Appendix B
Data Collection Instruments

CLINICAL PERFORMANCE MEASURES - HEMODIALYSIS DATA COLLECTION FORM

Facility Name **TEST FACILITY**	Facility Code	Provider Number	Month and Year Reporting
Patient Name	Social Security Number	Date of Birth	Height Ft In *or* cm
Physician Name / UPIN	Does patient have limb/leg amputation **YES NO**		Is patient hispanic **YES NO**
Treatment days (optional) **MWF TTS**	Shift Number 1-9 (optional)		

LAB DATA (HEMATOCRIT)

First monthly pre-dialysis laboratory hematocrit	**Vol %**
First monthly pre-dialysis laboratory hemoglobin	**g/dl**
Prescription for EPO ?	**YES NO**
What was the PRESCRIBED WEEKLY EPO dose during the week immediately BEFORE the above HCT/HGB were drawn	**units/week**
Was EPO administered as prescribed during that week	**YES NO**
What was the prescribed route of EPO administration	**IV SC**
First monthly Ferritin value	**ng/ml**
First monthly Transferrin Saturation value	**%**
Was iron prescribed at any time during the month	**YES NO**
If yes, what was the route of iron administration	**IV P.O. BOTH**

LAB DATA (ADEQUACY)

How many times per week was this patient scheduled to receive dialysis ?	**times per week**
First monthly Pre-dialysis BUN	**mg/dl**
First monthly Post-dialysis BUN	**mg/dl**
Patient's PRE- and POST-dialysis weight when above BUN's were drawn *(Circle either lbs or kgs)*	Pre: **lbs or kgs** Post: **lbs or kgs**
Patient's Ultrafiltration Volume when above BUN's were drawn	**Liters/Treatment**
Actual DELIVERED time on dialysis at session when BUN's were drawn	**Hours Minutes**
Delivered blood flow rate @ 60 min. during session at which BUN's were drawn	**ml/min**
Code for dialyzer used on dialysis at session when BUN's were drawn	
First monthly recorded URR	**%**
First monthly recorded Kt/V	**Kt/V**
Method used to calculate Kt/V	**1. UKM 2. Daugirdas II 3. Other 4. Unknown**
Serum Albumin *(Please circle lab method used)*	**gm/dL** **Bromcresol Green** **Bromcresol Purple**

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Facility Name	Facility Code	Provider Number	Month and Year Reporting
Patient Name			

VASCULAR ACCESS

Question	Response
What type of access was in use at the initiation of first time hemodialysis *(Regardless of setting)* **(Patients on dialysis less than 1 year)**	1. AV Fistula 2. Synthetic Graft 3. Bovine Graft 4. Catheter 5. Other 6. Unknown
When was the access in the previous question placed ?	____/____/____ ___ Unknown
What type of access was used 90 days after the initiation of hemodialysis *(Regardless of setting)* **(Patients on dialysis less than 1 year)**	1. AV Fistula 2. Synthetic Graft 3. Bovine Graft 4. Catheter 5. Other 6. Unknown
What type of access was used on the last hemodialysis session in December at the patient's primary in-center facility ? **(All Patients)**	1. AV Fistula 2. Synthetic Graft 3. Bovine Graft 4. Catheter 5. Other 6. Unknown
What was the insertion location of the catheter ?	1. Subclavian 2. Femoral 3. Jugular 4. Other 5. Unknown
Has this catheter (or another) been used for the past 90 days or longer prior to use in the last hemodialysis session ?	YES NO UNKNOWN
Was the catheter tunneled ? YES NO	Was the catheter cuffed ? YES NO

Reason for catheter (Circle one)

A. Fistula or graft maturing, not ready to cannulate.
B. Temporary interruption of fistula or graft due to clotting or revisions.
C. All fistula or graft sites in their body have been exhausted.
D. No fistula or graft surgically created in their body at this time.
E. Other, please describe in comment section below:

Comment ____

Was routine monitoring (screening) for the presence of stenosis performed ? YES NO

If YES, please indicate the frequency with which each monitoring method was utilized.

Method	Frequency
Color-Flow Doppler	1. Every Session 2. Weekly 3. Biweekly 4. Monthly 5. Quarterly 6. As Needed 7. Other
Dynamic Venous Pressure	1. Every Session 2. Weekly 3. Biweekly 4. Monthly 5. Quarterly 6. As Needed 7. Other
Static Venous Pressure	1. Every Session 2. Weekly 3. Biweekly 4. Monthly 5. Quarterly 6. As Needed 7. Other
Dilution Technique	1. Every Session 2. Weekly 3. Biweekly 4. Monthly 5. Quarterly 6. As Needed 7. Other
Other, please describe	

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Network 9/10 Facility Intervention Categorization Form
For Network Internal Use Only
January 2001

Purpose: This form will be used to identify the specific interventions the facility will be using in their local Quality Improvement Project. Facilities will be grouped into categories and URR outcome data will be analyzed.

Directions: Network staff RNs will review each facility intervention plan and identify areas that are targeted for improvement. Network staff will indicate a specific target for the intervention in the description column. Additional target descriptions can be made in the comment box.

Facility Letter Code: ____
Provider Number: __________
Facility Name: ____

Interventions	**Description (Circle all that apply)**	**Comments**
Policies & Procedures	Lab Draws Shift Issues Time Issues BFR Access Pathways Protocols Charting	
Prescription	Dr. Orders Time Frequency Dialyzer BFR Target Weight Needles Dialysate Flow	
Personnel	Education Training	
Patient	Education Counseling (i.e. dialysis, prescription, diet, compliance, access)	
Physical Equipment	Machines Needles BiCarb	
Vascular Access	Pathways Protocols Catheters BFR DVP Transonics	
Additional Comments:		