

Intermountain End-Stage Renal Disease Network, Inc.

(ESRD Network Organization #15)

ANNUAL REPORT 2006

CENTERS FOR MEDICARE & MEDICAID SERVICES
Contract Numbers: 500-03-NW15 and HHSM-500-2006-NW015C

**“The mission of
Intermountain End-Stage Renal Disease Network, Inc.
is to facilitate improvement of the quality
of care provided to ESRD patients.”**

January 1, 2006 - December 31, 2006

TABLE OF CONTENTS

I.	PREFACE.....	i
II.	INTRODUCTION.....	1
	A. Network Description	2
	B. Network Structure	22
	C. Network Staff	22
	D. Board of Directors	25
	E. Committees.....	25
	F. Emergency Preparedness for the Network Organization.....	27
III.	CMS NATIONAL GOALS AND NETWORK ACTIVITIES	28
	A. Introduction	28
	B. Improve the Quality and Safety of Dialysis Related Services Provided for Individuals with ESRD	28
	1. National Clinical Performance Measures Project.....	29
	2. Network #15 Lab Collection Project	31
	3. “Fistula First”-2006-2009 Quality Improvement Initiative.....	32
	4. Other Quality Management Activities	38
	C. Improve the Independence, Quality of Life and Rehabilitation of individuals with ESRD through Transplantation, use of Self-Care Modalities, In-Center self-Care, as Medically Appropriate, Through the End of Life	40
	1. Promotion of Self-Care Dialysis.....	40
	2. Encourage the Use of Transplant Modality	42
	3. Rehabilitation/Vocational Rehabilitation.....	44
	4. Other Patient Related Activities.....	46

D.	Improve patient perception of care and experience of care, and resolve patient’s complaints and grievances.....	46
1.	ICH-CAHPS Project	46
2.	Complaints and Grievances	48
E.	Improve Collaboration with providers to Ensure Achievement of the Goals Through the Most Efficient and Effective Means Possible, with Recognition of the Differences Among Providers and the Associated Possibilities/Capabilities	51
1.	ESRD Facilities/Providers	51
2.	ESRD Networks.....	54
3.	State and Regional Office Survey Agencies.....	55
4.	Quality Improvement Organizations (QIOs)	57
5.	The Renal Community.....	57
6.	Coalitions/Special Projects	60
7.	Professional Educational Program Attendance/Networking	64
8.	Newsletters.....	67
9.	Web site	67
10.	Facility Directory.....	68
F.	Improve the Collection, Reliability, Timeliness and Use of Data to Measure Processes of Care and Outcomes; Maintain Patient Registry; and to support the ESRD Network Program.....	68
1.	Description of the Network Data System	68
2.	Report Capability	71
3.	Special Data Requests.....	72
4.	Data Validity and Improvement Efforts	72

IV. SANCTION RECOMMENDATIONS 75

V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES 76

VI. DATA TABLES 77

Data Tables are not included in this pdf version of the Annual Report.
Please see the link: www.esrdnet15.org/aboutus.htm#table to view these files.

I. PREFACE

***STATEMENT BY PRESIDENT OF THE BOARD OF DIRECTORS OF THE
INTERMOUNTAIN ESRD NETWORK, INC.
(Also known as ESRD Network #15)***

This annual report for the period of January 1, 2006 through December 31, 2006 is submitted to the Centers for Medicare & Medicaid Services Office of Clinical Standards and Quality. This report provides both a narrative account and substantiating data to describe the activities and the ESRD patient population of Network #15 for that time period.

On July 29, 2006, the Intermountain End-Stage Renal Disease Network, Inc. was awarded the contract for the ESRD Network #17 organization. Western Pacific Renal Network, LLC (ESRD Network #17) finished its transition activities on September 13, 2006. The activities of ESRD Network #17 are summarized in a separate report.

During the twelve months covered by this report, ESRD Network #15 performed all functions and completed all activities required by its two contracts (500-03-NW15, January 1, 2006-June 30, 2006 and HHSM-500-2006-NW015C July 1, 2006-December 31, 2006). The majority of Network #15 resources were dedicated to Quality Improvement, Patient Services and Data Collection activities. As in past years, Network #15 ranks in the top quartile of ESRD Networks in most nationally measured ESRD outcomes.

The Board of Directors extends its appreciation to all Network #15 providers who have cooperated in working toward the successful accomplishment of Network goals in 2006. In addition, the time and energy spent by the renal professionals and patients serving on Network boards and committees are gratefully acknowledged.

Raymond L. Heilman, MD
President

2006 Annual Report

Intermountain End-Stage Renal Disease Network, Inc. Contract Numbers 500-03-NW15 and HHSM-500-2006-015C

II. INTRODUCTION

The ESRD Amendments to the Social Security Act of 1972 contained language for the establishment of a structure of “End-Stage Renal Disease Network Councils” to assist the entity now known as the Centers for Medicare & Medicaid Services (CMS) in the monitoring of the quality of care given to the ESRD patients by providers of dialysis services and transplantation. The Intermountain End-Stage Renal Disease Network, Inc. (ESRD Network #15) was one of the 32 original ESRD Networks and since 1988, has been one of 18 consolidated ESRD Network Organizations under contract with CMS. The Board of Directors of ESRD Network #15 has established the following goals:

- To facilitate optimal care to all ESRD patients working in cooperation with facilities’ internal quality improvement programs and through the support of the CMS Health Care Quality Initiative Program (HCQIP):
CMS’ definition of quality care under the HCQIP includes access to care, appropriateness of care, desired outcomes of care, and consumer satisfaction;
- To sustain the Network #15 administrative framework to optimally plan, implement, and evaluate Network responsibilities and goals and to complete all CMS contract requirements;
- To maintain a patient-specific medical information system based on the data set required by CMS and to meet and/or exceed all data reporting requirements of CMS;
- To support the CMS goal for the Network program of improving data reporting, reliability and validity between ESRD providers/facilities, Networks and CMS;
- To promote access to appropriate modalities, including self-care and transplantation;
- To promote patient knowledge of and involvement in their ESRD care, and to promote patient rehabilitation;

ESRD Network #15

- To serve as a resource and clearinghouse for information to the renal community including information on patterns, processes, and outcomes of care in order to aid in identifying opportunities for improvement as well as the results of both successful and unsuccessful improvement projects;
- To assist facilities in developing, implementing, and evaluating intervention strategies to improve patient care and outcomes;
- To facilitate resolution of patient grievances;
- To work collaboratively with other organizations to facilitate the improvement of care of ESRD patients; and
- To promote patient-centered care.

These goals are approached in a manner, which are patient-centered, safe, effective, efficient, equitable and timely. It is expected that the outcomes will be measurable, using valid, evidence-based measures of performance; developed through broad consensus and have strong correlation to patient outcomes. The Network will embrace cultural change and process redesign. These goals are communicated annually to the Network providers via the “Annual Update” mailing, which is sent to the facilities in each year (Appendix A).

Network #15 continues to pursue these goals through the leadership of knowledgeable individuals serving on the Network #15 Board of Directors, Medical Review Board, Patient Leadership Committee and other Network committees and with the cooperation of the personnel in the ESRD programs throughout the Intermountain region. This annual report will describe the activities Network #15 has undertaken with these goals as the focus.

A. Network Description

The following description of the Network #15 area provides an overview of the general pattern of the delivery of ESRD care in Network #15. The description of the states that comprise this geographically large Network is included in this report to assist in understanding the logistics and complexity of administering an ESRD Network Organization that covers a large geographic area and multiple governmental entities.

Network #15 includes the states of Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming. These states encompass 21% of the landmass of the contiguous states. They include mountains, plains, and desert. Tourism and travel are major industries. (Water availability limits growth.) Urban population centers contain the majority of residents; there are vast rural and wilderness areas in each state.

ESRD Network #15

The following demographic charts compare and contrast each state in Network #15 with United States demographics. This information has been compiled from the U.S. Census Bureau, 2005 American Community Survey, Statistical Abstract of the United States, 2006 Edition, National Center for Health Statistics FastStats, 2000, The Kaiser Family Foundation, statehealthfacts.org, 2004.

ESRD Network #15

Network #15 Demographics at a Glance

	US	AZ	CO	NV	NM	UT	WY
POPULATION in Thousands (2005 Estimates)¹							
Total	288,378	5,830	4,562	2,381	1,887	2,427	495
Percentages by age group							
0 to <5	7.0%	7.9%	7.4%	7.3%	7.0%	9.7%	6.3%
5 to <18	18.3%	19.1%	18.4%	18.7%	18.8%	20.7%	16.5%
18 to <45	37.5%	37.6%	40.1%	38.9%	36.3%	42.0%	35.8%
45 to <65	25.0%	22.7%	24.4%	23.8%	25.8%	19.1%	29.4%
65 to <75	6.4%	7.0%	5.4%	6.7%	6.9%	4.7%	6.5%
75 +	5.7%	5.6%	4.3%	4.5%	5.2%	3.8%	5.5%
Percent Urban²							
1990	78.0%	86.5%	83.8%	87.4%	75.0%	86.8%	67.1%
2000	79.0%	88.2%	84.5%	91.5%	75.0%	88.2%	65.1%
Race (2005 Estimates)¹							
White	74.7%	76.2%	83.5%	76.1%	69.5%	89.8%	92.4%
Black	12.1%	3.1%	3.6%	7.2%	1.9%	0.7%	0.7%
Am Indian/AK Nat.	0.8%	4.7%	0.9%	1.2%	9.6%	1.2%	1.9%
Asian	4.3%	2.2%	2.6%	5.8%	1.2%	1.9%	0.6%
Pacific Islander	0.1%	0.1%	0.1%	0.5%	0.1%	0.6%	0.0%
Some other race	6.0%	11.3%	6.7%	6.1%	14.5%	4.2%	2.4%
Two or more races	1.9%	2.4%	2.6%	3.1%	3.2%	1.5%	1.9%
Ethnicity (2005 Estimates)¹							
Not Hispanic or Latino	85.5%	71.4%	80.5%	76.3%	56.4%	89.1%	93.3%
Hispanic or Latino	14.5%	28.6%	19.5%	23.7%	43.6%	10.9%	6.7%
Physicians per 10,000 Population							
1995²	24.2	21.4	23.7	16.7	20.2	19.2	15.3
1999³	25.2	21.5	24.8	18.3	21.1	19.7	17.2
2004⁴	28.1	22.5	26.8	19.6	23.8	21.5	19.1

Sources:¹ U.S. Census Bureau, 2005 American Community Survey, (Margin of error +/-0.1) ² Statistical Abstract of the United States, 2006 Edition, ³ National Center for Health Statistics FastStats, 2000, ⁴ The Kaiser Family Foundation, statehealthfacts.org, 2004.

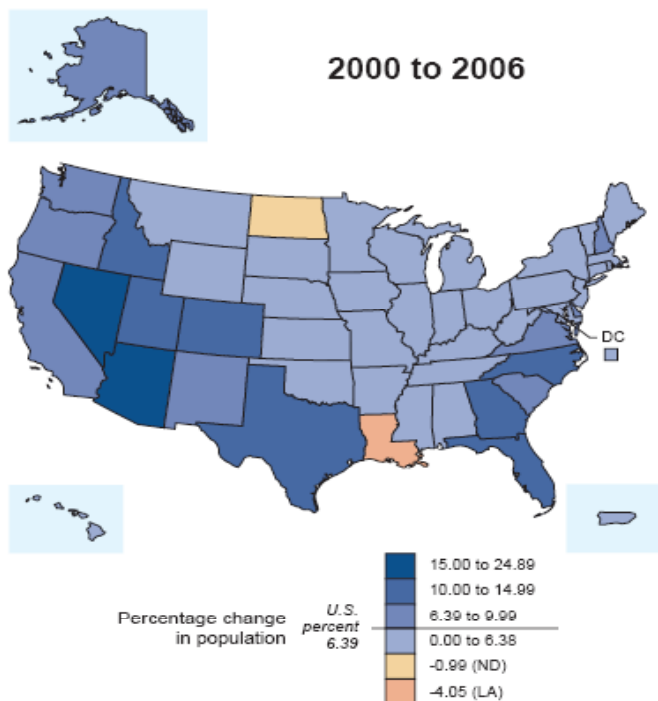
ESRD Network #15

Population -- Ranks

Population (In 1,000s)	1990 Population/ Rank	2000 Population/ Rank	2006 Population**/ Rank	% Change 2000 to 2006**
United States	248,700/NA	281,422/NA	299,399/NA	6.4%+
Arizona	3,665/ 24	5,131/ 20	6,166/ 16	20.2%+
Colorado	3,294/ 26	4,301/ 24	4,753/ 22	10.5%+
Nevada	1,202/ 39	1,998/ 35	2,496/ 35	24.9%+
New Mexico	1,515/ 37	1,819/ 36	1,956/ 36	7.5%+
Utah	1,723/ 35	2,233/ 34	2,550/ 34	14.2%+
Wyoming	454/ 50	494/ 50	515/ 51	4.3%+

Source: U.S. Census Bureau, Statistical Abstract of the United States, 2001 **Annual Estimates of the Population: April 1, 2000 to July 1, 2006 (CO-EST2006-01-04 and NST-EST2006-03) Source: Population Division, U.S. Census Bureau.

The two fastest growing states in the nation from 2000 to 2006 are in Network #15: Nevada (1) and Arizona (2). Utah ranks as the fourth fastest growing state, Colorado is 8th, New Mexico is 16th, and Wyoming is 26th. An increase in the number of dialysis patients and providers in the region have accompanied this population growth. Additionally, this region has a high percentage of Native Americans whose population growth rate is higher and whose incidence of ESRD is above that of the Anglo population.



Source: U.S. Census Bureau Population Estimates Program

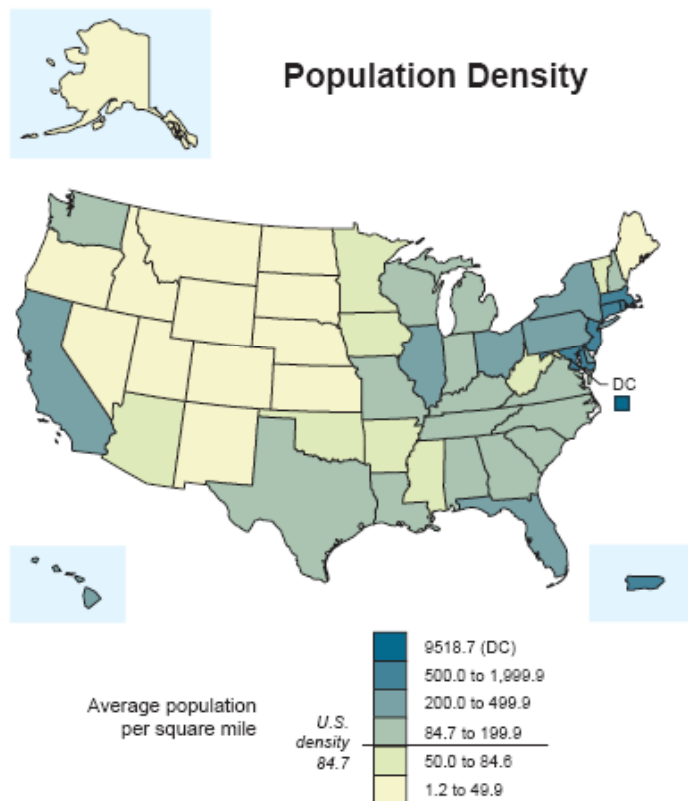
ESRD Network #15

Land Mass

	Total Land (Sq. Miles) ¹	Pop/Sq. Mile (1996) ²	Pop/Sq. Mile (2000) ¹	Pop/Sq. Mile (2006) ³
Arizona	113,635	39.0	45.2	54.3
Colorado	103,718	36.9	41.5	45.8
Nevada	109,826	14.6	18.2	22.7
New Mexico	121,356	14.1	15.0	16.1
Utah	82,144	24.3	27.2	31.0
Wyoming	97,100	5.0	5.1	5.3

Sources: ¹U.S. Census Bureau: State and County Quick Facts, 2000, ²Statistical Abstract of the United States, 1997, US Gov. Printing Office, ³Annual Estimates of the Population: April 1, 2000 to July 1, 2006 (CO-EST2006-01-04 and NST-EST2006-03) Source: Population Division, U.S. Census Bureau

Nationally, 28.8% of all land is federally owned (2004). In Network #15, that percent ranges from 84.5% in Nevada to 36.6% in Colorado. The average national population density is 84.7 persons per square mile of land, including Alaska and Hawaii (2006). In the Network #15 area, the population density ranges from five persons per square mile in Wyoming to 54 persons per square mile in Arizona.



Source: U.S. Census Bureau Population Estimates Program

ESRD Network #15

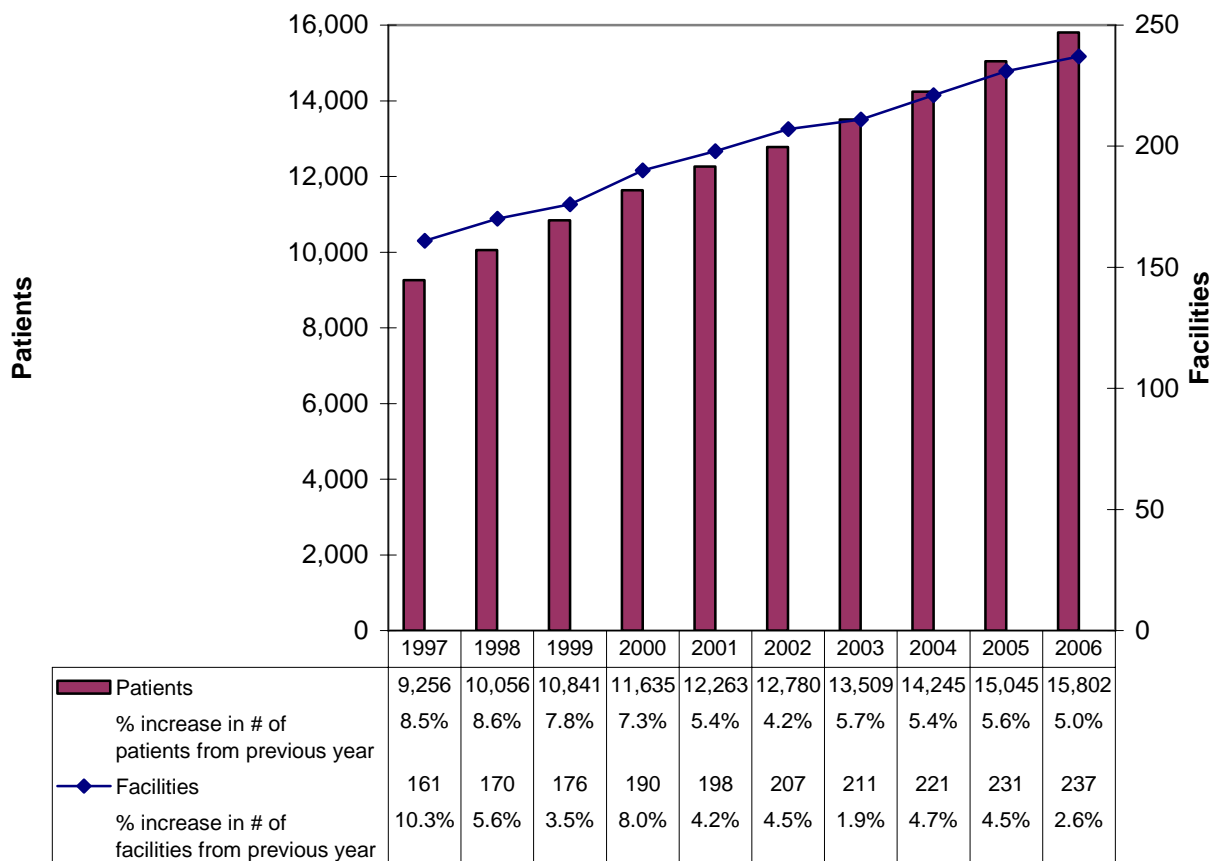
Network #15 ESRD Demographics at a Glance

As of December 31, 2006, there were 15,802 patients on chronic dialysis in Network #15's 237 Medicare-certified dialysis facilities. An additional 111 patients began chronic dialysis in Network #15 prior to January 1, 2007, but did not begin receiving care in a Medicare-certified chronic dialysis facility until 2007.

