2013 Annual Report

FMQAI: The Florida ESRD Network (Network #7)

Contract Number:
HHSM-500-2013-NW007C

Sponsoring Agency:
CMS

FMQAI

Mission Statement:

FMQAI champions patient-centeredness, effectiveness, efficiency, equity, and timeliness of health services with patients, providers, health plans, practitioners, and government to improve the quality and safety of healthcare services, and thereby, the quality of life of patients.

This material was prepared by FMQAI: The Florida ESRD Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. FL-ESRD-NW7-20147GR26-6-503

PREFACE

FMQAI

The Florida ESRD Network

LETTER FROM THE CHAIRMAN OF THE BOARD OF DIRECTORS

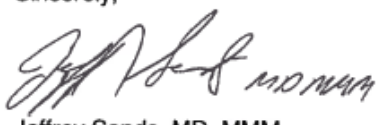
FMQAI has been at the forefront of healthcare improvement for Florida Medicare beneficiaries since 1992 and remains dedicated to improving healthcare delivery and outcomes through partnerships, outreach, education, advocacy, technical assistance, and quality improvement activities. We seek to ensure that beneficiaries receive the right care, in the right setting, at the right time.

FMQAI's unique position of having both ESRD Network and Quality Improvement Organization contracts enhances our mission to ensure the quality, effectiveness, efficiency, and economy of healthcare services. The synergy between these contracts has facilitated the sharing of best practices and strategies to achieve the three AIMs outlined in the National Quality Strategy and Centers for Medicare & Medicaid (CMS) priorities: Better Care for the Individual through Beneficiary and Family Centered Care; Better Health for the End Stage Renal Disease (ESRD) Population; and Reduced Costs of ESRD Care by Improving Care. As the ESRD Network for Florida, we collaborate with diverse partners—patients, family members, and care partners, ESRD and other healthcare providers, practitioners, patient organizations, the state survey agency (SSA), and other stakeholders—to improve the quality and experience of care for kidney patients in support of the CMS ESRD Network Program Strategic Goals.

In 2013, our efforts continued to prove successful in increasing arteriovenous fistula usage for hemodialysis access, decreasing the use of long-term catheters as a primary access, and increasing patient and family engagement within dialysis facilities. The distribution of ESRD and associated chronic care resources allowed the Network to provide timely education and technical support to a growing number of individuals related to the ESRD Quality Incentive Program (QIP), emergency preparedness, patient and care partner engagement in Plan of Care development, ESRD treatment options, National Healthcare Safety Network (NHSN) healthcare-acquired infection reporting, and averting involuntary discharges. The Network continued its efforts to facilitate positive resolutions to patient grievances and worked closely with its Patient Advisory Committee and other patient subject matter experts to ensure the incorporation of the patient perspective in Network projects, as well as in resources such as the patient newsletter and tools for facilities and patients. It has been through this strong partnership with its patients and providers that FMQAI: The Florida ESRD Network (Network 7) and its ESRD community has been able to continue to make significant strides in accomplishing Network and CMS goals.

On behalf of FMQAI: The Florida ESRD Network (Network 7), we are pleased to submit the 2013 Annual Report. We look forward to continued collaboration with the renal community as we improve the quality outcomes and experience of care for the patients we serve.

Sincerely,



Jeffrey Sands, MD, MMM
Network 7 Board Chair

Martha Hanthorn, MSW
Executive Director

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http://www.fmqai.com/ESRD.aspx

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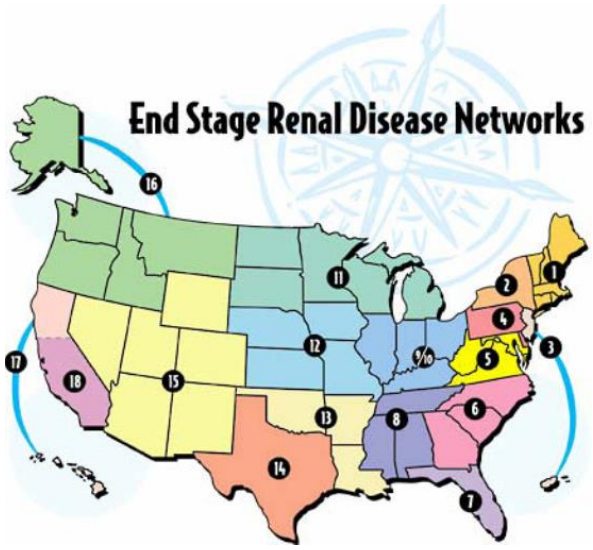
DESCRIPTION of the ESRD SYSTEM

The Social Security Act of 1972 ESRD amendments contained language for the establishment of a structure of "End-Stage Renal Disease Network Councils" to assist the Health Care Financing Administration (HCFA), now known as the Centers for Medicare & Medicaid Services (CMS), to monitor the quality of care given to the ESRD patients by providers of dialysis services and transplantation. The 32 original ESRD Networks were consolidated into18 ESRD Network Organizations under contract with CMS in 1988. The Network Program requires each Network Organization to be governed by boards and committees that are comprised of volunteer patients, providers, and caregivers in the Network community to assist with quality improvement activities and to provide oversight. FMQAI: The Florida ESRD Network (Network 7) is governed by a Board of Directors that is made up of renal patients and dialysis and transplant professionals including nephrologists, nurses, social workers, and dietitians.



FMQAI: The Florida ESRD Network provides oversight for dialysis and transplant facilities in Florida to improve the quality of care and quality of life for kidney patients. Following is a breakdown of the territories overseen by the 18 ESRD Networks in the ESRD Network Program under contract with CMS follows:

ESRD Network No. 1 - Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island

ESRD Network No. 2 - New York

ESRD Network No. 3 - New Jersey, Puerto Rico, U.S. Virgin Islands

ESRD Network No. 4 - Pennsylvania, Delaware

ESRD Network No. 5 - District of Columbia, Maryland, Virginia, West Virginia

ESRD Network No. 6 - Georgia, North Carolina, South Carolina

ESRD Network No. 7 - Florida

ESRD Network No. 8 - Alabama, Mississippi, Tennessee

ESRD Network No. 9 - Kentucky, Indiana, Ohio

ESRD Network No. 10 - Illinois

ESRD Network No. 11 - Michigan, Minnesota, Wisconsin, North Dakota, South Dakota

ESRD Network No. 12 - Missouri, Iowa, Nebraska, Kansas

ESRD Network No. 13 - Arkansas, Louisiana, Oklahoma

ESRD Network No. 14 - Texas

ESRD Network No. 15 - New Mexico, Colorado, Wyoming, Utah, Arizona, Nevada

ESRD Network No. 16 - Alaska, Idaho, Montana, Oregon, Washington

ESRD Network No. 17 - Northern California, Hawaii, Mariana Islands, Guam, American Samoa

ESRD Network No. 18 - Southern California

All ESRD Networks are required to submit an annual report in a specified format to the Secretary of the U.S. Department of Health and Human Services (HHS). This report covers activities conducted in calendar year 2013 by ESRD Network 7 under CMS Contract # HHSM-500-2013-NW007C.

