

InterMountain Messenger

News from ESRD Network #15

Medicare Alert!

At the time of this writing, Network 15 is working on an important fax to be sent to Social Workers. This dispatch will address the new Medicare prescription drug coverage, which is set to begin on January 1, 2006. The article will be extensive, touching on **specific plans, eligibility, creditability, enrollment, covered and not-covered items, costs, plan selection tips, assistance resources, kidney-specific info, and Medicare Part D timelines.** Please be on the lookout for this fax, which offers a pertinent foundation for further inquiry.

TIMELINE

10/01/005 -- *Medicare and You 2006* mailed to all Medicare beneficiaries; it includes information about PDPs and MA-PDs in their state.

10/17/05 -- The Personal Plan Finder website, found at www.medicare.gov, goes live; for those without Internet access, call 1(800) MEDICARE to request a booklet that compares plans.

10/27/05 -- Auto-enrollment mailing is sent to dual eligible beneficiaries.

11/15/05 -- Part D plans enrollment starts.

01/01/06 -- Part D plans coverage starts.

05/15/06 -- Last day for anyone with Medicare to join a plan without paying a penalty.




The DPC is A-OK!

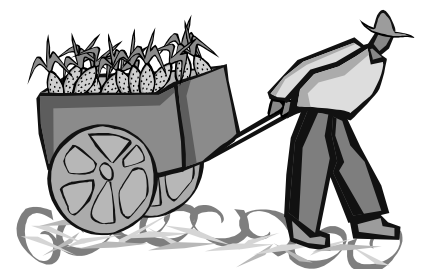
By now all dialysis facilities should have received the *Decreasing Dialysis Patient-Provider Conflict Toolbox: Conflict Resolution Resources for the Dialysis Professional* (DPC Toolbox). The kit itself was mailed to facility social workers at the end of October, while cover letters went to medical directors, administrators, and head nurses or clinical managers. Even though Toolboxes were sent to social workers, everyone on staff can utilize and learn from this educational resource.

The DPC project comprises an impressive nation-wide effort funded by CMS, developed by a number of key ESRD stakeholders, and coordinated through the Forum of ESRD Networks. It's truly a collaborative push for excellence!

Network 15 has recorded WebEx sessions to train facilities on the background, implementation, and use of DPC; training will be available anytime after November 15th (instructions were included in the Toolbox cover letter). We also encourage you to join a series of conference calls planned for December, January, and February. On those dates facilities can discuss their DPC experiences—problems and successes—and share tips. Expect a broadcast fax

with more information about these calls.

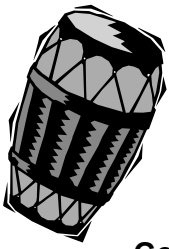
Please examine the Toolbox materials and familiarize yourself with its contents: staff training modules; interactive, self-paced training CD-ROMs; and QI tools that will help track and reduce facility conflicts. The objective of DPC is a peaceful dialysis setting where patients and staff feel safe and comfortable. 



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Quality Improvement Updates

The Beat Goes On . . .

FISTULA, FISTULA, FISTULA, FISTULA

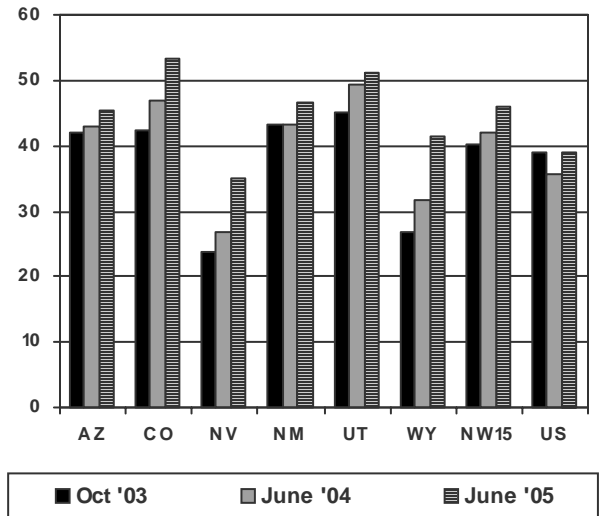
Good News! A greater number of patients in Network 15 are dialyzing with AV fistulas (AVFs). The AVF use rate in August 2005 was 47.3% and the placement rate was 55.8%. Kudos to Network 15 facilities and physicians; you deserve the credit for this improvement!