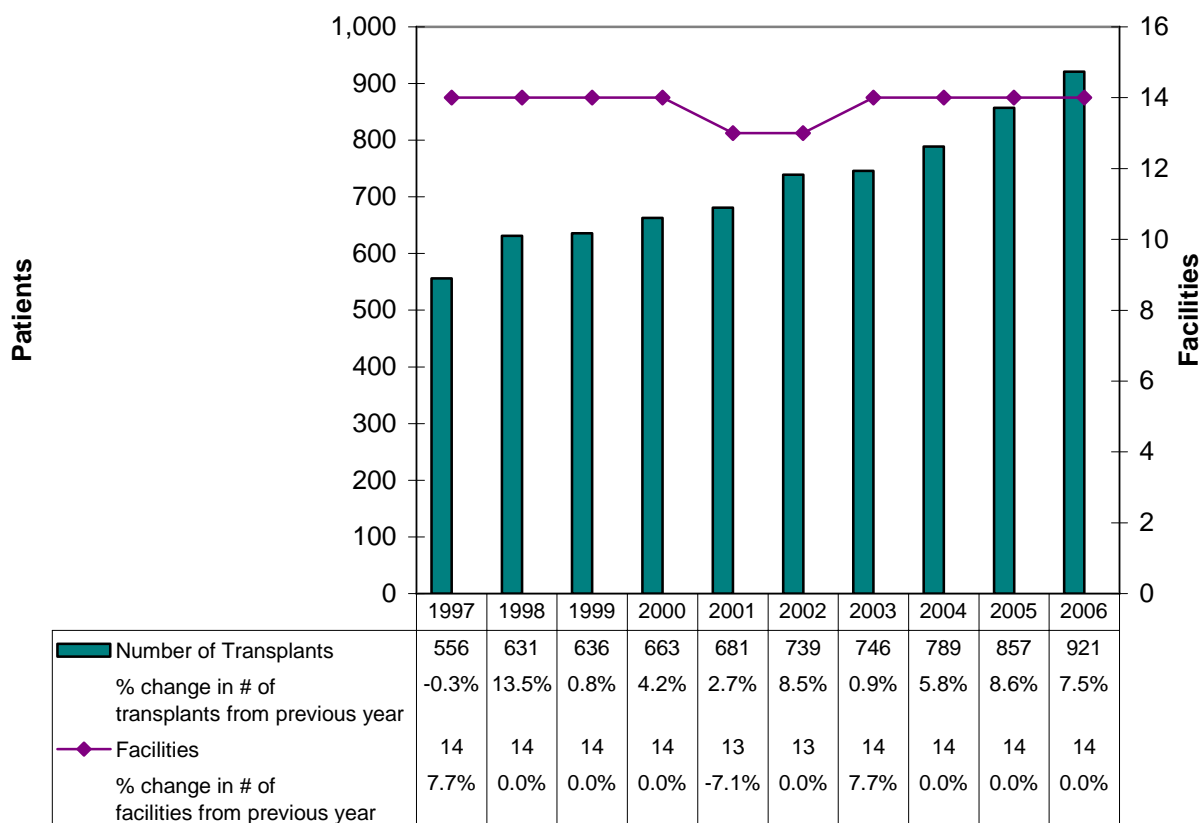
During 2006, Network #15's 14 active transplant centers performed 921 kidney transplants (an increase of 7.5% over the previous year).

Tables documenting the changes in the number of dialysis and transplant patients and facilities from 1997 through 2006 are shown below.

**Number of Patients Receiving Dialysis in Network #15 and Number of Facilities
1997-2006**



**Number of Patients Receiving a Transplant in Network #15 and
Number of Transplant Facilities
1997-2006**



The table on the following page is an overview of dialysis and transplant information for Network #15 and the six states it comprises.

ESRD Network #15

ESRD Network #15 2006 Demographics								
	Network #15	AZ	CO	NV	NM	UT	WY	
Total Population*	18,434,890	6,166,318	4,753,377	2,495,529	1,954,599	2,550,063	515,004	
Prevalent Dialysis Patients**								
Number of Patients	#	15,802	6,479	3,194	2,167	2,389	1,240	246
% of Total Population	%	0.09%	0.11%	0.07%	0.09%	0.12%	0.05%	0.05%
Male	#	8,787	3,541	1,785	1,298	1,275	701	144
% of patients	%	55.6%	54.7%	55.9%	59.9%	53.4%	56.5%	58.5%
Primary dx Diabetes	#	8,205	3,506	1,493	981	1,460	620	104
% of patients	%	51.9%	54.1%	46.7%	45.3%	61.1%	50.0%	42.3%
Hispanic Patients	#	4,504	1,994	921	381	1,012	156	29
% of patients	%	28.5%	30.8%	28.8%	17.6%	42.4%	12.6%	11.8%
American Indian Pts	#	2,160	1,160	68	73	732	80	24
% of patients	%	13.7%	17.9%	2.1%	3.4%	30.6%	6.5%	9.8%
InCenter Hemodialysis Pts	#	14,183	5,891	2,858	1,940	2,125	1,077	224
% of patients	%	89.8%	90.9%	89.5%	89.5%	88.9%	86.9%	91.1%
Mean age of Prevalent Pts		60.6	61.4	60.8	59.7	60.4	58.9	60.5
Incident Patients**								
Number of Patients	#	4,984	2,071	918	819	623	431	62
Male	#	2,855	1,158	502	506	374	234	42
% of incident patients	%	57.3%	55.9%	54.7%	61.8%	60.0%	54.3%	67.7%
Primary dx diabetes	#	2,515	1,054	440	390	361	220	28
% of incident patients	%	50.5%	50.9%	47.9%	47.6%	57.9%	51.0%	45.2%
Hispanic Patients	#	1,209	574	208	106	274	37	5
% of incident patients	%	24.3%	27.7%	22.7%	12.9%	44.0%	8.6%	8.1%
American Indian Pts	#	370	190	10	15	126	17	10
% of incident patients	%	7.4%	9.2%	1.1%	1.8%	20.2%	3.9%	16.1%
Mean age of Incident Pts		62.0	63.3	61.9	62.6	60.6	58.5	59.6
Facilities								
# of Dialysis Facilities		237	97	50	24	33	24	9
# of Transplant Units		14	4	4	2	2	2	0
# New dx units in 2006		9	3	3	1	2	0	0
# Units closed in 2006		3	2	1	0	0	0	0
Veterans Health Administration Units		5	2	1	0	1	1	0

* Annual Estimates of the Population: April 1, 2000 to July 1, 2006 (CO-EST2006-01-04) Source: Population Division, U.S. Census Bureau.

** Network #15 SIMS Data

Note: States do not add up to Network Total because some patients reside in states outside of Network #15 but dialyze in Network #15.

Arizona

Arizona is the sixth largest state in the nation with an area of 113,635 square miles. It is part of the Sun Belt area, the popularity of which is partially attributed to the sunny days and low humidity. From 2000 to 2006, Arizona's rate of population change was 20.2%, the second fastest in the nation; this growth is occurring largely in the over-65 age group. California, Nevada, Utah, New Mexico, and the Republic of Mexico bound Arizona. The topography can be divided into three areas: northern plateaus, central mountains, and southern deserts. The Grand Canyon is only one of several scenic areas that draw tourists. The mountain region is rich in minerals. The major industries are: manufacturing, tourism and travel, agriculture, and mining. Arizona leads the U.S. in copper production.

In 2006, 89% of the population lived in metropolitan areas. 12.6% of Arizona's population is 65 years of age or greater. Whites (including Hispanic Whites) comprise the largest racial group at 76.2%, followed by American Indians at 4.7%. As far as ethnicity, a large percentage (28.6%) is of Hispanic or Latino heritage.

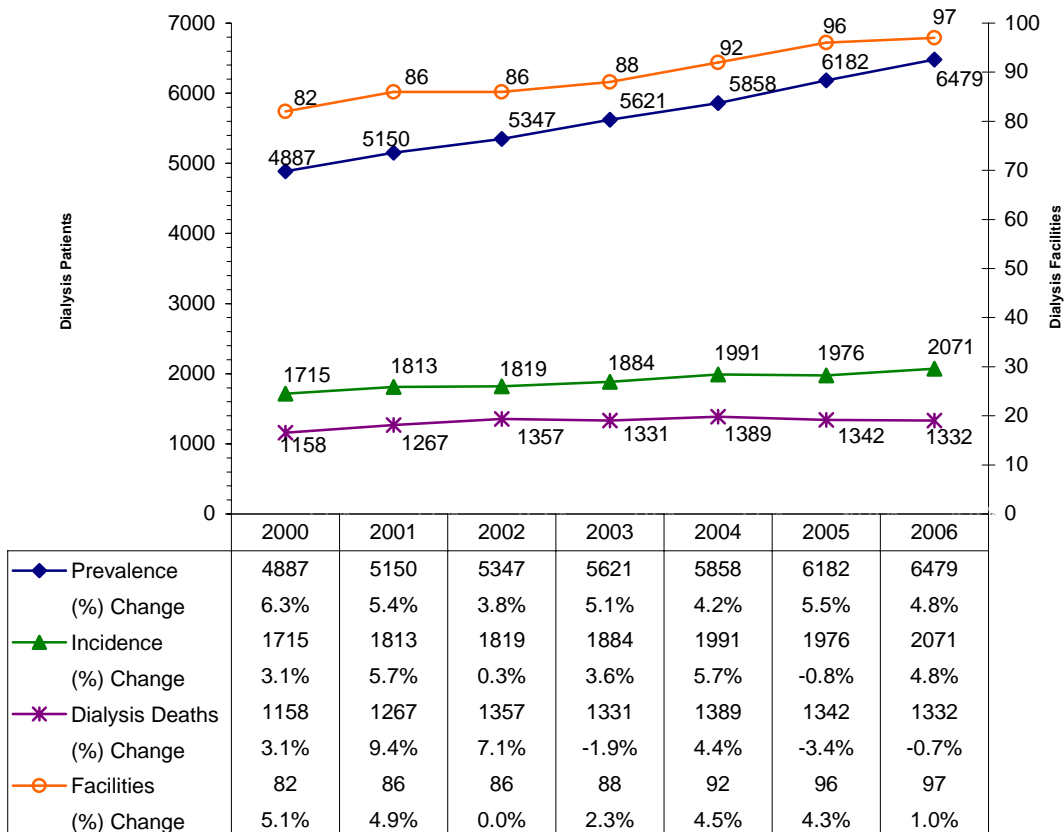
Dialysis Patients and Facilities in Arizona:

There were 97 Medicare-certified facilities providing dialysis services in Arizona at the end of 2006. Three new dialysis units opened in Arizona in 2006 and two closed.

Facilities in Arizona also provided dialysis (usually home care) for patients living in California, New Mexico, and Mexico.

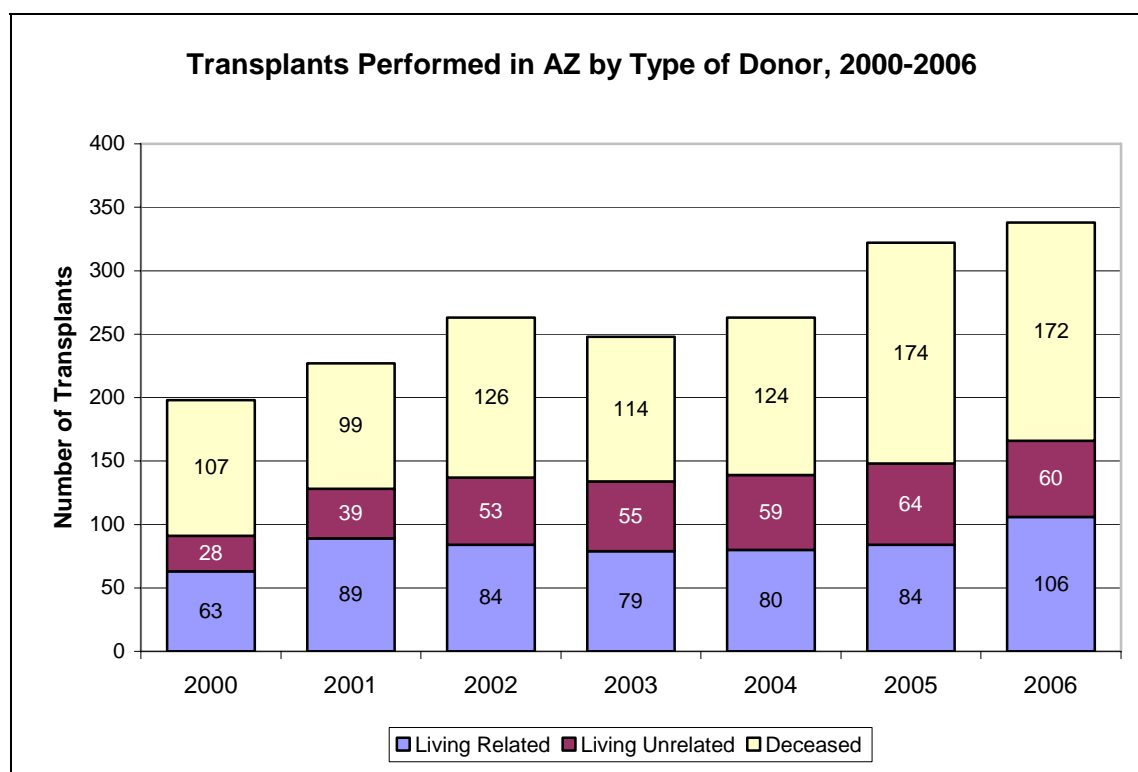
ESRD Network #15

**Time Trend of Arizona Patient Population and Facilities
2000-2006**



Transplantation in Arizona:

There were four active transplant facilities in Arizona, one in Tucson and three in the Phoenix metropolitan area, performing 338 renal transplants in 2006. Of those, 106 (31.4%) were from living related donors, 60 (17.8%) from living unrelated donors, and 172 (50.9%) from deceased donors. The table below illustrates Arizona renal transplants by donor type for the years 2000-2006.



Colorado

Colorado is the eighth largest state in the country, extending 387 miles east to west and 276 miles north to south, with an area of 103,718 square miles. The main feature of the state's geography is the Continental Divide, extending northeast to southwest and roughly bisecting Colorado into the Eastern and Western slopes. The state is bounded by Wyoming, Utah, New Mexico, Oklahoma, Kansas, and Nebraska. In the time period of 2000 to 2006, Colorado was the 8th fastest growing state in the nation with a 10.5% population change. Colorado was ranked 22nd in population by 2006 estimates. Eighty-seven percent of the population lives in metropolitan areas, nearly all in an 11-county urban corridor along the eastern edge of the Continental Divide, which includes the cities of Boulder, Denver, Colorado Springs, and Pueblo.

The other areas of the state are primarily rural, with agriculture, tourism, and mining being the major types of economic activities. Access to water is a factor that limits growth of eastern-slope communities. Air quality is an environmental problem in the urban areas of the eastern slope. The topography varies from semi-arid plains to high-mountain ranges. Climate and topography combine to make travel, availability, and accessibility difficult in sparsely populated, rural areas of the western slope. Metropolitan Denver is a major health-care referral center for Colorado and its neighboring states.

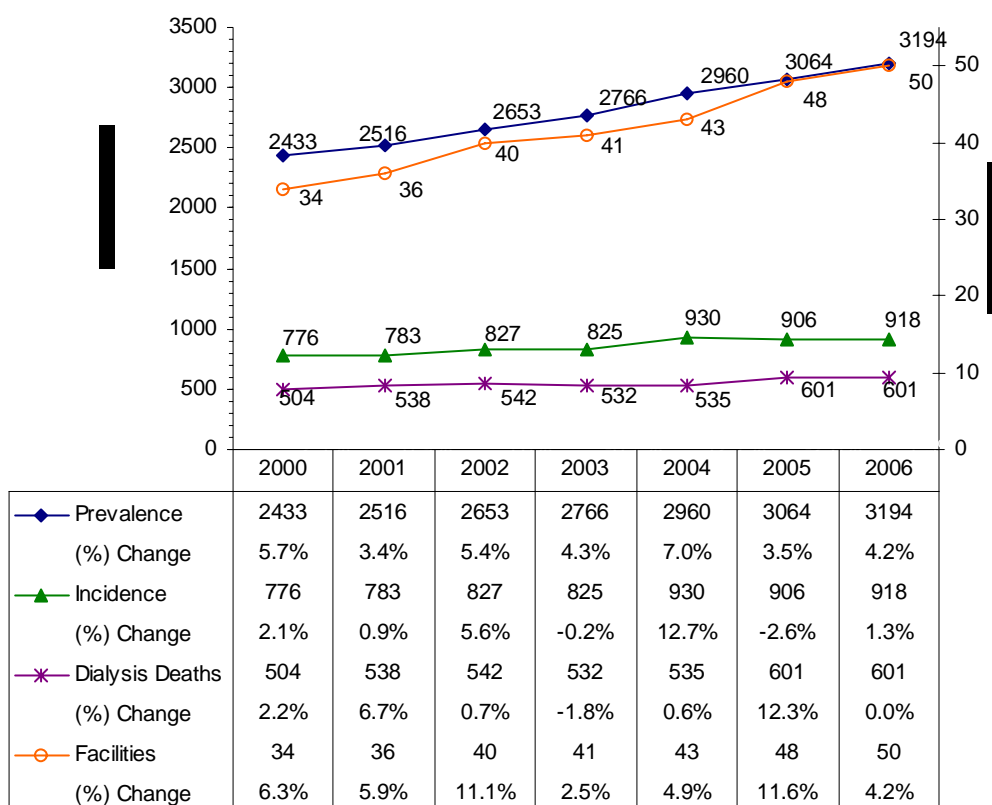
Dialysis Patients and Facilities in Colorado:

There were 50 Medicare-certified dialysis facilities in Colorado as of December 31, 2006. In 2006 three new dialysis units opened and one closed.

ESRD Network #15

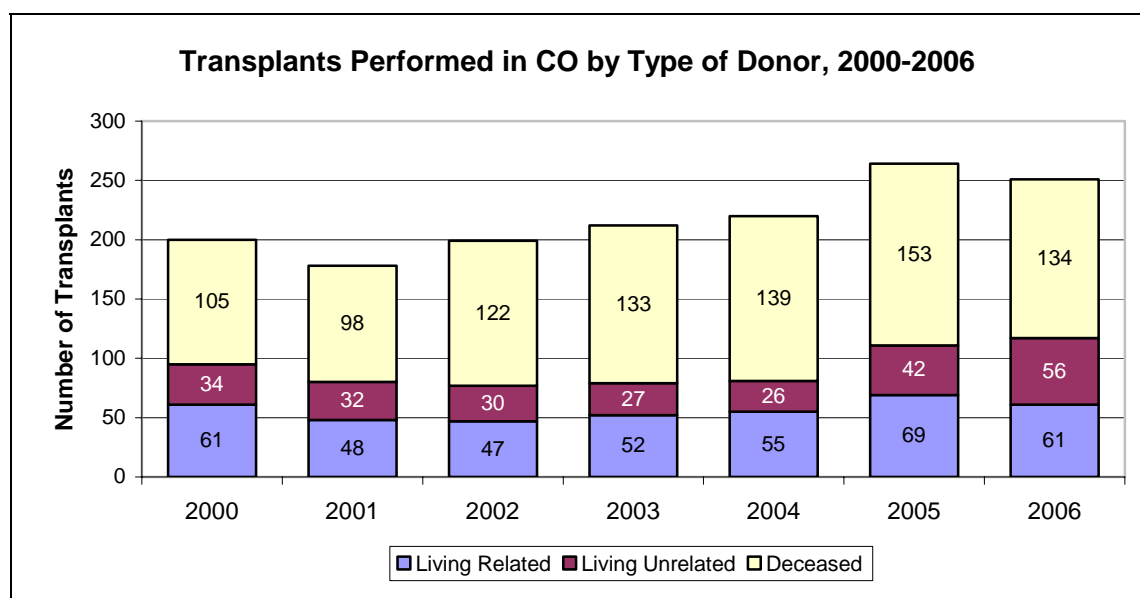
The majority of the patients receiving dialysis and transplant services are state residents. Additional transplant and peritoneal dialysis patients travel to Colorado from Wyoming, Nebraska, Arizona, Missouri, Montana, New Mexico, South Dakota, North Dakota, and Kansas.

**Time Trend of Colorado Patient Population and Facilities
2000-2006**



Transplantation in Colorado:

There are four transplant centers in Colorado, all located in the Denver metropolitan area. There were 251 renal transplants performed in Colorado during 2006. Of these, 61 (24.3%) were from living related donors, 56 (22.3%) from living unrelated donors, and 134 (53.4%) from deceased donors. The table on the following page illustrates Colorado renal transplants by donor type for the years 2000 through 2006.



