

Network Council Meeting

Westin Hotel
Indianapolis, IN
March 10, 2009
6:00PM

*The Renal Network facilitates the achievement of
optimal wellness for renal disease patients.*

PRESIDENT'S REPORT

George Aronoff, MD

Network 9/10 – By the Numbers

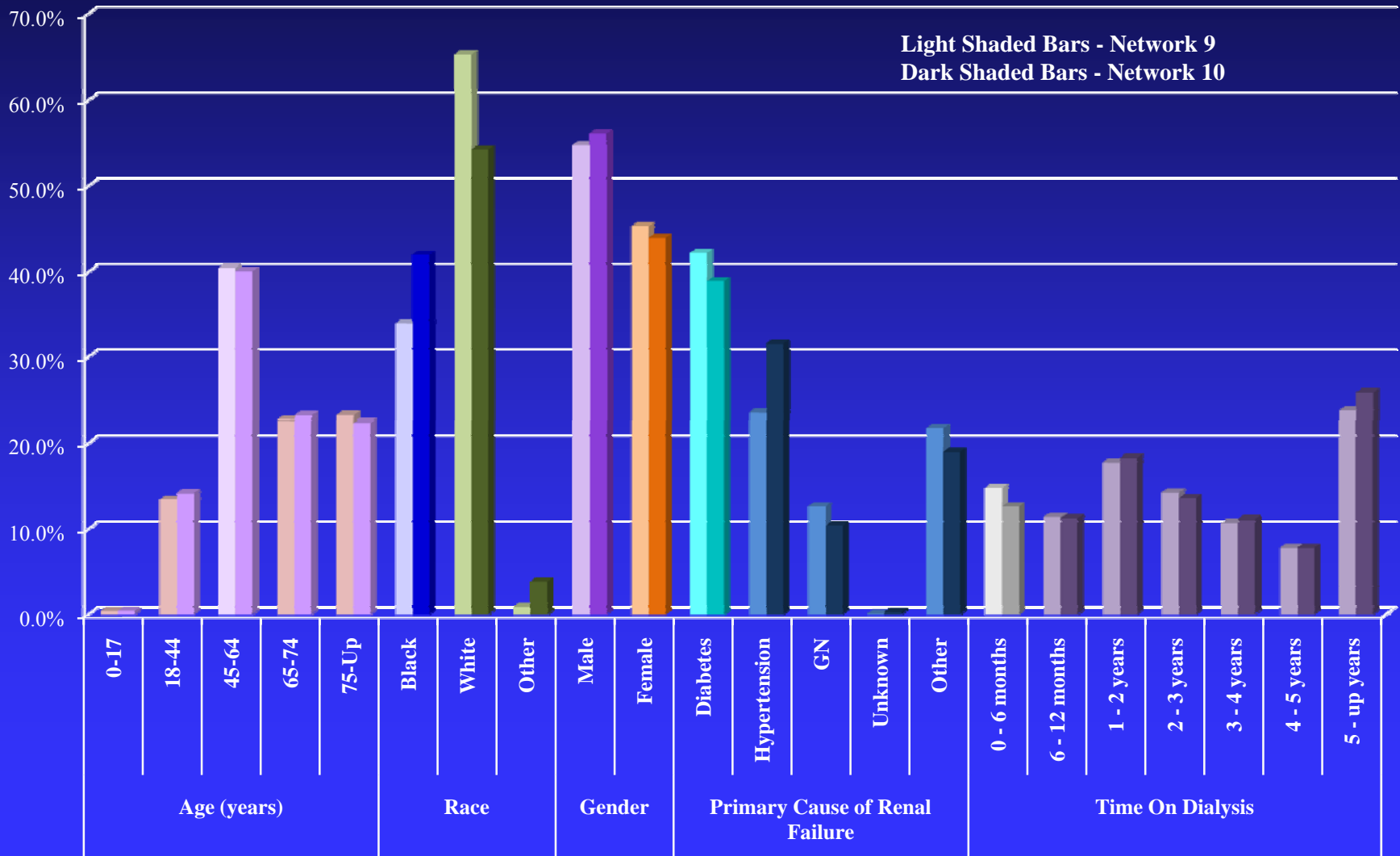
Network 9

- 470 Dialysis Facilities
- 13 Transplant Centers
- 26,228 Patients

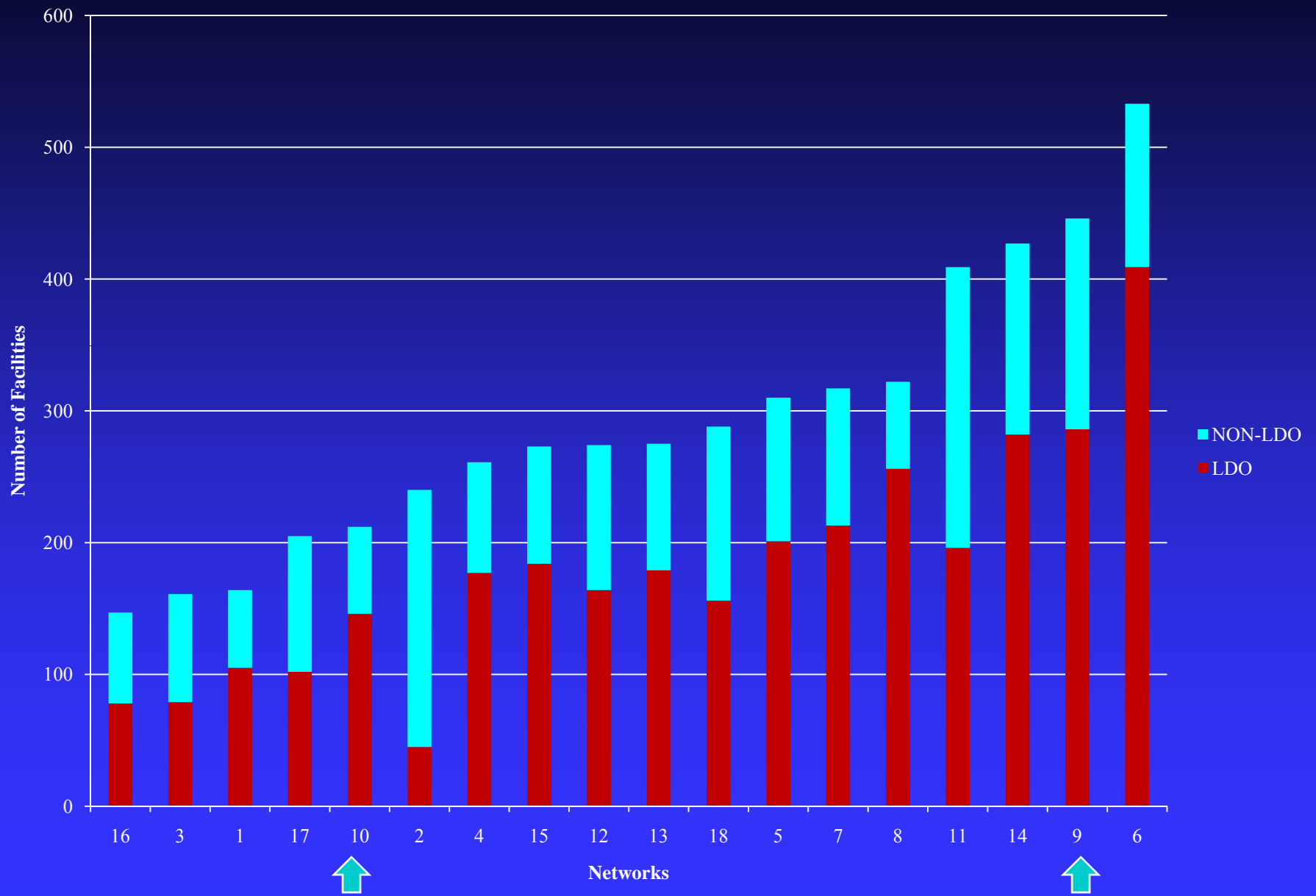
Network 10

- 218 Dialysis Facilities
- 8 Transplant Centers
- 15,607 Patients

Network 9/10 – Vital Stats



Dialysis Providers by Network by Ownership



Year In Review

- ◆ Conditions for Coverage - October 14, 2008
- ◆ CROWN Web Preparation
- ◆ MIPPA Legislation Passed
- ◆ Disaster Planning?
 - ☞ Earthquakes
 - ☞ Tornados
 - ☞ Floods
 - ☞ Ice Storms

NOMINATING COMMITTEE REPORT

Craig Stafford, MD

Nominations – Board of Trustees

Open Positions

- 1 Nephrologist
- 1 Social Worker
- 1 Dietitian
- 1 Administrator
- 1 Technician

Nominations – Medical Review Board

Open Positions

- 4 Nephrologists
- 1 Transplant Nephrologist
- 1 Nurse
- 1 Social Worker
- 2 Technicians

Election Process

- **MARCH 10, 2009:** Nomination process closes following the Network Council meeting.
- **JULY 2009:** The Nominating Committee will review all nominations to decide the slate.
- **AUGUST 2009:** The slate will be sent to the Board of Trustees for approval.
- **OCTOBER 2009:** Ballots will be sent to all voting members, to include:
 - ◆ Facility Representatives to the Network Council
 - ◆ Board of Trustees
 - ◆ Medical Review Board
 - ◆ Patient Leadership Committee
- **NOVEMBER 2009:** Successful candidates will be notified of their election.

MEDICAL REVIEW BOARD REPORT

Peter DeOreo, MD

QUALITY IMPROVEMENT WORK PLAN (QIWP)

Quality Improvement Projects:

Prevalent Fistula Rates

Catheter Reduction

Adequacy of Dialysis

Anemia Management



Fistula First Contract Goals

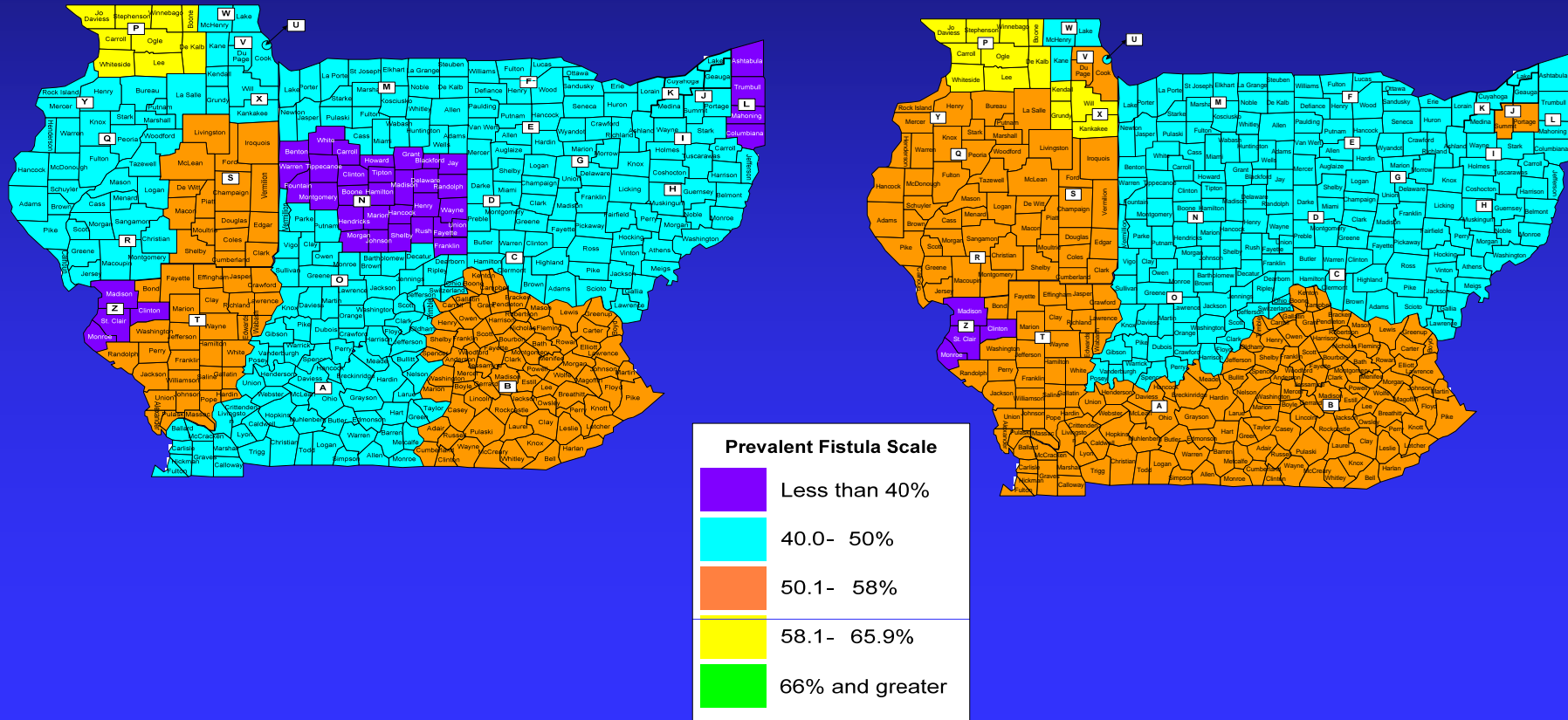
March 2009

Network	CMS 2009 Goal	December 2008	Variance
9	48.8%	47.3%	- 1.5
10	50.3%	49.1%	-1.2

