108	0	0	0	1	0	0	0	0	0	1
330125	0	0	6	0	66	0	0	0	72	0
330128	0	0	6	4	7	2	0	0	13	6
33012F	0	0	1	2	3	3	0	0	4	5
330136	0	0	7	7	15	15	0	0	22	22
330140	14	0	2	0	26	0	0	0	42	0
330141	0	0	0	1	0	0	0	0	0	1
330151	0	0	0	0	11	9	0	0	11	9
330158	0	0	1	5	1	1	0	0	2	6
330167	1	1	24	20	1	1	0	0	26	22
330169^	0	0	0	0	0	0	0	0	0	0
33016F	0	0	1	1	1	1	0	0	2	2
33017F	0	0	2	2	3	4	0	0	5	6
330191	6	6	7	11	1	2	0	0	14	19
330193	0	0	2	2	1	2	0	0	3	4
330195	0	0	0	0	0	0	0	0	0	0
330198	0	0	0	0	0	0	0	0	0	0
330199	0	0	0	0	0	0	0	0	0	0
33019F	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
330204	0	0	8	6	13	11	0	0	21	17
330209	0	0	15	12	10	11	0	0	25	23

Continued on next page

Dialysis Modality

Number of living patients by modality by dialysis facility self-care settings as of December 31, 2008 and December 31, 2009
Self-Care Settings – Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
33020F	0	0	1	1	0	0	0	0	1	1
330214	0	0	0	0	0	0	0	0	0	0
330219	0	0	0	0	0	0	0	0	0	0
330226	0	0	10	6	19	31	0	0	29	37
330229	0	0	0	0	0	0	0	0	0	0
330233	0	0	0	0	0	0	0	0	0	0
330239	0	0	3	0	7	9	0	0	10	9
330240	0	0	0	0	0	0	0	0	0	0
330250	0	0	0	0	0	0	0	0	0	0
330275^	0	0	0	0	0	0	0	0	0	0
330286	0	0	0	0	0	0	0	0	0	0
330290	0	0	0	0	0	0	0	0	0	0
330350	0	0	0	0	0	0	0	0	0	0
330357	0	0	4	0	4	0	0	0	8	0
330394	0	0	0	0	0	0	0	0	0	0
330395	0	0	0	0	0	0	0	0	0	0
330399	0	0	1	4	0	1	0	0	1	5
330401	0	0	5	3	4	4	0	0	9	7
332504	0	0	0	0	0	0	0	0	0	0
332506	0	0	0	0	0	0	0	0	0	0
332510	0	0	0	0	0	0	0	0	0	0
332511	0	0	4	3	1	0	0	0	5	3
332512	0	0	0	0	0	0	0	0	0	0
332513	5	6	6	3	13	14	0	0	24	23
332514	0	0	0	0	0	0	0	0	0	0
332516	0	0	4	1	0	0	0	0	4	1
332517	0	0	0	0	0	0	0	0	0	0
332518	0	0	7	3	3	9	0	0	10	12
332519	0	0	0	0	0	0	0	0	0	0
332520	30	28	16	19	21	16	0	0	67	63
332521	0	0	0	0	0	0	0	0	0	0
332522	0	0	0	0	1	1	0	0	1	1
332523	0	0	12	15	4	3	0	0	16	18
332524	0	0	0	0	0	0	0	0	0	0
332525	0	6	3	4	0	0	0	0	3	10
332528	0	1	3	7	6	6	0	0	9	14
332529	0	0	0	0	0	0	0	0	0	0
332530	0	0	0	0	0	0	0	0	0	0
332531	0	0	0	0	0	0	0	0	0	0
332532	0	0	4	6	9	7	0	0	13	13
332534	0	0	0	0	0	0	0	0	0	0
332535	0	0	0	0	0	0	0	0	0	0
332536	0	0	0	0	13	16	0	0	13	16
332537	0	0	0	0	0	0	0	0	0	0
332538	0	0	0	0	0	2	0	0	0	2
332539	0	0	0	0	0	0	0	0	0	0