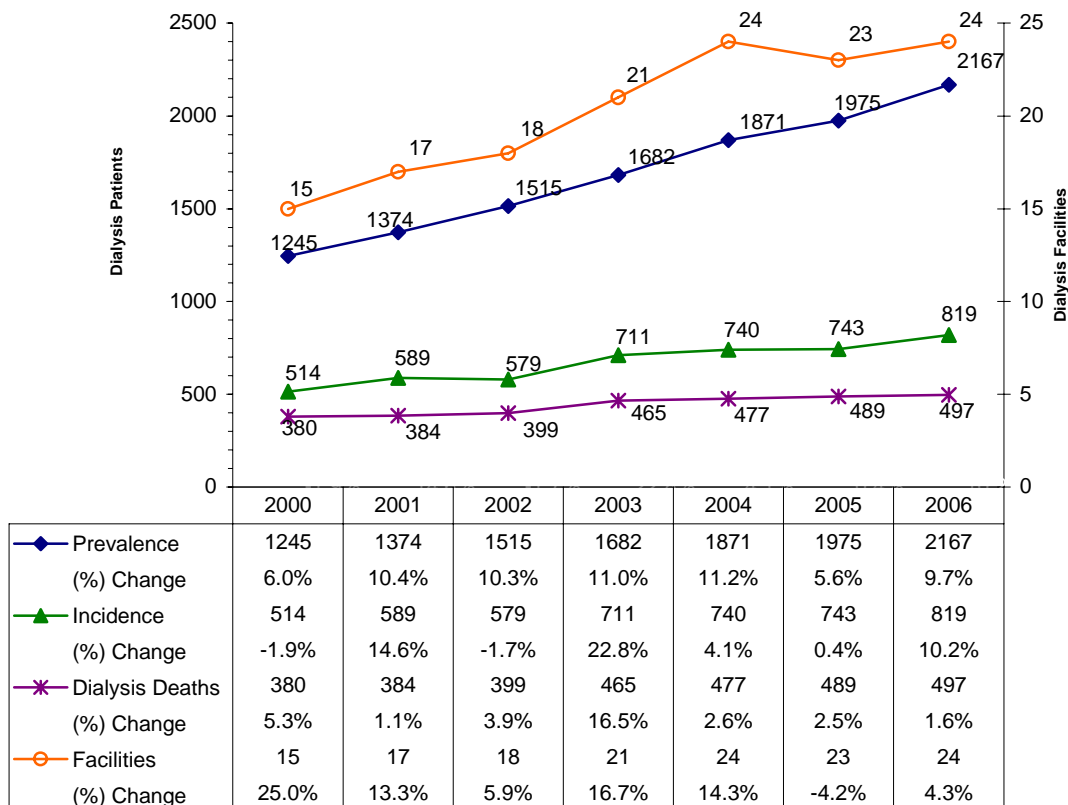
Nevada

Nevada is the seventh largest state, with an area of 109,826 square miles. The federal government owns 84.5% of the land. Eighty-three percent of the population is urban, mostly concentrated around two urban areas: Clark County SMSA (Las Vegas) and Washoe SMSA (Reno). From 2000 to 2006, Nevada was the fastest growing state in the nation (24.9% gain in population, compared to the next largest percent gain of 20.2% in Arizona). The density remains low at 23 persons per square mile. The growth has come from migration rather than births. Mountains and high desert characterize the topography. Nevada ranked 35th in population as of 2006.

Dialysis Patients and Facilities in Nevada:

There were a total of 24 Medicare-certified dialysis facilities in Nevada as of December 31, 2006. One new dialysis unit opened in Nevada in 2006.

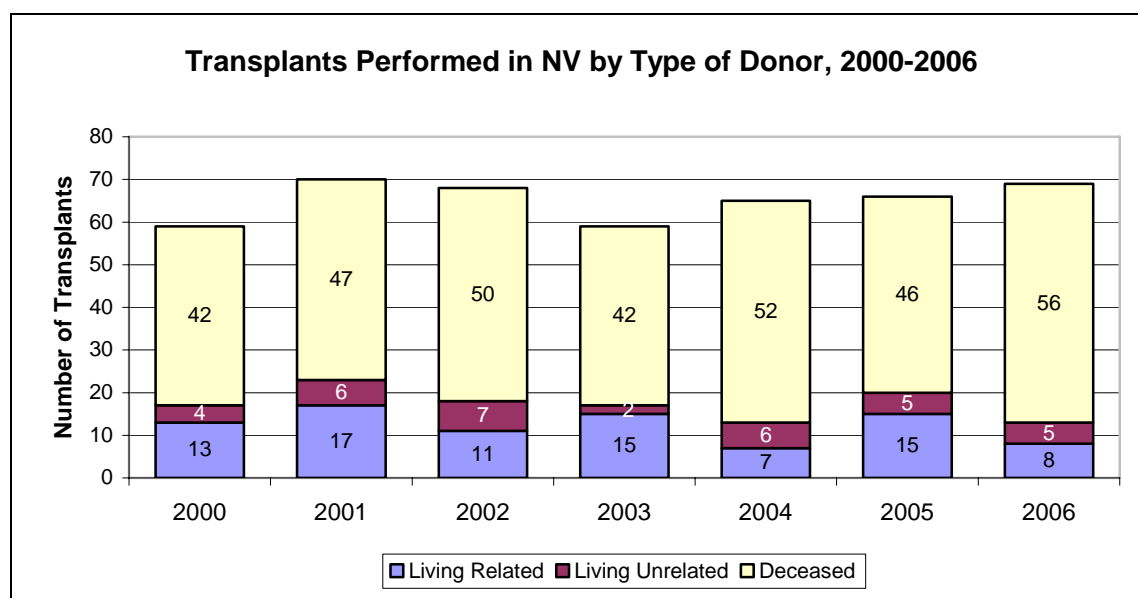
**Time Trend of Nevada Patient Population and Facilities
2000-2006**



Transplantation in Nevada:

Nevada has two active transplant programs. Transplant patients also go to California, Arizona, or Utah for transplant procedures.

There were 69 renal transplants performed in Nevada during 2006. Of these, 8 (11.6%) were from living related donors, 5 (7.2%) from living unrelated donors, and 56 (81.2%) from deceased donors. The following table illustrates renal transplants performed in Nevada by donor type for the years 2000-2006.



New Mexico

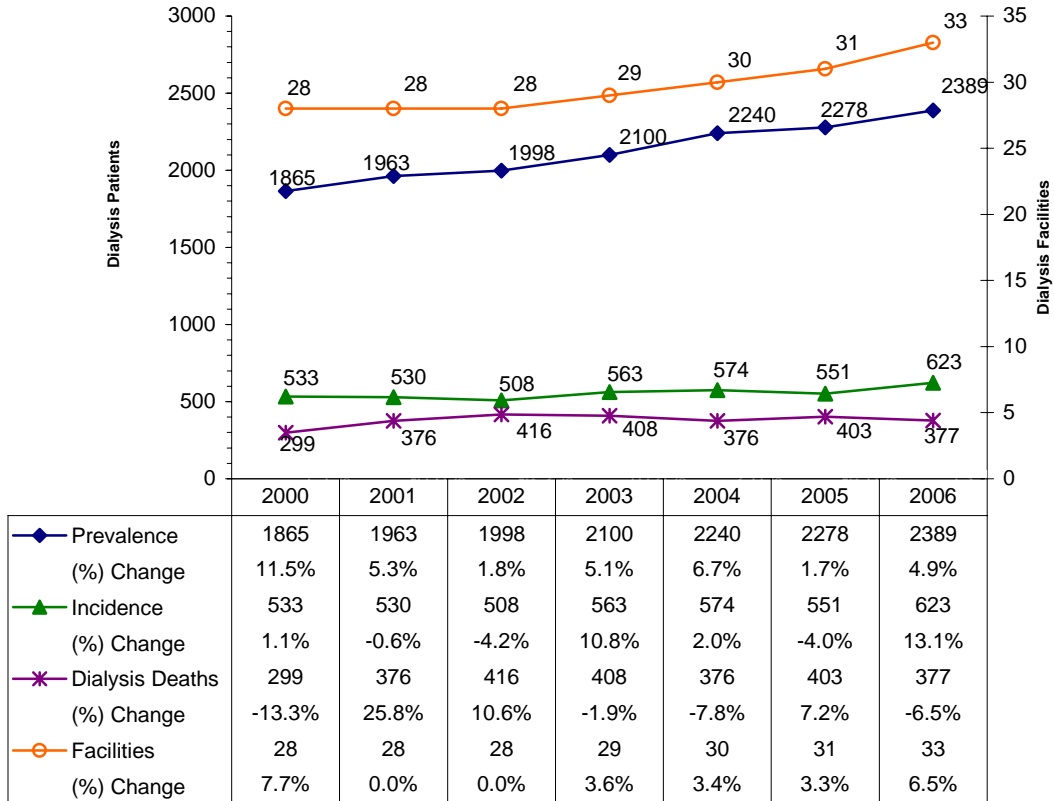
New Mexico is the fifth largest state in the country, with an area of 121,356 square miles, and ranks 36th in population. Forty-two percent of the land is federally owned. Ranching, nuclear energy research, and mining are major components of the economy; one out of four workers in New Mexico works for the federal government. Plains in the east and mountains and high desert in the west characterize the topography. Elevations range from 2,842 to 13,161 feet above sea level. The northwest portion of the state contains vast reservoirs of gas and oil.

From 2000 to 2006, New Mexico was the 16th fastest growing state in the nation (7.5% gain in population). Sixty-five percent of the population is considered urban. Transportation is mainly by private automobile or bus. Distances between population areas vary from 50 to over 300 miles. Settled in 1601, New Mexico has a long history of settlement by diverse cultural groups. New Mexico has one of the highest rates of poverty among the 50 states.

Dialysis Patients and Facilities in New Mexico:

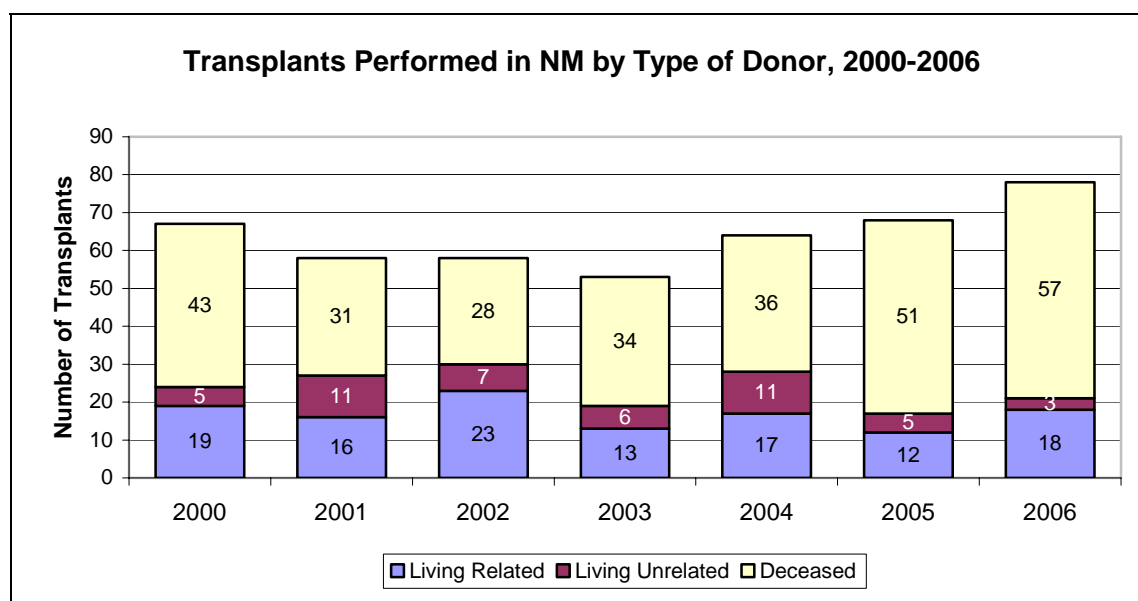
With the addition of two new facilities in 2006, there were a total of 33 Medicare-certified dialysis facilities in New Mexico on December 31st.

**Time Trend of New Mexico Patient Population and Facilities
2000-2006**



Transplantation in New Mexico:

There are two transplant centers in New Mexico, both located in Albuquerque. Between them they performed 78 renal transplants during 2006. Of those, 18 (23.1%) were from living related donors, three (3.8%) from living unrelated donors, and 57 (73.1%) from deceased donors. The following table illustrates renal transplants performed in New Mexico transplant facilities by donor type for the years 2000 through 2006.



Utah

Utah, the beehive state, has 82,114 square miles within its borders, ranking 13th in total area and 34th in population. The state is bounded by Nevada, Idaho, Wyoming, Colorado, and Arizona. Approximately 60% of state residents are adherents of the Church of Jesus Christ of Latter-day Saints (LDS Church), which has a religious prohibition of tobacco and alcohol use. Three-quarters of the population live along the western slope of the Wasatch Mountains, called the Wasatch Front Metropolitan area. Geographically, Utah is comprised of mountains and desert.

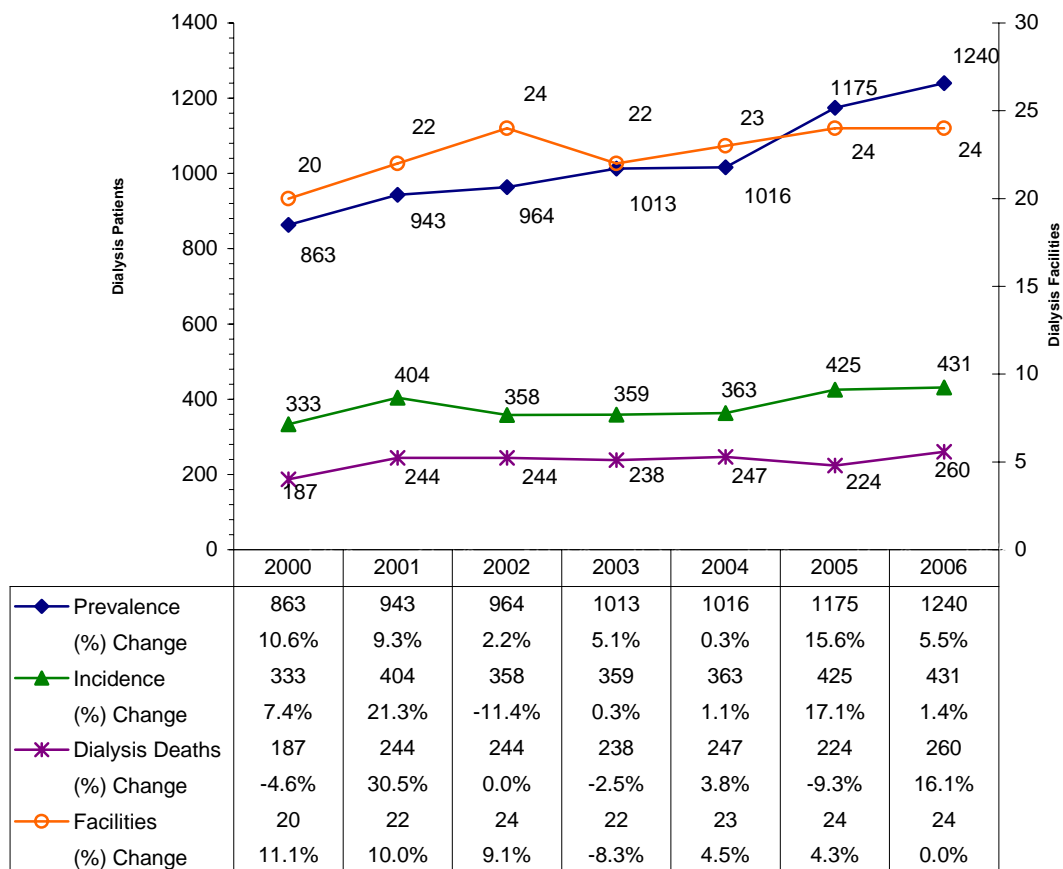
In Utah, 57.5% of the land is federally owned. Areas classified as urban contain 88.2% of the population. From 2000 to 2006, Utah was the fourth fastest growing state in the nation (14.2% gain in population). This growth is attributed to the high birth rate (90.6 births per 1,000 women 15-44, the highest in the nation), low mortality rate (7.9 deaths per 1,000 in 2004, the seventh lowest in the nation), and significant net in-migration.

Dialysis Patients and Facilities in Utah:

There were 24 Medicare-certified dialysis facilities in Utah as of December 31, 2006.

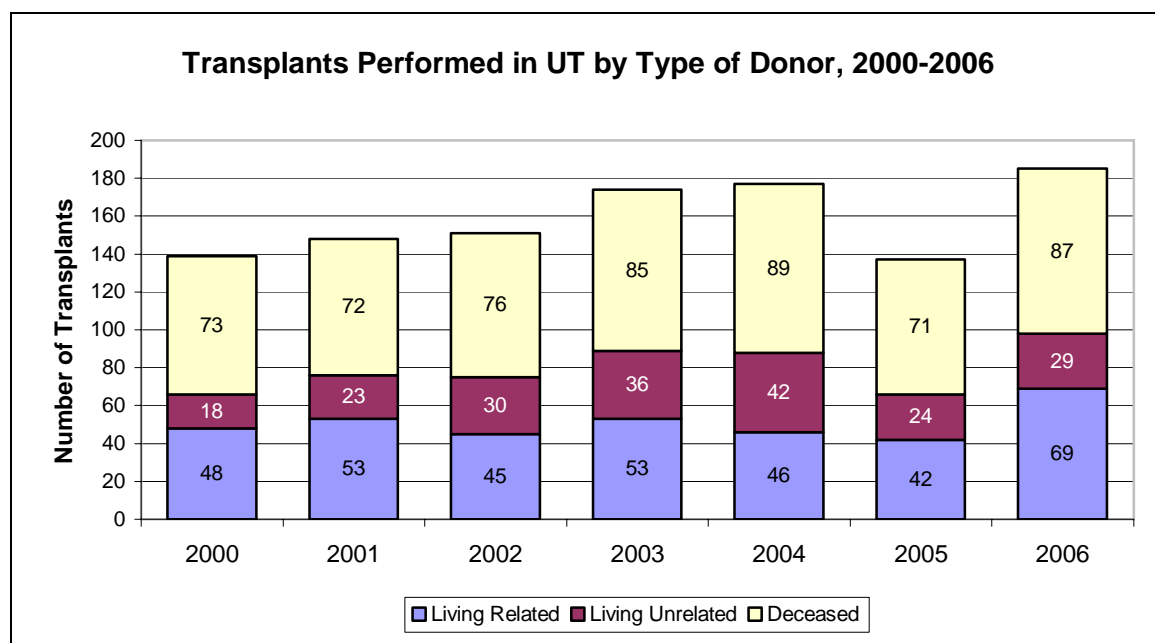
ESRD Network #15

**Time Trend of Utah Patient Population and Facilities
2000-2006**



Transplantation in Utah:

There are two transplant centers in Utah, both in Salt Lake City. There were 185 renal transplants performed in Utah during 2006. Utah saw the greatest jump in the number of transplants from 2005 to 2006 (a 35.0% increase). Thirty-seven percent (69) of transplants in Utah were from living related donors, 16% (29) were from living unrelated donors, and 47% (87) of transplanted kidneys came from deceased donors. The following table illustrates renal transplants at Utah transplant facilities by donor type 2000 through 2006.



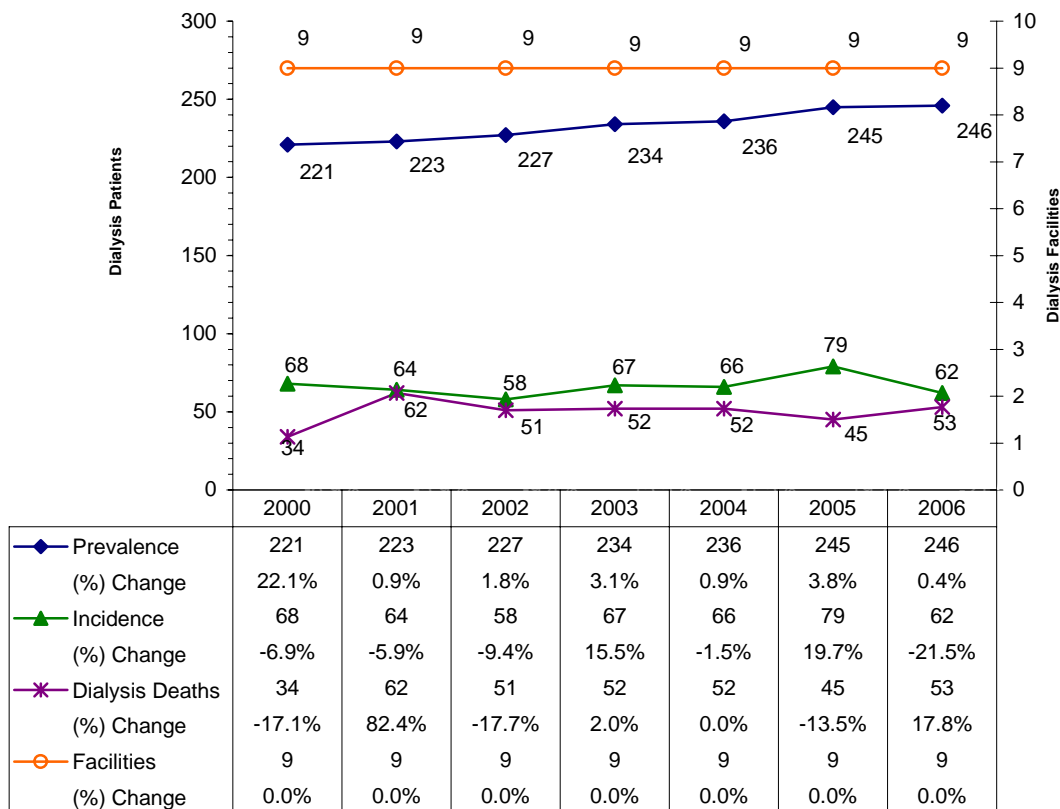
Wyoming

Wyoming is the ninth largest state, with an area of 97,100 square miles. It is, however, ranked 51st in population. The state is characterized by sparsely populated rural to wilderness areas with a few urbanized population concentrations. Only 65% of the population lives in urban areas. The topography varies from semi-arid grasslands to high mountain ranges. Climate and topography combine to make travel times, availability, and accessibility difficult (and sometimes impossible). Principle economic activity involves agriculture, mining, and tourism.