Fistula First Facts as of June 2005

- ◆ The AVF usage goal for all Networks is 66%
- ◆ Seventy-seven facilities in Network 15 have over 50% of their patients using AVFs, and 124 facilities have over 42.5% using a fistula
- ◆ Only 6 facilities have a use rate of less than 20%
- ◆ Only 3 facilities have a placement rate of less than 20%

State-by-State View

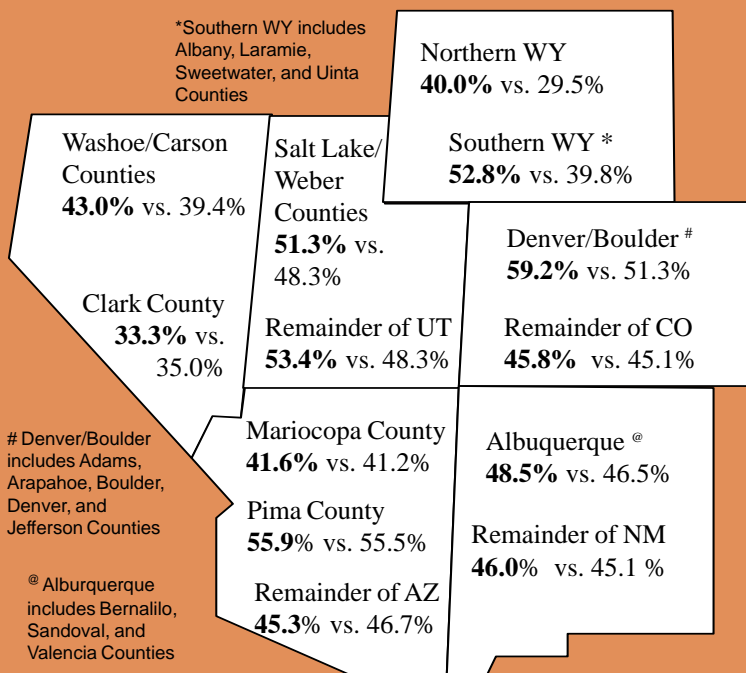
Fistula Use in Network 15, 2003 - 2005



AVF Usage Rates in Network 15

Prevalant Patients in Major Metro Areas
June 2005 vs. December 2004

*Southern WY includes Albany, Laramie, Sweetwater, and Uinta Counties



Between October 2003 and June 2004, Network 15's aggregate AVF use rate increased by 7.0 percentage points.

Arizona's AVF use rate has experienced a 3.3% absolute increase, Colorado is up 11.8 percentage points, Nevada is up 11.3 percentage points, New Mexico is up 3.6 percentage points, Utah is up 7.1 percentage points, and Wyoming is up 18.4 percentage points. Great job!

All states, with the exception of New Mexico, have had *statistically significant* increases in both AVF use rates and AVF placement rates. New Mexico has had a statistically significant increase in AVF placement rates.

Thanks for all your hard work!





Tips for Improving AVF Use Rates

Here are “best practice” scenarios from exemplary facilities:

- Nephrologists and surgeons work with dialysis staff.
 - Vascular labs perform vein mapping on patients before any access placement.
 - The surgeon’s office schedules the vein mapping, which is completed prior to the patient’s initial appointment with the surgeon.
- The surgeon is invested in doing a good job.
 - The surgeon’s office makes access surgery a priority.
 - Typically, the patient’s wait time for initial placement is only 7 to 12 days.
 - When an access intervention is required (e.g., for declotting), the patient rarely waits longer than 24 hours for the procedure and may receive same-day intervention.
- Nurse practitioners are involved in access assessment; they may refer 5 to 6 patients per day to the main surgeon for evaluation.
- Facilities use specific protocols—such as low blood flow rates (BFR) and small gauge needles—to cannulate new fistulas.
 - Once an access has matured and the patient can run at the prescribed BFR using large bore needles, staff introduces the buttonhole technique.
 - The buttonhole technique is offered only with patient consent. Patients who embrace this technique must watch the buttonhole video themselves (Mediasystems); the ultimate goal is self-cannulation.
 - At the beginning of the buttonhole program, consistency is important. It’s best when the same staff performs the initial cannulations; sometimes technicians are most successful.
- Surgeons have attended the “Creating AV Fistulae in all Eligible Hemodialysis Patients” seminar and have initiated the buttonhole program at their facilities.
 - These facilities report a surge in the percentage of patients using the technique as well as a significant reduction in the need for interventions and a reduction in access infections.
- Cannulation training modules and classes (for staff) include instruction on the buttonhole technique.
- A Vascular Manager helps the dialysis unit focus efforts on improving rates.
- Facility works diligently on one aspect of the Fistula First project then addresses another facet of the project.

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Data Notes

Raise your hand if this tip sounds familiar: “Spring forward, fall back.”

Now, raise your other hand if this advice also sounds familiar: “On December 31st, make a list of all the chronic, non-transient patients who are dialyzing at your facility.”

Both hands in the air? Great! Now, put your right leg in and shake it all about ...