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Dialysis Modality

Number of living patients by modality by dialysis facility self-care settings as of December 31, 2008 and December 31, 2009
Self-Care Settings – Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
332541	0	3	0	0	0	0	0	0	0	3
332542^	0	0	0	0	0	0	0	0	0	0
332543	0	0	0	0	0	0	0	0	0	0
332544	0	0	2	1	2	6	0	0	4	7
332545	1	3	15	12	17	20	0	0	33	35
332546	0	0	0	0	1	3	0	0	1	3
332547	0	0	0	2	0	7	0	0	0	9
332548	0	3	0	4	0	2	0	0	0	9
332549	5	3	0	0	5	3	0	0	10	6
332550	0	0	0	0	0	0	0	0	0	0
332551	4	11	31	17	4	9	0	0	39	37
332552	0	0	0	0	0	0	0	0	0	0
332554	0	0	0	0	0	0	0	0	0	0
332555	0	0	0	0	0	0	0	0	0	0
332556	0	0	0	0	0	0	0	0	0	0
332557	18	20	4	4	7	4	0	0	29	28
332558	0	0	0	0	0	0	0	0	0	0
332559	0	0	0	0	0	0	0	0	0	0
332560	0	0	2	2	0	0	0	0	2	2
332562	0	0	1	1	7	5	0	0	8	6
332563	5	9	0	0	0	0	0	0	5	9
332564	0	0	0	0	0	0	0	0	0	0
332565	0	0	0	0	0	0	0	0	0	0
332566	0	0	0	0	0	0	0	0	0	0
332567	0	0	0	0	0	0	0	0	0	0
332568	0	0	0	0	0	0	0	0	0	0
332569	0	3	12	8	29	27	0	0	41	38
332570	0	0	1	1	22	22	0	0	23	23
332571	0	0	0	0	0	0	0	0	0	0
332572	0	4	0	0	0	0	0	0	0	4
332574	0	0	0	0	0	0	0	0	0	0
332576	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	3	4	12	16	0	0	15	20
332580	0	0	0	0	0	0	0	0	0	0
332581	0	0	1	0	0	0	0	0	1	0
332582	0	0	0	0	0	0	0	0	0	0
332583	0	0	0	0	0	0	0	0	0	0
332584	0	0	0	0	0	0	0	0	0	0
332585	1	0	0	0	0	0	0	0	1	0
332586	0	0	7	12	9	9	0	0	16	21
332587	0	0	0	0	0	0	0	0	0	0
332588	0	0	12	10	9	6	0	0	21	16
332589	0	0	0	0	1	1	0	0	1	1
332590	0	0	0	0	0	0	0	0	0	0

ESRD Network 2
Table #3 — Part 4

Dialysis Modality

Number of living patients by modality by dialysis facility self-care settings as of December 31, 2008 and December 31, 2009
Self-Care Settings – Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
332591	0	0	0	0	0	0	0	0	0	0
332592	0	0	0	0	0	0	0	0	0	0
332593	0	0	2	3	1	0	0	0	3	3
332594	0	0	0	0	0	0	0	0	0	0
332595	0	0	0	0	0	0	0	0	0	0
332596	0	0	0	0	0	0	0	0	0	0
332597	0	0	0	0	0	0	0	0	0	0
332598	0	0	0	0	0	0	0	0	0	0
332599	1	1	0	0	0	0	0	0	1	1
332600	0	0	6	6	17	15	0	0	23	21
332602	0	0	0	0	0	0	0	0	0	0
332603	0	2	0	1	0	0	0	0	0	3
332604	0	0	0	0	0	0	0	0	0	0
332605	0	0	0	0	0	0	0	0	0	0
332606	0	0	0	0	0	0	0	0	0	0
332607	0	0	0	0	0	0	0	0	0	0
332608	0	0	4	5	11	8	0	0	15	13
332610	0	0	0	0	0	0	0	0	0	0
332612	0	0	8	11	2	2	0	0	10	13
332613	0	0	7	8	4	2	0	0	11	10
332614	0	0	0	0	0	0	0	0	0	0
332615	3	4	7	8	33	39	0	0	43	51
332616	0	0	0	0	0	0	0	0	0	0
332617	1	0	1	1	9	13	0	0	11	14
332619	0	0	3	7	0	0	0	0	3	7
332620	0	1	6	4	1	1	0	0	7	6
332621	5	2	9	11	15	16	0	0	29	29
332622	0	0	0	0	0	0	0	0	0	0
332625	0	0	0	0	0	0	0	0	0	0
332626	0	0	25	19	35	29	0	0	60	48
332629	0	0	0	0	0	0	0	0	0	0
332630	0	0	0	0	0	0	0	0	0	0
332631	0	0	0	0	0	0	0	0	0	0
332632	36	36	1	2	2	6	0	0	39	44
332633	0	0	5	4	33	36	0	0	38	40
332634	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
332638	0	0	0	0	0	0	0	0	0	0
332639	4	7	0	0	0	0	0	0	4	7
332640	0	0	0	0	0	0	0	0	0	0
332641	0	0	0	3	0	1	0	0	0	4
332642	0	0	0	0	0	0	0	0	0	0
332644	0	0	0	0	0	0	0	0	0	0
332645	0	0	0	0	0	0	0	0	0	0