Dialysis Patients and Facilities in Wyoming:

There were nine Medicare-certified dialysis facilities in Wyoming as of December 31, 2006.

**Time Trend of Wyoming Patient Population and Facilities
2000-2006**



Transplantation in Wyoming:

There are no transplant centers in the state of Wyoming. Transplant patients are generally referred to transplant programs in Colorado and Utah.

B. Network Structure

The Intermountain End-Stage Renal Disease Network, Inc. (also known as ESRD Network #15) service area covers the states of Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming. The Network carried out all administrative activities required by its CMS contract as well as those activities required to operate as a Colorado non-profit corporation. These activities included, but were not limited to the following:

- Maintained a Network Council comprised of professionals representing renal dialysis and transplant facilities located in the Network and kept Council members informed on Network activities;
- Maintained a Medical Review Board (MRB) with a membership that includes at least one patient representative in addition to physicians, nurses, social workers, administrators and renal dietitians engaged in treatment relating to end-stage renal disease. The Network #15 Medical Review Board continued its activities and programs related to the quality and appropriateness of care; and
- Maintained its corporate status as "qualified to do business in other states" in Arizona, Nevada, New Mexico, Utah, and Wyoming. The required corporate reports and forms were submitted to the appropriate state agencies.

C. Network Staff

The Network Executive Director supervises the Network staff members and is accountable to the Board of Directors for the overall performance and activities of the Network staff. Each employee has a primary area of responsibility. These responsibilities fall within four major areas: Administration, Quality Improvement, Data Management, and Patient Services. In 2006, the employees were:

- Darlene J. Rodgers, BSN, RN, CNN, CPHQ , Executive Director
Position Summary: Under the general direction of the Intermountain End-Stage Renal Disease Network, Inc. Board of Directors; administers, implements and evaluates the programs and activities of the Intermountain ESRD Network, Inc. in accordance with the CMS contract requirements.
- Karen L. Strott, BSN, RN, CPHQ Director, Quality Improvement
Position Summary: Under the general supervision of the Executive Director, this individual assumes the responsibilities for the Network Quality Improvement Program. Responsible for the

ESRD Network #15

development, implementation and evaluation of Continuous Quality Improvement (CQI) activities for dialysis facilities in Network #15's six state areas per contractual agreement with CMS.

- Matthew Howard, Director, Information Systems
Position Summary: Under the general supervision of the Executive Director, this individual assumes responsibility for all day-to-day data collection activities relating to CMS data deliverables, serves as primary Network point of contact for the CROWN (Consolidated Renal Operations in a Web-enabled Network) program, and serves as the liaison between CMS and dialysis facilities for CMS required data activities. This individual also provides data analytical support to Quality Improvement, Patient Services, and Administration; acts as the Network contact for the technical needs of the administration of the servers, software, and workstations; and serves as primary contact for all VISION/Quality Net Exchange issues between facilities and the Network.
- Barbara K. Campbell, MSW, ACSW, LSW, Director, Patient Services
Position Summary: Under the general supervision of the Executive Director, the Director of Patient Services develops, implements, and evaluates all programs relating to ESRD patient services in the Intermountain ESRD Network #15 six-state area, per contractual agreement with CMS. This individual is responsible for the complaint and grievance process utilizing CMS protocol, as well as for the development of programs and QI activities to impacting the quality of life for ESRD patients.
- Robin Bender, RN, BSN, CNN, Quality Improvement Coordinator
Position Summary: Under general supervision of the Executive Director and the Director of Quality Improvement, assists the Director of Quality Improvement in the management the Network's quality improvement activities and provide technical support to the Network #15 nephrology community.
- Lynne D. Wright, BSN, RN, CNN, Special Studies Nurse
Position Summary: Under general supervision of the Executive Director and the Director of Quality Improvement, this individual plans, revises, supports, monitors, and coordinates Network Quality Improvement Projects as well as facilitates completion of special studies and projects from various agencies in the Network's six state area.

ESRD Network #15

- Karolyn Forbes, Office Manager
Position Summary: Under the general supervision of the Executive Director, maintains financial records and files. This individual prepares financial statements and reports and supports staff in all team areas of the Network with a variety of tasks. This individual maintains office supplies and equipment. Additionally, this individual provides support to the IT staff as a backup/assistant. This individual also supervises and establishes work procedures for part-time temporary clerical staff.
- Betty Wyant, Administrative Assistant
Position Summary: Under the general supervision of the Executive Director, assists Executive Director and Director of Quality Improvement as needed and supports other staff members in a variety of tasks including clerical support, maintenance of files, and database support. This individual is responsible for answering incoming telephone calls and opening and distributing mail.
- Drew Lifset, Data Assistant for Information Systems and Quality Improvement
Position Summary: Under the general supervision of the Executive Director and the Director of Quality Improvement, this individual works closely with the data and quality improvement teams to assist with a variety of data needs, including data input, data integrity analysis and interface with the Network facility providers.
- Cynthia Nelson, Information, Information Savant
Position Summary: Under the general supervision of the Executive Director and the Director of Information Systems, this individual works with the Information Systems team to oversee the flow of data, to update and maintain the patient database, to promote facility/Network communication, and to detail processes pertaining to the transmission of data.
- Virginia Nelson, Information Systems Assistant/Communications Coordinator
Position Summary: Under the general supervision of the Executive Director and the Director of Information Systems, this individual assists in generating and editing the Network publications, maintains and updates Network web site, works with the Director of Information Systems to update and maintain patient database, assists in processing all CMS required forms and assists in general office duties.

ESRD Network #15

D. Board of Directors

Network #15 is governed by a Board of Directors, which is comprised of representatives from the Network #15 area and includes patient representation. The following list shows the Board of Directors membership by state and professional category as of December 31, 2006:

- Nephrologist Arizona
- ESRD Administrator Arizona
- Nephrologist Colorado
- Nephrologist Colorado
- Nephrologist Nevada
- ESRD Nurse Nevada
- Nephrologist New Mexico
- Transplant Nephrologist New Mexico
- ESRD Nurse Utah
- Patient Utah
- ESRD Dietitian Colorado

It is expected that members from the Network #17 geographic area will be added to the Network #15/17 Board of Directors in 2007 upon completion of the transitioning activities.

E. Committees*Medical Review Board (MRB)*

The Medical Review Board is a committee whose membership is qualified by education, experience, and position to evaluate the quality and appropriateness of care delivered to ESRD patients. The MRB serves as an advisory panel to the Network Organization on all matters relating to the evaluation of the quality and appropriateness of care. The MRB is responsible for the development and/or revision of all criteria and standards. The MRB committee membership as of December 31, 2006 included:

- *Arizona:*
Nephrology Social Worker
Nephrology Nurse/Regional Administrator
Pediatric Nephrologist
Nephrologist/Interventional Nephrologist
Nephrologist

Nephrologist
Patient

ESRD Network #15

- *Colorado:*
Nephrology Dietitian
Nephrology Nurse/Nurse Educator
Nephrology Social Worker/Administrator
Nephrologist
Nephrologist
Transplant Surgeon
- *New Mexico:*
Nephrologist
Nephrologist
Nephrology Advanced Practice Nurse
- *Nevada:*
Nephrology Nurse/Administrator
Nephrologist
- *Utah:*
Nephrologist
Nephrologist
Patient
- *Wyoming:*
Nephrologist

Patient Leadership Committee (PLC)

This committee is comprised of patient representatives from the Board of Directors and the Medical Review Board, as well as other patient representatives from the Network area, and works in conjunction with the Director of Patient Services and other Network staff members. In 2006 the name was changed to the Patient Leadership Committee. The purpose of the committee is to bring patient concerns to the attention of the Network and to serve in an advisory capacity to the Board of Directors on issues where patient input is appropriate. The Committee conducts its business by mail, e-mail, phone, and in person as necessary. One patient serves on the Board of Directors, and two on the Medical Review Board. In 2006 the members of this committee were from the following states:

- Arizona
- Nevada
- Utah

Grievance Committee

This committee is comprised of members of the MRB and is responsible for, in conjunction with the Director of Patient Services, the Network

grievance resolution process. It is appointed and activated as necessary upon submission of a formal grievance involving clinical or medical matters requiring education, experience, and/or expertise beyond that of Network staff. Care is taken to appoint Medical Review Board members with experience relevant to the grievance, and strict conflict of interest procedures are observed. Any individual who has a financial, professional or personal involvement with the beneficiary or provider, or who resides in or practices in the same state, is excluded from participation on the Grievance Committee. The Grievance Committee consists of, at minimum, a chairperson and two other members.

Network Council

The Network Council is composed of members from renal dialysis and transplant providers that are located in the six-state area of Network #15. In addition, the patient members of the Board of Directors and Medical Review Board are considered Council members. The Network Council meets the statutory requirements of 1881 (c) of the Social Security Act. The Network Council serves as a liaison between the Network and its provider membership. Every renal facility/provider is represented on the Council. At its September, 1997 meeting, the Board of Directors redefined Council membership. Instead of each facility appointing a representative, the Council consists of the Medical Director, Administrator, Head Nurse, Social Worker and Dietitian from each Network facility. All of these individuals are considered Network Council Representatives and receive general mailings. Additionally, each professional category receives mailings relevant to that area of practice.

F. Emergency Preparedness for the Network Organization

Given the increased concern about potential disasters, including an outbreak of the Pandemic Influenza, Network #15 began a disaster preparedness plan for the Network organization in 2006. This plan is an extension of the Business Continuity and Contingency Plan required by CMS and the work begun by the Western Consortium of ESRD Networks (Networks #15, #16, #17 and #18) Disaster Collaboration in July 2006. The plan speaks directly to the Network functions and how work within the Network office can be completed in the case of a disaster. The plan also encourages individual employee preparedness for a disaster. The plan will be reviewed annually and revised as needed. Disaster preparedness activities for the Network facilities will be discussed later in this document.

III. CMS END-STAGE RENAL DISEASE NETWORK PROGRAM STRATEGIC GOALS

A. Introduction

The Networks began the 2006 calendar year completing the final two quarters of the 2003-2006 Statement of Work (SOW). Beginning on July 1, 2006, the Networks entered into a new three-year SOW with the Centers for Medicare & Medicaid Services (CMS). The strategic goals described in this report are the goals as stated in the 2006-2009 SOW. In accordance with the legislative mandate for the ESRD Network program; to assist CMS in meeting Agency goals and in keeping with sound medical practice, the strategic goals of the ESRD Network Program (2006-2009) are to:

1. Improve the quality and safety of dialysis related services provided for individuals with ESRD;
2. Improve the independence, quality of life and rehabilitation (to the extent possible) of individuals with ESRD through 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;
3. Improve patient perception of care and experience of care, and resolve patient's complaints and grievances;
4. Improve collaboration with providers to ensure achievement of the goals through the most efficient and effective means possible, with recognition of the differences among providers (e.g., independent, hospital-based, member of a group, affiliate of an organization, etc.) and the associated possibilities/capabilities; and,
5. Improve the collection, reliability, timeliness and use of data to measure processes of care and outcomes; maintain a Patient Registry; and to support the ESRD Network Program.

The Health Care Quality Improvement Program (HCQIP) for the ESRD Network Program mission supports achievement of the strategic goals by assuring the Institute of Medicine aims, as they relate to individuals with ESRD, ensure that care delivery is patient-centered, safe, effective, efficient, equitable, and timely.

B. Improve the Quality and Safety of Dialysis Related Services Provided for Individuals with ESRD

As defined in the SOW, the mission of the CMS HCQIP is to promote the quality, effectiveness, and efficiency of services to Medicare beneficiaries by strengthening the community of those committed to monitoring and improving care. During 2006, Network #15 defined

Quality Improvement Projects (QIPs); and through the work of the Medical Review Board and in partnership with Network renal providers has directed or participated in the following projects:

1. National Clinical Performance Measures Project

In 1994, the Centers for Medicare & Medicaid Services initiated the ESRD Health Care Quality Improvement Program (HCQIP) to monitor and evaluate patterns of care and provide feedback to all ESRD providers. HCQIP is based on Continuous Quality Improvement (CQI) concepts. It has been proposed, and fostered by CMS, that the CQI model, utilizing a rapid-cycle methodology, is the best approach for ESRD Networks to take in guiding facilities toward quality care for their patients. In addition, CMS is responsible to the public for managing the financial resources it administers and assuring that an acceptable level of care is provided to ESRD beneficiaries. In order to provide feedback, CMS selected quantifiable clinical indicators, which could be measured easily to determine important aspects of dialysis care. Since the inception of HCQIP in 1994, CMS and the ESRD Networks have been committed to improving ESRD patient care and outcomes by providing data and tools to providers for assessing care and identifying opportunities for improvement. In 2006, one of the major ongoing HCQIP activities, the Clinical Performance Measures (CPM) Project, entered its fourteenth year.

The CPM Project was designed to assist ESRD caregivers to measure outcomes, assess their care processes, and identify opportunities for improvement. Another purpose of the project is to establish a consistent clinical database. The CPM Project measures key components of care associated with dialysis, which can be considered data points to use to trigger improvement activities. The clinical data provide information on dialysis adequacy (urea reduction ratio and dialysis prescription), anemia (hemoglobin, use of erythropoietin or darbopoetin and iron administration), vascular access, and nutritional status (serum albumin).

Facility-specific analysis for the national CPM Project is not possible due to the patient sampling methodology. However, this was addressed with Network #15's participation in the "Lab Data Collection" project that was begun in 2005 (*summarized later see B.2.*).

Following the annual ESRD Facility Survey reconciliation for calendar year 2005, the SIMS patient database was utilized to

choose the CPM Project random sample. The hemodialysis sample included adult, in-center patients and 100% of the Veterans Affairs' (VA) hemodialysis patients, who were alive on December 31, 2005; the sample size for Network #15 adult hemodialysis population was approximately 700 patients. Additionally, CPM information was collected on 100% of pediatric patients who were less than 18 years of age. The number of pediatric patients included was 112. The Network's peritoneal dialysis (PD) sample included 140 patients. This sample included 100% of the VA peritoneal dialysis patients.

The Veterans Administration 2005 (2004 data) CPM reports were mailed to Medical Directors, Facility Administrators and Clinical Managers on May 15, 2006. VA Medical Directors also received a disc containing patient specific data.

During May-July, the 2006 CPM data collection forms and instructions were distributed to facilities, LDOs, Independents, and VA facilities for completion. In Network #15, approximately 192 facilities participated in the project. Approximately 99.8% of the forms were received and reviewed.

The Network requested facility staff to abstract the required information and return the forms to the Network office. Network staff answered numerous questions from facilities regarding the standardized CPM instructions and the data collection forms for this project. Completed and/or edited CPM forms were returned to the Network office and entered into SIMS. Numerous telephone calls were made to the facilities for clarifications and corrections. Due to the unusual problems created by electronic data collection for selected LDO facilities with the 2006 CPM data collection, additional time was required to review and edit forms.

Data validation of 2006 CPM data was conducted as directed by CMS. Data were re-abstracted by the Network staff on assigned adult and pediatric hemodialysis and peritoneal dialysis cases (5% sample) by requesting copies of the medical records for review and re-abstraction. The data validation was completed and materials were entered into SIMS by Network staff by the deliverable date.

Annually, the Network #15 Medical Review Board reviews the National and Network CPM results and formulates a plan of action to address opportunities to improve care within the Network. The 2005 (2004 data) CPM Preliminary Data was reviewed with the MRB during its meeting in February 2006. The CPM Action Plan was developed and submitted to the Project Officer on March 29,

2006, within the 60-day timeframe allotted for this deliverable. In accordance with the CPM plan, a CPM resource mailing was sent to all facilities. A copy of these resources can be found in Appendix B.

Formulating a plan of action based on 2006 CPM results (to be reported to the Network Project Officer in 2007) was not completed during the 2006 calendar year. As of December 31, 2006 the preliminary data results were not available.

2. *Network #15 Lab Collection Project*

The national CPM Project data provides aggregate data that is Network-specific and national in scope. These data cannot be used to define state-specific or facility-specific results (due to the limited sampling technique). Historically, Network #15 collected facility-specific aggregate data via its “Key Data” annual project. As in the 2003-2006 SOW, facility-specific data collection continues to be limited as directed by CMS and the Network was unable to continue this project. In the light of this, Network #15’s MRB directed the Network to collect facility-specific data using a different vehicle. The Medical Review Board (MRB) of Network #15 agreed to collect this valuable clinical data by participation in the 2006 “Lab Data Collection” project. This data collection involving, large dialysis organizations (LDO) and independent dialysis facilities, was approved by CMS. Within Network #15, 100% of the eligible dialysis facilities operating in 2005 participated in the data collection for the fourth quarter of 2005. Data were collected and reported to the Network in January of 2006. The collected data elements included the following laboratory values: hemoglobin, TSAT (if done), ferritin (if done), pre BUN, Post BUN, albumin, albumin method, phosphorous, Kt/V for hemodialysis patients, weekly CrCl for PD patients, Weekly Kt/V for PD patients and calcium.

Network #15 facilities received a copy of the clinical outcomes as reported for the 2005 lab data collection (E-Lab) in December of 2005. At that time the facility representatives were encouraged to review the information that was provided and to develop an improvement plan(s) if appropriate. In March 2006, letters were sent to 37 facilities that were not meeting target in the areas of anemia management and/or adequacy, to request a follow-up action plan and to offer assistance to facilities in need. Follow up and QI assistance was offered to these facilities by the Network QI staff throughout 2006. Collection of the 2006 Electronic Lab Data will begin in early 2007.

During 2006, a poster was developed to educate staff and patients regarding NKF/KDOQI laboratory targets. These targets cover adequacy, anemia, iron, albumin and bone metabolism for hemodialysis and peritoneal patients. The poster accompanied the lab results mailing in the third quarter 2006 (Appendix C).

3. *“Fistula First” Quality Improvement Initiative*

In the SOW issued in June 2003 the Networks moved from methodologically prescribed QIPs with significant CMS oversight to autonomous development of effective facility-based rapid-cycle improvement initiatives. The Institute for Healthcare Improvement (IHI) was contracted to work with CMS, Networks and dialysis facilities/corporations to develop a collaborative approach to prioritize a quality improvement topic, identify and “package” effective approaches for improvement, assist in the design of an approach that maximizes the “spread” and “adoption” of effective solutions, and “coach” collaborative teams.

All Networks were required to develop and implement a quality improvement project aimed at increasing fistulas within their Networks. This portion of the Network SOW is performance-based with the target for performance developed by CMS. The Network #15 fistula rate target, to be achieved by the end of the 2006 contract period (June 2006), is 42.5%. The target prescribed for Network #15 by the end of the base contract year, which began on July 1, 2006 and ends on June 30, 2007 is 51.12%. During 2006, the Fistula First Initiative was the primary focus of many of the Network’s QI activities.

Data continued to be downloaded from the large dialysis organizations (LDOs) via SIMS each month throughout 2006. A list of current patients was mailed to independent facilities monthly and staff members at these facilities either submitted aggregate data to Network #15 using the computerized tool or a paper form. Network staff then manually entered the aggregate information into the Fistula First database. Approximately 20 of the 60 independent facilities elected to use the computerized tool to submit summary reports, while the remaining independent facilities opt to fill out the paper forms.

Network #15 produced a quarterly summary report during each quarter of 2006, as well as a report containing facility-specific fistula use data with a calculated facility median. The Network facility-specific report allowed facilities that have on-going

ESRD Network #15

vascular access initiatives to better assess whether specific interventions have had an effect on their rates. That report along with the quarterly summary and monthly facility-specific reports generated through SIMS, were disseminated to each Facility Administrator and Medical Director on a quarterly basis. The quarterly summary reports were also mailed to project partners involved in other aspects of the project (e.g., surgeons in Network #15's six-state region and the appropriate IHS participants). The Network QI staff continued to work with facilities and physicians who are in need of help with their Fistula First Activities.