Vascular Access Prevalent Fistula Rates

December 2007

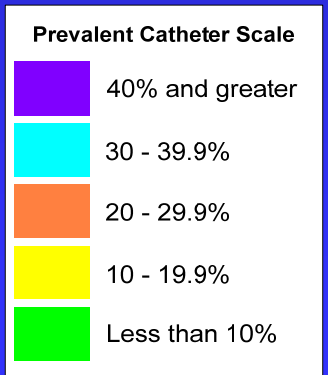
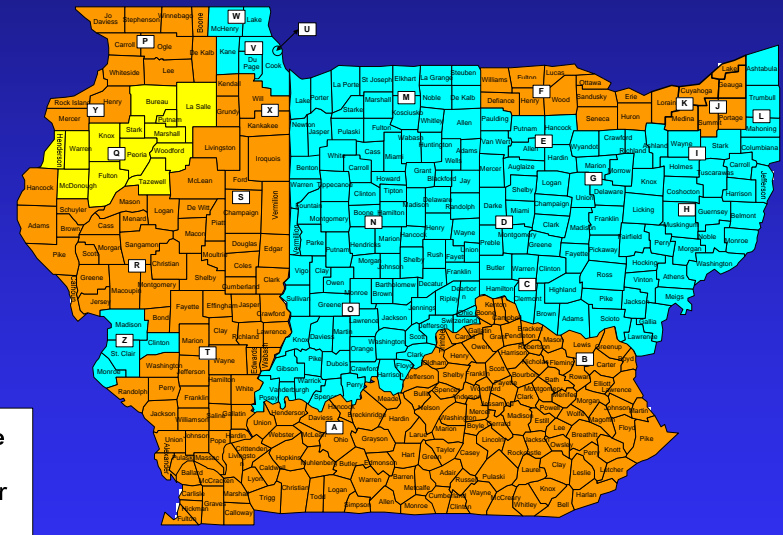
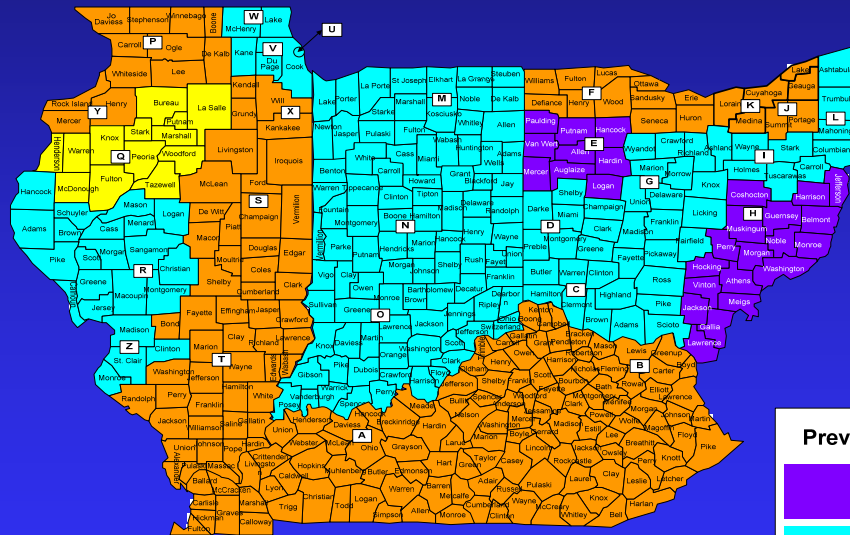
December 2008



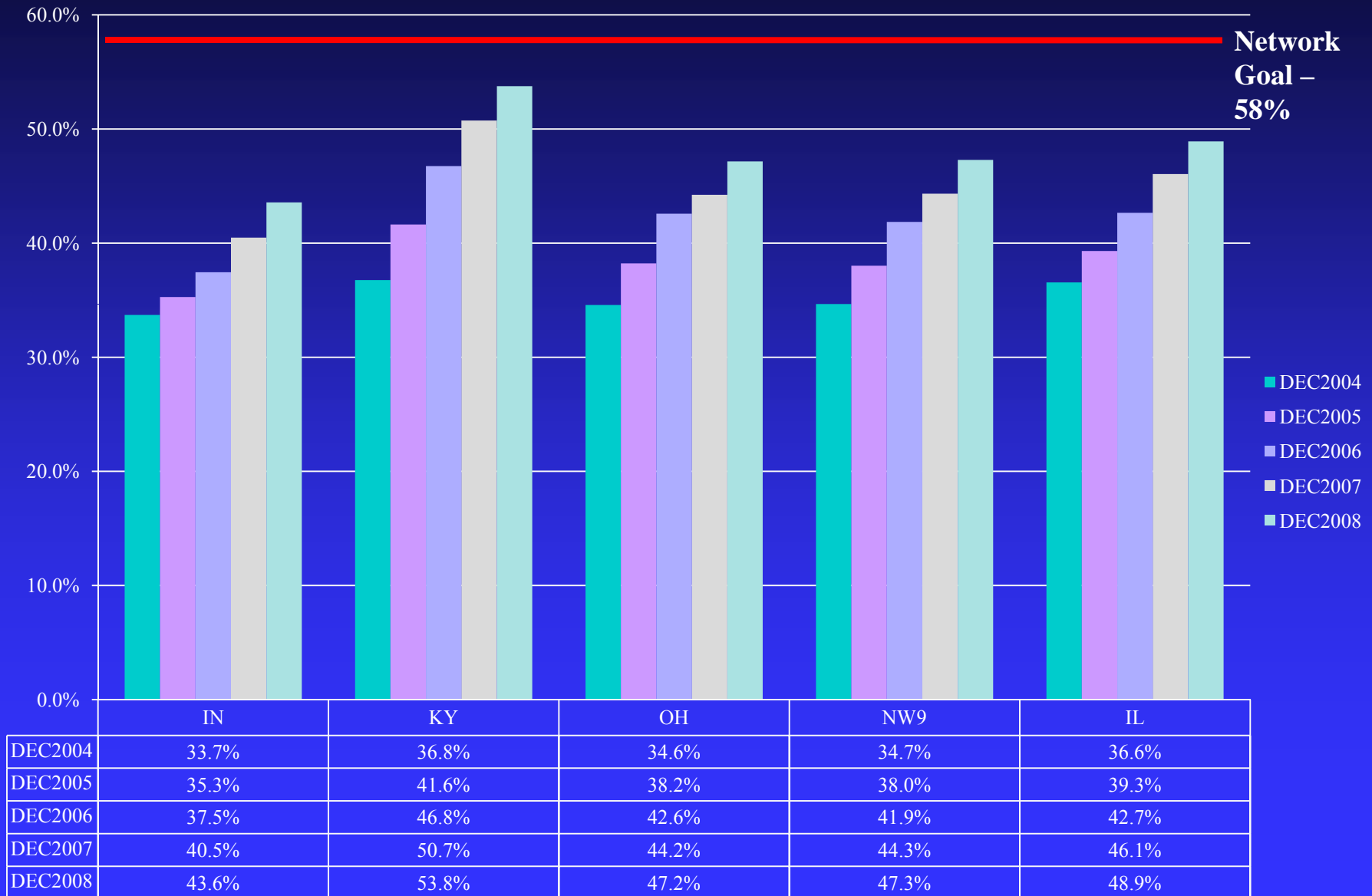
Vascular Access Prevalent Catheter Rates

December 2007

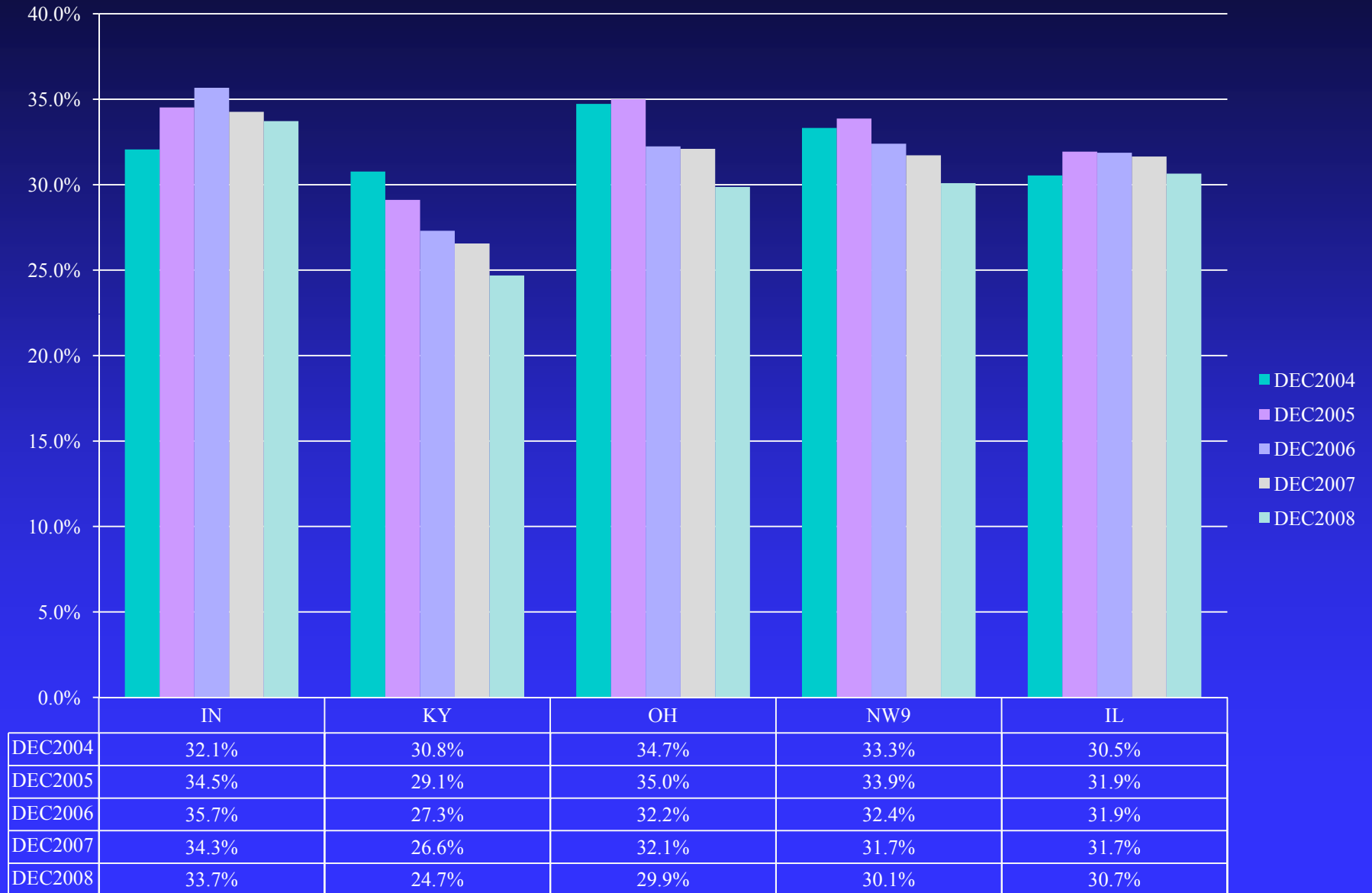
December 2008



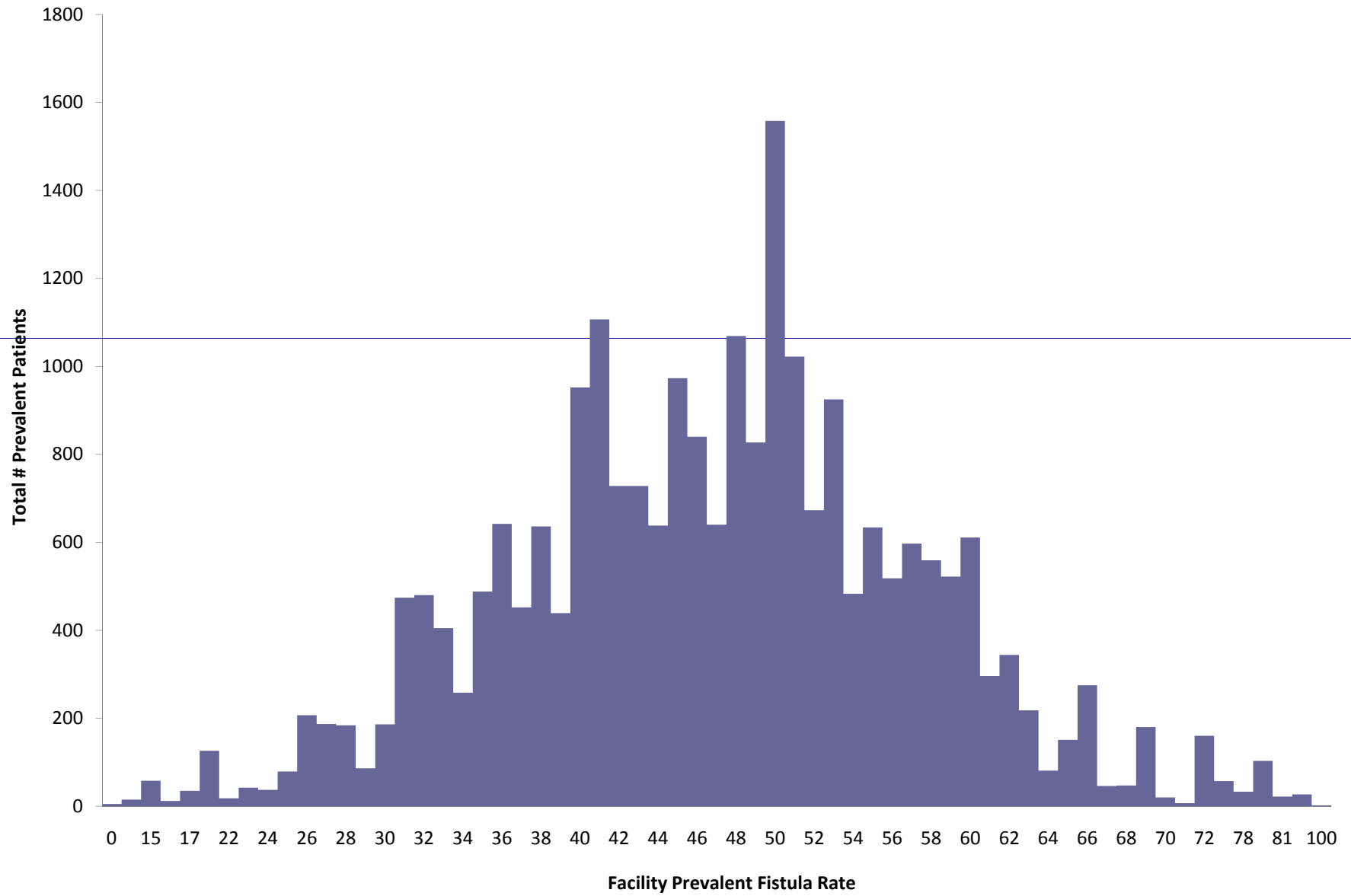
% Prevalent Patients Using a Fistula by State & Network