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Dialysis Modality

Number of living patients by modality by dialysis facility self-care settings as of December 31, 2008 and December 31, 2009
Self-Care Settings – Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
332646	0	0	0	0	0	0	0	0	0	0
332647	0	0	0	0	0	0	0	0	0	0
332648	0	6	0	0	0	0	0	0	0	6
332649	4	2	7	6	3	5	0	0	14	13
332650	0	0	0	0	0	0	0	0	0	0
332651	0	0	0	0	0	0	0	0	0	0
332652	0	0	0	0	0	0	0	0	0	0
332653	1	3	1	2	7	4	0	0	9	9
332654	0	0	0	0	3	7	0	0	3	7
332655	0	0	0	0	0	0	0	0	0	0
332656	0	0	0	0	0	0	0	0	0	0
332657	0	0	0	0	0	0	0	0	0	0
332658	0	0	0	0	4	2	0	0	4	2
332659	0	0	0	0	0	0	0	0	0	0
332660	0	0	0	0	0	0	0	0	0	0
332661	0	0	0	0	0	0	0	0	0	0
332662	0	0	0	0	0	0	0	0	0	0
332663#	0	0	0	0	0	0	0	0	0	0
332664#	0	12	0	2	0	24	0	0	0	38
332665#	0	0	0	0	0	0	0	0	0	0
332666#	0	0	0	0	0	0	0	0	0	0
332667#	0	0	0	0	0	0	0	0	0	0
332668#	0	0	0	0	0	0	0	0	0	0
332669#	0	0	0	0	0	0	0	0	0	0
332670#	0	0	0	0	0	0	0	0	0	0
333300	0	0	2	1	3	2	0	0	5	3
333503	5	3	0	0	0	0	0	0	5	3
333504	1	7	2	1	5	4	0	0	8	12
333506	0	0	0	0	0	0	0	0	0	0
333510	0	0	0	0	0	0	0	0	0	0
333511	0	0	0	0	0	0	0	0	0	0
333515	0	0	0	0	0	0	0	0	0	0
333517	0	0	0	0	0	0	0	0	0	0
333518	0	0	0	0	0	0	0	0	0	0
333519	0	0	0	0	0	0	0	0	0	0
333520	0	0	0	0	0	0	0	0	0	0
333521	0	2	3	5	6	4	0	0	9	11
333522	0	0	0	0	0	0	0	0	0	0
333523	0	0	0	0	0	0	0	0	0	0
333524	0	0	1	0	8	7	0	0	9	7
333525	0	0	0	0	0	0	0	0	0	0
333526	0	0	0	0	0	0	0	0	0	0
333527	1	0	4	5	0	1	0	0	5	6
333529	0	0	0	0	0	0	0	0	0	0
333531	1	1	0	0	0	1	0	0	1	2
333532	0	0	0	0	0	0	0	0	0	0

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ESRD Network 2
Table #3 — Part 6

Dialysis Modality										
Number of living patients by modality by dialysis facility self-care settings as of December 31, 2008 and December 31, 2009										
Self-Care Settings – Home										
Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
333533	0	0	0	0	0	0	0	0	0	0
333534	0	0	0	0	1	0	0	0	1	0
333535	0	0	0	0	0	0	0	0	0	0
333536	0	0	14	12	4	2	0	0	18	14
333538	0	0	0	0	0	0	0	0	0	0
333539	0	0	5	4	1	2	0	0	6	6
333541	0	0	0	0	0	0	0	0	0	0
333542	0	0	0	0	0	0	0	0	0	0
333543	1	1	0	0	0	0	0	0	1	1
333544	4	3	7	8	9	8	0	0	20	19
333545	0	0	0	0	0	0	0	0	0	0
333546	6	5	6	8	42	49	0	0	54	62
333547	0	0	33	29	11	11	0	0	44	40
333548	0	0	3	1	2	3	0	0	5	4
333550	0	0	13	17	15	9	0	0	28	26
333551	0	0	0	0	0	0	0	0	0	0
333552	0	0	0	0	0	0	0	0	0	0
333553	0	0	0	0	0	0	0	0	0	0
333554#	0	2	0	6	0	59	0	0	0	67
NY TOTAL:	167	217	480	466	770	784	0	0	1417	1467
NETWORK TOTAL:	167	217	480	466	770	784	0	0	1417	1467

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

Date of Preparation: May 2010

This table includes 9 Veterans Affairs Facility patients for 2007 and 12 Veterans Affairs Facility patients for 2009.

Provider not operational in CY 2008

^ Provider not operational in CY 2009

Dialysis Modality

Number of living patients by modality by dialysis facility in-center as of December 31, 2008 and December 31, 2009

In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME AND IN-CENTER*	
	2008	2009	2008	2009	2008	2009	2008	2009
330005	103	100	0	0	103	100	115	110
330006	16	14	0	0	16	14	17	15
330012	36	32	0	0	36	32	36	32
330013	3	3	0	0	3	3	3	4
330024	19	21	0	0	19	21	65	63
330027	100	110	0	0	100	110	109	124
330044	250	215	0	0	250	215	277	254
330045	16	14	0	0	16	14	16	14
330046	0	0	0	0	0	0	0	0
330053	36	34	0	0	36	34	36	34
330055	26	25	0	0	26	25	26	25
330056	14	23	0	0	14	23	25	35
330058	77	81	0	0	77	81	80	85
330059	29	22	0	0	29	22	38	24
330064	54	45	0	0	54	45	54	45
330065#	0	60	0	0	0	60	0	60
330072	63	62	0	0	63	62	63	62
330079	26	23	0	0	26	23	26	23
330080	67	65	0	0	67	65	67	65
330090	114	83	0	0	114	83	132	98
33009F	4	29	0	0	4	29	4	29
330101	11	10	0	0	11	10	11	10
330103^	0	0	0	0	0	0	0	0
330108	16	31	0	0	16	31	16	32
330125	318	0	0		318	0	390	0
330128	36	0	0	0	36	0	49	6
33012F	66	80	0	0	66	80	70	85
330136	40	48	0	0	40	48	62	70
330140	131	0	0	0	131	0	173	0
330141	24	16	0	0	24	16	24	17
330151	57	56	0	0	57	56	68	65
330158	129	130	0	0	129	130	131	136
330167	184	190	0	0	184	190	210	212
330169^	0	0	0	0	0	0	0	0
33016F	73	61			73	61	75	63
33017F	42	43	0	0	42	43	47	49
330191	126	124	0	0	126	124	140	143
330193	101	102	0	0	101	102	104	106
330195	1	2	0	0	1	2	1	2
330198	0	0	0	0	0	0	0	0
330199	49	50	0	0	49	50	49	50
33019F	31	39	0	0	31	39	31	39
330201	88	85	0	0	88	85	88	85
330202	122	121	0	0	122	121	122	121
330204	54	47	0	0	54	47	75	64