ESRD NETWORK PROGRAM QUALITY INITIATIVE

Under the direction of CMS, the ESRD Network Program strives to achieve bold strides towards the achievement of the CMS National Quality Goals which align with the HHS National Quality Strategy. Towards this end; CMS re-aligned the ESRD Network Statement of Work (SOW) in 2012 to produce a quality and patient-centered focus for the new contracting cycle that started on January 1, 2013. This report is the first that focuses on the outcomes of this re-alignment to incorporate the HHS National Quality Strategy, the CMS Three-part Aim, and other CMS priorities designed to improve the care for individuals with ESRD.

NETWORK DESCRIPTION

The service area of ESRD Network 7 is the state of Florida. In 2013, the most current U.S. Census American Community Survey data available, Network 7 had a combined estimated general population of 19,552,860. As of December 31, 2013 there were 376 Medicare-certified dialysis centers situated in urban, suburban, and rural areas throughout the state and 7 transplant facilities located in the major urban areas.

The table on the next page provides an overview of the demographics in Florida and a comparison to those same demographics nationally.

In 2013, there were 7,224 individuals who were newly diagnosed with ESRD in Network 7. As of December 31, 2013, the Network had 26,431 ESRD patients on dialysis in 376 Medicare-certified dialysis facilities and 11 non-Medicare facilities and Federal correctional institutions across its region. The following section provides summary information on Florida's geography and general population, as well as ESRD patient demographics.

Geography and General Population

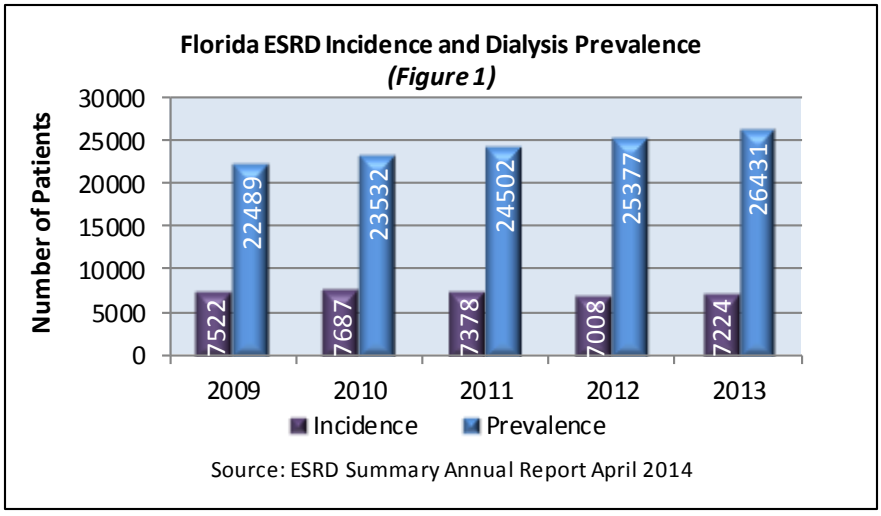
The state of Florida covers 54,090 square miles and is bordered by the Gulf of Mexico and the Atlantic Ocean. According to the U.S. Census Bureau, Florida's population was estimated at 19,552,860 in 2013, ranking as the fourth largest state in the country. This represented a 2.7% increase from the 2010 census. In addition, Florida ranked as eighth largest in population density at about 353.4 people per square mile.

According to U.S. Census Bureau demographic data available at the time of this report (2012), 78.3% of Florida's population was categorized as white as compared to 77.9% nationally. In the non-white population, 16.6% were African-American compared to 13.1% at the national level, and 2.7% were Asian compared to 5.1% nationally. Florida continued to have the highest percentage of senior citizen residents with 18.2% of the population aged 65 years and older compared to the nation at 13.7%. The median age for Florida residents was 41.1 years in 2012.

ESRD Population

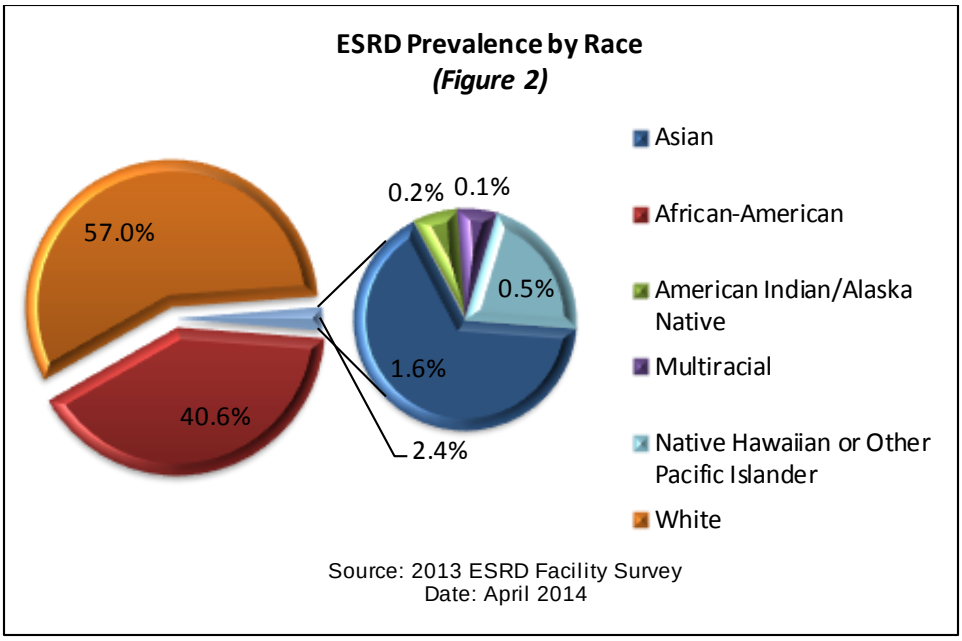
Network 7 worked in collaboration with the Florida renal community and other key stakeholders to improve the quality of life and quality of care of over 26,000 individuals with ESRD in 2013. The following section describes the characteristics of the ESRD patient population in Florida.