Facilities in Network #15 have used multiple strategies to increase their AVF rates. There is not "one-way" to make improvements because facilities face many different vascular access challenges. Quarterly, phone interviews were conducted with facilities demonstrating the most improvement, as well as with facilities that are having difficulty improving their rates. Staff from high achieving facilities, made the following comments when asked about the keys to their success. The information continues to be similar each quarter, leading the Network to believe that these areas really are the "key" points facilities should focus on to improve rates:

- Reasons for "non-AVFs" for each patient are reviewed each month during QI meetings. Individual action plans are developed during the meeting;
- Units are proactive in addressing problem accesses, they are monitoring for stenosis monthly (using the twister line or transonic) and access problems are immediately referred to IR, nephrologist or surgeon;
- Becoming familiar with patients' accesses is extremely important. It allows for timely identification of problems when they occur;
- Patients are referred to the surgeon with the most expertise for access placement (even when they are not local surgeons);
- Materials from the Network #15 website and the FistulaFirst.org website are utilized for patients;
- Vein mapping is done pre-placement and angiograms utilized if post-placement problems identified;
- Facilities focus on decreasing the number of catheters that are placed;
- Facilities have designated a "patient vascular access educator";
- Fistulas are placed as first access automatically;

ESRD Network #15

- Vascular coordinators manage all data, coordinate appointments, monitor for access maturation and track interventions;
- Facilities work on one aspect of the Fistula First project at a time;
- Vein mapping is done both pre-access placement and upon access failure to select viable veins for AVF placement;
- Some facilities use the “Fistula Exercise” booklet and demonstrate the exercises to patients to help enhance the development of fistulas. Evidence from the most recent K/DOQI guidelines now supports the use of Fistula exercises to aide in the development of new fistulas.
- One corporation now has multi-disciplinary training modules available for their staff and a renewed “team approach”;
- A new information packet for patients was developed by the facility that includes information on risks of catheters and infections;
- During the past few months facility staff and nephrologists have focused on talking about permanent access placement each time they round on patients. They emphasize the importance of permanent access placement as soon as patients are admitted with Central Venous Catheters (CVCs). Staff and nephrologists also emphasize the increased risk of infection associated with CVCs;
- Vascular labs are used to perform vein mapping. Vein mapping is ordered by either the nephrologist’s office or the surgeon’s office staff and is completed prior to the patient’s appointment with the surgeon. Star surgeons remain invested in doing a good job;
- A protocol to cannulate new fistulas is used in all of the high performing facilities;
- Buttonhole technique used for new and prevalent patients in some facilities;
- Some facilities have nurse practitioners involved in access assessment and are referring 5-6 patients/day to main surgeon.

Staff from **lower achieving facilities**, made the following comments when asked about the barriers to achieving higher AVFs.

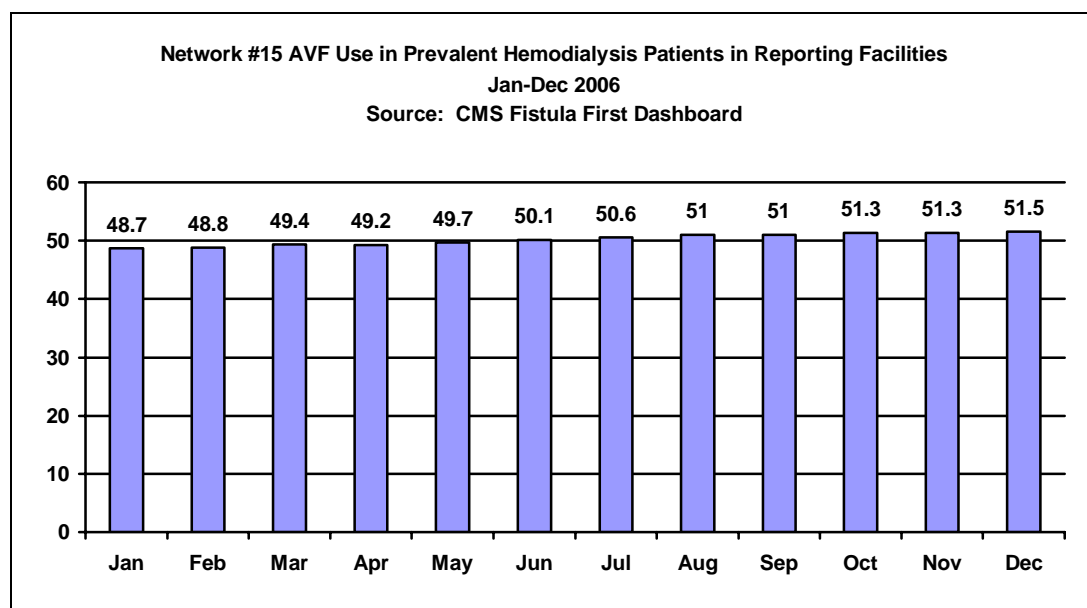
- Their low rates may be partially due to not having an actively involved Medical Director/Nephrologist group at this facility;

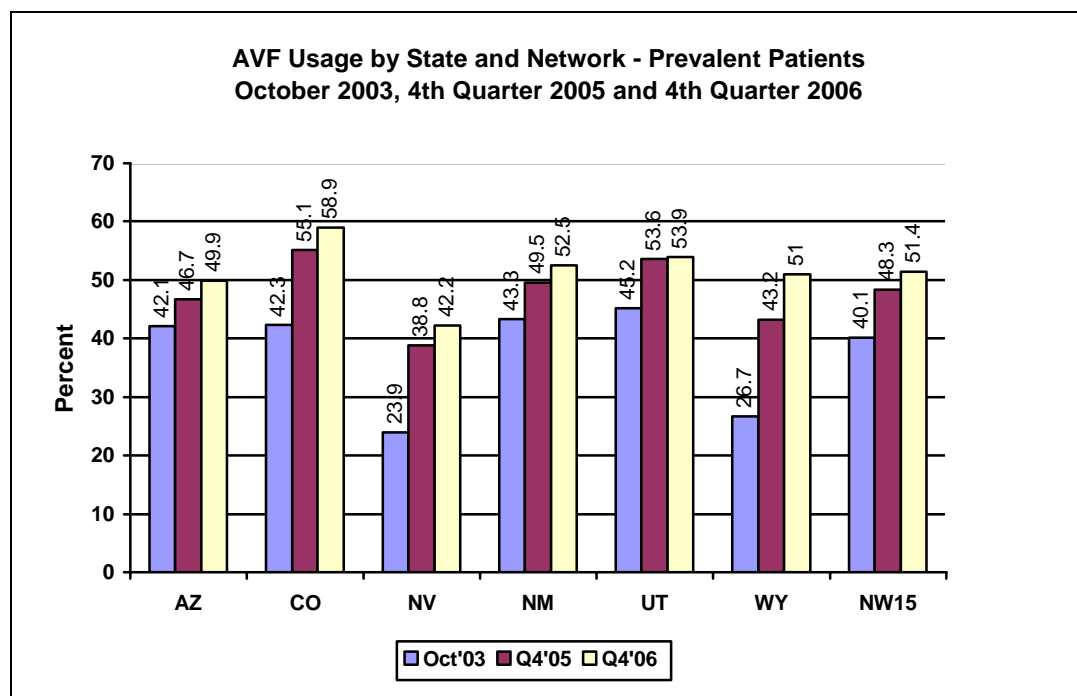
ESRD Network #15

- Facility is having difficulty with AVF development and early AVF failure (within the first 3 months), surgeons have difficulty knowing how to fix the failing fistula so come back to the unit with grafts;
- Facility has difficulty with a nurse practitioner who is “not on board” with current recommendations, the nurse practitioner refers patients to surgeons who can’t place viable AVFs”;
- Vein mapping is not done (or done and not interpreted correctly) at facilities with lower rates.

The Network #15 contract goal for the period of July 1, 2003-June 30, 2006 was 42.5%. The Network surpassed this goal early in the contract period and by the end of the contract, June 30, 2006, the Network #15 prevalent AVF rate was 50.1%. CMS calculated a prevalent AVF goal for Network #15 for the period of July 1, 2006-June 30, 2007 was 51.12%. The Network met this new goal during the third quarter of 2006. Of those facilities submitting Fistula First data in December 2006, 114 out of 216 facilities (52.8%) had already met the March 2007 CMS goal for the base contract year.

Prevalent AVF rate improvements across the provider types continued to be monitored throughout 2006.





The Network continued its educational efforts at the facility level in the form of cannulation workshops and discussions with dialysis facility personnel regarding QI endeavors. Requests for “On Course with Cannulation” workshops continued through the contract year. Network #15 staff offered resources and direct assistance to facilities to develop individual action plans to help improve their AVF rates. Corporations continued to provide enhanced cannulation training for dialysis facility staff. Corporations have a renewed “team approach” to vascular access placement and management that is enhancing the likelihood that a hemodialysis patient will receive a viable working AVF as a first access.

Network #15 held a *Faithful Fistula Contest*, in which three patients with the oldest functioning fistulae won prizes. The contest rules and questionnaire was sent to all Network facilities through a broadcast fax. The contest ran throughout the month of February 2006 and 50 entries were received back to the Network. The three top winners were notified individually and the remaining entries received honorable mention. With permission of the winners, their stories were published in the Network’s professional newsletter, the *Intermountain Messenger* and the patient newsletter, the *Renal RoundUp*.

Also in February 2006, during the Southwest Nephrology

conference, Network #15 sponsored a half-day presentation, by Dr. William Jennings (from the University of Oklahoma, Tulsa) titled, "Overview of Vascular access." Area nephrologists, surgeons and facility staff attended this presentation.

The QI department provided "Fistula First Starter Kits" containing post-operative care instructions, a tourniquet, a gripper ball and an exercise booklet developed by Network #15, to requesting facilities during this calendar year. The Fistula First initiative is a recurring topic in the Network professional newsletter, the *Intermountain Messenger*. Additionally, the Network web site is regularly updated with new resources as it becomes available.

During the summer of 2006, Network #15 coordinated an educational offering and collaborative effort between Network #15, Network #16, a corporate dialysis company, ANNA and patients. The offering was presented to facility personnel and patients in the Albuquerque, New Mexico area. Segments of the presentation included: OCWC, Physical Assessment of Vascular Access and the Buttonhole Technique.

In the fall of 2006, Network # 15 hosted an American Nephrology Nurses Association (ANNA) audio conference titled; *New Vascular Access Guidelines from K/DOQI*, in an effort to expand awareness of the new vascular guidelines. Seventeen nurses and technicians attended the audio conference from Colorado as well as four staff members from Network # 15. Network #15 recruited two host sites in the states of Arizona and New Mexico. Sixteen nurses and technicians from Tempe, Arizona and four from Albuquerque, New Mexico joined us from their respective states.

Also in the fall of 2006, Network staff distributed Fistula First information and displayed the Fistula First poster at the Current Concepts in General Surgery and Trauma Update in Albuquerque, New Mexico.

During the second option year of the 2003-2006 SOW, the Network assisted in the organization of a coalition whose focus is Dialysis Access and Chronic Kidney Disease (DA/CKD). Throughout 2006, the Network continued to work with this coalition to focus on early identification of CKD patients and early access placement. Please see section III.E.6. for additional information on this collaborative effort. The DA/CKD coalition is composed of members from the nephrology community, QIO representatives from all six of the states within Network #15, patients, CKD educators and others. Through the work of the

coalitions two workgroups, the Provider Advisory Committee (PAC) and the Beneficiary Advisory Committee (BAC) the Network hopes to continue to see an increase in prevalent AVF rates.

The CMS Fistula First Breakthrough Initiative (FFBI) has had a positive impact on the Fistula First project during 2006. Network #15 has been an active participant with four staff members participating on national task groups. Through the collaboration of Surgeons, Interventional Radiologists, LDOs, independent facilities, Networks, payers, patient organizations, RPA, ANNA, NANT, and USRDS an increase in prevalent AVF rates have been demonstrated throughout the country. Please see Appendix D for Fistula First information.

3. *Other Quality Management Activities (QMA)*

While preparing for the annual GFR review, Network #15 noted that the number of 2728 forms included on the SIMS-generated report, *Summary of GFR Reviews*, did not match the number of forms processed. Network #15 had processed 4,624 CMS-2728 forms for patients initiating dialysis between January 1, 2005 and December 31, 2005. The summary on the GFR report showed 1,687 CMS-2728 Forms. Since the number of forms was so dramatically different, the Network also questioned the threshold, which is set at the mean +2 standard deviations. On Friday, June 9, 2006 CMS hosted a conference call in which the Networks were told that no further resources would be directed towards the current systems (SIMS-VISION-REMIS). Instead, there would be a concerted effort to get CROWN-Web operational by May of 2007. The initial release of CROWN-Web would be comprised of four forms (2728, 2746, 2744, and 820/821). Due to this administrative decision, and the inability to correct the problem, CMS waived the annual GFR review process for 2005.

Network #15 responded to the CMS request for help in increasing ESRD facility staff awareness about pandemic flu by publishing *The Pandemic Newsletter*. The Pandemic Flu Newsletter contained educational and prevention information from the Centers for Disease Control (CDC). Several enclosures: "Business Pandemic Influenza Checklist" and "Cover Your Cough" and "Hand Washing Is the In Thing To Do" posters were, also, included in this mailing. The newsletter was mailed to all dialysis and transplant Clinical Managers, Board of Directors, Department of Health and State Surveyors. A copy of the newsletter is available on the Network #15 web site. Additionally, the Network contacted

multiple individuals and organizations within its six states to gather information regarding preparation for the possibility of the pandemic flu. Responses were forwarded to CMS Central Office and the Network Project Officer. Pandemic flu information and links were added to the Network #15 web site in 2006. Directors of the State Department of Health in each state in Network #15 were sent a letter detailing suggestions for including Networks and dialysis facilities in their state public Health Influenza Pandemic Preparedness Plans. The Executive Director attended the Pandemic Flu Preparedness Conference in Denver, Colorado in March 2006. This conference focused on the need for each community, employer and family to be prepared to respond, as the Federal and State governments may not be able to assist on an individual level. The information from the conference was shared with the Network #15 staff and was used in the Network's Pandemic Influenza information.

During 2006, the QI Department continued to provide "*Network #15 Guidelines for Care of the ESRD Patient*" to new (and several existing) facilities.

A broadcast fax was sent to all Network #15 facilities to promote completion of the on-line patient safety survey "Patient Health and Safety Project".

Facility Administrators and Medical Directors received a copy of the Dialysis Facility Report (DFR) and the 2006 Lab Collection Reports at the end of July 2006. The University of Michigan Kidney Epidemiology and Cost Center (UMKECC) conducted the statistical analysis for the DFR information with funding from the Centers for Medicare & Medicaid Services (CMS). Medical Directors also received a poster of the National Kidney Foundation-Kidney Outcomes Quality Initiatives Guidelines.

With the start of the 2006-2009 SOW on July 1, 2006, the Networks were required to implement a Quality Improvement Work Plan (QIWP). This plan details the quality improvement activities through the contract year and is used as a guide to the current QI activities. The MRB assisted with the QIWP development and is instrumental in monitoring the progress through the year.

In order to continuously improve the Network's internal processes and to promote good QI practices within the Network organization, Network #15 has in place a dynamic Internal Quality Improvement (I-QI) program. The Network #15 Project Officer has recognized

Network's I-QI program as a model program and the content of this program has been shared with other Network organizations. Examples of current I-QI focus areas as of the end of 2006 include, but are not limited to:

- Improving the % of facilities reporting Fistula First monthly data
- Improve the timeliness and accuracy of manually submitted Fistula First data
- Reduce the number of phone calls necessary to complete data collection projects
- Evaluate the satisfaction and effectiveness of TOPIC calls
- Improve the effectiveness of facility-profiling and trend analysis for complaints and grievances
- Improve the effectiveness of communication with DOH contacts
- Monitor for timely submission of required administrative reports
- Database management
- Timeliness of reporting renal status of Medicare ESRD beneficiaries
- Refining missing UNOS transplant registration and follow-up form tracking procedure

C. Improve the Independence, Quality of Life and Rehabilitation (to the extent possible) of Individuals with ESRD Through Transplantation, Use Self-Care Modalities (e.g., peritoneal dialysis, home hemodialysis), and In-Center Self-Care, as Medically Appropriate, Through the End of Life

1. Promotion of Self-Care Dialysis

Network #15 promoted the use of self-care dialysis through educational activities such as distribution of the CMS National New Patient Packet and the Network-specific New Patient Packet and through the adoption of criteria and standards that encourage the use of self-dialysis. Information on patient self-care, both as a patient mindset as well as a treatment modality, can be found on the Network #15 web site to encourage patient interest and involvement in self-care. The MRB's goal for self-care is to ensure that patients are receiving information about self-care dialysis and that they are aided in obtaining this modality if it is their choice and is medically appropriate. During 2006, the Network's MRB expanded its Self-Care Subcommittee to include non-members of the MRB who are actively involved in facility self-care programs.

The utilization of self-care (home dialysis) in Network #15

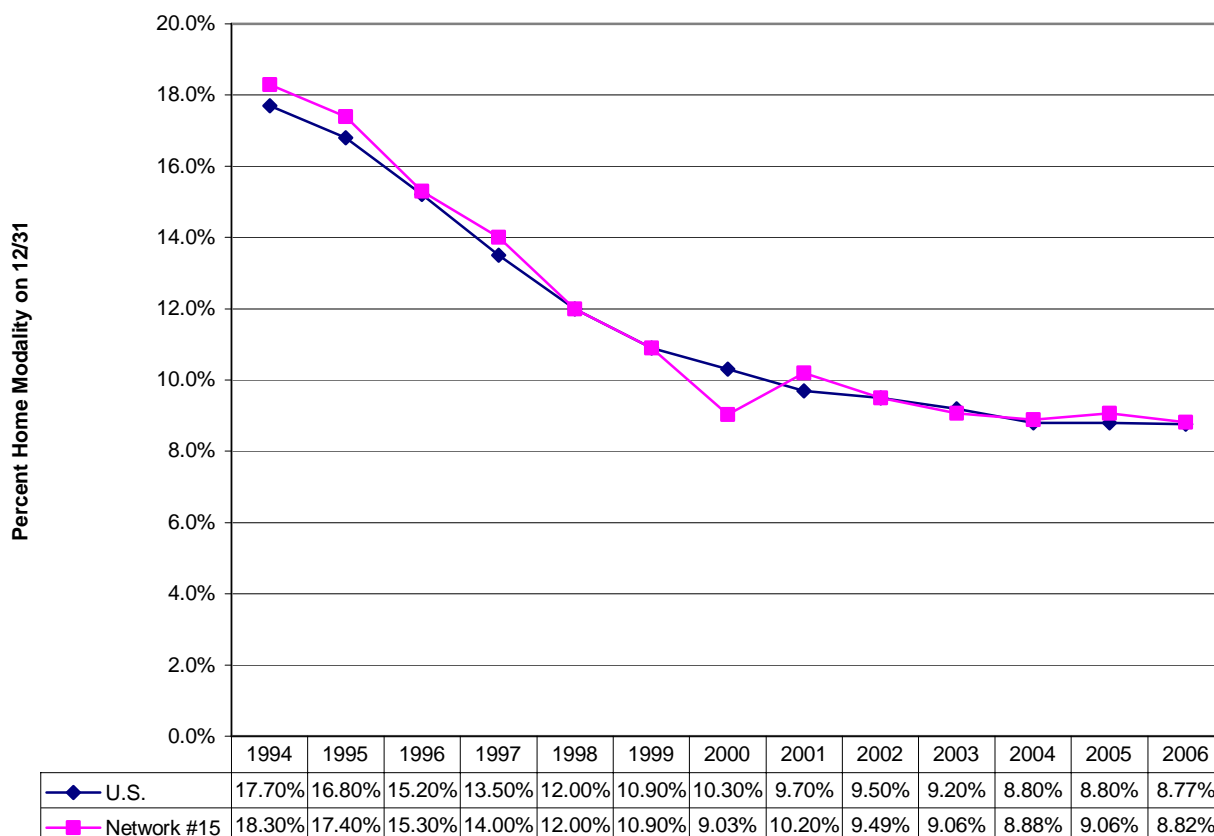
ESRD Network #15

remains near the national rate but has, in general, mirrored the decline seen nationally in recent years. The Network #15 rate for 2006 is 8.82%, showing a modest decrease compared to 2005's rate of 9.06%. 2002 to 2006 national data included in the chart below was obtained through national figures entered into the Standard Information Management System (SIMS). Prior to 2002, data was pulled through Renal Beneficiary Utilization System (REBUS), formerly used by CMS for tracking renal patients. It appears that the percent of patients utilizing home dialysis care in Network #15 in recent years is close to the national figures. These rates were calculated using the number of patients in a self-care setting on the last day of each year divided by the total dialysis population on that date. This methodology is limited in that it does not include patients who start dialysis, go on self-care, and then stop self-care in the same calendar year (numerator). Also, it does not include patients who begin dialysis, may or may not go on self-care, and then have a transplant or die in the same calendar year (numerator and the denominator).

See the table below showing percent of patients on home dialysis modalities:

ESRD Network #15

Percent Home Dialysis Patients, US and Network #15



2. *Encourage the Use of Transplant Modality*

The Network #15 continues to promote the use of transplantation as a treatment modality through distribution of the Network #15 New Patient Packet and via clearinghouse mailings regarding pertinent technological innovations and modality information on the Network web site.