Dialysis Modality

Number of living patients by modality by dialysis facility in-center as of December 31, 2008 and December 31, 2009

In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME AND IN-CENTER*	
	2008	2009	2008	2009	2008	2009	2008	2009
330209	123	122	0	0	123	122	148	145
33020F	55	77	0	0	55	77	56	78
330214	8	0	0	0	8	0	8	0
330219	54	58	0	0	54	58	54	58
330226	165	262	0	0	165	262	194	299
330229	59	63	0	0	59	63	59	63
330233	12	19	0	0	12	19	12	19
330239	67	68	0	0	67	68	77	77
330240	88	83	0	0	88	83	88	83
330250	3	5	0	0	3	5	3	5
330275^	93	0	0	0	93	0	93	0
330286	17	20	0	0	17	20	17	20
330290	7	0	0	0	7	0	7	0
330350	2	0	0	0	2	0	2	0
330357	0	0	0	0	0	0	8	0
330394	117	102	0	0	117	102	117	102
330395	87	102	0	0	87	102	87	102
330399	212	225	0	0	212	225	213	230
330401	84	92	0	0	84	92	93	99
332504	81	80	0	0	81	80	81	80
332506	118	106	0	0	118	106	118	106
332510	61	67	0	0	61	67	61	67
332511	168	163	0	0	168	163	173	166
332512	133	131	0	0	133	131	133	131
332513	100	82	0	0	100	82	124	105
332514	172	147	0	0	172	147	172	147
332516	187	188	0	0	187	188	191	189
332517	331	323	0	0	331	323	331	323
332518	130	123	0	0	130	123	140	135
332519	93	108	0	0	93	108	93	108
332520	276	260	0	0	276	260	343	323
332521	123	121	0	0	123	121	123	121
332522	188	194	0	0	188	194	189	195
332523	137	137	0	0	137	137	153	155
332524	118	125	0	0	118	125	118	125
332525	134	149	0	0	134	149	137	159
332528	148	164	0	0	148	164	157	178
332529	59	55	0	0	59	55	59	55
332530	171	180	0	0	171	180	171	180
332531	216	207	0	0	216	207	216	207
332532	88	80	0	0	88	80	101	93
332534	110	122	0	0	110	122	110	122
332535	176	170	0	0	176	170	176	170
332536	33	34	0	0	33	34	46	50
332537	58	0	0	0	58	0	58	0

Dialysis Modality

Number of living patients by modality by dialysis facility in-center as of December 31, 2008 and December 31, 2009

In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME AND IN-CENTER*	
	2008	2009	2008	2009	2008	2009	2008	2009
332538	128	136	0	0	128	136	128	138
332539	183	181	0	0	183	181	183	181
332541	279	310	0	0	279	310	279	313
332542^	0	0	0	0	0	0	0	0
332543	62	69	0	0	62	69	62	69
332544	136	138	0	0	136	138	140	145
332545	132	140	0	0	132	140	165	175
332546	62	56	0	0	62	56	63	59
332547	182	197	0	0	182	197	182	206
332548	157	163	0	0	157	163	157	172
332549	87	101	0	0	87	101	97	107
332550	111	112	0	0	111	112	111	112
332551	157	152	0	0	157	152	196	189
332552	57	60	0	0	57	60	57	60
332554	77	73	0	0	77	73	77	73
332555	38	43	0	0	38	43	38	43
332556	152	191	0	0	152	191	152	191
332557	90	85	0	0	90	85	119	113
332558	136	124	0	0	136	124	136	124
332559	50	51	0	0	50	51	50	51
332560	142	129	0	0	142	129	144	131
332562	60	55	0	0	60	55	68	61
332563	148	133	0	0	148	133	153	142
332564	103	108	0	0	103	108	103	108
332565	120	118	0	0	120	118	120	118
332566	173	175	0	0	173	175	173	175
332567	138	125	0	0	138	125	138	125
332568	92	133	0	0	92	133	92	133
332569	173	175	0	0	173	175	214	213
332570	128	130	0	0	128	130	151	153
332571	99	92	0	0	99	92	99	92
332572	132	134	0	0	132	134	132	138
332574	63	62	0	0	63	62	63	62
332576	161	151	0	0	161	151	161	151
332577	173	167	0	0	173	167	173	167
332578	110	105	0	0	110	105	110	105
332579	0	0	0	0	0	0	15	20
332580	47	48	0	0	47	48	47	48
332581	179	175	0	0	179	175	180	175
332582	172	182	0	0	172	182	172	182
332583	147	138	0	0	147	138	147	138
332584	47	46	0	0	47	46	47	46
332585	94	103	0	0	94	103	95	103
332586	72	74	0	0	72	74	88	95
332587	36	76	0	0	36	76	36	76

Dialysis Modality

Number of living patients by modality by dialysis facility in-center as of December 31, 2008 and December 31, 2009