From 2012 – 2013, the prevalent patient census increased by 1,054 patients (4.2%), for a total of 26,431 prevalent patients in the state of Florida (*Figure 1)*. The number of incident patients increased by 216, for a total of 7,224 residents newly diagnosed with ESRD. This represents a 3.1% increase. Overall, Florida's incident rate has increased by 24.7% since 2000.



Race and Ethnicity

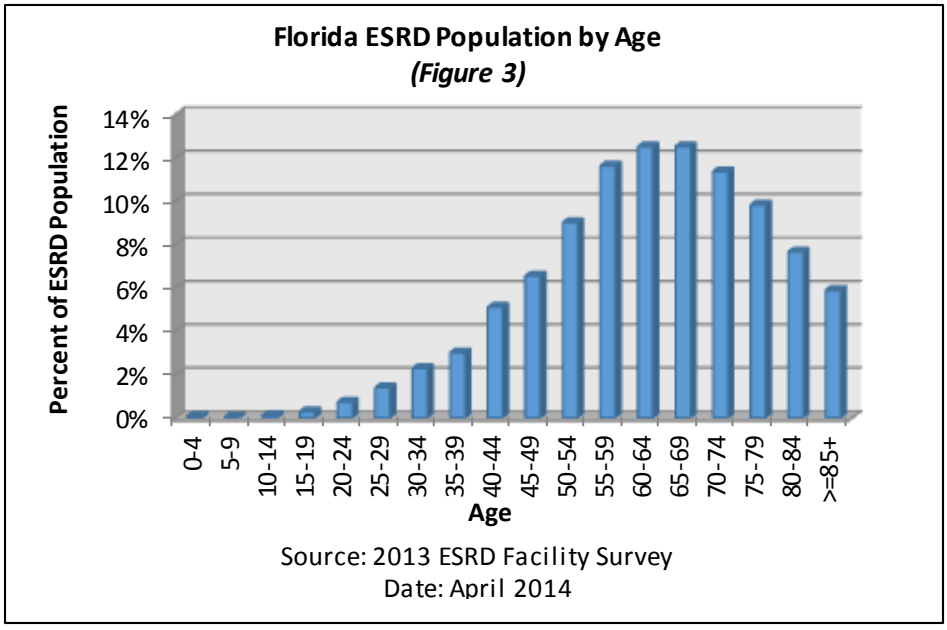
The demographics of Florida's ESRD population are similar to that of the United States' ESRD population, with 57.0% of Florida's ESRD population characterized as white and 40.6% as African-American *(Figure 2).* Compared to Florida's general population, however, in which only 16.6% were categorized as African-American, the proportion of African-Americans with ESRD remained disproportionately high at 40.6%. The third largest racial demographic in Florida was Asian, representing 2.1% of the entire ESRD population in Florida.



As noted previously, with respect to race and ethnicity, individuals that identified as Hispanic or Latino accounted for 23.2% of Florida's general population. In 2013, 15.6% of Florida ESRD patients were reported as Hispanic or Latino.

Gender and Age

Forty-three percent of Florida's ESRD population was female and 57% was male. Additionally, 59.7% of Florida's ESRD population was age 60 or older (*Figure 3*). This figure is also disproportionately large when compared to Florida's general population, in which only 27.9% of residents are age 65 or older.

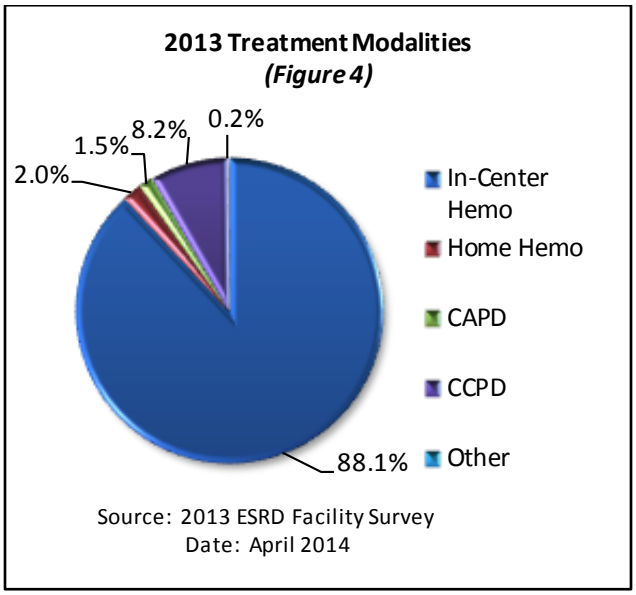


Treatment Options

In Florida, there are four main categories of dialysis treatment modalities that patients receive (*Figure 4*):

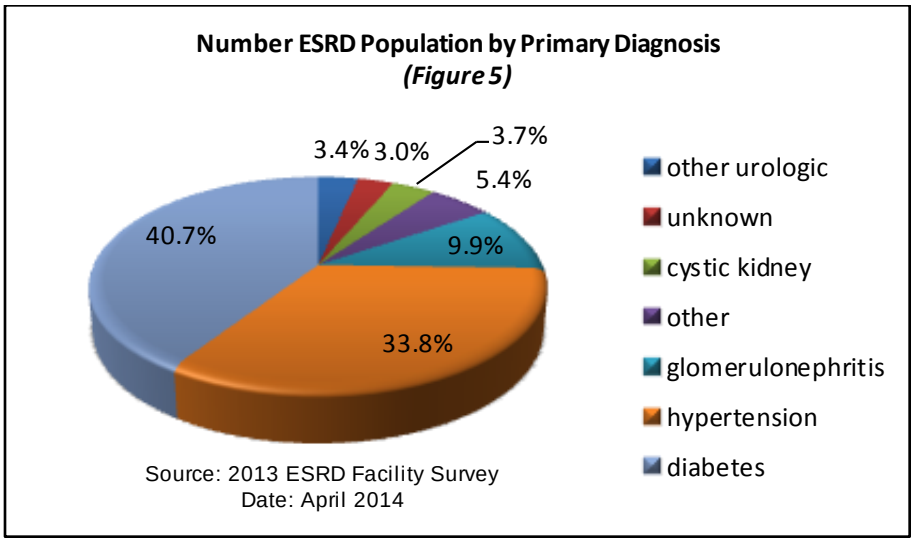
- In-center hemodialysis decreased from 88.8% in 2012 to 85.3% in 2013.
- Continuous cycling peritoneal dialysis (CCPD) remained steady at 7.5%.