The MRB has established the Network goal that all patients receive information regarding transplant and be assisted in receiving a transplant if medically appropriate. The USRDS-computed standardized transplant ratio for Network #15 was 1.16 for 2002-2005. As in the case with self-care dialysis, the MRB identified important factors affecting patients' choices about transplantation. Cultural factors, age, financial disincentives, co-morbid conditions, and psychosocial factors play significant roles in the patients' decision making regarding modality. The MRB observed that age alone is an insufficient reason for a patient not to be on self-care

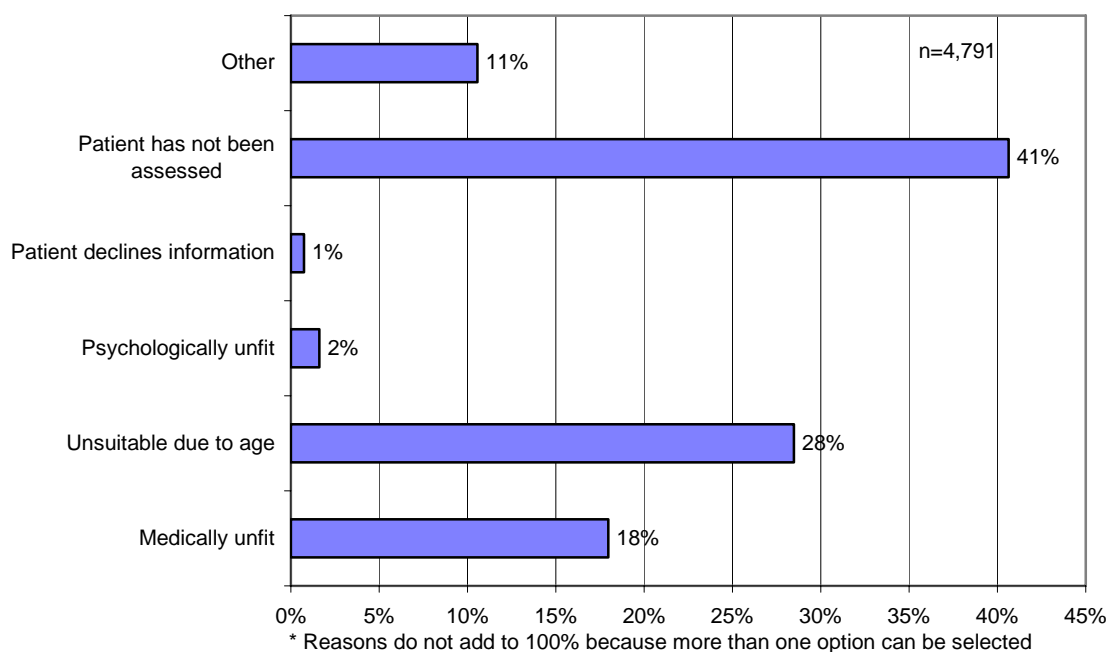
ESRD Network #15

dialysis, or not to be a candidate for transplantation. The MRB noted that age must be considered along with other factors, most importantly the presence of co-morbid conditions.

Contact information from all fourteen Network #15 transplant facilities is available in the patient information section of the Network #15 web site. There is also web site information regarding transplant listing issues (“Kidney Transplant: Am I Ready?”) as well as various links to other renal transplant Web sites of interest. Additional information related to the subject of transplantation was accumulated by Network staff and was used for the 2006 issue of the patient newsletter, *Renal Roundup* (Appendix E).

The 2728 Form that was released in June 2005 contained new questions that pertained specifically to transplant options. The questions read, “Has the patient been informed of transplant options? If patient NOT informed of options, please check all (the reasons) that apply.” When the Network analyzed the responses to these questions, it was found that 67% of new patients (incident) were informed of transplant options. Of the 33% that were not, the reasons given were as follows:

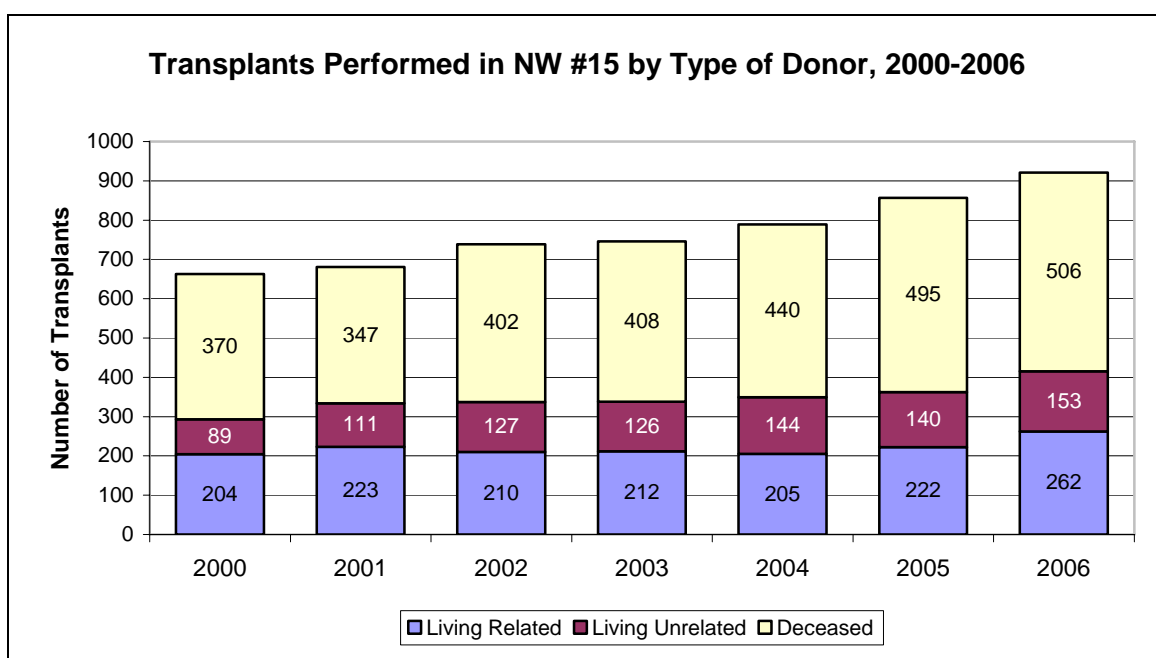
**Reasons Selected for Patient not Informed of Transplant Options
For Patients Initiating Dialysis in Network #15 in 2006**



ESRD Network #15

Using this information, as well as information gathered from transplant facilities, the Network staff is in the process of developing a transplant referral related quality improvement activity for 2007.

The number of transplants performed in Network #15 in 2006 was 921, compared to 857 in 2005. Fifty-five percent (506) of the renal transplants performed in Network #15 during 2005 were from deceased donors. Living-related donors accounted for 28% of the year 2006 transplants, and 17% were from living-unrelated donors.



3. *Rehabilitation/Vocational Rehabilitation (VR)*

Network #15 encourages patient and facility participation in vocational rehabilitation in a variety of ways:

- Through the mailing a packet of information directly to each new patient in its six state areas. This packet includes the National Kidney Foundation brochure “*Working with Kidney Disease.*”
- By encouraging facilities to increase their involvement with vocational rehabilitation programs through the inclusion of an annual delineation of the patient's vocational rehabilitation status and needs on the Vocational

Rehabilitation Referral Status Code sheet, a suggested adjunct form to the patient Long Term Program (LTP).

- Provides an ongoing single-number source of information for VR counselors to obtain information about dialysis and transplantation in general or about specific facility resources.
- In November 2006, dialysis facility social workers were sent a Vocational Rehabilitation Resource Folder with the following contents:
 - Facility-specific vocational rehabilitation data (survey years 2004/2005)
 - Life Options Rehabilitation Program resource information
 - Materials on Health-Related Quality of Life (HRQOL) measures
 - List of ESRD Network #15 state Vocational Rehabilitation Office websites*
 - List of state-specific Vocational Rehabilitation Offices*
 - Sample Employment Facilitation letters to be signed by the patient's physician and sent to the patient's employer or prospective employer, as appropriate
 - Family and Medical Leave Act of 1993 summary
 - *The ADA: Your Employment Rights as an Individual with a Disability**
 - *Social Security: Working While Disabled—How We Can Help (2006)**
 - *Social Security Online—Red Book—Table of Contents (2006)**
 - Vocational Rehabilitation Survey Tracking Tool for survey year 2007*
 - *The Benefits of Volunteering**

(* Indicates new or updated material from 2005 mailing)
- The Network provides links to VR services on its web site, including Life Options Rehabilitation Advisory Council (LORAC) and the 27th Institute on Rehab Issues "Effective Strategies for Improving Employment Outcomes for People with Chronic Kidney Disease."

Additionally, the Network conducts the annual vocational rehabilitation (VR) surveys of all dialysis facilities per its contract with CMS. The 2006 survey, compiling data on VR activities, profiled:

Number of patients ages 18 through 54
 Number of patients receiving services from VR providers
 Number of patients employed
 Number of patients in school
 If the dialysis unit offers an after 5pm shift

Please see Table 8 for Network #15 VR data for 2006.

4. *Other Patient Related Activities*

During 2006 several facilities requested the information prepared by the Director of Patient Services, National Kidney Foundation Medicare Modernization Program staff, and staff from CMS Region VIII office on the Medicare Prescription Drug program (Appendix F).

The December 2005 edition of the Network #15 patient newsletter, *Renal Roundup*, was sent to all Network #15 dialysis and transplant facilities in December 2005 with a request for distribution to their patients, and was sent to new patients in the Network #15 New Patient Packets during the first quarter 2006. Articles in this issue contained information about dialysis accesses, emphasizing the importance of having a fistula, as well as information describing what the Network is and how to access its website (as well as toll-free phone numbers), the grievance process, renal resource websites, and how to get help with Medicare Part D (Appendix E).

Network #15 coordinated an educational offering and collaborative effort between Network #15, Network #16, a corporate dialysis company, ANNA and patients. The offering was presented to facility personnel and patients in the Albuquerque, New Mexico area. Segments of the presentation included: OCWC, Physical Assessment of Vascular Access and the Buttonhole Technique.

D. Improve patient perception of care and experience of care, and resolve patient's complaints and grievances

1. *ICH-CAHPS Project*

During the first quarter of 2005 Network #15 volunteered to participate in the ICH-CAHPS Quality Improvement pilot program, as well as to serve as the coordinating Network of those Networks chosen by CMS. ICH-CAHPS activities, measuring the patient experience of care, included extensive communication between the Network Executive Director, the lead Grantee (AIR), CMS and AHRQ developing a draft work plan, planning for kick-

off activities and sharing ideas regarding the project. Multiple conference calls were held with the participating Networks, the Grantees and the participating facilities. The pilot data collection results were released to the participating facilities and Networks in July 2005. The Kick-off Implementation and Design meeting was held in Baltimore on August 3-4, 2005. All participating Networks, Grantees, Facility representatives, a panel of patient speakers, invited experts and CMS attended.

During this project, Network #15 was allowed to recruit a facility to work with the Network staff on QI activities addressing issues identified in the pilot data collection report. Network #15's ICH-CAHPS quality improvement pilot program QI activities focused on receiving facility pilot data collection results, working with facility to select targets of quality improvement activities, and assisting facility in improvement efforts by Network staff interviewing facility patients and compiling resulting data in a useful manner for the facility. The Network #15 Director of Patient Services and Director of Quality Improvement worked closely with this facility throughout the first six months of 2006.

During the first quarter 2006 ICH-CAHPS activities consisted of providing staff with a Pareto analysis of patient interview data, coaching regarding quality improvement steps, suggestions, staff support, and creating a poster of the facility's project. This poster was displayed during the Poster Session at the annual CMS/Forum of ESRD Networks Meeting in April 2006.

In May 2006, CMS notified Network #15 that the ICH-CAHPS project would be allowed to continue into the next SOW as it is budgeted through the Network Coordinating Center (NCC) and the NCC budget ran through September 2006. Re-measurement was delayed to allow for continued intervention activities. Re-measurement was completed during the summer 2006. When the re-measurement results for the Network #15 facility were examined, the facility demonstrated statistically significant improvement in the targeted areas.

The final ICH-CAHPS face-to-face meeting took place on September 28, 2006. As the subcontracting Network to the Network Coordinating Center, Network #15 was responsible for the logistics of this meeting. A final report containing recommendations to CMS was completed by the Grantees with review by all participating Networks and appears as Appendix G.

2. ***Complaints and Grievances***

Network #15's "Protocol for the Evaluation of Patient Complaints and Grievances" was sent out to all facilities in 2006. It is used to guide Network #15 action taken on patient complaints and grievances (Appendix H).

The document on grievances to be given to patients, "Network #15 Patient Grievance Protocol," is posted on the Network #15 web site and appears in Appendix I.

In 2006, Network #15 reminded all facilities that their facility-level grievance procedures must be posted for patients, as well as the Network grievance procedures. Two laminated Network grievance posters, both in English (*Have a Problem?*) and Spanish (*Tiene algun Problema?*), were sent to new facilities. The posters detailed the suggested steps to resolve a problem and gave patient resources specific to each Network #15 state. The toll-free telephone number of Network #15 was on the posters, as well as the phone numbers of the State Health Department and CMS Regional Office. The posters had been previously sent in 2003 and 2004 to the existing facilities at that time, with the expectation that facilities post the documents on a patient bulletin board or in another appropriate location and retain them indefinitely.

Some calls to Network #15 directly seek information or require information from another agency or government entity for problem resolution, such as a new patient calling to inquire when his or her Medicare benefits will be approved. When a call necessitates referral to another source, Network #15 staff members make every attempt possible to make accurate and expedient referrals to link the caller to the proper resource.

When dealing with issues that are under its quality of care purview, Network #15 encourages patients and facilities to work together toward reconciling differences and coming to an acceptable solution about matters called to the Network's attention, if the matters do not involve serious care issues. Network #15 maintains a file of submitted complaints and Network staff members are always alert for signs of trends in concerns or complaints as to issue and/or location. Network #15 involvement in the grievance process, even at the "informal grievance" (complaint) level, includes, but is not limited to, discussions of the care disputes, interfacing with providers, and when appropriate, referral to various agencies or other sources of information.

The Director of Patient Services and other Network staff provided

ESRD Network #15

technical assistance to multiple facilities in 2006, a number of which had considered the permanent discharge of a patient. During these discussions, suggestions were made to facility administrators, head nurses, social workers, and physicians, concentrating on options for dealing with the challenging patient in order to prevent/delay patient discharge. Options included behavior contracting and shortened treatment time immediately following inappropriate behavior, as well as making referrals to deal with root causes of some inappropriate behavior, such as unaddressed or under-addressed substance abuse and mental health issues. Education and technical assistance were given concerning federal regulations governing patient discharge. Also, print and video resources for use to supplement staff in-services were suggested to facilities to aid in their dealings with challenging patient situations.

Network #15 acknowledges the CMS-funded Decreasing Patient-Provider Conflict (DPC) Program as an invaluable resource for conflict resolution in dialysis facilities, and promoted the use of the DPC Program by the following: sending all dialysis facilities the DPC Toolkits in October 2005; providing a recorded WebEx training session on the implementation of the DPC program for facility viewing from October 15 to May 15, 2006; conducting a series of three monthly DPC training follow-up conference calls from November 2005 through February 2006; and including an article on DPC in the facility newsletter, *Intermountain Messenger*.

During the first quarter 2006, in an attempt to provide additional facility information about solutions to difficult patient situations, the Director of Patient Services co-developed and co-presented with another Network PSC a session at the Southwest Nephrology Conference on February 24, 2006 in Phoenix, AZ on “Decreasing Patient-Provider Conflict: Barriers, Expectations, and Resources.” The audience was primarily Arizona facility administrators, nurses, and social workers, and the presentation highlighted risk factors for patient-provider conflict, noncompliance, the root of noncompliant behavior, and strategies to address it (Appendix J).

During 2006, Network #15 Quality Improvement and Patient Services staff members worked collaboratively with specific Network #15 facilities to improve care in those facilities, based upon patient complaints and concerns. Efforts were made to foster quality improvement activities in not only staff competency and patient safety, but also staff respect, dignity, and sensitivity issues stemming from previous patient complaints and/or State Survey Agency facility survey results.

Prior to 2006 to address the nationally rising trend of patient involuntary discharge for non-adherent behavior (non-compliance), the Network #15 Medical Review Board convened a subcommittee in 2003 to examine all relevant issues. The subcommittee and full Medical Review Board determined that a letter to all Network #15 providers should be sent addressing the issue and entreating all administrators to consider every option in dealing with problematic patient issues before considering patient discharge, and offering the Network as a resource to assist with attempts at problem resolution. This letter was sent to all facilities in December 2004 to provide facility direction in 2005. The subcommittee decided to then await the further resources of the Decreasing Dialysis Patient-Provider Conflict (DPC) toolbox, and will make additional recommendations to the full Medical Review Board when necessary. A copy of the MRB created document "Guidelines for Patient Discharge" was distributed to all facilities in 2006 (Appendix K).

Since the inception of the monthly Patient Activity Report (PAR) on April 1, 2004, which mandated facilities to provide data to Networks regarding involuntary patient discharge, the Director of Patient Services has reviewed the circumstances of all reported patient involuntary discharges by calling the facility administrator of each facility involved. All 2006 involuntary discharges, unless previously discussed with the facility, were audited in this fashion. Results were trended by facility, state, and patient demographics, for review by both the Network Medical Review Board and Board of Directors. In 2006 the Network MRB convened a subcommittee to examine Network statistics regarding complaints, grievances, and involuntary discharges using the methodology of rates of occurrence per thousand patient-years. In this fashion, facility- and state-specific rates could be calculated and compared to the overall Network rates.

The Network staff continues to provide a patient-centered problem resolution process at the entry level of a complaint, thus potentially decreasing the number of concerns that escalate into formal grievances.

As reported using the SIMS Aggregate Contact Information for Network #15, in 2006 there were 460 total Contacts (note: a Contact represents a call lasting 5 minutes or longer. Calls under five minutes in duration are tabulated separately). An attachment (Appendix L) to this Annual Report summarizes the Contacts entered into SIMS in the year 2006, profiling all data using the 18

ESRD Network #15

standard SIMS categories of Areas of Concern (e.g., Treatment Related/Quality of Care, Staff Related, Patient Transfer/Discharge, Abusive, Disruptive, Non-Compliant).

In 2005, there was one formal grievance filed. The issue concerned the appropriateness of medical care and supervision of a hemodialysis patient with an infected catheter. This grievance continued into 2006 due to the complicated nature of the situation and the numerous entities that required contact for information. This formal grievance was processed utilizing the Network #15 Grievance Protocol. The Network Project Officer was kept informed of the progress throughout the process.

To summarize Network #15 grievance activity for 2006:

Total number of formal grievances received in 2006: 0

Total number resolved (“resolved” meaning: “the complaint or grievance has been explained, corrected, or settled by the Network so that the complainant is in agreement with the determination or outcome”): 1 (received in 2005)

Total number processed and closed, but unresolved: 0

Total number referred: 0

Status of grievance(s): 1 facility continued in an Improvement Plan through 2006.

- E. Improve collaboration with providers to ensure achievement of the goals through the most efficient and effective means possible, with recognition of the differences among providers (e.g., independent, hospital-based, member of a group, affiliate of an organization, etc.) and the associated possibilities/capabilities**

1. *ESRD Facilities/Providers*

Developing and maintaining cooperative and constructive relationships with the facilities within the Network is the MRB’s approach to its responsibilities for continuous quality improvement. The MRB’s philosophy is to meet CMS mandates by implementing programs that provide both the Network and facilities with useful information about the ESRD care being delivered, programs that are least burdensome and most easily carried out within the existing practices of facilities, and those that maintain and improve, where possible, the quality of patient care.

Network #15 provided education for dialysis providers on the tools and techniques of CQI, as well as mentoring for individual QI projects was provided in various venues within Network #15. Some examples of activities conducted with Network facilities and providers in 2006 follow:

- Educational material concerning continuing quality improvement including the Network Electronic Data Project, the National CPM Project, USRDS and KECC-generated, facility-specific reports such as Standardized Mortality Rates, Standardized Transplantation Rates, Standardized Hospitalization Rates, as well as additional quality improvement materials as directed by the MRB or BOD.
- Educating dialysis providers on the tools and techniques of Continuous Quality Improvement.
- Broadcast fax to all facilities in Network #15 to alert them of pressing issues.
- Information was sent to pediatric renal facilities in Network #15 to invite their participation in the Fall Pediatric Renal symposium sponsored by Network 9/10.
- Network #15 staff members have worked collaboratively with specific facilities to improve care in those facilities, based on patient complaints/concerns or State Survey Agency reports. There were efforts to foster quality improvement efforts in staff competency/conduct and patient safety issues, providing the facilities with specific suggestions and provision of material, as needed.
- Network goals and objectives are distributed annually. They were included in the administrative “Annual Update” (Appendix A), which was sent to all facilities in December 2005.
- Vocational Rehabilitation data are requested from facilities annually. All Network #15 dialysis facilities were sent the survey in March 2006. Please see Table 8.
- A separate mailing from the Vocational Rehabilitation survey was the Vocational Rehabilitation Resource Packet, sent to all facilities in December 2006.

ESRD Network #15

- The Executive Director, Director of Quality Improvement, and/or the Director of Patient Services send an administrative update on current issues, with help from the Administrative Assistant, as necessary.
- The Network provided facilities with information concerning advances in ESRD technology and treatment, to encourage the use of medically appropriate treatment settings most compatible with patient rehabilitation.
- Network #15 staff provides “Network Updates,” in the form of face-to-face meetings or conference calls to facilities upon request.
- Information sent out as a clearinghouse function came primarily from federal sources (regulations, federal register issues, FDA, CDC, OSHA) to which facilities have limited access. The Network did not disseminate material that is published in renal journals because all facilities receive several of these journals.
- Network #15’s ICH-CAHPS quality improvement pilot program activities in 2006 focused on receiving facility pilot data collection results, working with the one chosen Network #15 facility to select targets of quality improvement activities, and assisting the facility by conducting patient interviews by Network staff and compiling the resulting data in a useful manner (including Pareto charts) for the facility. Technical assistance has been given the facility regarding the implementation of changes and re-measurement activities.
- There are periodic regional meetings of nurses, dietitians, social workers, physicians and administrators facilitated by Network #15, as necessary and appropriate to discuss advances in the field and issues of mutual concern.
- The Network updated its Dialysis Facility Compare web site poster and instructions and distributed them to all Network #15 facilities letting patients and unit staffs know how to access the site and the types of information available on it. These posters (and black and white paper version for copying) included easy-to-read directions and screen shots to assist patients in navigating to and through Dialysis Facility Compare (Appendix M).