In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME AND IN-CENTER*	
	2008	2009	2008	2009	2008	2009	2008	2009
332588	119	109	0	0	119	109	140	125
332589	232	243	0	0	232	243	233	244
332590	121	124	0	0	121	124	121	124
332591	40	49	0	0	40	49	40	49
332592	81	80	0	0	81	80	81	80
332593	168	179	0	0	168	179	171	182
332594	73	75	0	0	73	75	73	75
332595	126	117	0	0	126	117	126	117
332596	120	122	0	0	120	122	120	122
332597	56	56	0	0	56	56	56	56
332598	157	197	0	0	157	197	157	197
332599	83	82	0	0	83	82	84	83
332600	107	128	0	0	107	128	130	149
332602	132	123	0	0	132	123	132	123
332603	115	103	0	0	115	103	115	106
332604	63	62	0	0	63	62	63	62
332605	94	96	0	0	94	96	94	96
332606	115	117	0	0	115	117	115	117
332607	163	196	0	0	163	196	163	196
332608	134	118	0	0	134	118	149	131
332610	124	125	0	0	124	125	124	125
332612	173	177	0	0	173	177	183	190
332613	181	171	0	0	181	171	192	181
332614	56	59	0	0	56	59	56	59
332615	170	163	0	0	170	163	213	214
332616	12	7	0	0	12	7	12	7
332617	88	84	0	0	88	84	99	98
332619	164	159	0	0	164	159	167	166
332620	146	156	0	1	146	157	153	163
332621	159	146	0	0	159	146	188	175
332622	166	158	0	0	166	158	166	158
332625	79	84	0	0	79	84	79	84
332626	211	221	0	0	211	221	271	269
332629	182	179	0	0	182	179	182	179
332630	23	20	0	0	23	20	23	20
332631	49	55	0	0	49	55	49	55
332632	99	86	0	0	99	86	138	130
332633	173	183	0	0	173	183	211	223
332634	42	45	0	0	42	45	42	45
332635	132	120	0	0	132	120	132	120
332636	32	30	0	0	32	30	32	30
332637	124	129	0	0	124	129	124	129
332638	22	23	0	0	22	23	22	23
332639	95	102	0	0	95	102	99	109
332640	34	33	0	0	34	33	34	33

Dialysis Modality

Number of living patients by modality by dialysis facility in-center as of December 31, 2008 and December 31, 2009

In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME AND IN-CENTER*	
	2008	2009	2008	2009	2008	2009	2008	2009
332641	53	57	0	0	53	57	53	61
332642	162	168	0	0	162	168	162	168
332644	125	144	0	0	125	144	125	144
332645	59	65	0	0	59	65	59	65
332646	188	210	0	0	188	210	188	210
332647	100	129	0	0	100	129	100	129
332648	77	83	0	0	77	83	77	89
332649	126	134	0	0	126	134	140	147
332650	40	44	0	0	40	44	40	44
332651	68	72	0	0	68	72	68	72
332652	85	89	0	0	85	89	85	89
332653	127	127	0	0	127	127	136	136
332654	33	39	0	0	33	39	36	46
332655	51	65	0	0	51	65	51	65
332656	54	65	0	0	54	65	54	65
332657	37	36	0	0	37	36	37	36
332658	86	91	0	0	86	91	90	93
332659	7	31	0	0	7	31	7	31
332660	28	40	0	0	28	40	28	40
332661	44	73	0	0	44	73	44	73
332662	36	90	0	0	36	90	36	90
332663#	0	48	0	0	0	48	0	48
332664#	0	145	0	0	0	145	0	183
332665#	0	55	0	0	0	55	0	55
332666#	0	40	0	0	0	40	0	40
332667#	0	48	0	0	0	48	0	48
332668#	0	43	0	0	0	43	0	43
332669#	0	31	0	0	0	31	0	31
332670#	0	27	0	0	0	27	0	27
333300	7	5	0	0	7	5	12	8
333503	180	182	0	0	180	182	185	185
333504	188	189	0	0	188	189	196	201
333506	178	184	0	0	178	184	178	184
333510	47	0	0	0	47	0	47	0
333511	178	182	0	0	178	182	178	182
333515	180	181	0	0	180	181	180	181
333517	44	0	0	0	44	0	44	0
333518	48	46	0	0	48	46	48	46
333519	64	60	0	0	64	60	64	60
333520	30	40	0	0	30	40	30	40
333521	71	87	0	0	71	87	80	98
333522	93	93	0	0	93	93	93	93
333523	23	24	0	0	23	24	23	24
333524	174	176	0	0	174	176	183	183
333525	49	0	0	0	49	0	49	0

Dialysis Modality

Number of living patients by modality by dialysis facility in-center as of December 31, 2008 and December 31, 2009