- CAPD had a 1.6% utilization rate.
- Home hemodialysis had a 1.7% utilization rate.



Primary Diagnoses/Co-Morbidities

The Network data reflected that 74.5% of patients had a primary diagnosis (*Figure 5*) of either the first largest category of diabetes (40.7%) or the second largest category of hypertension (33.8%). This reflected a slight decrease for diabetes diagnosis (0.1 percentage point) and an increase for hypertension diagnosis (0.3 percentage point) from 2012 – 2013. The third largest category of primary diagnosis was glomerulonephritis (9.9%).



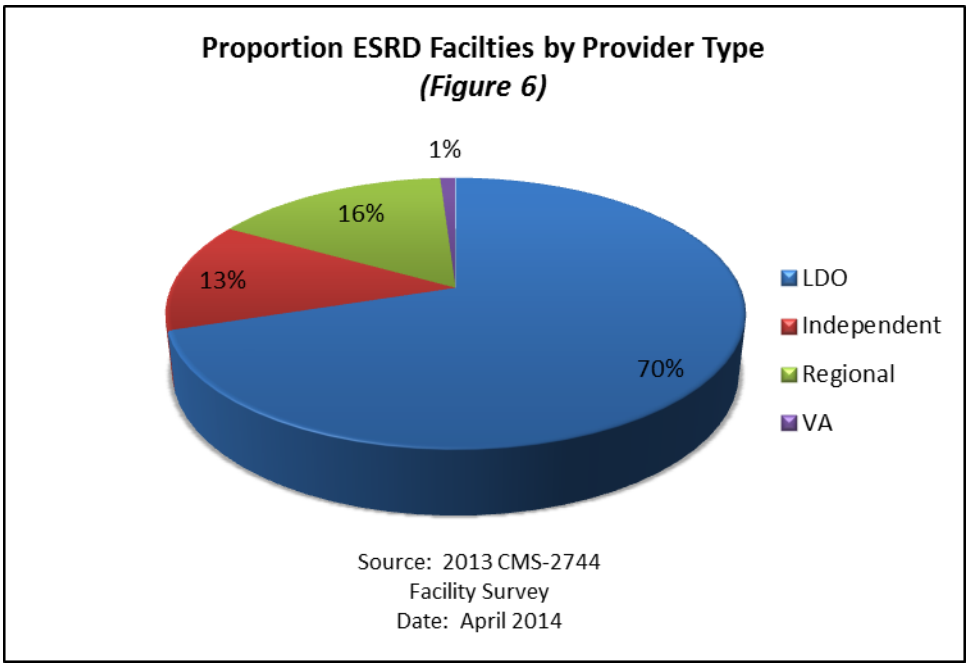
Providers

As of December 2013, Network 7 had a total of 387 ESRD care providers (including providers pending Medicare certification, and federal/prison facilities) representing 12 different affiliations.

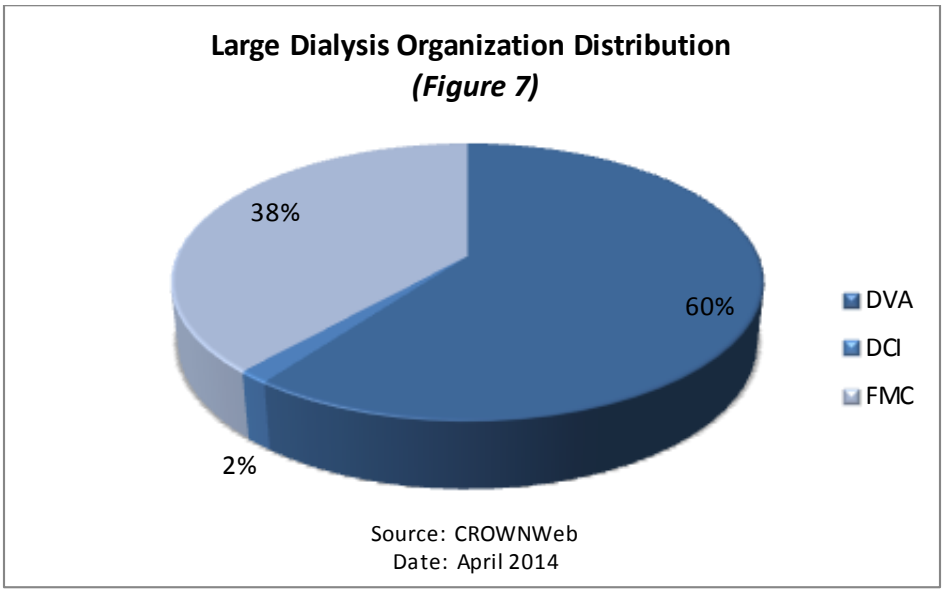
Dialysis facilities were located in 55 (82%) of the 67 Florida counties. Miami-Dade County had the largest number of providers (51), followed by Broward County, (42) and Palm Beach County (31). Together, these three counties accounted for 32% of Florida dialysis facilities. Affiliations included:

ARA – American Renal Associates
DVA – DaVita, Inc.
DCI – Dialysis Clinics, Inc.
FMC – Fresenius Medical Care
NRI – National Renal Institutes
IND – Independent (Single Facility)
DSI – Diversified Specialty Institutes
CFKC – Central Florida Kidney Centers
MKC – Melbourne Kidney Centers
RAI – Renal Advantage, Inc.
RCP – Renal Care Partners
VA – Veterans Administration

The majority of Florida's providers are owned by the three Large Dialysis Organizations (LDOs), DaVita (DVA), Fresenius (FMC), and Dialysis Clinics, Inc. (DCI). These three corporations owned and/or operated 64.6% of Florida's 356 ESRD facilities at the end of 2009. By December 31, 2013, they represented 66.9% of the 387 providers of ESRD care *(Figure 6)* in the state. Between those dates, the number of independent facilities and facilities pending certification also increased, from 11% to 12.4% and 1.6% to 2.3% respectively. The number of facilities owned by smaller, regional chains increased from 14.4% to 16% of the total, an increase of 1.6 percentage points.



Within the LDO facility group, 60% were affiliated with DVA, 38% with FMC, and 2% with DCI *(Figure 7).*



STRUCTURE

The FMQAI corporate oversight of FMQAI: The Florida ESRD Network (Network 7) was re-established with the re-award of the Network 7 contract to FMQAI by the Centers for Medicare & Medicaid Services on January 1, 2013. FMQAI is proud of the professional and productive mix of skills and talents that make up the organization. With a corporate oversight team that encourages and promotes collaboration between the three ESRD Networks contracted under FMQAI and the corporate team, we worked together to find the best solutions for our providers and beneficiaries. This diverse workforce was led by the corporate team identified below in support of the highly skilled staff at Network 7.