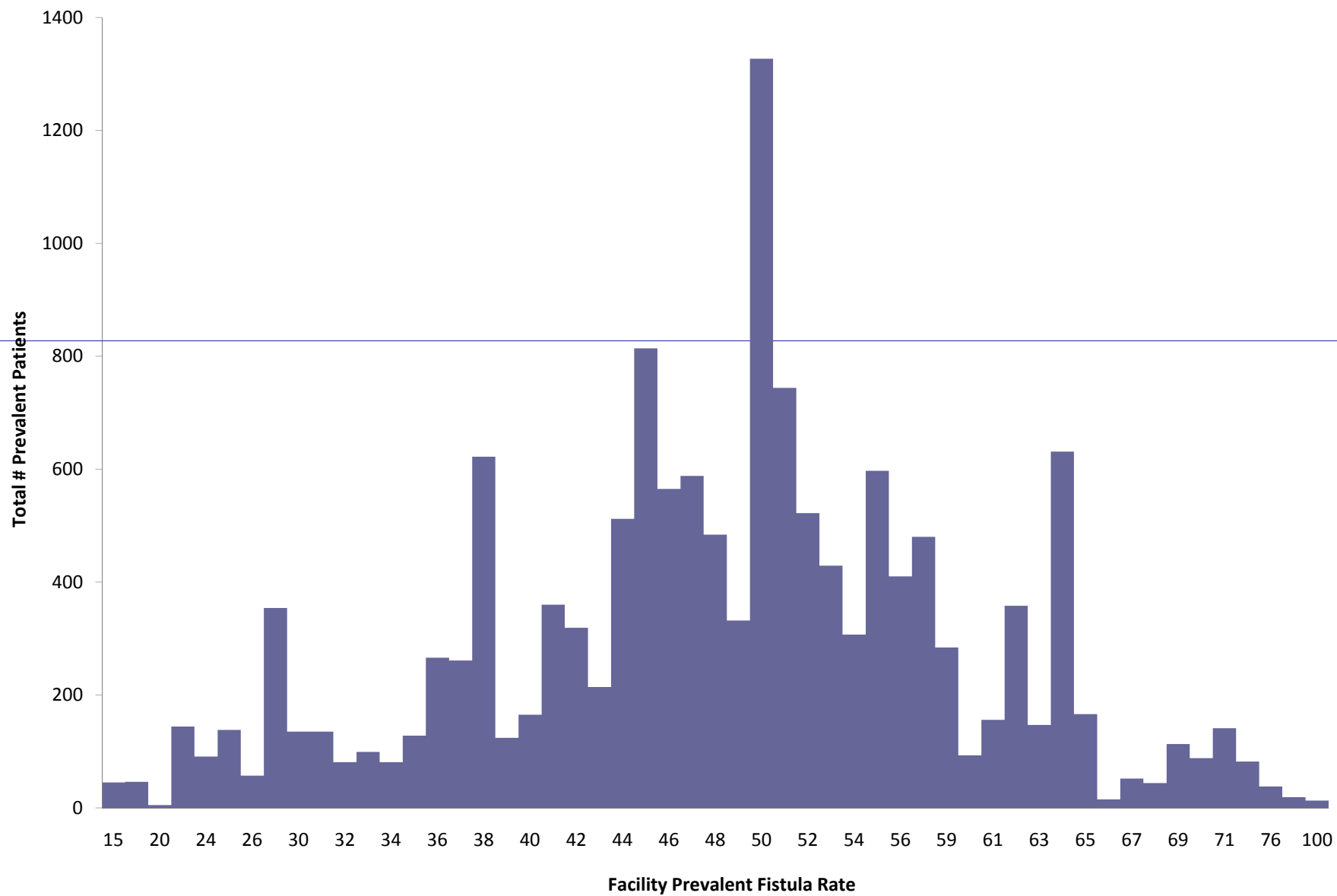
% Prevalent Patients Using a Catheter by State & Network



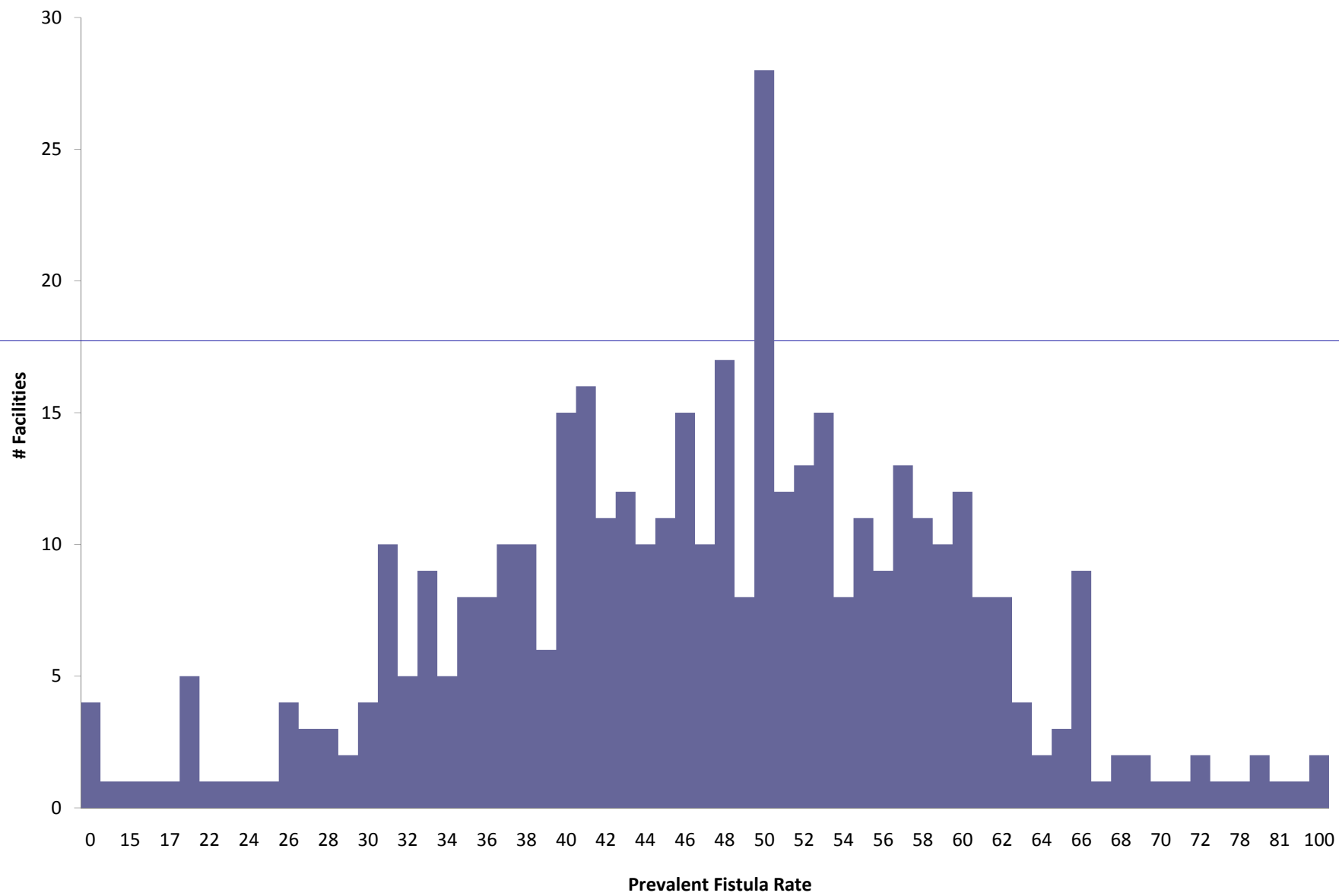
Network 9 - December 2008



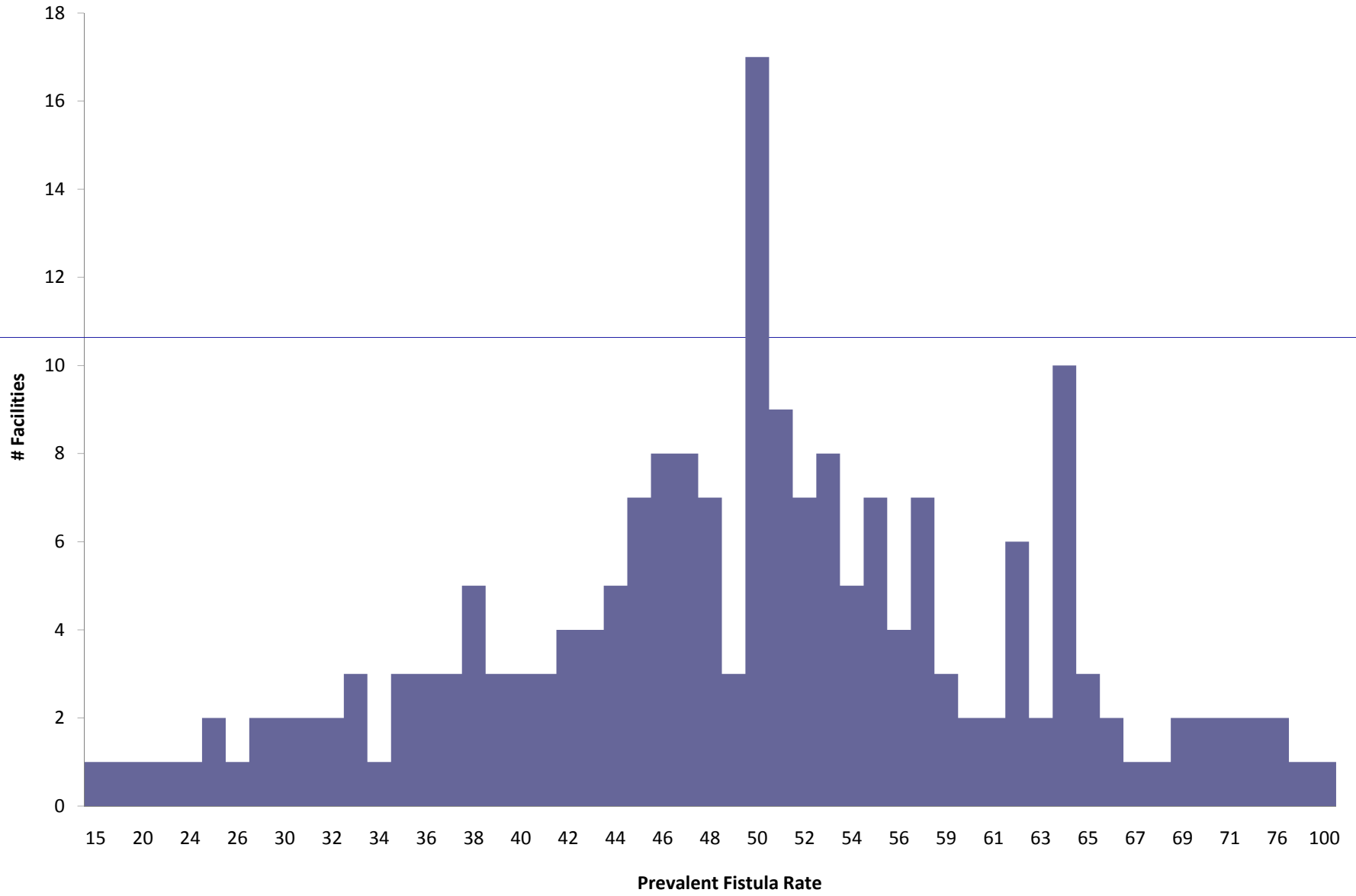
Network 10 - December 2008



Network 9 - December 2008



Network 10 - December 2008



Vascular Access Program Management QIP

- Program management training including continuous quality improvement (CQI) techniques
 - ◆ Assemble a vascular access interdisciplinary team
 - ◆ Conduct regular team QAPI meetings
 - ◆ Collect data monthly and report outcomes to the Network
 - ◆ Identify barriers to fistula placement and usage
 - ◆ Develop/change structured processes
 - ◆ Utilize the reports provided in the collection tool for specific surgeon and Nephrologist reporting
- Nine Network 9 facilities participating
- Nine Network 10 facilities participating

Vascular Access Coordinator QIP

- Assign vascular access coordinator at participating facilities
 - ◆ Root cause analysis to identify facility barriers to fistula placement and usage
 - ◆ Develop intervention strategies
 - ◆ Complete a project plan to improve prevalent fistula rates
 - ◆ Submit the project plan to the Network
 - ◆ Share project plans and ideas with other participants
 - ◆ Report progress quarterly through updated project plans

- 167 facilities participating in Networks 9 and 10

Physician Regional Learning Sessions

Learning session goal - to increase physician leadership, commitment and involvement in fistula prevalence quality improvement and to encourage facility adoption of policies and procedures for improved vascular access management.

- Learning session programs include the following topics:
 - ◆ facility data including trends and regional comparisons
 - ◆ physician specific data
 - ◆ routine CQI techniques
 - ◆ best practices in fistula placement and usage
 - ◆ process change tools and resources
 - ◆ surgical and interventional techniques for AVF placement and use
 - ◆ networking with mentor facilities
 - ◆ patient & staff culture
- 15 facilities in Network 9
- 7 facilities in Network 10

Fistula Surveillance QIP

- Targets facilities needing assistance in monitoring and maintenance of placed fistulas.