In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME AND IN-CENTER*	
	2008	2009	2008	2009	2008	2009	2008	2009
333526	70	75	0	0	70	75	70	75
333527	153	159	0	0	153	159	158	165
333529	30	40	0	0	30	40	30	40
333531	80	79	0	0	80	79	81	81
333532	40	38	0	0	40	38	40	38
333533	53	55	0	0	53	55	53	55
333534	55	66	0	0	55	66	56	66
333535	131	129	0	0	131	129	131	129
333536	62	72	0	0	62	72	80	86
333538	26	28	0	0	26	28	26	28
333539	178	177	0	0	178	177	184	183
333541	138	140	0	0	138	140	138	140
333542	30	37	0	0	30	37	30	37
333543	4	4	0	0	4	4	5	5
333544	158	158	0	0	158	158	178	177
333545	25	31	0	0	25	31	25	31
333546	86	87	0	0	86	87	140	149
333547	222	219	0	0	222	219	266	259
333548	109	113	0	0	109	113	114	117
333550	192	188	0	0	192	188	220	214
333551	38	0	0	0	38	0	38	0
333552	31	28	0	0	31	28	31	28
333553	36	57	0	0	36	57	36	57
333554#	0	360	0	0	0	360	0	427
NY Total	22821	23495	0	1	22821	23496	24238	24963
NETWORK TOTAL:	22821	23495	0	1	22821	23496	24238	24963

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: May 2010

This table includes 271 Veterans Affairs Facility patients for 2008 and 329 Veterans Affairs Facility patients for 2009.

Provider not operational in CY 2008

^ Provider not operational in CY 2009

Renal Transplant by Transplant Center				
Number of transplants performed by transplant center CY 2008 and CY 2009				
Transplant Center	TOTAL TRANSPLANTS PERFORMED		PATIENTS WAITING FOR TRANSPLANT *	
	2008	2009	2008	2009
330005	60	65	280	118
330012	250	261	0	191
330013	63	49	280	295
330024	171	199	170	28
330046	16	10	133	135
330059	118	116	705	0
330101	224	238	586	1,130
330214	44	21	263	267
330219	41	41	85	88
330234	68	44	263	156
330241	37	36	176	223
330285	52	64	326	331
330350	68	26	556	497
330393	79	68	286	355
333300	0	0	9	13
339801	11	25	41	101
NY Total	1,302	1,263	4,159	3,928
NETWORK TOTAL:	1,302	1,263	4,159	3,928

Source of information: Network SIMS Database/CMS-2744

Date of Preparation: May 2010

* 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 CY 2008

^ Provider not operational in CY 2009

Renal Transplant Recipients

Renal transplant recipients by transplant type, age, race, gender and primary diagnosis for CY 2009

AGE GROUP	CADAVERIC	LIVING RELATED	LIVING UNRELATED	TOTAL
00-04	5	1	0	6
05-09	5	2	0	7
10-14	8	4	2	14
15-19	28	14	1	43
20-24	10	27	6	43
25-29	11	30	1	42
30-34	24	27	10	61
35-39	38	29	5	72
40-44	66	46	18	130
45-49	54	48	16	118
50-54	89	45	18	152
55-59	92	59	19	170
60-64	107	37	15	159
65-69	87	32	13	132
70-74	52	18	11	81
75-79	16	6	2	24
80-84	5	3	0	8
>=85	0	1	0	1
Missing	0	0	0	0
Total	697	429	137	1263

Gender				
Female	258	181	46	485
Male	439	248	91	778
Missing	0	0	0	0
Total	697	429	137	1263

Race				
American Indian/Alaska Native	6	0	1	7
Asian	58	25	4	87
Black or African American	244	89	17	350
More than one race selected	15	12	4	31
Native Hawaiian or Other Pacific Islander	2	3	0	5
White	359	287	109	755
Missing	13	13	2	28
Total	697	429	137	1263

Primary Diagnosis				
Cystic Kidney	54	41	24	119
Diabetes	210	78	35	323
Glomerulonephritis	123	91	25	239
Hypertension	128	65	17	210
Other	106	104	21	231
Other Urologic	11	8	5	24
Missing	12	14	3	29
Unknown	53	28	7	88
Total	697	429	137	1263

Source of information: Network SIMS Database

Date of Preparation: May 2010

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.

Dialysis Deaths

Deaths of dialysis patients by state of residence, age, race, gender, primary diagnosis
and cause of death for CY 2009

AGE GROUP	NY	OTHER	TOTAL
00-04	0	0	0
05-09	1	0	1
10-14	1	0	1
15-19	2	0	2
20-24	10	0	10
25-29	9	0	9
30-34	30	1	31
35-39	39	0	39
40-44	86	1	87
45-49	161	2	163
50-54	251	2	253
55-59	332	2	334
60-64	479	5	484
65-69	541	4	545
70-74	616	9	625
75-79	703	10	713
80-84	704	7	711
>=85	743	6	749
Missing	0	0	0
Total	4708	49	4757

Gender			
Female	2062	19	2081
Male	2646	30	2676
Missing	0	0	0
Total	4708	49	4757

Race			
American Indian/Alaska Native	27	0	27
Asian	145	1	146
Black or African American	1408	7	1415
More than one race selected	58	2	60
Native Hawaiian or Other Pacific Islander	19	3	22
White	3017	36	3053
Missing	34	0	34
Total	4708	49	4757

Primary Diagnosis			
Cystic Kidney	72	1	73
Diabetes	2033	19	2052
Glomerulonephritis	272	1	273
Hypertension	1264	16	1280
Other	630	7	637
Other Urologic	87	1	88
Missing	41	0	41
Unknown	309	4	313
Total	4708	49	4757

Continued on next page

Dialysis Deaths

Deaths of dialysis patients by state of residence, age, race, gender, primary diagnosis and cause of death for CY 2009

Primary Cause of Death	NY	OTHER	TOTAL
Cardiac	2093	20	2113
Gastro Intestinal	41	0	41
Infection	693	8	701
Liver Disease	39	0	39
Vascular	235	1	236
Missing	135	5	140
Other	915	11	926
Unknown	557	4	561
Total	4708	49	4757

Source of information: Network SIMS Database

Date of Preparation: May 2010

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

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

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

This table includes 0 patients receiving treatment at VA facilities.