Tony Freedman, BA, Chief Executive Officer (Retired December 2013)
As the Chief Executive Officer (CEO) for FMQAI, Mr. Freedman gave direct oversight and managed the operations of Network 7 through collaboration with the Board of Directors, and supplied the administrative support personnel to ensure Network 7's success. Mr. Freedman provided recommendations to the Board of Directors concerning FMQAI functions to facilitate sound policy and program guidance by the Board of Directors.

Zak Henshaw, MHA, MPH, MLIS, Executive Vice President/Chief Operations Officer
As the Chief Operations Officer (COO) for FMQAI, Mr. Henshaw managed the operational aspects of all FMQAI contracts and provided oversight for the development and implementation of intervention strategies and analysis of operational variances. Mr. Henshaw helped to align Network 7's practices with FMQAI's operational structure during the transition into FMQAI and over the 2013 contract cycle.

Demetra Denmon, MA-WSD, Executive Director, ESRD Services (as of 11/01/2013)
As the Executive Director, ESRD Services, Ms. Denmon serves as the corporate liaison between the three FMQAI Networks, Centers for Medicare & Medicaid Services, and the

corporate leadership team. Her role guides the work of the Networks to provide advice on goals, objectives, work plans and operational policies. Ms. Denmon facilitates communications between Senior Management and the development of a Tri-Network focus in support of the Network activities and the completion of administrative responsibilities and reporting.

Staffing

The Network 7 staff of eight (8) team members is responsible for, but not limited to, completing the tasks and deliverables of the CMS Scope of Work. These tasks include assuring effective and efficient administration of the benefits provided under the Social Security Act for individuals with ESRD. Network 7 is responsible for conducting activities in the areas of Quality Improvement, Community Information and Resources, Administration, and Information Management. The Network's primary function is to 1) Provide an efficient organizational structure for improving ESRD quality of care; 2) To identify opportunities to improve care, develop quality improvement interventions, and measure the effectiveness of the interventions; 3) Identify and address instances of sub-standard care including patient safety concerns; 4) Investigate and resolve patient complaints and grievances, and 5) Coordinate the collection, analysis and reporting of data which is used to monitor and evaluate the quality of care and to determine beneficiary entitlement. Network 7 also had a staff of six (6) team members assigned to the Business Requirements for ESRD Systems (BRES) Special Innovation Project. During the calendar year 2013, Network 7 staff included:

Martha Hanthorn, MSW – Executive Director: The Executive Director provides oversight for the successful completion and delivery of the requirements of the Network contract requirements. This position serves as a resource to organizational leadership regarding goals, objectives, work plans, and operational policies. An important function is to establish and maintain relationships with ESRD patients, providers, and other stakeholders to ensure community collaboration towards goals to improve ESRD care. Additionally, responsibilities include management of operational and financial performance and ESRD personnel, and daily office operations.

Kathleen Lightbourne, MPH - Project Director (January - April 2013): The Project Director supports the activities of the Executive Director, including communication with Senior Management, direction on Network activities, and completion of administrative reporting. In addition, this position oversees collaborative activities, provides technical assistance for quality improvement projects, and patient concerns.

Sandra Woodruff, MPH - Project Director (May-October 2013): The Project Director supports the activities of the Executive Director, including communication with Senior Management, direction on Network activities, and completion of administrative reporting. In addition, this position oversees collaborative activities, provides technical assistance for quality improvement projects, and patient concerns.

Helen Rose, MSW, LCSW – Patient Services Director: The Patient Services Director leads community information and resource activities, including management of the Network's patient grievance process, in collaboration with the Medical Review Board grievance subcommittee, patient-focused quality improvement activities and campaigns, and patient volunteer activities with the Patient Advisory Committee (PAC) and Patient Subject Matter Experts (SMEs). This

position also provides technical assistance and education to patients, providers, and other stakeholders for patient concerns, disaster preparedness, and vocational rehabilitation (VR).

Leonardo Denaro, BS – Quality Improvement Director (April 2013 – Present): The Quality Improvement Director coordinates and provides oversight of Network quality initiatives and activities, as well as the internal quality control (IQC) process. Responsibilities include coordinating the development of quality improvement project plans, evaluating educational components of activities in coordination with staff and Network committees to ensure that appropriate subject matter is being addressed, and directing the activities of the Network Council (NC) and Medical Review Board (MRB).

Mary Fenderson, RN, CNN, MSHSA – Quality Improvement Coordinator: The Quality Improvement Coordinator conducts quality improvement project activities including project design, interventions, measurement and sustainment. Additional activities include the provision of assistance in the clinical aspects of investigation and resolution of patient grievances, development of patient and professional educational materials, provision of clinical knowledge and subject matter expertise to the community and other CMS contractors, and support of technical assistance to patients and providers. This position also provides subject matter expertise to the BRES Special Innovation Project team.

Beverly Whittet, RN, CDN – Quality Improvement Coordinator: The Quality Improvement Coordinator conducts quality improvement project activities including project design, interventions, measurement, and sustainment. Additional activities include the provision of assistance in the clinical aspects of investigation and resolution of patient grievances, development of patient and professional educational materials, provision of clinical knowledge and subject matter expertise to the community and other CMS contractors, and support of technical assistance to patients and providers.

Janet Lea Hutchinson – Director of Information Management: The Director of Information Management coordinates activities to meet the Network's data management and information systems responsibilities, including dialysis provider data submission and reporting via CROWNWeb, development and management of the Network's Business Continuity and Contingency Plan, and maintenance of the ESRD computer network. Responsibilities also include serving as the Network's primary Security Point of Contact (SPOC), ensuring the integrity of the Network's database and the continuous operations of the computer network, and serving as a subject matter expert (SME) for the BRES Special Innovation Project.

LeChrystal "Chrys" Williams – Data Control Specialist: The Data Control Specialist provides technical assistance to dialysis providers on QIMS registration and CROWNWeb data submission requirements, supports the maintenance of the Network server and equipment, and tracks data for quality improvement activities including project-specific facility reporting and tools such as environmental scans and needs assessments. This position also supports maintenance of the Network server and equipment, and serves as the Network's secondary SPOC.