- The facilities were be asked to:
 - ◆ Complete a questionnaire designed to identify the facility barriers to fistula maturation in patients with placed fistulas
 - ◆ Provide an action plan to improve fistula maturation
 - ◆ Provide data monthly using a data collection tool that identifies patient level fistula rates by physician and surgeon
 - ◆ Utilize the specific physician and surgeon data in the CQI activities as a comparison reporting tool
 - ◆ To attend two learning sessions to discuss barriers to appropriate fistula placement and best practice models

- 19 facilities in Network 9
- 5 facilities in Network 10

Vascular Access Reporting QIP

- Enhanced Fistula First report - sent to all facility medical directors, administrators, vascular access coordinators/nurse managers quarterly.
- Report now includes:
 - ◆ the number of patients needed to reach the Network goal
 - ◆ the percentage of prevalent AV fistulas within their facilities.
- The report will assist facility QAPI Interdisciplinary teams in managing the prevalent patient fistula rate by having a concrete number of patients to change vascular access.
- Facility staff will be asked to:
 - ◆ Use this report as a part of their vascular access QI program to chart their progress in reaching Network and CMS targets
 - ◆ Use the number of fistulas needed as a guide to manage identification of patients that need vascular access intervention
 - ◆ Complete and submit to the Network, an environmental scan to determine how the reports were used by the vascular access team

Vascular Access QIPs

Network 9

Project	March 31, 2009 Goal	December 2008	Variance
Fistula Rate – Network 9	48.8%	47.3%	-1.5 percentage points
Interventions			
VA Program Management	28 New Fistulae	52	+24
VA Coordinator	295 New Fistulae	211	-84
Regional Learning Sessions	35 New Fistulae	40	+5
Fistula Surveillance	38 New Fistulae	41	-3
Total New Fistulae Needed to reach 4%	932		

Vascular Access QIPs

Network 10

Project	March 31, 2009 Goal	December 2008	Variance
Fistula Rate – Network	50.3%	49.1%	-1.2 percentage points
Interventions			
VA Program Management	26 New Fistulae	56	+30
VA Coordinator	138 New Fistulae	210	+72
Regional Learning Sessions	19 New Fistulae	26	+7
Fistula Surveillance	13 New Fistulae	10	-3
Total New Fistulae Needed to reach 4%	546		

Catheter Reduction QIP

Interventions address facility policies/procedures for reducing the prevalence of permanent catheters including:

1. No policies or procedures in place for evaluating catheter patients for an AVF
 - ◆ Tools and resources on policy and procedure development provided
 - ◆ Learning sessions. - Topics include best practice models, and data describing patient and facility infection, hospitalization and mortality rates related to increased chronic catheter usage.
2. No formal tracking of catheter patients to ensure that a plan is developed for catheter removal
 - ◆ vascular access quality improvement data collection tool provided to collect and analyze data monthly.
 - ◆ Quarterly feedback reports comparing outcomes to other QIP participants

Catheter Reduction QIP

3. No structured CQI vascular access management program
 - ◆ Facility VAC and Medical Directors will receive instruction on using the vascular access quality improvement template including the vascular access needs assessment.
 - ☞ designed to provide a structure for a vascular access management program.
 - ◆ Facility VAC and Medical Directors will submit a facility barriers questionnaire and an action plan
 - ◆ Facility VAC and Medical Directors will attend scheduled learning sessions.
 - ☞ Topics will include best practice models and QAPI development to assist in catheter

9 facilities in Network 9

9 facilities in Network 10

Catheter Reduction QIP

Network	Goal	December 2008 Results	Variance
9	≥ 5 Targeted Facilities decrease chronic catheter population by 20 percent	8 targeted facilities have decreased chronic catheter population by 20 percent	+3
10	≥ 5 Targeted Facilities decrease chronic catheter population by 20 percent	8 targeted facilities have decreased chronic catheter population by 20 percent	+3

Fistula First Update Other Activities

- Buttonhole Technique Webex
- Physician Incident Reports based on 2728 data
- Vascular Access QAPI Template
- Change Concept Education Mailing
- Medical Director Mailing

Hemodialysis Adequacy Goal

95% or More Patients Achieve a

URR of $\geq 65\%$

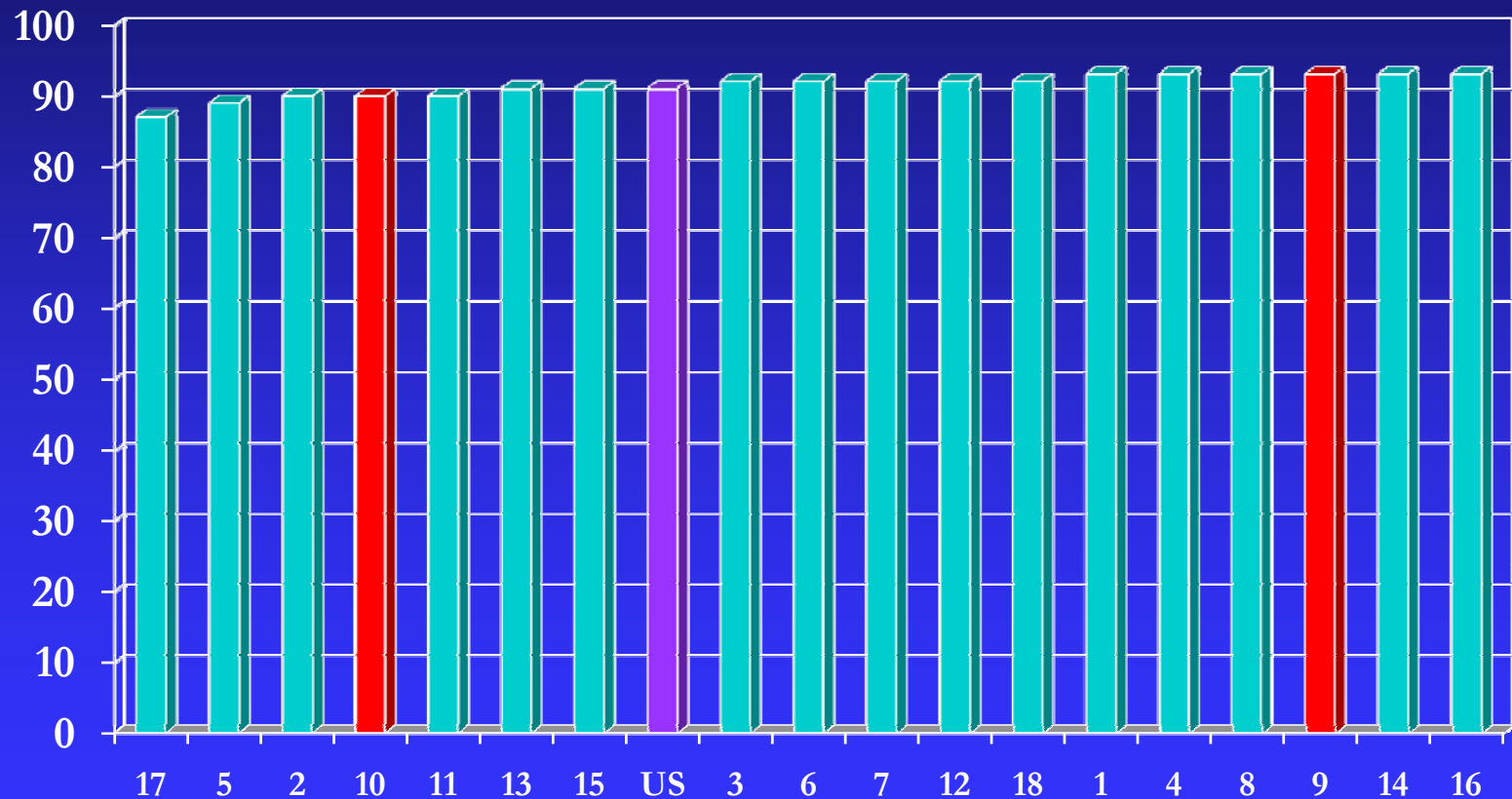
And

a Kt/V of ≥ 1.2

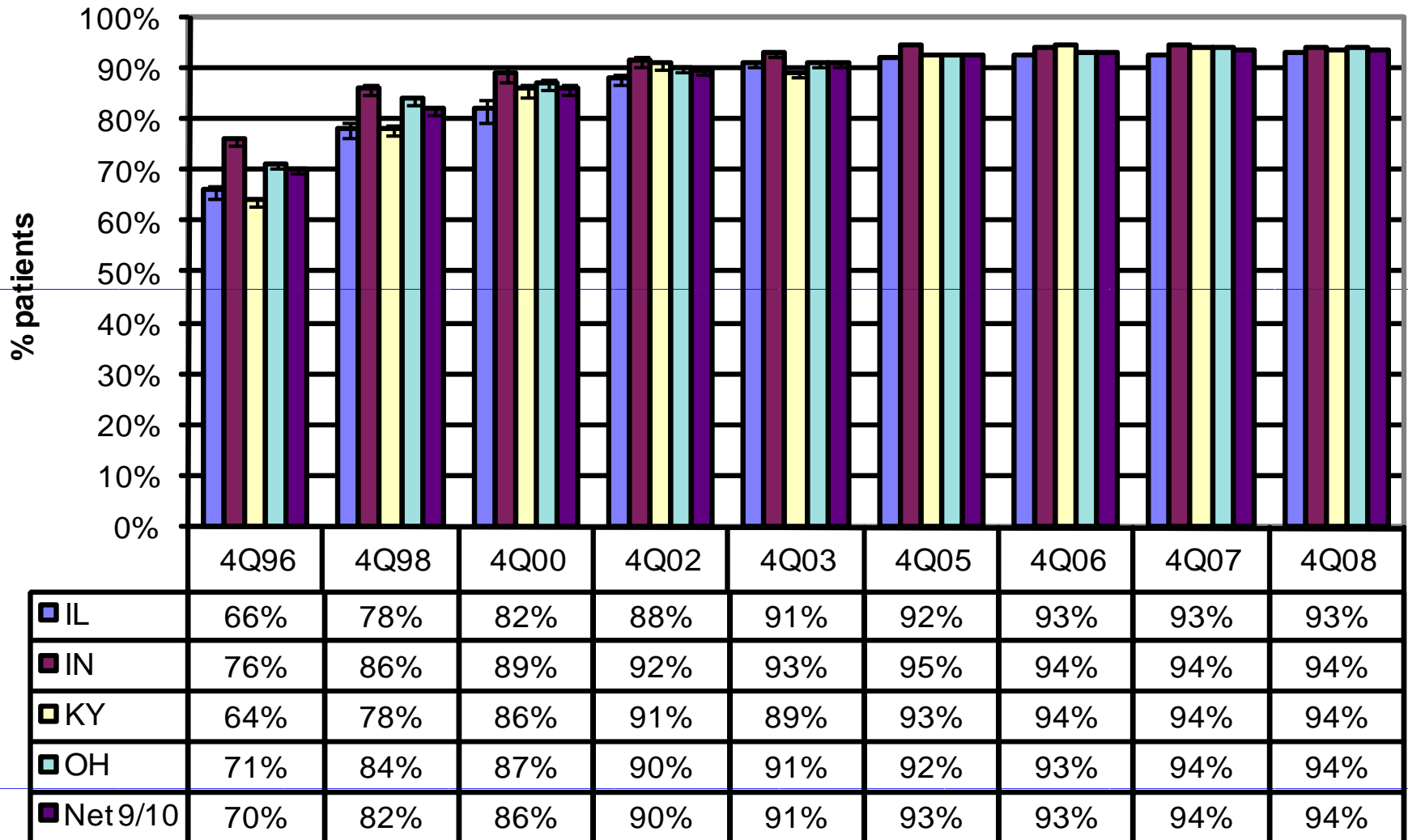
National CPM Data Collection

% Patients with $Kt/V \geq 1.2$

4th Quarter 2007



**Percentage of HD Patients with Reported Kt/V \geq 1.2
by State and Network 9/10 for Selected Collection Periods**



Adequacy QIP

- Target facilities include dialysis facilities with <74.7% of patients with URR \geq 65%
- To address barriers, the medical director, head nurse and other facility staff will:
 - ◆ Complete a Facility Barriers to Adequate Dialysis Questionnaire and submit to the Network. Network QI staff work with the facilities to develop action plans to address facility specific barriers.
 - ◆ Receive model policies and algorithms to address adequacy protocols from Network QI staff
 - ◆ Submit data and complete the “Needs Assessment Report” monthly via the Hemodialysis Adequacy Template data collection tool

Adequacy QIP

Goal	4 th Quarter 2008 Results	Variance
60% of Targeted facilities meet the Network average of 88%	77.8% of targeted facilities have met goal	+ 17.8

Anemia Management Goal

Goal has been replaced by –

“A Statement on the Use of ESA in CKD Patients Requiring Dialysis”