- A letter to administrators of new facilities, as well as a reminder letter to administrators of existing facilities was sent in 2006 requesting the display of the previously sent laminated poster in English and Spanish entitled *Have a Problem? (Tiene algun Problema?)*, with suggested steps for problem resolution within a facility and external resources specific to each Network #15 state. Facilities were requested to post the document on a patient bulletin board or another appropriate location.
- All dialysis facilities were sent the *Decreasing Dialysis Patient-Provider Conflict (DPC)* toolkits in October 2005, and were notified of a pre-recorded WebEx training program on the implementation of the DPC program. This WebEx resource was available November 15, 2005-February 15, 2006. Facilities were also notified of a series of monthly follow-up telephone conference calls to field questions about the implementation (or problems with the implementation) of the DPC program. These calls began on December 8, 2005 and extended into 2006 on January 10 and February 8, 2006.
- Dissemination of clearinghouse information was accomplished in the following ways:
Information that needed immediate dissemination to facilities was mailed directly to the appropriate facility personnel through issuance of a Network administrative newsletter. Small news items that did not demand immediate dissemination were saved up and sent at one time in order to conserve resources. The timing of the newsletter depends upon the occurrence of events. Items, which are deemed to be of high priority, are faxed to the appropriate people.

2. ESRD Networks

Network #15 is an active member of the Forum of ESRD Networks. The Network Immediate Past President served as Vice-President of the Forum Board of Directors. The Network Executive Director was asked to fill an “at-large” Forum BOD position upon the resignation of another Executive Director. Network #15 participates in Forum activities and contributes to Forum projects. Network #15 staff members value the relationships that have been forged with other Networks’ staff members and utilize these relationships as valuable resources in

ESRD Network #15

Network activities. Network #15 distributes newsletters, project reports, and Network #15-created resources to other Networks.

On an ongoing basis, Network #15 staff members provide consultation, technical assistance, or give actual Network #15 work products to members of other Networks who have contacted Network #15 seeking help with an issue.

The Quality Improvement staff has made efforts to assist new Quality Improvement Directors from other Networks in their daily activities. More specifically Network #15 has shared examples of Fistula First resources; letters, Internal Quality Improvement plan and CPM plan with other Networks.

When the ESRD Network #17 contract was awarded to Network #15, the Network #15 staff began to mentor the new staff to allow for a smooth transition and support through the transition period and the start up of the new organization.

The Data staff has fielded questions from many of the other Networks concerning VISION and now CROWN Web. Network #15 has shared educational resources developed and has worked collaboratively with other Networks on a variety of proposals sent to CMS.

The Director of Patient Services has worked collaboratively with the Patient Services staff members of other Networks and has volunteered to serve on a subcommittee to deliberate patient depression issues for core data set purposes. Specifically during 2006, The Director of Patient Services provided consultation with other Networks about the following issues: vocational rehabilitation facility mailing format, tracking complaints and grievances, and complaint and involuntary discharge profiling. She also co-facilitated a session of the annual Patient Service Coordinators summit meeting regarding patient involuntary discharges and underlying mental health problems. The Director of Patient Services for Network #15 provided orientation and direction for the new Network #17 Director of Patient Services.

3. *State and Regional Office Survey Agencies*

The six states in Network #15, Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming, relate to their six respective state health departments and to three Regional Offices (RO VI - Dallas, RO VIII - Denver, RO IX - San Francisco). In addition, RO X in Seattle provides program oversight for the Network #15 program.

Historically, Network #15 has had a cooperative relationship with the state survey agencies in its six-state area. Individuals in each of these six state agencies and three regional offices have frequent contact with the Network staff. The ESRD technical expertise of the Network is always available to these agencies. Network #15 routinely participates in the quarterly San Francisco Regional Office conference calls (ROSAN) to discuss areas of concern for that CMS component.

Internal Quality Improvement (IQI) efforts by Network #15 continued to focus on improving communication between the Network and the various Departments of Health with which the Network interacts. As part of this effort, Network #15 provides each state health department with the *Annual Clinical Performance Measures Report*, Network newsletters, Network-specific data and other informational mailings. The Network QI staff has also presented Network Updates and Fistula First information to DOH representatives of each state during 2006. These updates were provided during conference calls, web-ex sessions, mailings and/or face-to-face presentations.

Network #15 has developed and maintained a cooperative relationship with the government agencies that work with renal providers. These include the Survey and Certification Branch staffs of the three Regional Offices that cover Network #15 states as well as the individual state health department surveyors in the six states. Cooperative activities during 2006 included reciprocal information sharing and joint problem solving:

- Network staff referred a number of patient/family/other concerns that involved survey and certification issues to State Survey Agencies and received requests of information from the State Survey Agencies.
- Quarterly ROSAN conference calls to discuss areas of concern for the states covered by the San Francisco Regional Office (AZ, NV)
- Network #15 provided a packet of information to each agency regarding the Network's information on the Pandemic Influenza activities
- Several Network staff members collaborated with various State Survey Agency personnel regarding facility quality improvement issues following facility surveys.

- The Network maintains a current list of contacts for each of the six Departments of Health within Network #15.

4. *Quality Improvement Organizations (QIOs)*

Relationships for on-going ESRD-related studies have continued with the five Quality Improvement Organizations (QIOs), Colorado Foundation for Medical Care (CFMC) in Colorado, the Health Services Advisory Group (HSAG) in Arizona, the New Mexico Medical Review Association in New Mexico, Mountain-Pacific Quality Health Foundation in Wyoming and HealthInsight, the QIO for Nevada and Utah.

In December 2005 the Network coordinated and sponsored a coalition meeting that was held in Denver, Colorado. This coalition began examining the issue of pre-dialysis access placement and early identification of CKD patients. The coalition meeting included QIO representatives from all six states in Network #15, Network #15 staff, a nephrologist, a surgeon a PCP and nurse educators from 2 of the corporate dialysis companies that have facilities in the Network. The meeting resulted in the formation of the Dialysis Access-Chronic Kidney Disease Coalition (DA-CKD). Two sub-committees, a Provider Advisory Committee (PAC) and a Beneficiary Advisory Committee (BAC) continue work in this area. Every QIO in the Network area continued to be active in this coalition throughout 2006

5. *The Renal Community*

Network #15 continues to recognize the importance of developing and maintaining cooperative relationships with the renal community in its area. Network #15 has made a determined and ongoing effort to coordinate its activities with other renal-related organizations and has participated in a variety of joint activities. Network #15 has worked with both the National Kidney Foundation (NKF) and the American Association of Kidney Patients (AAKP) to avoid duplication of service to patients in the Network area.

Network #15 continued to work with the American Nephrology Nurses Association (ANNA) and the NKF to help provide annual educational opportunities for nephrology nurses and technicians, renal dietitians, renal social workers and nephrologists. The Network Director of Patient Services is a member of the NKF Council of Nephrology Social Workers. The Executive Director is a member of the Board of Directors for the NKF affiliate in Denver, CO. Many members of the Network BOD and MRB are active in their local NKF. During 2006, Network #15 staff members attended national meetings of ANNA and RSN. In 2006, the QI Director

ESRD Network #15

and the Executive Director continued to serve on the advisory board of one of the fiscal intermediaries that serve Network #15 states. The Director of Patient Services continued to serve on a Technical Expert Panel for the purpose of designing an instrument to measure the consumer's perspective of health care quality in ESRD (ICH-CAHPS survey).

- Network #15 has encouraged and helped to facilitate statewide and regional councils for the various professional groups. These groups include nephrology nurses, social workers, dietitians and renal physicians. Network staff has made presentations at some of these meetings.
- The Organ Procurement Organizations (OPOs) receive general Network mailings and are invited to attend Network educational meetings.

Network #15 maintains a cooperative relationship with the following renal organizations that are active in its six-state area:

- Arizona Chapter of the NKF
- NKF Chapter serving Colorado and Wyoming
- New Mexico Chapter of the NKF
- Utah Chapter of the NKF
- Phoenix Chapter of AAKP
- CNSW Chapters in Arizona and Colorado
- ANNA Chapters in Arizona, Colorado, New Mexico, and Utah.

Below is a summary of specific Network #15 community outreach activities:

- Information and referral to facility staff (telephone, e-mail or written inquiries).
- Information and referral to patients/families/advocates (telephone, e-mail, or written inquiries).
- Information and referral to members of other renal organizations (telephone, email, or written inquiries)

ESRD Network #15

- Network #15 continues to participate in the ESRD Networks' Clearinghouse New Patient Packet project, updating information as necessary. The clearinghouse office mails this packet to all new patients for whom a 2728 has been received in the previous month. This project began September 2000.
- Network #15 mails a packet of Network-specific information directly to each new patient in its six state area. In 2006 its contents included: the Network #15 brochure; *Dialysis Keeps People with Kidney Failure Alive...Are You Getting Adequate Hemodialysis?*; the Network #15 Patient Grievance Protocol; the "Network #15 Statement of Patient Rights and Responsibilities;" and the *Renal Roundup* patient newsletter, and the National Kidney Foundation brochure "*Working with Kidney Disease*;" The contents of this packet were altered to complement those of the national mailing and to avoid duplication of material. A total of 4,509 Network #15 facility-specific new patient packets were mailed to incident patients in 2006.
- The Network #15 patient newsletter, *Renal Roundup*, was published in December 2005 with the importance of fistulas as vascular accesses being its main focus. Understanding Medicare Part B and general information about Network #15 was also discussed. It was sent to Network #15 facilities as well as being included in Network #15 New Patient Packets in 2006, referenced above.
- The Network #15 *Statement of Patient Rights and Responsibilities*, included in all New Patient Packets (referenced above), is available in both English and Spanish. This Statement has been adopted by the American Association of Kidney Patients (AAKP) and has previously been used by another ESRD Network in its patient newsletter.
- The Network #15 newsletter for renal professionals, *Intermountain Messenger*, was published and distributed two times in 2006. Examples of article subject matter are as follows:
 - The successful Faithful Fistula Contest
 - Detailed Patient Activity Report completion instructions
 - Albumin Rates within Network #15
 - Network #15 transplant facility list
 - "The Black Ribbon Campaign", a Network #15 facility QI project focusing on raising patient awareness about the prevalence of missed treatments and the consequences of missed/shortened treatments

- Network #15 has maintained a toll-free phone number for use by patients (1-800-783-8818) for many years. A second number (1-888-777-0105) was added in 2004. These numbers are included in the letter accompanying the Patient Orientation Package sent out by the Network's Clearinghouse Office, as well as on Network materials designed for patients. This number is listed on the Patient Resources section of the Network's Web site.

6. *Coalitions/Special Projects*

Dialysis Access/Chronic Kidney Disease Coalition

During the second option year of the 2003-2006 SOW, the Network assisted in the organization of a coalition whose focus was Dialysis Access and Chronic Kidney Disease (DA/CKD). Throughout 2006, the Network continued to work with this coalition to focus on early identification of CKD patients and early access placement. The DA/CKD coalition is composed of members from the nephrology community, QIO representatives from all six of the states within Network #15, patients, CKD educators and others. Through the work of the coalition, two workgroups, the Provider Advisory Committee (PAC) and the Beneficiary Advisory Committee (BAC) the Network hopes to continue to see an increase in prevalent AVF rates. Work accomplished by the coalition in 2006 included:

- A draft of a "GFR message" that after the review and approval of the CMS Project Officer, was provided to AARP for inclusion in their regional newsletters
- A CKD fault tree analysis, and a "Fault Tree Analysis" web-ex, which, was provided to Network participants from across the country by a DACKD coalition member
- The patient organization, Renal Support Network (RSN) and the BAC worked on a public service announcement that will assist in educating patients to ask for a GFR when visiting their doctor
- The PAC group began work on physician profile reports and at the end of 2006, the QIO who volunteered to analyze the data was still awaiting its arrival from CMS
- The Director of Quality Improvement and a coalition representative from the New Mexico QIO provided booth support for a surgeon meeting held in New Mexico in September 2006
- BAC members began work on an environmental scan that will be sent to organizations such as: AAKP, NKF, AKF, and RSN etc. This scan will help the group identify the organizations' educational resources, what type of patient/family support is offered, their target groups and geographical areas covered

Barriers to Outpatient Admission Dialysis Placement Project

ESRD Network #15

In 2005 Network #15 agreed to participate in the “Barriers to Outpatient Admission Dialysis Placement Project,” coordinated by Network 9/10. Activities in 2006 included a conference call among collaborative partners, and Network #15 staff members collecting data on patients in Network #15 who had dialysis facility placement issues, due to either special medical requirements (e.g., tracheotomy, bariatric patient, etc.) or behavioral issues (e.g., previous abusive behavior resulting in involuntary patient discharge from outpatient dialysis facility). The project is anticipated to extend three years, with an optional fourth year.

Safe and Timely Immunization Coalition-STIC

During 2005 Network #15 was invited to join Networks #6, and #11 as a partner in the Safe and Timely Immunization Coalition (STIC) project, aimed at improving immunization rates for patients at dialysis facilities. This project continued through 2006. The Executive Director and Director of Quality Improvement have participated in numerous conference calls for the project with more than 37 other members of the coalition (CDC, Corporations, CMS, State Survey Agencies, and Networks). The final results of this collaborative effort will be to develop guidelines for immunization that are specific to patients with ESRD, provide a toolkit of educational materials for facilities to use to improve their immunization rates, produce an immunization practice patterns survey and formulate an immunization data collection tool and feedback reports for facilities. Activities conducted in 2006 included:

- Network #6 received approval from the CMS Data Collection committee for the survey and data collection effort. During the second quarter 2006, two CMS approved STIC Surveys were sent to chronic hemodialysis facilities. The first Survey attempted to capture information related to the facility’s immunization practices, beliefs, and attitudes coinciding with behavioral sciences’ Health Belief Model. Network #15 received a response rate of approximately 94%. The second STIC Survey collected patient-specific vaccination information.
- The Network #15 staff assisted in the collection and review of resource materials for an Immunization Tool Kit. Each facility in Network #15 received these resource materials in the second quarter 2006.
- The Network #15 staff provided input on the new CDC “Guidelines for Immunization Kidney Dialysis Patients and Patients with Chronic Kidney Disease” (Appendix A).
- The Quality Improvement Directors from ESRD Networks #6, #11 and #15 worked together with Network #15’s biostatistician to develop the facility-specific immunization feedback reports that will be distributed to facilities upon completion of the data analysis which is anticipated to occur early in 2007 (Appendix N).

ESRD Network #15

- The Director of Quality Improvement assisted in the development of a sample standing order format for influenza vaccination, which was shared with Networks #6, and #11 and the STIC intervention workgroup (Appendix N).
- The Director of Quality Improvement drafted a letter of endorsement for the STIC project in conjunction with the Network #15 MRB. The letter will be disseminated with the facility-specific immunization reports in early 2007. The QI Director shared the letter of endorsement with the Executive Director for Network #6 and the QI Director for Network #11, with permission to use if they so chose (Appendix N).

National Disaster Coalition

Network #15 continues to be an active participant in the National Disaster Coalition. Through the work with this coalition, the Network has added a number of resources for both facilities and patients to the Disaster Preparedness section of its website. As directed by CMS, the Network staff has collected two emergency contacts and two ways to reach those contacts for each facility within the Network. This information is contained within the Network's Emergency Preparedness Plan. Network #15 participated in the mock disaster drill directed by Network #7 in June 2006.

Other outreach activities:

- Responding to requests for data from entities outside Network #15: All Network staff, but usually the Director of Information Systems, Executive Director, Director of Patient Services or Director of Quality Improvement respond to a wide variety of agencies, individuals, and groups. Network #15 may collaborate with other agencies to furnish the requested information.
- Network #15 works with directors of the state Diabetes Control Programs for five of the six states in the Network, sharing information regarding diabetes-related ESRD in the Network. A special report was designed to identify age-stratified incidence and prevalence of diabetes-related ESRD in Network #15 states (Appendix O).
- Permission was given to the Life Options Rehabilitation Advisory Council to use Network #15 Employment Facilitation Letter templates in its revised *Employment: A Guide to Work, Insurance, and Finance for People on Dialysis*.
- Network #15 staff participate on various list serves, and respond,

ESRD Network #15

as appropriate, with information other participants are requesting.

- Network #15 staff participated in a phone call with the Medical Education Institute (MEI) to discuss collaborating in a future needle fear project.
- At the direction of CMS, Network #15 contacted multiple individuals and organizations within its six states to gather information regarding preparation for the possibility of the pandemic flu. Responses were forwarded to CMS Central Office and the Network Project Officer. Resources continue to be collected for dissemination to all Network #15 providers and other interested parties. Pandemic flu information and links have been added to the Network #15 website.
- The Director of Patient Services prepared information on the Medicare Prescription Drug program collaboratively with the National Kidney Foundation Medicare Modernization Program staff, as well as staff from CMS Region VIII office. This information was disseminated to all Network #15 facilities.
- The Dialysis Access/CKD Intermountain Action Coalition began in December 2005, from a meeting in Denver, Colorado convened by the Network and conducted by Tom Wolff. Network #15 nephrologists, nephrology nurses, and QIOs attended. The ultimate goal of the meeting was to plan strategies aimed at increasing Arteriovenous Fistula (AVF) rates in incident patients across Network #15's six states. The focus included early identification of CKD patients to allow for appropriate treatment of CKD (prevent progression), and education of patients and timely and appropriate dialysis access placement. Two committees have been formed: the Provider Action Committee (PAC) and the Beneficiary Action Committee (BAC). These committees have addressed increasing fistula placement from the perspective of each group. There were monthly conference calls for each group, and additional partners, including patients, recruited for the BAC. A second face-to-face meeting of the Provider Action Committee was held in Denver, CO in December of 2006. Details of additional DA/CKD Coalition activities may be found in section E.6. above.

7. Professional Education Program Attendance/Networking

Ongoing education and networking is a vital element to Network #15.

Meetings hosted/presentations made by Network #15 staff:

- “On Course with Cannulation” workshops to facilities in Nevada, New Mexico, and Colorado January through December 2006.
- Southwest Nephrology Conference Phoenix, AZ, February 24-25, 2006, the Network sponsored a half-day presentation, by Dr. William Jennings (from the University of Oklahoma, Tulsa) titled, “Overview of Vascular Access.” This presentation was attended by area Nephrologists, Surgeons and local facility staff.
- During the summer of 2006, Network #15 coordinated an educational offering and collaborative effort between Network #15, Network #16, a corporate dialysis company, ANNA and patients. The offering was presented to facility personnel and patients in the Albuquerque, New Mexico area. Segments of the presentation included: OCWC, Physical Assessment of Vascular Access and the Buttonhole Technique.
- In October of 2006, Network #15 sponsored four sites for the ANNA Audio Conference Call: *New Vascular Access Guidelines from K/DOQI*, presented by Leslie Dinwiddie.
- December 11, 2006, the Network sponsored an anemia web-ex by Patricia McCarley RN, to update facilities of the new K/DOQI anemia guidelines. The presentation is posted on the Network #15 website for those who were unable to attend.
- QA and QI for Dialysis Providers presentation at the Annual Dialysis Conference, February 28, 2006, San Francisco, CA.
- “Decreasing Dialysis Patient/Provider Conflict: Intermountain ESRD Network #15 Training on the Implementation and Use of the DPC Toolbox pre-recorded WebEx, posted on Internet site until May 15, 2006, as well as three Network-facilitated monthly DPC discussion calls for facility staff in December 2005, January 2006, and February 2006.
- Exhibited the Fistula First poster and distributed surgical DVDs at the General Surgery and Trauma Update in Albuquerque, NM in September 2006. This meeting was by invitation from the New Mexico Medical Review Association.
- The Network Data Staff hosted and moderated six calls with facilities that covered different data related topics.