Vocational Rehabilitation
Beginning through End of Survey Period CY 2009

DURING THE SURVEY PERIOD

FACILITIES REPORTING	AGED 18 THROUGH 54 as of Dec. 31	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5PM
330005	39	0	8	0	Y
330006	2	0	0	0	Y
330012	19	0	4	4	Y
330013	0	0	0	0	N
330024	32	0	0	0	Y
330027	60	0	12	2	Y
330044	70	8	12	7	N
330045	5	0	0	0	N
330046	0	0	0	0	N
330053	7	1	3	0	N
330055	7	0	5	0	Y
330056	14	0	1	1	N
330058	15	0	5	0	N
330059	12	0	0	0	Y
330064	8	0	2	0	Y
330065	13	0	0	0	N
330072	21	0	2	1	N
330079	6	0	4	1	N
330080	38	0	18	0	Y
330090	18	1	6	0	N
33009F	3	0	1	0	N
330101	3	0	2	0	Y
330108	7	0	0	0	N
330125	0	0	0	0	Y
330128	4	0	0	0	Y
33012F	9	0	0	0	N
330136	20	0	0	0	N
330140	0	0	0	0	Y
330141	4	0	2	0	Y
330151	12	0	3	0	Y
330158	45	2	18	0	Y
330167	55	0	19	2	Y
33016F	7	0	0	0	N
33017F	8	1	3	0	N
330191	32	1	5	0	Y
330193	31	0	9	1	Y

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Vocational Rehabilitation
Beginning through End of Survey Period CY 2009

DURING THE SURVEY PERIOD

FACILITIES REPORTING	AGED 18 THROUGH 54 as of Dec. 31	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5PM
330195	0	0	0	0	Y
330198	0	0	0	0	N
330199	30	0	13	0	N
33019F	4	0	0	0	N
330201	19	0	2	1	Y
330202	53	1	31	3	Y
330204	31	0	0	0	N
330209	50	0	0	0	Y
33020F	12	0	0	0	N
330214	0	0	0	0	N
330219	28	0	6	0	N
330226	70	1	8	1	Y
330229	13	0	0	0	N
330233	3	0	0	0	Y
330234	0	0	0	0	N
330239	14	0	3	1	N
330240	45	3	10	10	Y
330241	0	0	0	0	N
330250	0	0	0	0	N
330286	2	0	0	0	Y
330290	0	0	0	0	N
330350	0	0	0	0	N
330357	0	0	0	0	Y
330393	0	0	0	0	N
330394	21	0	0	0	Y
330395	37	1	4	0	N
330399	86	1	13	1	N
330401	17	0	6	1	Y
332504	24	0	10	1	N
332506	46	0	3	1	N
332510	30	0	0	0	Y
332511	50	0	6	2	Y
332512	58	1	18	3	Y
332513	26	0	9	0	Y
332514	38	0	0	1	Y
332516	43	0	8	0	N

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Vocational Rehabilitation
Beginning through End of Survey Period CY 2009

DURING THE SURVEY PERIOD

FACILITIES REPORTING	AGED 18 THROUGH 54 as of Dec. 31	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5PM
332517	119	2	54	2	Y
332518	14	0	4	0	N
332519	26	1	5	1	N
332520	132	3	30	6	Y
332521	23	0	7	0	Y
332522	50	0	9	0	Y
332523	45	0	12	1	N
332524	37	0	4	0	N
332525	35	0	11	2	Y
332528	72	0	26	2	Y
332529	17	0	5	0	N
332530	74	0	10	4	Y
332531	67	0	9	0	Y
332532	19	0	4	1	N
332534	48	1	3	0	Y
332535	66	0	14	1	Y
332536	17	1	6	0	Y
332537	0	0	0	0	Y
332538	50	0	7	2	Y
332539	53	0	9	0	Y
332541	113	1	17	1	Y
332543	27	0	3	0	N
332544	40	0	12	2	N
332545	77	2	8	7	Y
332546	13	0	0	0	N
332547	59	0	14	1	Y
332548	55	3	14	1	Y
332549	18	2	5	0	Y
332550	39	0	9	2	Y
332551	53	5	17	1	Y
332552	5	0	1	0	Y
332554	21	1	3	1	N
332555	9	0	1	0	N
332556	62	3	18	1	Y
332557	24	0	2	0	N
332558	14	0	6	0	Y