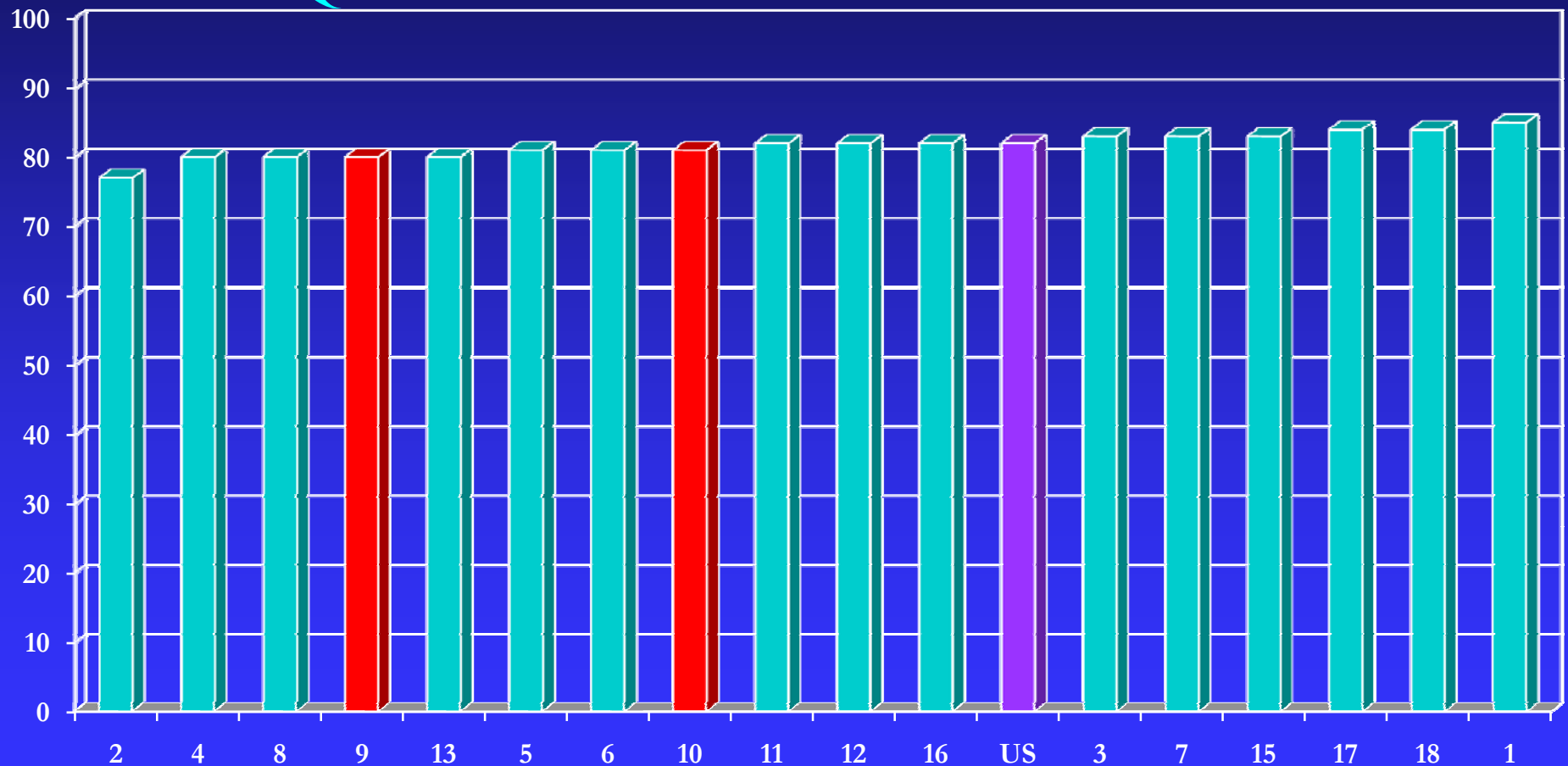
Developed by the Medical Review Board

www.therenalnetwork.org

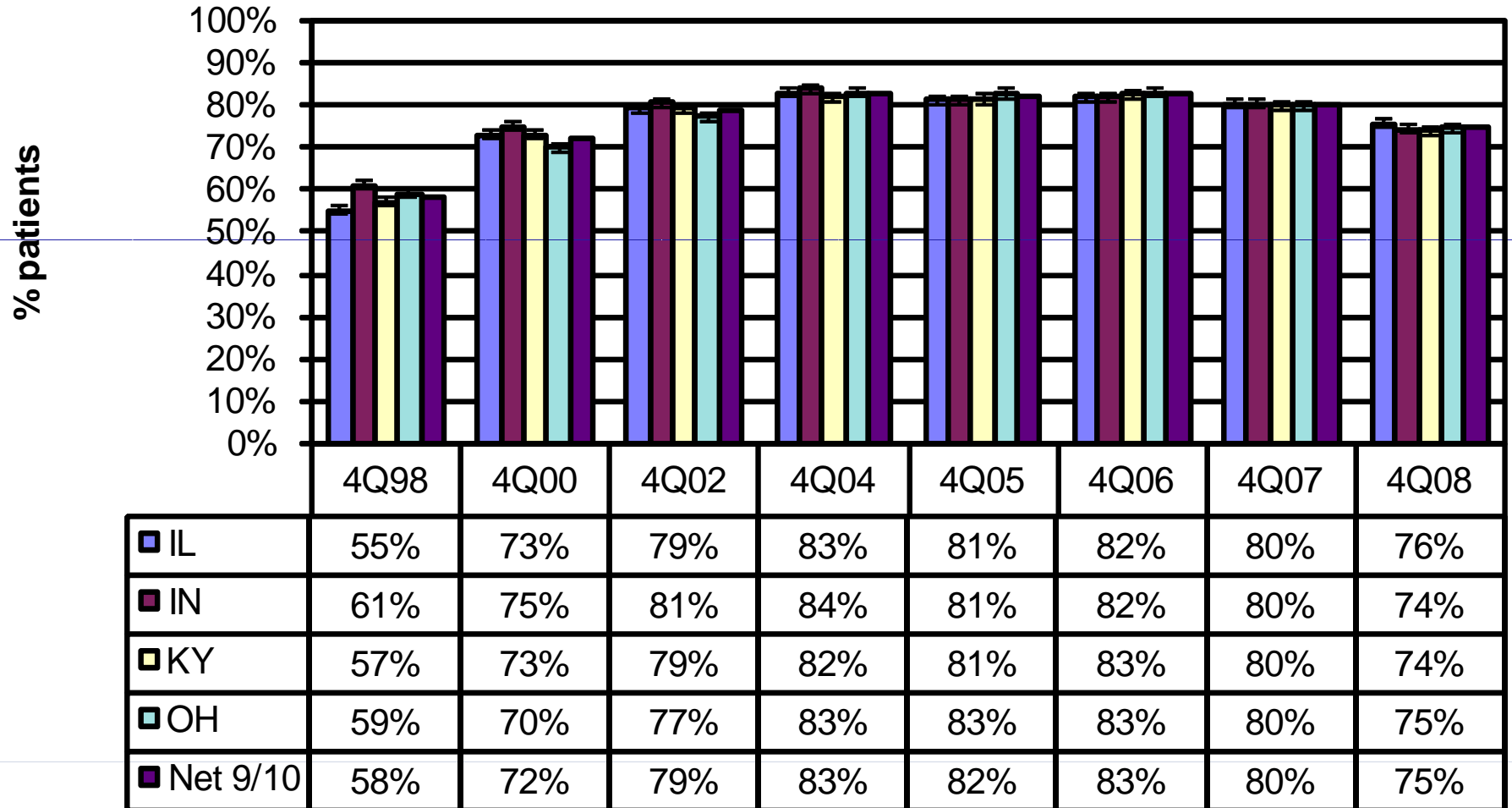
National CPM Data Collection

% Pts with mean Hgb \geq 11g/dl

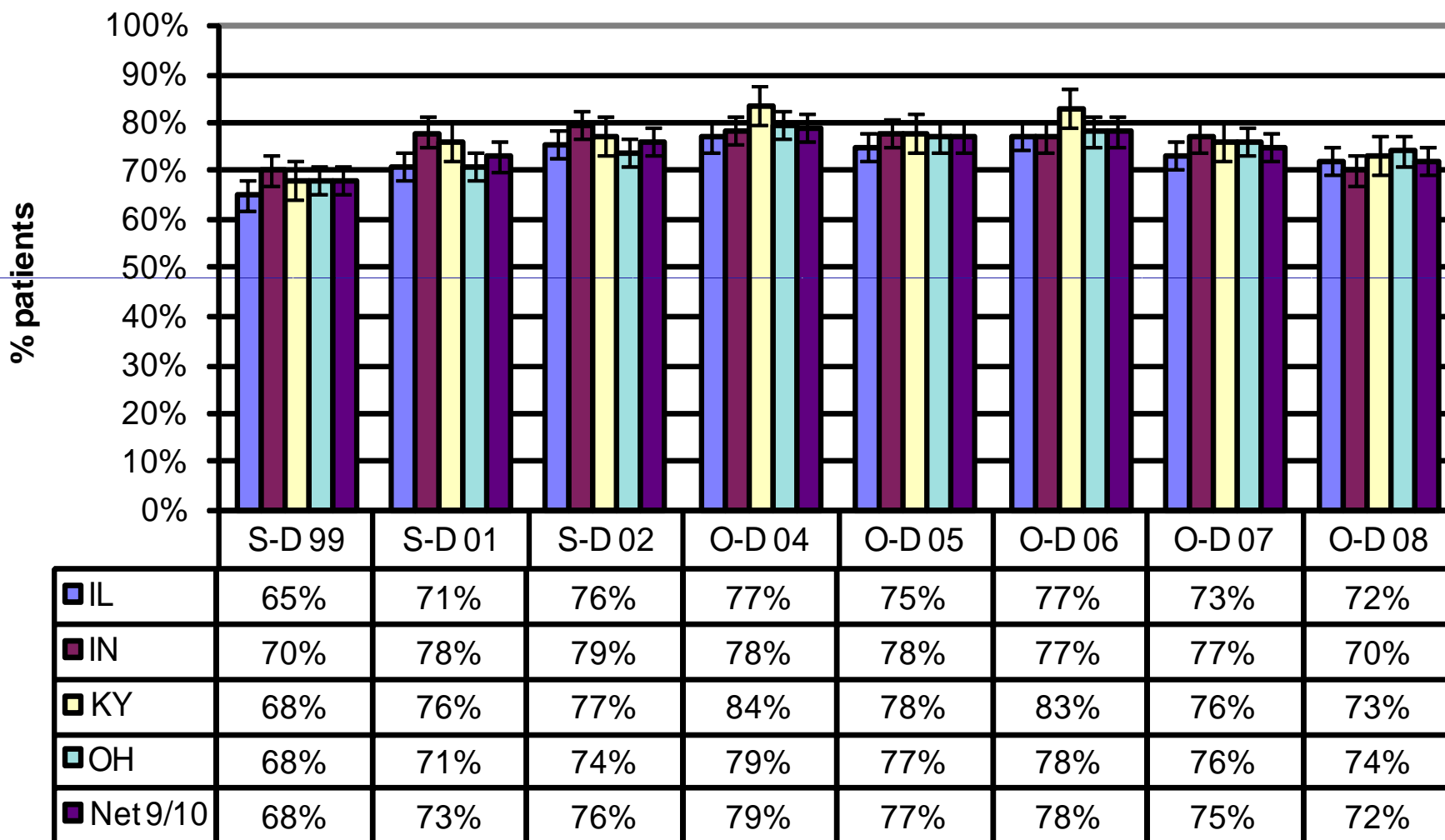
4th Quarter 2007



Percentage of HD Patients with HGB \geq 11 gm/dL by State and Network 9/10 for Selected Collection Periods



Percentage of PD Patients with HGB \geq 11 gm/dL by State and Network 9/10 for Selected Collection Periods



Anemia Management QIP

- The MRB identified three barriers to increasing the hemoglobin target range (percent of patients in 10-12 gm/dl):
 - ◆ Lack of awareness and understanding of the new FDA hemoglobin target range of 10-12 gm/dL
 - ◆ Failure to adapt ESA dosing algorithms to new hemoglobin target range
 - ◆ Lack of awareness that based on the underlying distribution of the hemoglobin concentration in the population (all patients in the Network), one can reasonably expect to see specific percentages outside the target range and that this is dependent on facility size.

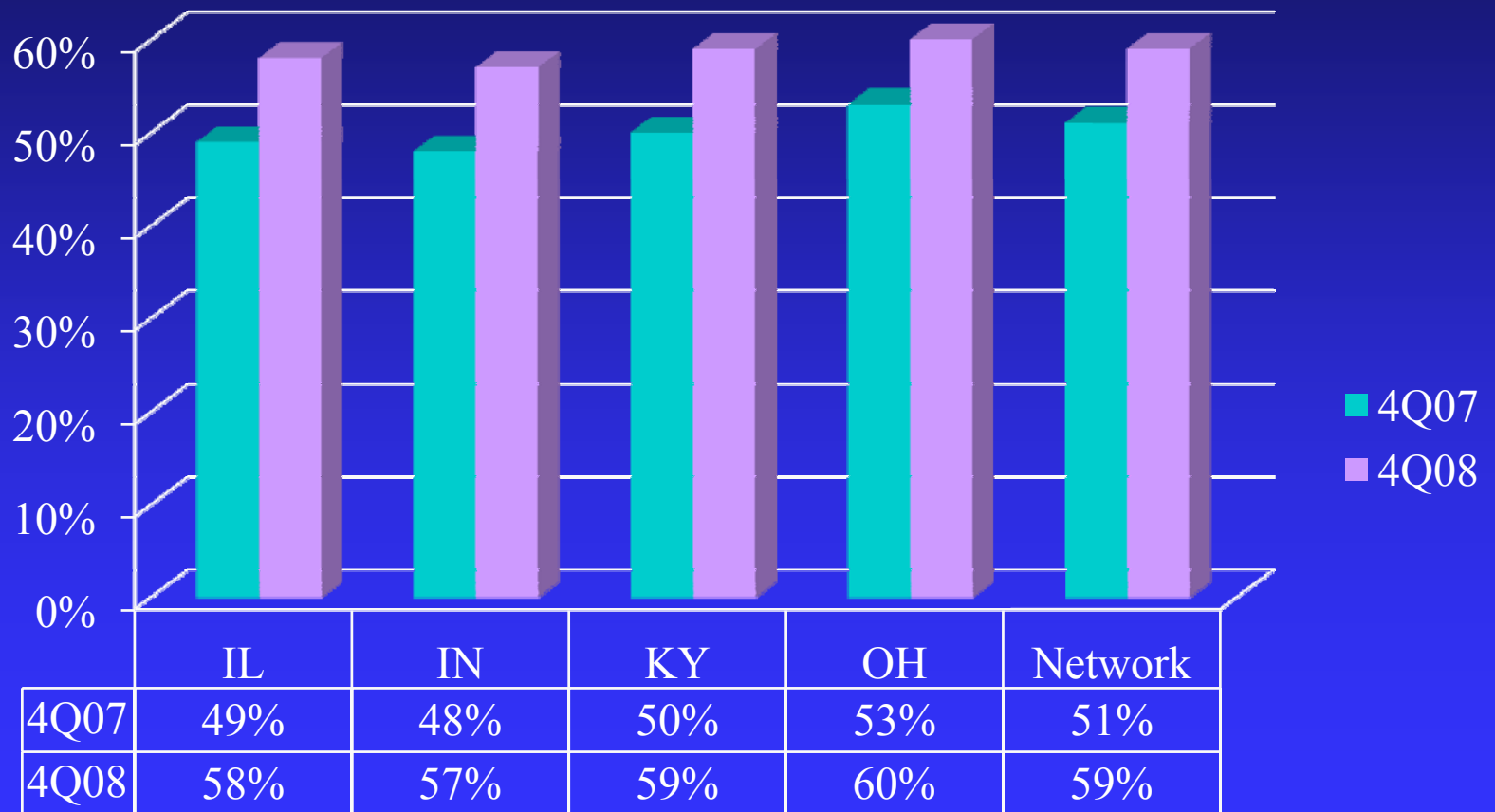
Anemia Management QIP

- To address barriers, all dialysis facilities in the Network 9/10 area will be educated on the new clinical performance measures and be provided with dosing algorithms to help achieve target hemoglobin.
- Dialysis facilities will receive five resources:
 - ◆ FDA Statement on ESAs along with revised Network 9/10 goal for Anemia Management
 - ◆ Facility specific anemia data report based on 2007 Elab data with regional comparatives
 - ◆ The Hemoglobin Target Calculator and instructions for use
 - ◆ MRB Recommendations to Medical Directors on achieving hemoglobin targets
 - ◆ Notification that sample algorithms targeting a mean Hgb of 11 gm/dl are posted on the Network website

Anemia Management QIP

- Recommendations to all medical directors, physicians and nurse managers include-
 - ◆ Head nurses track their monthly mean hemoglobin to ensure that this average is moving to the target (11 gm/dl) recommended by the calculator.
 - ◆ Failure of the mean hemoglobin to fall below 11.5 gm/dL should prompt a review of the facility's anemia management protocol.
 - ◆ Medical Directors should compare the **observed** percentage of patients in each of the three monitoring ranges to the **expected** percentage identified by the calculator and make changes to the facility's anemia management protocol as necessary.