Welcome to “The Year-End Hokey Pokey.” It goes something like this:

- * You create a list of all the permanent patients (including PD) who are dialyzing at your facility on December 31st.
- * We create a list of all the permanent patients (including PD) who are dialyzing at your facility on December 31st.
- * You compare our list to your own and make necessary changes—adding some names, maybe, or taking some names off.
- * We look at your changes and enter those corrections into our database.
- * We send you a new year-end roster for final approval.
- * You send us your final, approved list.
- * We do the Hokey Pokey and turn ourselves around ...

That’s what it’s all about!

Really, the year-end survey is a lively, synchronized jig. Each year we get better at coordinating the steps. You can help by practicing your own moves: Use the Patient Activity Report (PAR) to notify us of all changes that take place at your facility; be sure to send all necessary forms; look carefully at quarterly rosters; and **MAKE A LIST OF ALL CHRONIC, NON-TRANSIENT PATIENTS WHO ARE DIALYZING AT YOUR FACILITY ON DECEMBER 31, 2005.**

That’s what it’s all about!

Thank you. And please, during this Season of Thanks be sure to remember all of the fine people who contribute to your daily wealth.



Is “Yes” Always Best?

When filling out the Medical Evidence Report (2728) it is usually, but not always, in the patient’s best interest to say yes to question #11 (Is patient applying for ESRD Medicare?). Here are some scenarios for which this holds true:

1. A patient who currently receives Medicare because of age or disability should apply for ESRD Medicare because it is a different type of Medicare. This difference could 1) reduce premiums, or 2) allow patients who previously declined Part B benefits a new opportunity to receive them. Disability beneficiaries should file because Medicare based on ESRD may continue longer or start earlier than disability benefits.
2. A patient should apply if he/she

currently has no other medical insurance and no foreseeable prospects for obtaining other medical insurance. (Social Security will then determine whether the patient is eligible to receive Medicare.)

If the patient currently has medical insurance other than Medicare, he/she needs to talk with the facility Social Worker about whether or not it is beneficial to apply for Medicare. Some of these patients will benefit by answering YES while others will benefit by answering NO on question # 11.

Patients who currently have other medical insurance and wish to defer applying for Medicare until a later date (i.e., to coincide with the end of the 30-month coordination-of-benefits period) should check NO for question #11. In

these cases the facility should NOT send the blue copy of the 2728 to Social Security; instead the blue copy should be kept in the patient’s file.

Later, when the patient is ready to apply for Medicare, the facility should 1) change question #11 on the blue copy to YES, 2) have the physician currently following the patient sign #51, re-certifying that the patient is end-stage renal, and 3) send this blue copy of the 2728 to Social Security.

Network #15 has provided these guidelines as a starting point for determining how to answer question number 11 on the 2728; variables such as types of coverage, limits of coverage, and future plans-- such as the possibility of a transplant, should all be considered when determining what is best for the patient.



AAMI to Launch New Hemodialysis Publication and Website

The Association for the Advancement of Medical Instrumentation (AAMI) will publish *Hemodialysis Horizons: Patient Safety & Approaches to Reducing Errors* in February 2006. This one-time publication and companion website will provide a thorough examination of the current state of hemodialysis technology and the practices, policies, and problems that play a part in the industry. In addition, special sections devoted to research and new technology will provide a glimpse into what lies ahead for the industry in its attempts to treat a disease that takes the lives of 67,000 patients a year in the U.S. alone.

Hemodialysis Horizons will feature contributions from industry leaders and expert authorities. Article topics include:

- Cutting-edge research and disease prevention updates
- Hemodialysis technology
- Reuse in the U.S. and abroad
- Home dialysis
- Water treatment issues
- Computerization in hemodialysis facilities
- Finances of dialysis
- Practical guidance for water treatment, chloramines removal, water purification and distribution systems and QC/QA, bicarbonate mixing, microbiological surveillance, and dialysate
- Infection control
- A special report on Hurricane Katrina’s effect on the industry, and lessons learned.

The intended audience for *Hemodialysis*

Horizons includes medical equipment technicians; medical, technical, and clinical staff of hemodialysis facilities; and dialysis patients. It will be distributed free of charge to more than 20,000 industry professionals through the mail and at meetings and conferences. In addition, a website (www.aami.org/publications/hh/) will feature the complete newsletter and may be accessed by hemodialysis professionals at no cost.

AAMI has partnered with the National Association of Nephrology Technicians/Technologists (NANT) to make the project possible. Sponsorship positions are still available, and interested organizations should contact AAMI for more information.





Tips for Improving ...

Continued from page 3

- Facility focuses on conversion of central venous catheters (CVCs) to AVFs.
- Vein mapping occurs before access placement and upon each access failure.
- Facility uses the “Fistula Exercise” booklet to demonstrate exercises that help patients enhance fistula development.
- The nephrologist brings an ultrasound machine on monthly rounds and immediately refers patients when problems are noted.
- The surgeon makes rounds when possible and is involved in educating dialysis facility staff.