Continued on next page

Vocational Rehabilitation
Beginning through End of Survey Period CY 2009

DURING THE SURVEY PERIOD

FACILITIES REPORTING	AGED 18 THROUGH 54 as of Dec. 31	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5PM
332559	10	0	6	1	Y
332560	42	0	2	1	N
332562	20	0	2	0	N
332563	33	1	11	2	N
332564	38	0	2	2	Y
332565	37	1	4	1	N
332566	38	1	10	3	Y
332567	27	0	6	0	N
332568	39	0	11	0	N
332569	74	7	22	1	Y
332570	55	0	55	3	N
332571	24	0	9	0	Y
332572	20	0	8	0	N
332574	11	0	4	0	N
332576	43	0	9	0	N
332577	50	42	8	0	Y
332578	48	0	13	2	Y
332579	8	0	2	0	N
332580	13	0	0	0	N
332581	57	1	11	3	Y
332582	71	3	2	5	N
332583	39	8	8	1	Y
332584	9	0	2	0	N
332585	17	0	1	0	Y
332586	31	0	7	0	N
332587	21	0	11	0	N
332588	34	0	11	0	N
332589	61	0	7	2	Y
332590	47	2	2	0	N
332591	7	0	2	0	Y
332592	17	0	4	0	N
332593	41	2	15	2	Y
332594	12	0	1	0	N
332595	37	0	12	0	N
332596	18	0	7	0	Y
332597	13	0	1	0	N

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Vocational Rehabilitation
Beginning through End of Survey Period CY 2009

DURING THE SURVEY PERIOD

FACILITIES REPORTING	AGED 18 THROUGH 54 as of Dec. 31	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5PM
332598	66	0	2	0	Y
332599	20	0	5	0	N
332600	23	0	5	1	Y
332602	28	1	13	1	Y
332603	25	0	3	0	N
332604	20	0	5	0	N
332605	19	0	5	0	N
332606	34	1	12	0	Y
332607	40	2	12	2	Y
332608	25	0	8	1	Y
332610	23	0	4	1	N
332612	72	0	21	0	Y
332613	80	0	23	2	Y
332614	10	0	4	0	N
332615	66	1	11	4	N
332616	3	0	0	0	N
332617	30	0	10	2	Y
332619	72	0	8	4	N
332620	34	0	13	1	Y
332621	58	3	15	3	N
332622	38	0	5	1	N
332625	29	0	11	1	N
332626	115	0	5	3	Y
332629	64	2	15	1	Y
332630	2	0	0	0	N
332631	14	0	1	2	Y
332632	34	0	13	1	Y
332633	64	0	17	0	Y
332634	4	0	0	0	Y
332635	20	0	3	0	Y
332636	3	0	0	0	N
332637	26	0	6	2	N
332638	1	0	0	0	N
332639	34	1	7	2	N
332640	1	0	1	0	N
332641	23	0	3	0	N

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Vocational Rehabilitation
Beginning through End of Survey Period CY 2009

DURING THE SURVEY PERIOD

FACILITIES REPORTING	AGED 18 THROUGH 54 as of Dec. 31	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5PM
332642	73	2	7	1	Y
332644	30	0	12	0	Y
332645	1	0	0	0	N
332646	63	3	16	5	N
332647	65	2	17	1	Y
332648	18	1	3	0	N
332649	49	0	4	1	N
332650	4	0	0	0	Y
332651	15	0	8	0	N
332652	23	0	3	1	N
332653	45	0	8	1	N
332654	11	0	0	0	N
332655	10	0	4	0	Y
332656	19	0	6	0	N
332657	0	0	0	0	N
332658	15	0	6	0	N
332659	1	0	0	0	N
332660	6	0	0	0	N
332661	26	26	25	26	N
332662	42	1	4	1	N
332663	6	0	5	0	N
332664	60	4	14	4	N
332665	13	0	5	0	N
332666	7	0	0	0	N
332667	5	0	0	0	N
332668	11	0	4	0	N
332669	6	0	6	0	N
332670	9	0	0	0	N
333300	3	0	1	2	N
333503	56	1	21	0	Y
333504	64	2	20	2	Y
333506	54	0	17	1	Y
333510	0	0	0	0	Y
333511	82	1	18	1	Y
333515	52	0	12	3	Y
333517	0	0	0	0	Y

Continued on next page

Vocational Rehabilitation
Beginning through End of Survey Period CY 2009

DURING THE SURVEY PERIOD

FACILITIES REPORTING	AGED 18 THROUGH 54 as of Dec. 31	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5PM
333518	10	1	1	0	Y
333519	19	0	1	0	N
333520	4	1	0	0	N
333521	22	1	2	3	N
333522	7	0	6	0	Y
333523	3	0	0	0	N
333524	66	0	12	2	Y
333525	0	0	0	0	N
333526	19	0	2	0	N
333527	40	0	10	1	Y
333529	10	1	1	0	N
333531	19	0	0	0	Y
333532	8	0	1	0	N
333533	10	0	7	0	N
333534	20	1	7	1	Y
333535	30	0	18	2	Y
333536	28	0	4	0	N
333538	4	0	0	0	N
333539	64	1	17	0	N
333541	32	0	12	0	Y
333542	4	0	0	0	N
333543	0	0	0	0	N
333544	73	2	22	1	Y
333545	8	0	1	0	N
333546	44	2	11	1	N
333547	59	2	23	5	Y
333548	33	1	7	2	N
333550	84	1	23	7	N
333551	0	0	0	0	N
333552	5	0	0	0	N
333553	11	0	0	0	N
333554	103	2	24	5	N
339801	0	0	0	0	N
State Total	7,234	185	1,665	228	Y= 112 N= 137
Network Total	7,234	185	1,665	228	Y= 112 N= 137
Grand Total	7,234	185	1,665	228	Y= 112 N= 137