Percentage of All Patients with Hgb 10-12gm/dl



Other CPM Outcomes

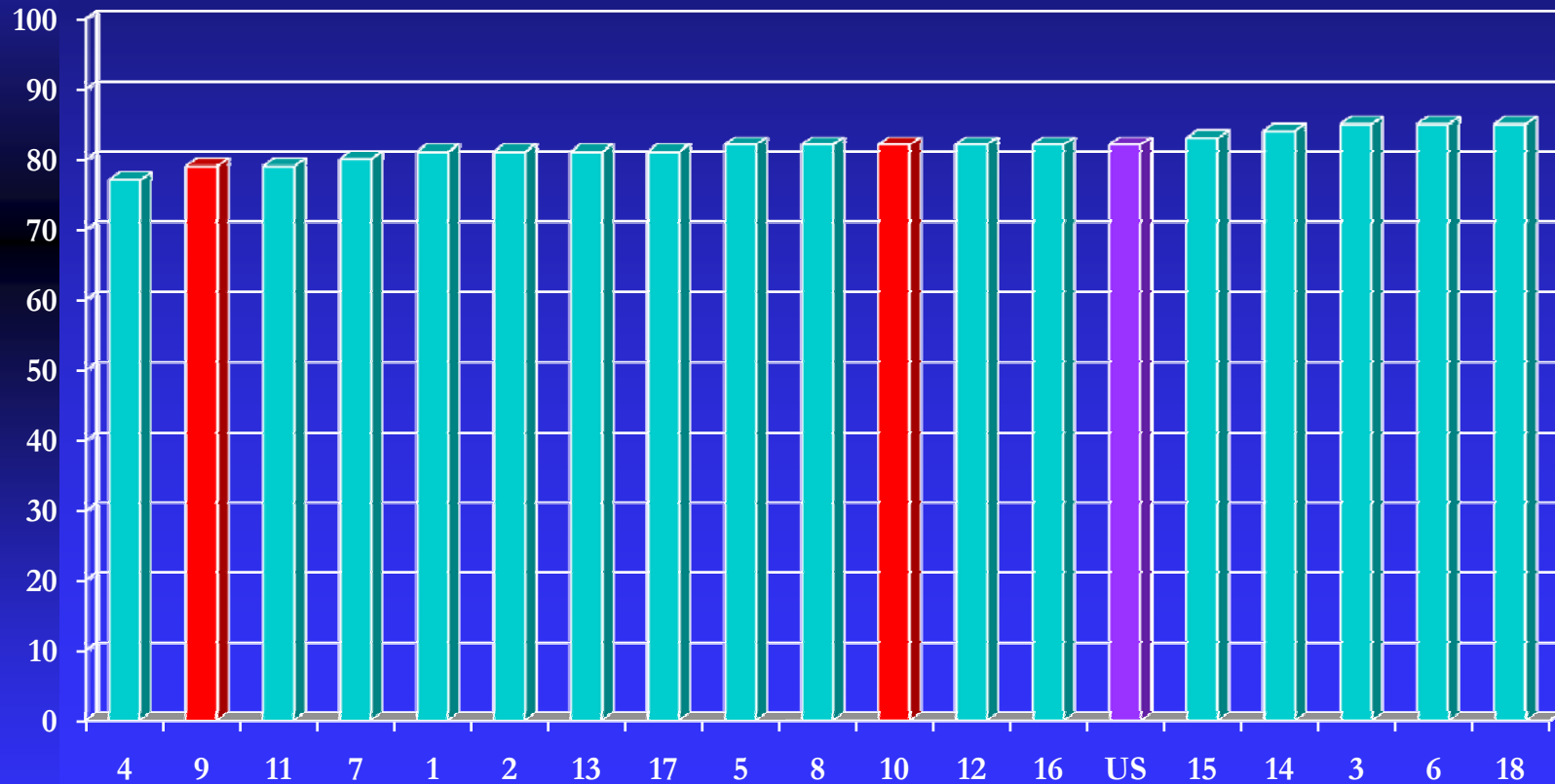
Nutrition Goal

All patients will have serum albumin measured and evaluated each month.

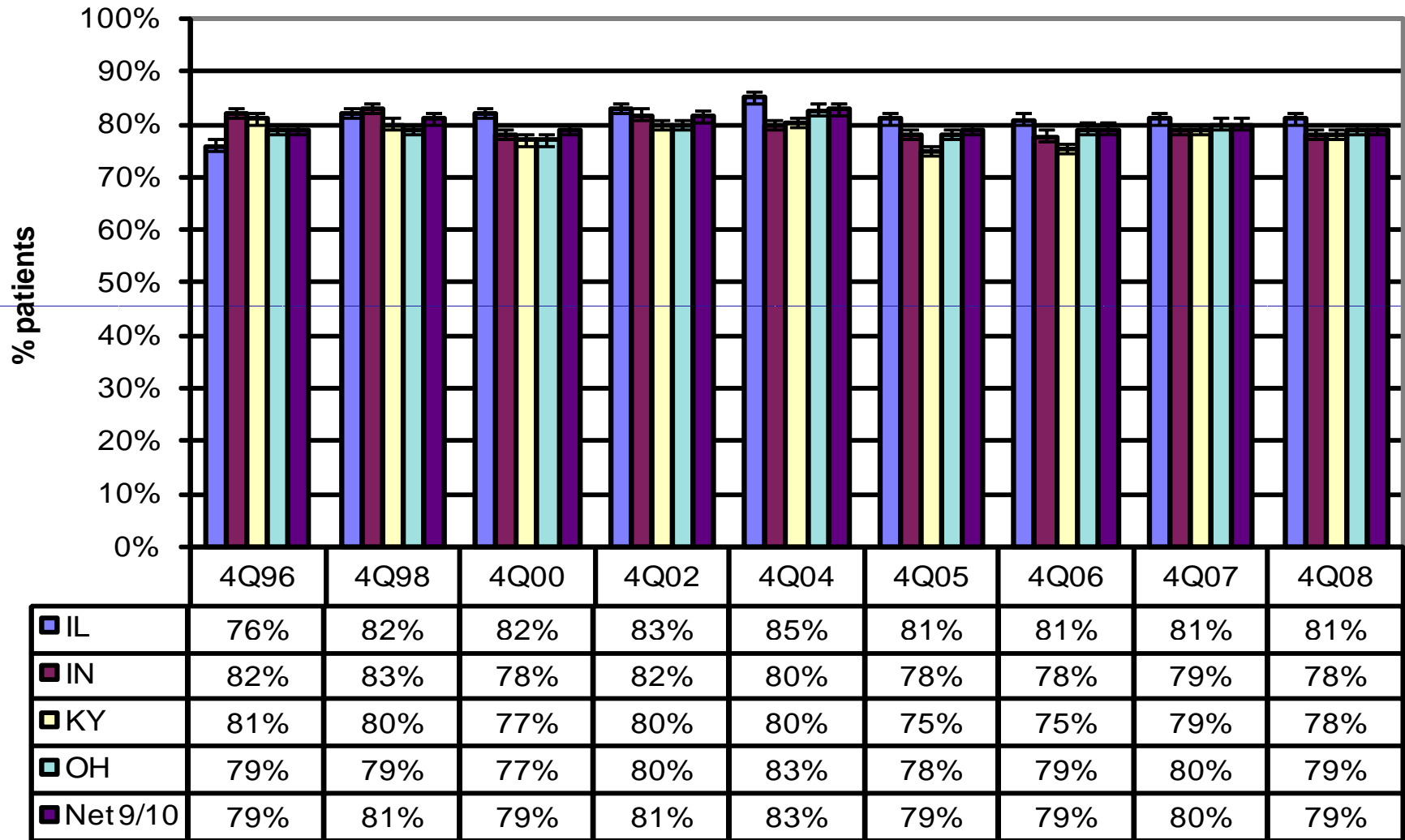
A stabilized serum albumin equal to or greater than the lower limit of the normal range (approximately 3.5g/dl for bromcresol green)

National CPM Data Collection

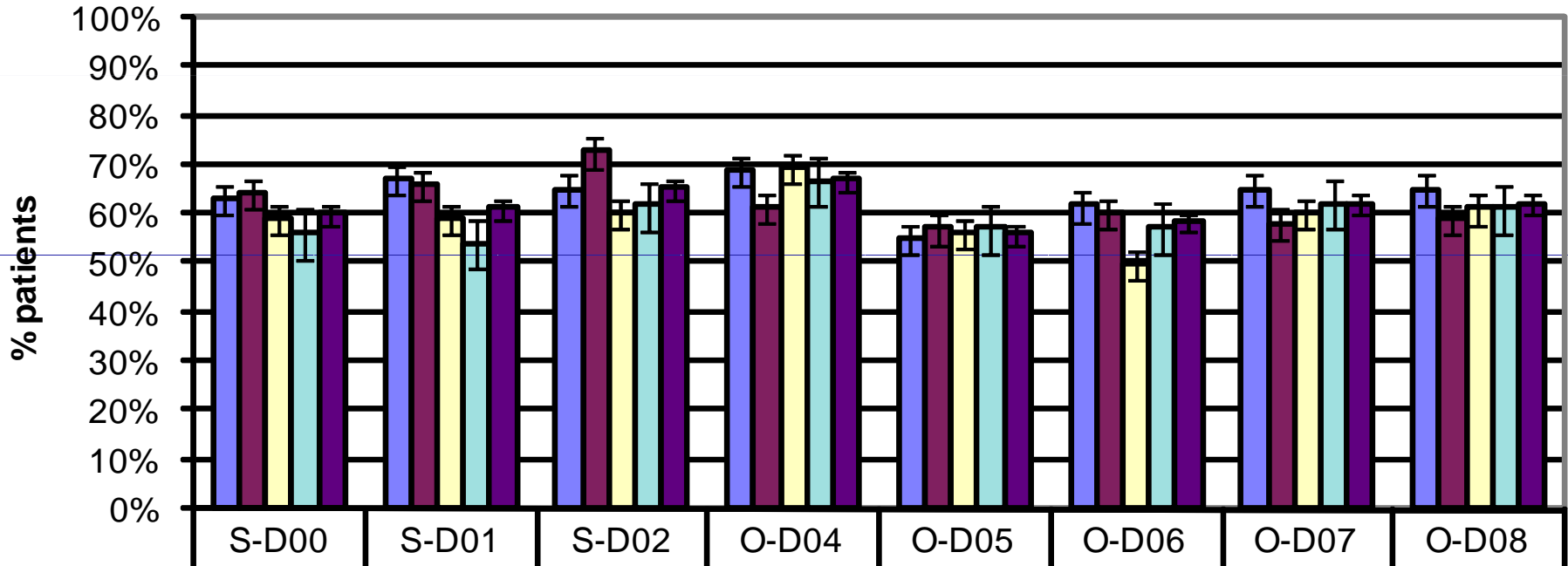
% Pts with mean serum albumin $\geq 3.5/3.2$ g/dl
4th Quarter 2007



**Percentage of HD Patients with Average Albumin \geq 3.5 gm/dL
by State and Network for Selected Collection Periods**



**Percentage of PD Patients with Average Albumin \geq 3.5 gm/dL
by State and Network 9/10 for Selected Collection Periods**



	S-D00	S-D01	S-D02	O-D04	O-D05	O-D06	O-D07	O-D08
IL	63%	67%	65%	69%	55%	62%	65%	65%
IN	64%	66%	73%	61%	57%	60%	58%	59%
KY	59%	59%	60%	70%	56%	50%	60%	61%
OH	56%	54%	62%	67%	57%	57%	62%	61%
Net9/10	60%	61%	65%	67%	56%	58%	62%	62%

Mineral Metabolism Goals

All patients measured for calcium &
phosphorus every month

$\geq 75\%$ of patients will have a Ca/PO_4
product of
 $< 55 \text{ mg}^2/\text{dL}^2$