Kolina Ford – Senior Administrative Assistant: The Senior Administrative Assistant assists with Network activities and campaigns through graphic design and development of materials for quality improvement and education, including patient and provider newsletters and resource materials, and event planning and management for Network educational events. This position also supports activities with other FMQAI Networks and QIO teams.

Michael W. Kennedy, PMP, MSMPM – Director of Informatics: The Director of Informatics leads FMQAI informatics operations and project management. Activities include collaborating with key government, ESRD Network, renal community, and other stakeholders, providing recommendations for business requirements and standard operating procedures, and serving as the main contact for CMS and other stakeholders for the BRES Special Innovation Project.

Dianna Christensen, BS – Study Director:
The Study Director provides oversight of activities and manages day-to-day operations of the BRES Special Innovation Project team. Activities include collaboration with CMS, its contractors, and stakeholders conducting specific tasks, including elicitation and analysis related to CROWNWeb, and serving as a conduit between the renal community and the development team.

Michael Seckman, CHT – Senior Technical Writer: The Senior Technical Writer provides development and technical expertise for the Project CROWNWeb website content and collaborates with ESRD stakeholders, including CMS and its contractors, for the BRES Special Innovation Project.

Harold "Anthony" Seabrook, MBA, MCP – Information Technology (IT) Manager: The IT Manager supports the functionality of the Network Contacts Utility (NCU) and Patient Contacts Utility (PCU) systems. Additional activities include assisting with website development and elicitation of feedback to increase functionality, and working with the Director of Information Management to ensure the procurement of appropriate hardware/software for the BRES Special Innovation Project.

John Jennings, MEd – Web Developer: The Web Developer leads the design and development of the Project CROWNWeb website, provides technical assistance to the communication team on implementing strategic goals, and provides technical assistance to the IT team to support database design and administration.

Melissa Johnson – Administrative Assistant: The Administrative Assistant provides coordination and administrative assistance for the BRES Special Innovation Project and other contracts as needed. Activities include managing updates to the deliverables database, documenting meeting minutes, and developing reports for the BRES Special Innovation Project. This position also provides administrative assistance for other ESRD contracts.

Committees

In order to support Network operations and comply with the CMS Statement of Work, FMQAI has established a Board of Directors and various committees. The members represent ESRD patients, dialysis facilities, transplant centers, and other strategic organizations within the Network area. The contributions of these volunteer members are critical to the success of Network activities. Their efforts truly improve the quality of care and quality of life for Florida's ESRD patients.

FMQAI Board of Directors (BOD)

The Board of Directors conducts governance activities according to corporate bylaws including overseeing successful completion of CMS contract deliverables, monitoring financial and business operations, and the efficient operation of FMQAI. Oversight of the Network is provided by the ESRD BOD members, who are also members of the FMQAI BOD.

Corporate Chairman		
Mary Ellen Dalton, PhD, MBA, RN	HSH President and FMQAI Board of Directors Chairman	Phoenix, AZ
Members		
Jeffrey J. Sands, MD, MMM	ESRD Board Chairman – Renal Administrator	Celebration, FL
Mark Russo, MD, PhD	ESRD Board Member, Medical Review Board Chairman – Nephrologist	Naples, FL
Candace Ann Magiera, BS	ESRD Board Member, Network Council Chairman – Renal Administrator	Sarasota, FL
Adam Pugh	ESRD Board Member, Patient Advisory Committee Chairman – Beneficiary	Jacksonville, FL
Julie A. Brophy	ESRD Board Member – Beneficiary	St. Petersburg, FL
Robert Loeper, MBA	ESRD Board Member – Renal Administrator	St. Petersburg, FL
Sue Rottura	ESRD Board Member – Renal Administrator	Boca Raton, FL
Ignacio Sotolongo, MD	ESRD Board member – Nephrologist	St. Petersburg, FL
Diane I. Marcello, MS, Med, NHA	Nursing Home/Assisted Living Administrator	Sarasota, FL
James V. Palermo, MD	Vice President of Quality Management	Merritt Island, FL
Robert Perry, PhD	Beneficiary	Brooksville, FL
Kim Streit, FACHE, MBA, MHS	Vice President of Health Research and Information	Orlando, FL

Rebecca H. Yackel, DHA, BSN, NHA, MS, LHRM	Nursing Home Administrator	New Port Richey, FL

ESRD Board of Directors (BOD)

The BOD; in concert with the corporate team, oversees management of the Network in meeting contract deliverables and requirements, as well as the financial performance of the Network contract including its Internal Quality Improvement program. BOD responsibilities include approval of requests for contract modifications for the Network that involve requests for additional funding, review and approval of any recommendations from the MRB to sanction ESRD facilities, and to meet as necessary to ensure successful operation of the Network. The FMQAI ESRD BOD held three in-person meetings and one telephonic meeting in 2013, including an in-person meeting of the three BODs of the FMQAI ESRD Networks (7, 13, and 18) held in Tampa, FL.

The following accomplishments and activities resulted:

- Provided financial and program oversight for the Network contract;
- Reviewed the Network Internal Quality Improvement plan and outcomes;
- Reviewed the Quality Improvement Activities developed by the Network and Medical Review Board;
- Reviewed the input and recommendations provided by the Network Council;
- Reviewed the input and recommendations of the Patient Advisory Committee;
- Reviewed the Network 7 Annual CMS Evaluation results; and
- Collaborated regarding Tri-Network activities and goals.

Medical Review Board (MRB)

The MRB serves as an advisory panel to the Network on patient quality of care, outcomes, and appropriate ESRD patient access to care, patient grievances, quality improvement activities, including analysis of local data such as clinical performance measures, and development of criteria and standards for ESRD care. The MRB monitors quality of care though facility monitoring projects and Network analyses, and may conduct facility site visits as part of monitoring activities. Based on facility review, the MRB may submit facilities to the BOD to be considered for recommendation to CMS for sanctions.