Anticipate an immunization data collection near the end of 2005 or early 2006. Be sure to keep track of dates patients are vaccinated for Influenza, Pneumovax, and Hepatitis B so that you can easily complete the upcoming data collection requests!



Safe & Timely Immunizations Coalition

ESRD Network 6 (North Carolina, South Carolina, and Georgia), Network 11 (Michigan, Minnesota, North Dakota, South Dakota, and Wisconsin) and Network 15 are working together on a special project to increase immunizations.

The two-year goal is to increase the rate of Hepatitis B, Influenza, and Pneumococcal immunizations in dialysis patients and staff. To date, more than twenty organizations have joined the coalition effort.

STIC Members first met on August 17, 2005, in Atlanta, GA. The coalition identified factors that support the

two-year goal and barriers to reaching that goal. Working groups will focus on immunization education, data collection, and guidelines. The Education Working Group is currently

reviewing materials to be included in an immunization toolbox. The Data Working Group is focusing on a best practices survey and data collection tools. The

Guidelines Working Group is exploring the K/DOQI process and hopes to develop a standard set of guidelines for each vaccine. More project information is forthcoming.

Remember: Vaccinations are a safe and easy way to protect patients and staff against influenza, pneumococcal pneumonia, and hepatitis B!

Please see insert for specific vaccination info and adult immunization recommendations!!



The BIG 3 ... a Quick Romp



Looking for ways to improve your facility’s compliance rates? Think about fields. The 2728 form is littered with fields ... each of which requires your response. We’ve noted that people frequently neglect numbers 18, 23, and 26. Here are some tips that will help you romp through these essential fields:

Field #18 (“Prior to ESRD therapy”)

- All parts of this field are REQUIRED. Anytime you respond “yes” to items 18a, 18b, or 18c, you MUST include a time frame. If the time frame is 0 – 6 months, please handwrite this information on the form.
- All pieces of 18d are REQUIRED for hemodialysis patients. You must tell us which access was used during first outpatient dialysis AND whether or not a maturing AVF or maturing graft was present.

Field #23 (“Primary Type of Dialysis”)

- All pieces of this field are REQUIRED for hemodialysis patients—including method of dialysis PLUS sessions per week PLUS hours per session prescribed by nephrologist.
- For PD patients, only the method of dialysis is required in section B; however, it is important to complete section D if the patient is applying for ESRD Medicare.

Field #26 (“Has patient been informed of kidney transplant options?”)

- This REQUIRED field is often overlooked. If the answer to 26 is “no,” you must also complete question #27.

Remember, timeliness and accuracy depend on attentive fieldwork!



UPDATE ON VASCULAR ACCESS CODING

We know that dialysis facilities understand the importance of using AV Fistulas. Unfortunately, correct billing for vascular access procedures can be perplexing. That is why Nancy Daoust, CPC, from the University of Oklahoma has written a detailed article on the tribulations of coding for vascular access procedures. She suggests that if you or your physicians have billing/reimbursement problems, contact your local Medicare carrier and check their Local Coverage Determinations. The contact number for local Network 15 carriers is listed below.

Medicare Part B Carrier

Arizona	Noridian Mutual Insurance Company	1-800-933-0614
Colorado	Noridian Mutual Insurance Company	1-800-933-0614
Nevada	Noridian Mutual Insurance Company	1-800-933-0614
New Mexico	Blue Cross Blue Shield of Arkansas	1-866-345-0274
Utah	Regence BlueCross BlueShield of Utah	1-866-539-5600
Wyoming	Noridian Mutual Insurance Company	1-800-933-0614

You will find the full article "Our Perspective: Billing Rules for Non-Invasive Vascular Studies" by Nancy Daoust, CPC, on the Network 15 website at www.esrdnet15.org.



We're Looking for a Few Good fistulas!

Watch for more information about the "Faithful Fistula Contest" that will be held in January and February 2006. The three patients with the oldest continuously functioning AV fistulas will win prizes. Entry forms will be available on the Network 15 website in early January.



Network #15

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Denver, CO 80203-5012

Not a Ding

One of the reports that Network 15 sends out to facilities is the Death Notification Report. We send this to facilities [as a resource](#) so that you will be aware of death events for people who may have been in a hospital or other acute setting just prior to death. **This report is NOT a list of late 2746 forms; in many cases it has been less than 30 days since these patients have died.**

Facilities are NOT required to return or respond to this report UNLESS the patient is still alive, or had transferred to another licensed, chronic, Medicare dialysis unit prior to death. In those cases we ask that you call us at 303-831-8818.

Again, this report is for informational purposes only, and should not be construed as a list of missing or late forms. As long as we receive the 2746 within 30 days of the patient's death the 2746 will NOT be considered late.