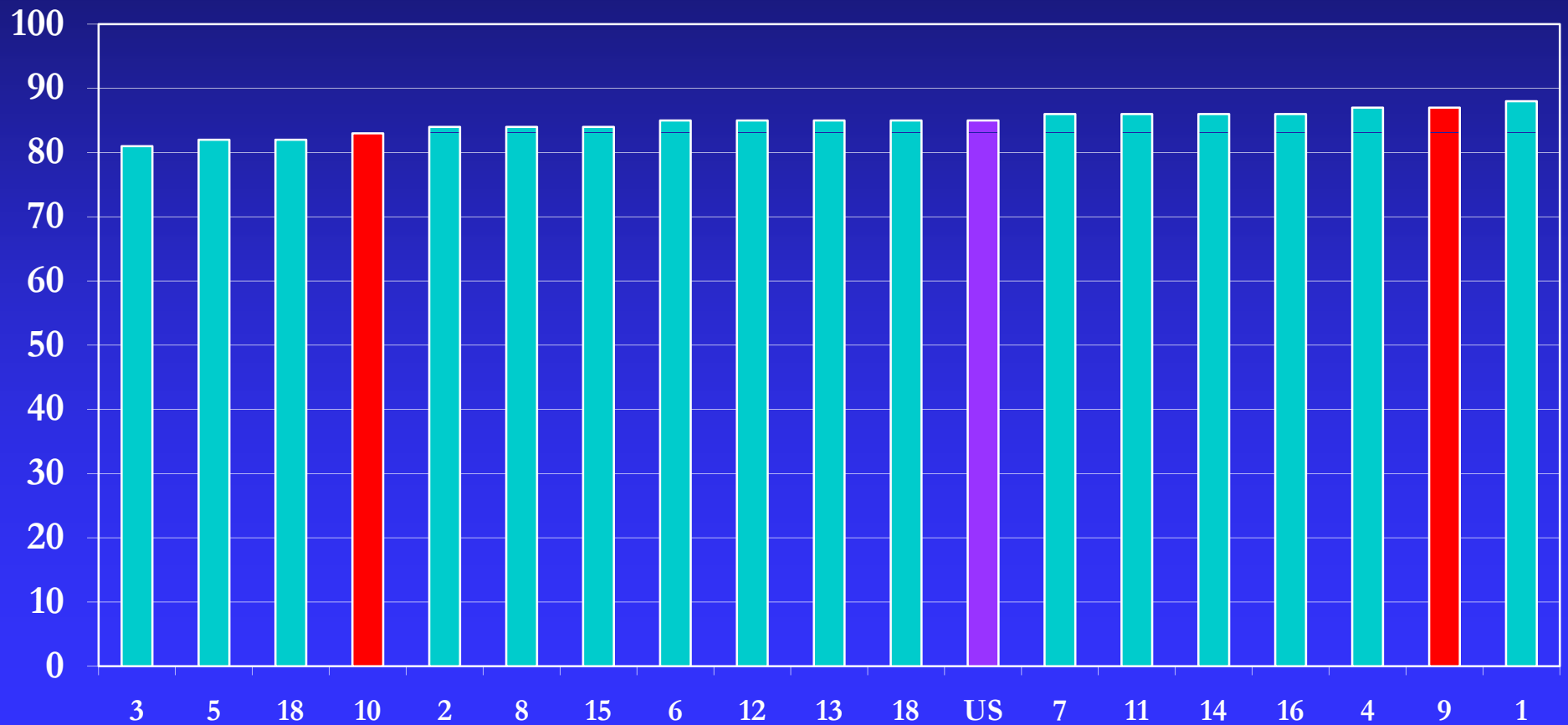
All patients will be measured for “intact”
PTH quarterly

National CPM Data Collection

% Patients with Adjusted Calcium

8.4 – 10.2

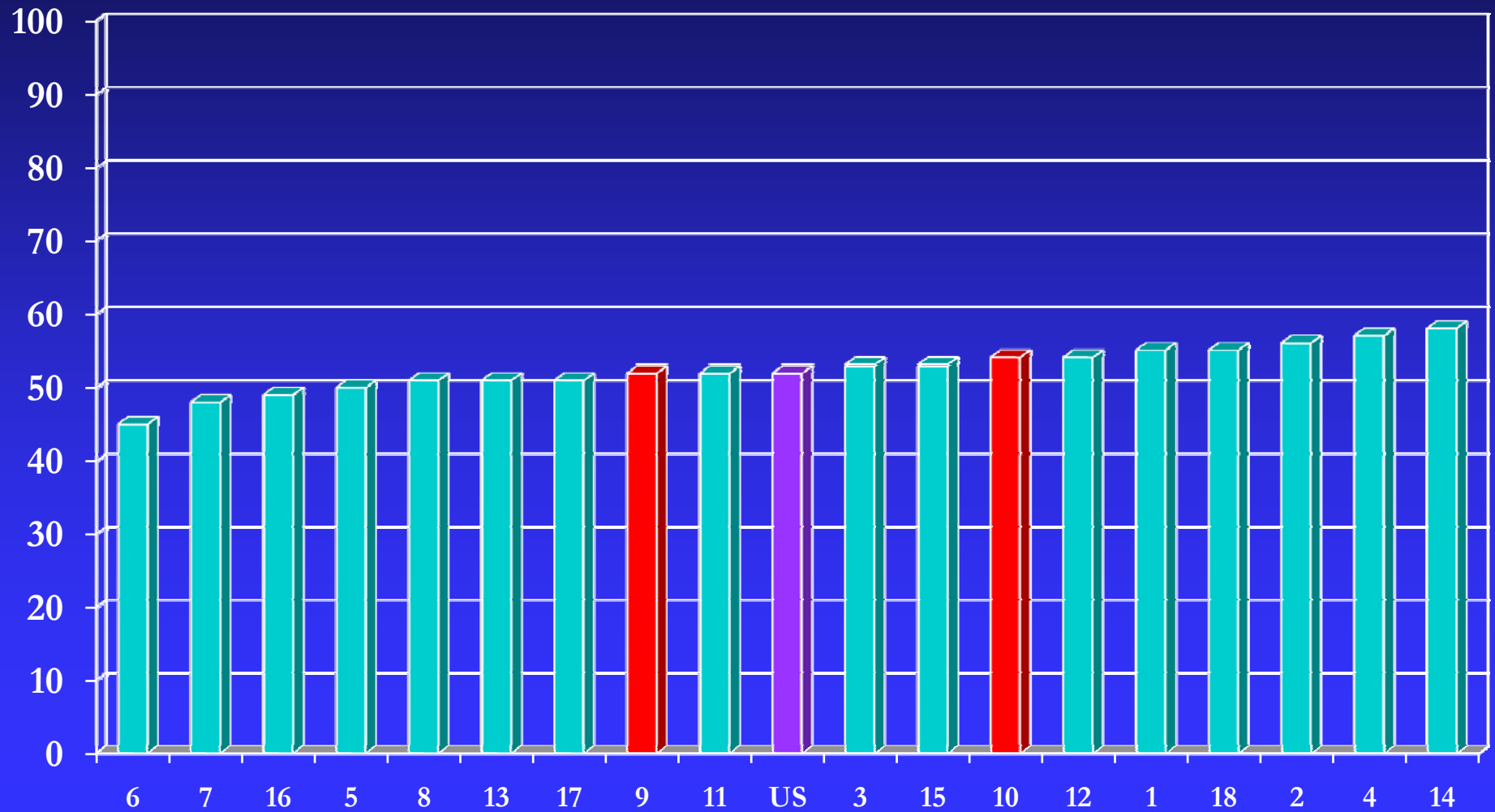
4th Quarter 2007



National CPM Data Collection

% Patients with Mean Phosphorus

3.5 – 5.5 - 4th Quarter 2007



Proposed Future Quality Improvement Topics

- Phosphorus Management
- Medication Reconciliation
- Vaccination
- Diabetes
- Involuntary Discharge

Hospital Alliance → “Disparities in Care Project”

- Purpose – increase awareness and address consequences of disparities in healthcare
 - ◆ Involuntary discharge
 - ◆ Barriers to admission
 - ◆ Patient “dumping”
 - ◆ “Adherence” issues
 - ◆ Case mix adjustment
 - ◆ Social and economic needs and resources to address them
 - ◆ Staff recruitment and retention
 - ◆ Rehabilitation

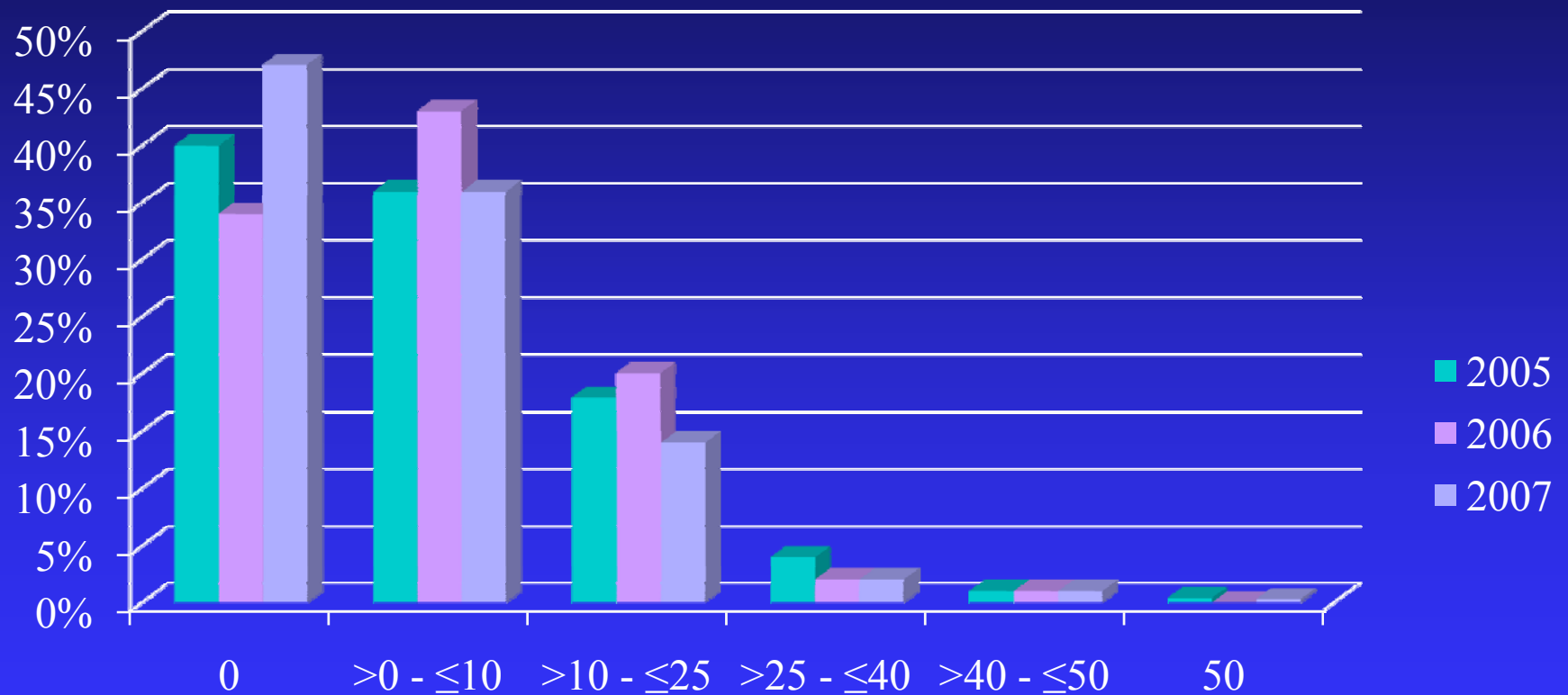
Facility Intervention Profiling

- Annual Review
 - ◆ Elab Data
 - ◆ Dialysis Facility Reports
 - ☞ Lab values
 - ☞ SMR
 - ☞ SHR
 - ◆ Vascular access
 - ◆ Data submission compliance
 - ◆ Grievances & complaints

Facility Intervention Profiling

- Goal – Targeted facilities will be expected to improve by next year's intervention profiling analysis (as measured by the assignment of < 10 Points)
- Interventions
 - ◆ > 10 - < 40 points – Facility internal review
 - ◆ > 40 - < 50 points – MRB required facility review & action plan
 - ◆ > 50 points - VIP Status - MRB required facility review, action plan & site visit if no improvement with 6 months of report date

Intervention Profiling – Points Distribution 2005 - 2007



Weather Related Events Affecting Network 9/10 Area

Date	Disaster	States Affected	# Facilities Affected
March 2008	Flooding	IL	2
April 2008	Earthquake	IL, IN, OH	0
June 2008	Flooding Tornado	IN, IL	1
September 2008	Hurricane Ike	KY, IN, OH	32
January 2009	Snow, Ice	KY, IN, OH	19

Emergency Preparedness – Conditions For Coverage

- Implement processes and procedures to manage medical and non-medical emergencies
- Emergencies include
 - ◆ Fire
 - ◆ Equipment or power failures
 - ◆ Care-related emergencies
 - ◆ Water supply interruption
 - ◆ Natural disasters

Disaster/Emergency Plan

- Must address failure of basic systems
 - ◆ Power
 - ◆ Source water
 - ◆ Air conditioning/heating
 - ◆ Water treatment system
 - ◆ Supply delivery
- Responsible staff must have knowledge of the plan
- Conduct drills annually
- Coordinate with local emergency management agency annually

Staff Emergency Preparedness Training Annually

- Staff must demonstrate knowledge of emergency procedures
 - ◆ What to do
 - ◆ Where to go
 - ◆ Whom to contact
 - ◆ How to disconnect patients from dialysis

Patient Emergency Preparedness Training

- Instruction on facility emergency plan
- How to contact facility – alternate emergency phone number
- What to do if they cannot get to dialysis
- Seek treatment elsewhere (immediately) in the event that their dialysis facility is closed

EXECUTIVE DIRECTOR'S REPORT

Susan Stark
Executive Director

Executive Director's Report

■ CMS Update

- ◆ Network contract extension – December 2010
- ◆ No changes to Network work plan

Conditions for Coverage Update

- QAPI Templates Completed
 - ◆ Adequacy
 - ◆ Infection Control
 - ◆ Anemia
 - ◆ Vascular Access
- QAPI Templates Being Developed
 - ◆ Nutritional Status
 - ◆ Mineral Metabolism
 - ◆ Medical Injuries and Errors
 - ◆ Reuse
 - ◆ Patient Satisfaction & Grievances
- Webex & Information Sessions
 - ◆ QAPI Webex – September 16 & 18
 - ◆ Information Sessions
 - ☞ October 30 – Chicago
 - ☞ November 18 – Cleveland
 - ☞ November 20 - Indianapolis
- Medical Director's Education & Technical Assistance
 - ◆ Meetings – October 21 & March 11
 - ◆ Web Site – www.therenalnetwork.org

Medical Director's Site

www.therenalnetwork.org



Medical Director - Main Page

[Main Page](#) | [Links](#)

Welcome to the Medical Director's Resource Pages for the new ESRD Conditions for Coverage.