Chairman		
Mark Russo, MD, PhD	Nephrologist	Naples, FL
Members		
Carlos Bejar, MD	Nephrologist	Ft. Lauderdale, FL
Mary Ann Blanchard, BS, RN	Renal Administrator	Lakeland, FL
Fred Bowers, PCT	Certified Patient Care Technician	Orlando, FL
Douglas Curtis	ESRD Beneficiary	Sarasota, FL
Lillian Dence	ESRD Beneficiary	Gainesville, FL
Avon Doll, MD	Nephrologist	Tallahassee, FL
Steven Fineman, MD	Nephrologist	Sarasota, FL
Rebecca Brooks, RD, LDN	Renal Dietitian	Tampa, FL
Debbie Glidden, MSN, ARNP	Nurse Practitioner	Winter Park, FL
Elizabeth Howard, RN, CNN	Nurse	Oldsmar, FL
Helen Hutteri, RN, CDN	Nurse	Palm Harbor, FL
Patricia Lebron-Johnson, RN, CNN	Nurse	Tallahassee, FL
Beverly Moreland, MSW, LCSW	Renal Social Worker	Jacksonville, FL
David Ramdon, RN	Nurse/Administrator	Pembroke Pines, FL
A. Oussama Rifai, MD	Nephrologist	Panama City, FL
Anna T. Samarkos	Biomed Specialist	Tarpon Springs, FL
Gary Strange, MBA	Regional Vice-President	Boynton Beach, FL

The MRB met six times in 2013, including one in-person meeting, providing guidance and ongoing feedback regarding the development and implementation of innovative quality improvement projects and activities in accordance with the new 2013-2015 Network Statement of Work. In addition, the Grievance Review subcommittee met on a quarterly basis to review

beneficiary grievances, involuntary discharges, patient access to care concerns and trends, and provided direction to the Network on the development of facility-specific and statewide improvement plans. The Standardized Mortality Ratio (SMR) subcommittee met twice between regular MRB meetings as they monitored facility outcomes and continued a focus project with 10 facilities. Of those, nine were released from the project and four additional facilities were identified to participate in the project during 2013. The SMR subcommittee also began reviewing outcomes data regarding home assisted dialysis programs.

Network Council (NC)

The Network Council serves as a liaison between the Network, and provider and patient members of the renal community, providing input on community concerns and recommendations for Network activities.

Chairman		
Candace A. Magiera, BS	Renal Administrator	Sarasota, FL
Members		
Christina Beale, RN	Nurse	Tallahassee, FL
Juan Cuellar, MD	Nephrologist	Miami, FL
Douglas Curtis	ESRD Beneficiary	Englewood, FL
Robin Wood-Gay, RD	Renal Dietitian	Panama City, FL
Mark M. Geisler, ACSW	Transplant Social Worker	Fr. Myers, FL
Julie Glennon	ESRD Beneficiary	West Palm Beach, FL
Susan Witzel-Kreuter, LCSW	Dialysis Social Worker	Miami, FL
Stacey McCormack, RN	Nurse	Jacksonville, FL
Stacey Moon, RN	Nurse	Gainesville, FL
Rachel Santos, LCSW	Renal Social Worker	Apopka, FL
Janice Starling-Williams	ESRD Beneficiary	St. Petersburg, FL
Camille Tate, RN	Nurse	Ft. Lauderdale, FL

The NC met three times in 2013, providing the Network input on community concerns and recommendations regarding Network activities including the development and implementation of innovative quality improvement projects and activities in accordance with the new 2013-2015 Network Statement of Work. The NC reviewed results from the Network's Patient and Provider Needs Assessments that were distributed to all Network facilities in July 2013. Feedback was provided to the Network and included recommendations regarding topics for patient and provider newsletters including the In-Center Hemodialysis Consumer Assessment of Healthcare Provider Services (ICH CAHPS) survey and the Quality Incentive Program (QIP), as well as methods of dissemination for Network educational materials. Additionally, the NC participated in a collaborative presentation by Ms. Denise Heady, the Regional Vulnerable Populations Consultant and Mr. Kenneth Devin, Clinical & Operational Project Manager, both with the Florida Department of Health (FDOH), regarding the Department's new emergency response system, EMSystem, prior to its release to all ESRD facilities in Florida in 2014. The NC provided input to the Network on dissemination of education for dialysis facilities regarding the EMSystem.

Patient Advisory Committee (PAC)

The PAC assists the Network in identifying barriers to obtaining quality health care from all perspectives on behalf of ESRD beneficiaries. This committee serves an important role in providing the patient voice and perspective to Network activities and the renal community, and collaborates with the Network's Patient SMEs in Learning and Action Network (LAN) activities to increase patient engagement and patient-centered care. Activities include development of educational materials for patients via website, newsletter, or teleconference; provision of recommendations and feedback regarding patient related healthcare messages, materials, and activities planned by the Network; and Provide feedback on the effectiveness of Network patient related activities.

Chairman		
Adam Pugh	ESRD Beneficiary	Jacksonville, FL
Members		
Stephanie Bates	ESRD Beneficiary	St. Petersburg, FL
Shakur Bolden	ESRD Beneficiary	Jacksonville, FL
Nick Crespo	ESRD Beneficiary	Tampa, FL
Elowisa Cox	ESRD Beneficiary	Sarasota, FL
Lillian Dence	ESRD Beneficiary	Gainesville, FL

Members (cont.)		
Julie Glennon	ESRD Beneficiary	West Palm Beach, FL
Carl Johnson	ESRD Beneficiary	Miami, FL
Jacqueline Thomas, RN	ESRD Beneficiary/Nurse	St. Petersburg, FL
Linda Thompson	ESRD Beneficiary	Tampa, FL

In 2013, the PAC included 10 patients representing the demographics of the Network's ESRD patient population and the different geographical areas of Florida. Members also represented diversity in ESRD treatment modalities including in-center and home hemodialysis, home peritoneal dialysis, and kidney transplant. The committee provided feedback on the development of the Network's Patient Needs Assessment as well as review of the results. The committee provided feedback on patient education materials, including the patients and families page of the Network's website. The group recommended topics for future patient education materials including the CMS QIP, disaster planning, and dietary information for dialysis patients. Committee members provided content for The Patient Voice, a regular article in the Network's quarterly patient newsletter. The PAC collaborated with the Network's Patient SME group regarding the Network's Patient Engagement LAN activities and in development of Campaign materials.

NETWORK-SPECIFIC ACTIVITIES & INFORMATION

NETWORK-SPECIFIC ACTIVITIES & INFORMATION

INTRODUCTION

The ESRD Network organizations received a redesigned Statement of Work (SOW) from the Centers for Medicare & Medicaid Services (CMS) in 2013. The SOW was revised to align ESRD Network activities with the HHS National Quality Strategy (NQS), the CMS three AIMs, and other priorities with the goal of improving the care and outcomes of individuals with ESRD. The NQS and three AIMs focus on making care safer, effectively coordinated, and person- and family-centered. Additionally, the strategies include promoting prevention and treatment of leading causes of mortality, helping communities support better health, and making care more affordable by reducing costs through continual improvement.