Publications/Posters:

ESRD Network #15

- Dialysis Facility Compare Poster and Instructions, March 2006
- Poster: CMS/Network Meeting: ICH-CAHPS Collaborative Process, April 2006

Meetings/conference calls attended:

- CMS and ESRD Network ED, QID, and PSC conference calls, monthly through 2006
- LDO Monthly Meeting conference through June 2006
- Data replication issues conference call February 2 and 21, 2006
- CMS Ombudsman Open Door Forum conference call, February 15, 2006
- Participated in Patient Services Coordinators quarterly conference calls
- Attended Quarterly Data Managers Conference calls
- Improving QualityNet Exchange for VISION users, February 16, 2006
- Southwest Nephrology Conference 2006 Phoenix, AZ, February 24-25, 2006
- Participated in monthly CROWN and CRAFT conference calls
- Participated with other Quality Improvement Directors in the QID Conference calls quarterly
- Participated in multiple Fistula First Conference calls throughout 2006
- COGNOS Beta Testing conference calls, January 4, 12, 18, 25, February 1, 8, and February 15, 2006
- Forum BOD and Administrative Committee conference calls throughout the year
- Numerous ICH-CAHPS calls through September 2006
- Decreasing Dialysis Patient/Provider Conflict (DPC) Conference Calls, January 10, 2006 and February 8, 2006
- MRB-Patient Advisory Committee vascular access conference call, January 17, 2006
- MRB Self-Care Subcommittee conference calls throughout 2006
- Alternatives to Email Archive Location conference call, January 31, 2006
- Chronic Kidney Disease Coalition Focusing on Vascular Access, multiple PAC and BAC phone calls monthly through 2006
- Medical Review Board Meeting, February 23, 2006, Phoenix, AZ and September 8, 2006, Denver, CO
- Network #15 Project Officer and Science Officer Annual Evaluation Site Visit, March 15-16, 2006
- Western Consortium Executive Director/Project Officer calls

ESRD Network #15

- monthly April through December 2006
- Monthly 2007 Southwest Nephrology Conference Planning Committee calls
- CMS/Forum of ESRD Networks' Annual Meeting 2006 Baltimore, MD, April 3-7, 2006, Planning Committee calls
- Participated in annual Patient Services Coordinators meeting, Baltimore, April 3, 2006
- Barriers to Admissions Special Project calls as scheduled through 2006
- Partnership Calls (National Coalition calls with Tom Wolff) throughout 2006
- Network-specific "check-in" calls with Tom Wolff monthly
- National Disaster Coalition Workgroup call
- Medicare Preventive Services conference call, May 24, 2006
- Forum CMS 2007 Planning Committee call, May 25, 2006
- Maximizing Microsoft Outlook 2003, May 25, 2006
- Collier Hospice Center welcome and opening, June 22, 2006, Denver, CO
- Seattle Regional CMS Office meeting, July 2006
- NKF of Colorado, Wyoming and Montana Board of Directors Meeting monthly June through December 2006
- Safe and Timely Immunization Coalition Meeting, July 13-14, 2006, Atlanta, GA
- Multiple Fistula First Breakthrough Initiative workgroup calls
- Numerous conference calls regarding the Network #17 transition August-September 2006
- Numerous Safe and Timely Immunization Coalition conference calls through 2006
- Special Open Door Forum Conference call: Medicare Compliance and Conditions of Participation for Transplant Centers, September 1, 2006
- Quarterly ROSAN calls with the San Francisco RO and the Dallas RO
- Multiple Western Network Consortium Disaster Collaboration calls
- ICH-CAHPS Meeting, September 21, 2006, Baltimore, MD
- Change of Ownership and Management Conference call, October 4, 2006
- ESRD Measures TEP Meeting, October 11-12, 2006, Baltimore, MD
- ESRD Networks Base Contract WebEx sessions, October 20, 27, and November 3, 2006
- Vascular Access Lab visit, November 9, 2006
- OSCAR Training, Seattle CMS RO, December 5, 2006

ESRD Network #15

- Quality Infrastructure Data Management Workshop, December 11-12, 2006, Baltimore, MD

8. *Newsletters*

Written media continues to be an effective method of disseminating information to both the professional and patient members of Network #15. Network #15 published three newsletters to keep the members of the Network up-to-date on important issues.

- *Intermountain Messenger*, the Network #15 professional/administrative newsletter, was distributed to all Network #15 facilities, Network Council members, Network Committees, state health departments, NKF chapters, and other interested parties during 2006 (Appendix P).
- *Renal Roundup*, the patient newsletter, is published periodically as an information-sharing resource for the patients in Network #15. The 2005 issue, published in December, focused on the importance of AV Fistulas, with articles from the patient perspective as well as from a professional viewpoint. The *Renal Roundup* also provided information about and additional references for understanding the new Medicare Part D. This issue continued to be utilized in Network #15 facility-specific new patient packets through 2006. An additional issue of *Renal Roundup* was published in 2006 with a focus on transplantation (Appendix E).
- *Data Notes* is a section of the *Intermountain Messenger*. This recurring column clarifies CMS forms requirements and assists facilities in the accurate reporting of patient events and the processing of Medicare paperwork.

9. *Web Site*

The Network #15 web site, www.esrdnet15.org, was updated regularly in 2006 to keep information current and to increase the amount of material available for both Network #15 patients and Network #15 professionals. Additional resources addressing emergency preparedness and the pandemic flu were added in 2006. The number of visitors both new and returning continues to increase from year to year. In 2005 there were a total of 309,553 hits to the web site during 25,918 user sessions. In 2006 these numbers increased to a total of 483,152 hits to the Web site during 33,941 user sessions. The Network web site is checked for compliance with CMS regulations semi-annually.

10. *Facility Directory*

Network #15 maintains a current Facility Directory and roster of renal professionals by category (physicians, administrators, nurses, dietitians, social workers) for use within the office. Traveling patients, renal vendors, and other interested individuals requesting information are provided with a directory of facilities by city and state as requested. Directories are created as needed to include the name, address, telephone number, type of facility and services provided for any facility in the area about which the individual is inquiring. These reports/directories can be e-mailed or mailed to individuals as requested. The Network no longer publishes an annual Facility Directory. Individuals are also referred to Dialysis Facility Compare.

F. Improve the Collection, Reliability, Timeliness and Use of Data to Measure Processes of Care and Outcomes; Maintain Patient Registry; and to Support the ESRD Network Program.

1. Description of Network Data System

In 2006, the Network #15 data system was comprised of a CMS leased server, a Network #15 server, and desktop workstations. The Network #15 CMS server was connected to the SIMS Central Repository and to the Internet through the GSS firewall. All Network #15 communication/connectivity software/hardware and protocols met CMS/QualityNet regulations and requirements for ERB approval.

All patient tracking, facility information, and Medicare required forms were entered into and saved in the Standard Information Management System (SIMS) database. Network staff members continued to work with facilities in the use of the Vital Information System to Improve Outcomes in Nephrology (VISION) software. VISION facilities entered forms and events, and transmitted that information through the facility-based software program and QualityNet Exchange, the secure Web-based file transfer program maintained by the Iowa Foundation for Medical Care (IFMC). Information was then downloaded from QualityNet and imported with varying success into SIMS. In 2006, a total of 688 files from 10 of Network #15's facilities were downloaded from QualityNet and imported into SIMS.

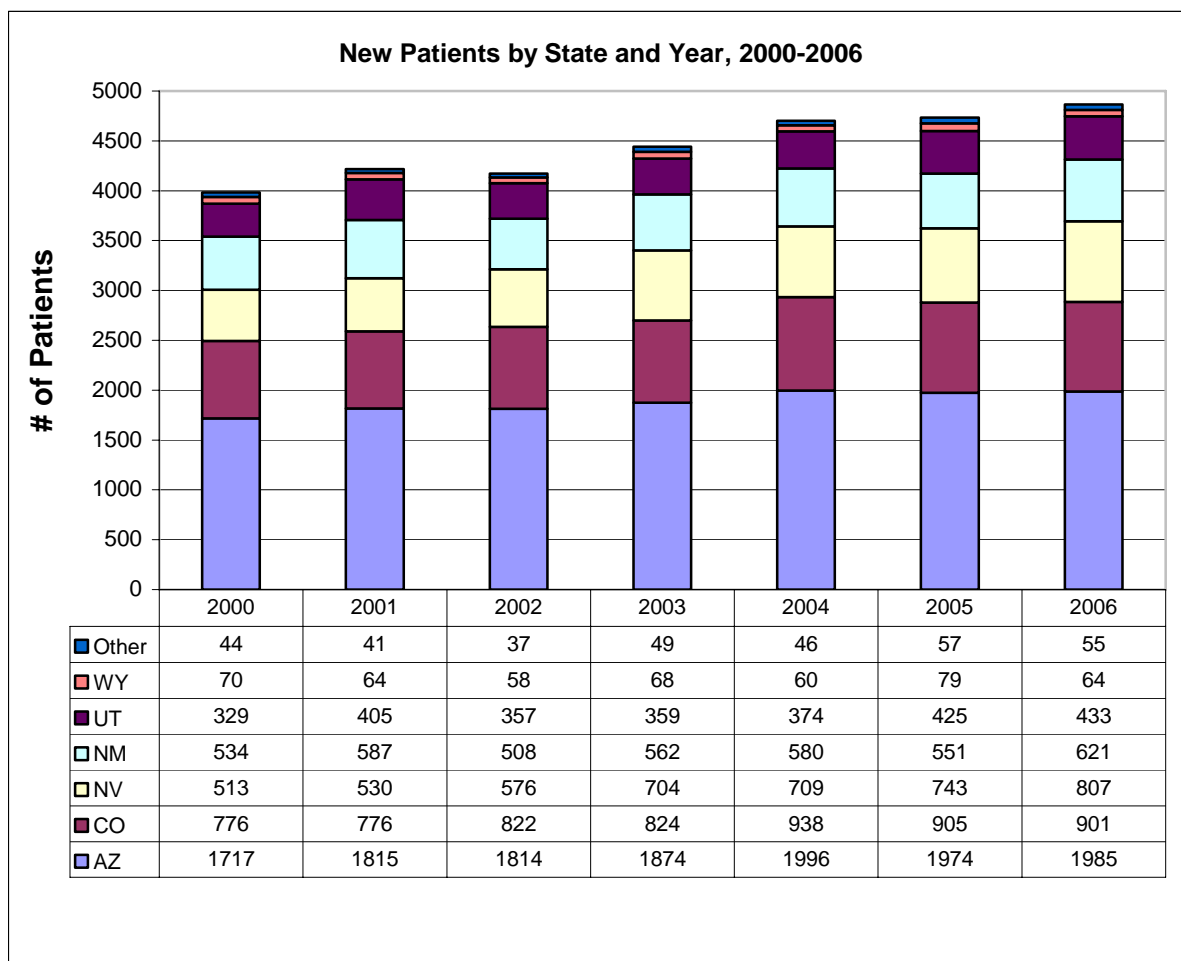
All SIMS files and tables were backed up on a nightly basis. Replication of all SIMS information to/from the Central Repository and to/from other Networks took place nightly through the SIMS replication process. A daily log was kept of all back ups and replications as well as a log of required maintenance on the server. All other programs and files were backed up nightly on the Network #15 server. All accounting information was backed up on tape drive on the second network.

ESRD Network #15

The following forms were received, validated, logged, and entered into the Network #15 SIMS database: CMS-2728, CMS-2746, monthly Patient Activity Reports (PARs), Network #15 patient event notifications, quarterly roster corrections, and the CMS-2744. Incomplete forms were returned to facilities for correction and completion.

In 2006, 5,180 CMS-2728s and 3,205 CMS-2746s were entered into the SIMS data system and replicated to the Central Repository.

The following table illustrates the increase in the number of new-patient 2728 forms by year in Network #15. In addition to the initial patient forms, 2728s are submitted for patients who have been off dialysis for over a year and then return to dialysis (recovered function/restarted); for patients who start on in-center dialysis and then switch to a PD modality in the first three months of treatment (supplemental training form); and for patients who must go back to dialysis more than three years post transplant. These are not reflected in the following table.



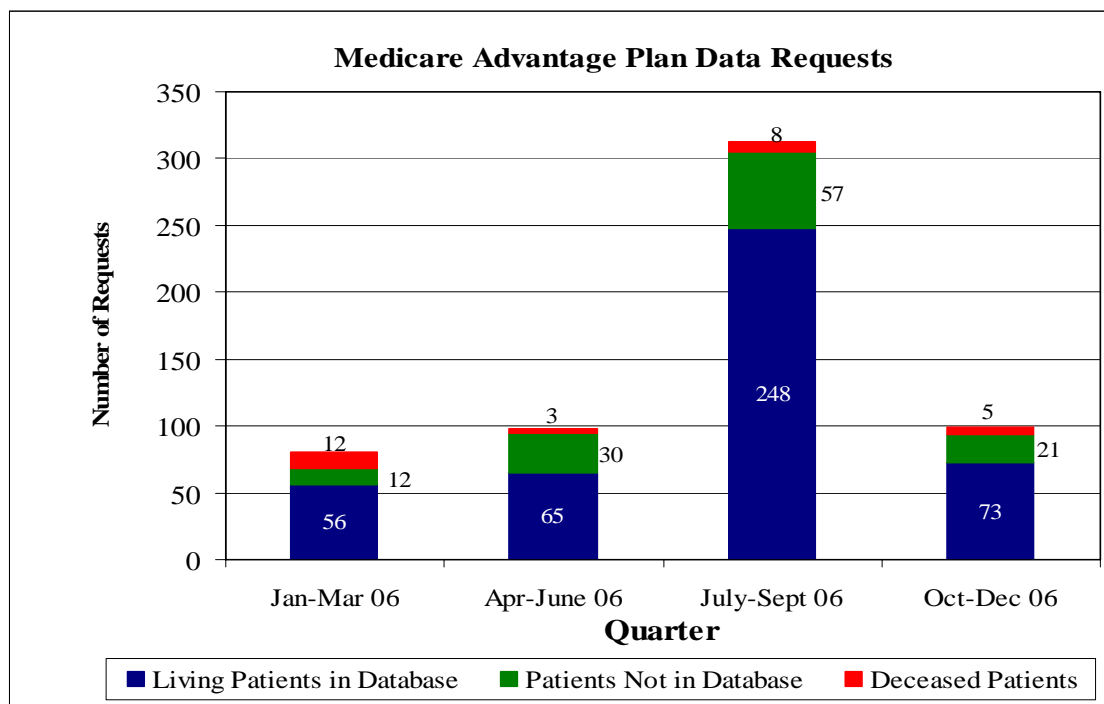
ESRD Network #15

Facility-specific information was updated on an ongoing basis to facilitate monthly transmission of information for Dialysis Facility Compare.

Notifications are processed weekly using the SIMS notifications utility. Twice a month, any notifications that need verification by the patient's facility are included in a report that is sent to any facility with outstanding notification issues.

The 2005 Facility Survey (HCFA-2744) was completed as required in April of 2006. As part of the Network #15 Internal Quality Improvement Initiative, the strategy continues to be "tweaked" as necessary to facilitate smooth, accurate collection of all necessary information. All Annual Report tables for 2005 were generated through the SIMS system in April and May of 2006.

The number of Medicare Advantage verification requests has increased since 2004. The number of requests had declined from 2000-2003 due to efforts made by CMS to help Medicare + Choice organizations streamline their request process. However, over the past couple years when asked about the increase in requests, HMO's replied that they are completing some "cleanup" of old, outstanding records. In 2006, Network #15 was asked to verify ESRD status for 590 patients, slightly higher than the 518 status verifications in 2005, and the 474 status verifications in 2004. However, this increase needs to be tempered by the number of requests in 2001 (1,697) and 2000 (1,524).



2. *Report Capability*

The SIMS system now produces most of the reports needed by CMS and the Network. The programs most commonly used to generate additional reports for use by Network staff were ISQLW, Microsoft Access, and Crystal Reports. Complicated reports for specific cleanup activities or QI activities are created by a consulting programmer who utilizes SAS. Staff members continued to create additional queries on a daily basis that assist Networks with their day-to-day work.

Semi-annual forms compliance reports for 2006 were generated using the SIMS utility. Facility aggregated reports were submitted to the Project Officer in October of 2006 (for forms submitted in the first half of 2006), and then in March of 2007 (for all forms submitted in 2006). Facility reports with patient-specific information were mailed to facility administrators with appropriate cover letters based on compliance levels reached.

3. *Special Data Requests*

Most special data requests are for patient counts by zip codes. These reports are generated based upon SIMS data and are posted to the Network Web site. Other requests come from state Health Department Diabetes Control Programs, looking for cumulative demographic information on the Diabetes-related ESRD cases in each state.

ESRD Network #15

Facility information (location, hours, services) is provided in hard copy format upon request and all requestors are referred to the Dialysis Facility Compare (DFC) Web site for additional and more detailed information.

With the inclusion of much of Network #15 demographic information on the Network #15 Web site, there has been a slight decrease in the number of data requests received at the Network office.

4. Data Validation and Improvement Efforts

VISION Validation

Pursuant to CMS requirements, Network #15 conducted a validation of patient and physician signatures on the CMS-2728 forms received electronically through VISION. Three percent of 2728 forms per VISION facility (with a minimum of one form per facility) were randomly selected from all forms submitted electronically in 2006. These forms were then sent to the Network office. Two facilities submitted 2728 forms with signature dates prior to the date the form was printed. Because of this abnormality, the two facilities were required to provide evidence of patient and Nephrologist signatures on all 2728 forms submitted via VISION in 2006, and they have been banned from using VISION in the future.

Compliance

Compliance rates continue to rebound after the drop in the last half of 2005 due to the release of the new CMS-2728 form. In order to help facilities with compliance issues, the Network instituted the TOPIC (Telephonic Open Participation and Information Call) initiative, a series of monthly conference calls designed to improve the quality, accuracy, and timeliness of the data that the Network receives. TOPIC is an opportunity for facilities to gain valuable knowledge about CMS forms and requirements, and learn about the most common mistakes that the Network sees on these forms; it also gives facilities an opportunity to ask questions of the Network. During the fourth quarter 2006, the Network #15 Data Department held two TOPICs on compliance. All facilities were invited to attend the presentations but new facilities and new personnel were especially encouraged to participate. Also, facilities who were identified as failing to maintain an 80% compliance rate were required to attend.

Alpha Testing

Network #15 and three of the Network's dialysis facilities began testing the CROWNWeb system on November 30, 2006. CROWNWeb is the next generation of data collection software for the ESRD program, and

ESRD Network #15

will transform the current CROWN *Application Suite* (VISION, SIMS, and REMIS) into a single Web-based *Application*. Also, rather than Networks being the owners of the data, facilities would take over that responsibility along with the data entry. During the Alpha 0.1 testing cycle, only initial CMS-2728 forms were allowed to be entered. Even so, Network #15 data staff reported 69 bugs and suggestions in four weeks of testing.

Status Requests

In July of 2003, CMS discontinued the transmission of status requests with the initiation of the REMIS program. Until that time, status requests were processed on a monthly basis.

Other

In addition to Alpha testing the CROWNWeb software, Network #15 assisted in the creation of the business requirements for the software. Various Network personnel served on several Technical Expert Panels (TEPs) related to the new software.

COGNOS Reporting Tool

Network #15 volunteered to participate in the Beta Testing of the COGNOS reporting tool software. As originally conceived, COGNOS would be the tool that the Networks would use to access CROWNWeb data. Because the data set (consisting of millions of rows of data) had to be translated from SQL to Oracle before it could be used in COGNOS, there was no way to view live data in COGNOS. The data anomalies that were discovered during testing were due to the fact that the data was over a month old. Further, the Network was unable to replicate a single report that it currently uses; not because there was anything fundamentally wrong with COGNOS or the *integrity* of the data, but because *choices* of fields in COGNOS were too limited. The age of the data along with the lack of patient-level access data, 2728 and 2746 forms, and REMIS billing data made it an inadequate tool for use by a Network analyst. On March 7, 2006, the ESRD-Reporting tool was discontinued at the request of CMS.

VISION Goals

Based on the 21 facilities eligible to participate in the VISION project, the Network #15 June 30, 2006, goals were:

- 11 facilities trained on the software (50%)
- 5 facilities using the software (25%)

As of June 30, 2006, Network #15 had:

- 21 facilities trained on the software (190% of goal)

ESRD Network #15

- 11 facilities using the software (220% of goal)

Starting in July 2006, CMS funding was directed toward the development of a new facility-based software entry tool (CROWNWeb). VISION training and usage goals were removed from the Networks' 2006-2009 contract. The Network will continue to support those units using VISION until such a time as CROWNWeb is released.

ESRD Network #15

IV. SANCTION RECOMMENDATIONS

During 2006, Network #15 did not identify any providers as consistently failing to cooperate with Network goals and objectives. A copy of the Network's current Sanction and Alternative Sanctions Policy appears in Appendix Q. This protocol provides several levels of warning and repeated offers of Network technical assistance for solving problems and improving care.

No sanctions against facilities or providers were recommended. The Network continued to monitor forms submission, QA/QI participation, and other outcomes as described in Sections IIIA and IIIB.

ESRD Network #15

V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES

Network #15 shared aggregate data (planning data) with all six state governments and three regional offices encompassed by its territory:

Region IX
(San Francisco)

Arizona
Nevada

Region VIII
(Denver)

Colorado
Utah
Wyoming

Region VI
(Dallas)

New Mexico

Network #15 made no specific recommendations for additional or alternative services.

ESRD Network #15

VI. DATA TABLES

The data tables included in the following section are those specified in Attachment J-10 of the CMS/ESRD Network Organization Scope of Work. The data utilized in these tables come from Network #15's SIMS database.

All Tables and Charts refer to Network #15 specific data as of December 31, 2006.

Data Tables are not included in this pdf version of the Annual Report. Please see the link: www.esrdnet15.org/aboutus.htm#table to view these files.