The purpose of this section is to provide a single point of access to materials, tools and resources necessary or useful to the implementations of the provisions under the new rule. Be sure to click on the *Resources for Implementation* link below to access additional resources for each of new provisions of the rule. Updates and new resources will be added as they are made available.

Conditions and Interpretives Guidelines

CfC Timeline

The new ESRD Conditions for Coverage Final Rule became effective April 15, 2008. Implementation of all provisions are effective 180 days after publication, on 10/14/2008. Three provisions have delayed effective dates: isolation room requirements (2/9/2009), mandate Life Safety Code items (2/9/2009) and CROWNWeb data submission requirements (2/1/2009). More recently CMS has issued a [Waivers & Time Extensions for CfC](#) implementation.

[Conditions for Coverage \(CfCs\) Final Rule](#)

Medical Director's Site

www.therenalnetwork.org



ESRD Medical Director Resources - CFC Resources - Water and Dialysate Quality

[Main Page](#) | [CFC Resources](#) | [Links](#)

§ 494.40 Condition: Water and Dialysate Quality

Overview	Water: What's New & What To Do James Baker, AmeriWater, Dayton , OH Survey Manual Lesson 9 - Water and Dialysate PDF, 720KB]
Implementation	Survey Manual Tool: AAMI RD 52: Table 4—Monitoring guidelines for water purification equipment and distribution systems and dialysate Dialysate for Hemodialysis (AAMI RD52:2004)
Link	Association for the Advancement of Medical Instrumentation (AAMI) http://www.aami.org AAMI is the primary resource for the industry, the professions, and government for national and international standards. AAMI announced the 2008 release of a new product for dialysis professionals. New AAMI Standards are available in in PDF, book or CD formats. For more information visit http://www.aami.org/publications/standards/dialysis.html

CROWNWeb

- Concerns sent to CMS
 - ◆ SIMS Decommissioned on January 16th
 - ☞ No transition period
 - ◆ Inadequate testing
 - ◆ Registration system is too intricate
 - ◆ Significant data burden to providers (non-LDO)
 - ◆ No validation plan
 - ◆ Patient tracking in a disaster will be compromised
 - ◆ Fistula First data is changing

CROWNWeb - Launch 2/2/09

■ Phase 1

◆ Pilot

☞ 4 small Networks

☞ 8 dialysis facilities

■ Phase 2

◆ Expand pilot to all Networks

◆ Volunteer dialysis facilities

■ Phase 3

◆ Implementation nationally

CROWN Web – What you need to know to prepare

- Register
- Understand entry deadlines
 - ◆ 2728
 - ◆ 2746
- Clinical Performance Measures
 - ◆ Hemodialysis – January through March
 - ◆ Peritoneal Dialysis – January through May
 - ◆ CPMs due within 30 days of the close of the month

Forms Compliance

- 2728 – Patient Registration & Entitlement
 - ◆ Due within 45 days of the first date of dialysis
 - ◆ Physician signature required
 - ◆ Patient signature required
- 2746 – Death Notification
 - ◆ Due within 30 days of the date of death
 - ◆ No signature required
- Patient Activity Reports
 - ◆ Due by the 10th working day of the month

CPM Data Collection - 2009

- No national collection of clinical performance measures in 2009
- ELAB data will be collected from non-LDO dialysis facilities next January

Lab Data Collection Project

- Fourth Quarter Lab Data Collection – 100% Hemodialysis Patient Population
 - ◆ Reported Kt/V
 - ◆ Calculated URR
 - ◆ Hemoglobin
 - ◆ Albumin
 - ◆ Vascular Access Rates
 - ◆ Mineral Metabolism
- PD Patients

Patient Services Department

- Assistance to Patients and Staff
 - ◆ Mediation
 - ◆ Technical Assistance
 - ◆ Involuntary Discharges
- Education and Training Programs
 - ◆ Patient Whisperer
 - ◆ Professionalism
 - ◆ Emergency Preparedness / Adherence in Crisis
 - ◆ Dialysis Patient-Provider Conflict Web Ex Training

Patient Services Department

- 2008 Patient Education Meeting
 - ◆ In cooperation with RSN
- Resources
 - ◆ *Renal Outreach* Poster
 - ◆ Updated Patient Rights and Responsibilities
 - ◆ Grievance Poster
 - ◆ Quality of Care Concerns Handout
 - ◆ Access Site Packet and Poster
 - ◆ Upcoming Adherence Packet

Patient Services Department

■ Patient Leadership Committee

◆ Advisory role

- ☞ Patient and facility cultures
- ☞ Update of Network resources
- ☞ Reduction of complaints

◆ Educational materials

- ☞ Fistula First education materials
- ☞ *Renal Outreach* articles

Top Patient Complaint Comparison 2004 -2008

YEAR	NUMBER OF COMPLAINTS	PATIENT TRANSFER/ DISCHARGE	STAFF RELATED	TREATMENT RELATED/ QUALITY OF CARE
2004	134	21	30	41
2005	117	21	36	24
2006	128	20	30	40
2007	123	8	60	26
2008	114	6	31	35

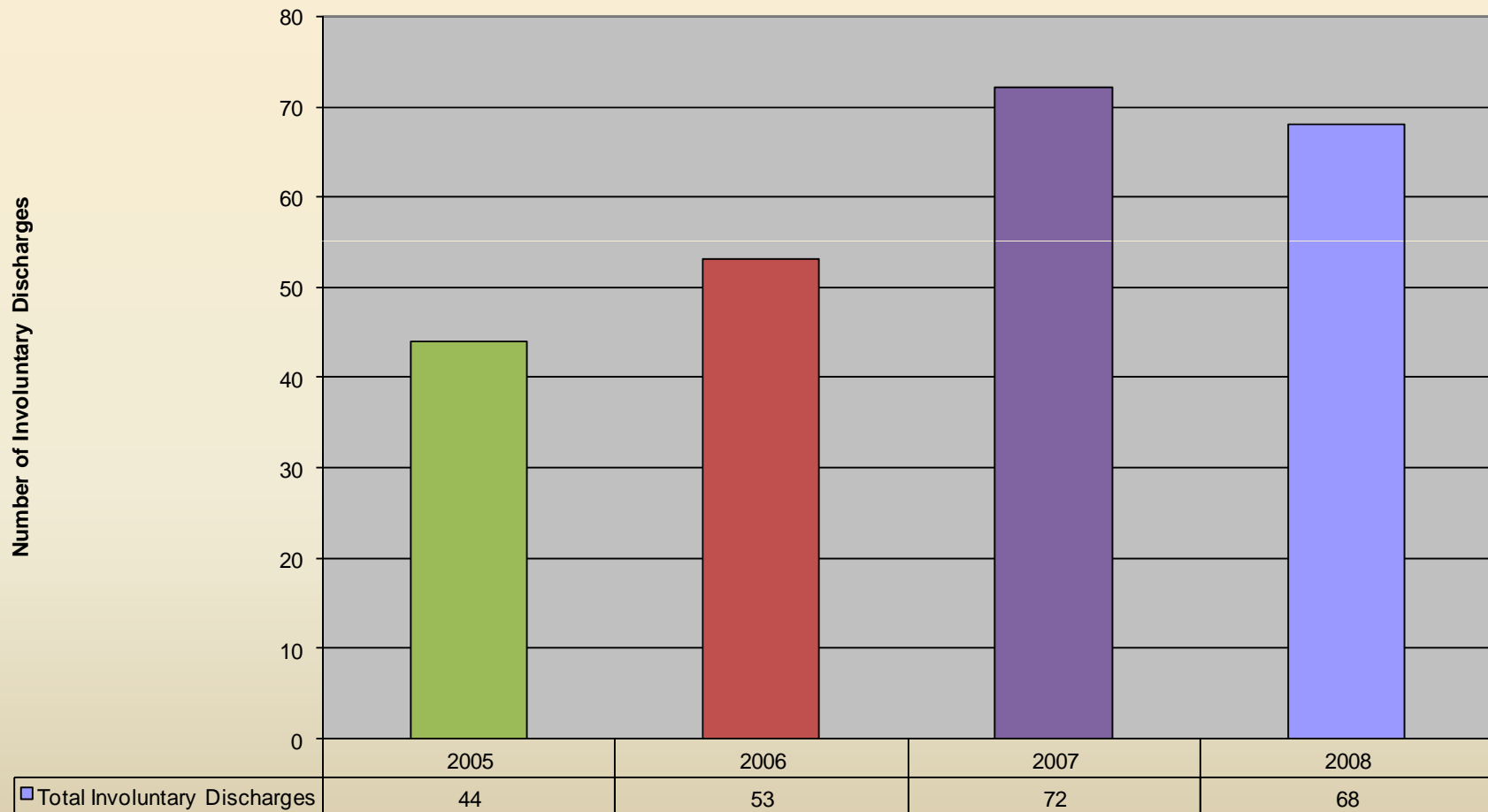
Top Grievance Comparison 2004 - 2008

Year	Number of Grievances	Staff Related	Patient Transfer/Discharge	Treatment/Quality of Care
2004	7	1	2	1
2005	3	1	1	0
2006	2	1	0	0
2007	3	2	0	0
2008	2	1	0	1

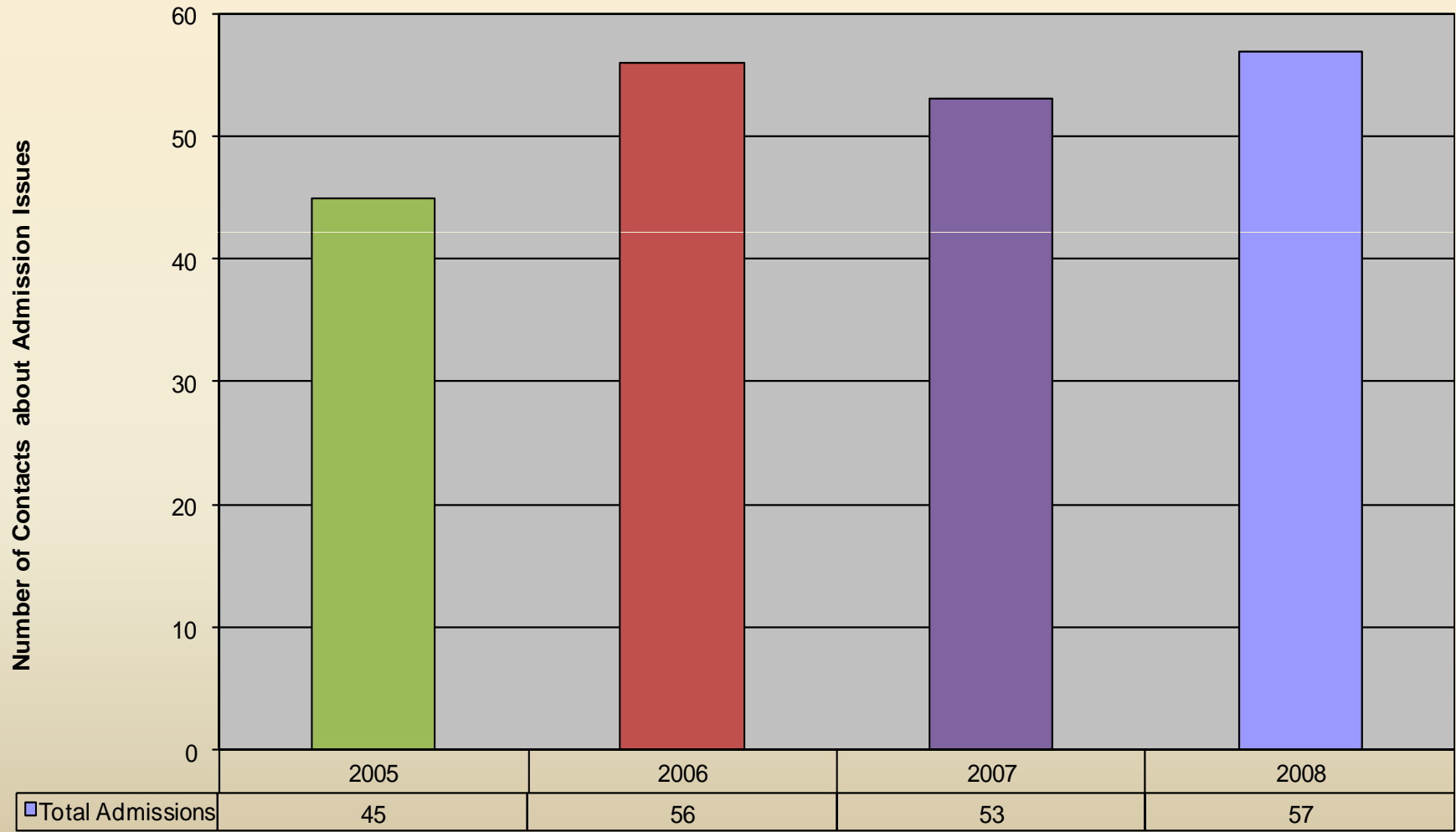
Top Facility Concern Comparison 2004 -2008

YEAR	NUMBER OF FACILITY CONCERNS	DISRUPTIVE	PATIENT TRANSFER/ DISCHARGE	NON-COMPLIANT
2004	148	24	53	22
2005	208	18	61	39
2006	235	27	76	39
2007	254	33	84	41
2008	307	33	70	37

Involuntary Discharges 2005 - 2008



Admission Contacts 2005 - 2008



Awards!

Other Business