To support these goals and lead transformation, Network 7 and its boards and committees developed and implemented innovative activities in collaborative partnerships with patients and family members, clinicians, healthcare providers, patient organizations, other Networks, quality improvement organizations and local, state and federal agencies. These activities addressed key areas including patient and family engagement; patient experience of care, appropriate access to care, and safety; healthcare acquired infections; vascular access management; increasing vaccination rates and reducing disparities; and supporting the ESRD QIP and facility data submission for CROWNWeb.

Network-Specific Activities and Information

Disaster Preparedness Activities and Manual

Disaster Preparedness Activities

Disaster preparedness is an essential component of facilitating successful outcomes for ESRD patients and providers during emergencies and/or disasters. The ESRD Conditions for Coverage (CFC) include specific language related to disaster preparedness and response. Activities required for ESRD providers include:

- Providing training and orientation in emergency preparedness to staff and patients, including information on what to do, where to go, and who to contact;
- Evaluating, at least annually, the effectiveness of emergency and disaster plans and updating those plans as necessary;
- Having a plan to obtain emergency medical system assistance when needed; and
- Contacting the local disaster management agency, at least annually, to ensure that the agency is aware of dialysis facility needs in the event of an emergency.

In order to assist providers in complying with the CFC, and to ensure that patients had timely access to treatment during emergencies, the Network disseminated resources, provided technical assistance, and coordinated the Florida Kidney Disaster Coalition.

Disaster preparedness activities in 2013 included:

- "Are You Ready" hurricane planning posters provided in all Facility Resource Materials packets;
- Pre-hurricane season fax blast to providers regarding preparedness;
- Disaster preparedness articles in the May 2013 patient newsletter and the June 2013 provider e-newsletter;
- Tropical Storm Andrea weather alerts sent to facilities via fax blast in June 2013;
- Fax blasts and posting of FDA alerts to the Network website;
- Disaster preparedness webinar conducted with the Network Council in October 2013 regarding the implementation of the EMSystem, a web-based healthcare facility data application, by the Department of Health for dialysis providers throughout the state;
- Fax blast to Hillsborough County facilities regarding an emergency management meeting hosted by the Hillsborough County Emergency Operations Center (EOC); and
- Memo sent via e-mail to all facilities in September 2013 regarding the Kidney Community Emergency Response (KCER) Coalition Kidney Disaster Week.

Network 7 regularly assisted with disaster preparedness via the help-line and through e-mail. Information, tools, and other resources for disaster preparedness and response were also posted on the Network website, including:

- Disaster Preparedness: A Guide for Chronic Dialysis Facilities, Second Edition
- Preparing for Emergencies: A Guide for People on Dialysis.
- Tips for ESRD Disaster Planning
- Boil Water Advisory
- Patient Disaster "To Do" List
- Questions for the Emergency Operations Center (EOC)

Florida Kidney Disaster Coalition

The Network also supports the activities of the Florida Kidney Disaster Coalition (FKDC). The FKDC was established subsequent to the disastrous hurricane seasons of 2004 and 2005. It is comprised of both renal and non-renal stakeholders who recognize a continuing need to improve planning and preparation for emergencies within the renal community. FKDC members included 41 stakeholders representing 25 agencies, including dialysis and transplant providers, the Florida Department of Health, a utility company, patient and professional organizations, a transportation provider, hospitals, and emergency management representatives. The coalition objectives are to:

- Ensure the coordination and communication of care and services between renal care providers, renal organizations, and local, state, and federal agencies;
- Educate renal care providers, renal organizations, local, state, and federal agencies,

patients, families, and the general public about the needs of ESRD patients and how to implement disaster preparedness and response activities; and
- Aid state and local policymakers and emergency management organizations in developing comprehensive disaster preparedness and response plans that address the needs of the renal community.

Key activities implemented by the coalition in 2013 included:

- Community Partner Meeting – A Community Partner Meeting (CPM) was facilitated by a coalition member in Miami-Dade County on April 23, 2013 and included 60 attendees. The Network provided Community Partner Packets and promotional support for the meeting. The target audience included dialysis facility social workers and administrators, transportation agencies, and emergency management personnel.
- A WebEx conducted on May 15, 2013 by two coalition members and the Network with statewide hospitals via the Florida DOH titled "Information Sharing Webinars for Healthcare Partners: Dialysis and Disasters – Is Your Facility Prepared? " Provision to the Office of Emergency Management (OEM) for Miami-Dade County of an updated list of dialysis facilities so the county could plot the facilities on their evacuation zone grid.
- FKDC Webinar held on Thursday, October 10, 2013, 1:30 p.m. – 2:30 p.m. EDT with 15 attendees and the Florida DOH, which provided an overview of the web-based EMSystem Dialysis Dashboard.
- Staffing of an FKDC information booth at the Network 7 Annual Forum.
- Piecing Together Preparedness Program – This FKDC-developed interactive program serves as an effective way of incorporating year round, all-hazards preparedness into dialysis and transplant facilities. Modules include:
    - Conduct a Mock Drill
    - Conduct an In-Service on All-Hazards Preparedness
    - Make Contact with the Local Emergency Management Agency
    - Complete a Patient Emergency Planning Needs Assessment
    - Develop an Emergency Management Plan
    - Provide Patient Resources for Disaster Preparedness

All materials needed to complete the program are accessible via the FKDC website and are linked from the Network 7 website.

Comprehensive Emergency Management Plan (CEMP)

ESRD Networks are required by CMS to have an emergency management plan. The Network 7 plan outlines general principles and procedures for administration and staff to follow when responding to all types of emergencies or occurrences either within the Network or within the community.

The foundation of the CEMP is the Network Incident Command System (NICS), which is an incident management tool that provides for efficient and effective utilization of Network resources in response to any type of unusual event. This tool was based on the same Incident Command System (ICS) utilized by public safety agencies and other participants in a regional

emergency response, which enhances interoperability and streamlines communication and coordination during a crisis.

The CEMP consists of the following main elements:

- Outline of responsibilities of the Network Emergency Management Plan
- Network procedures to mitigate, prepare, respond, and recover to emergencies
- Emergency Management Overview
- Hazard Vulnerability Analysis (HVA) to measure the risks of all hazard types
- Standard Content Elements (SCE) Tool to measure the plan

The Network participated in a drill exercise hosted by the Network Coordinating Center (NCC), KCER Coalition on October 23, 2013. The exercise was a four-hour table-top discussion-based exercise which was open to participation by all 18 ESRD Networks. The exercise assisted Networks in evaluating their decision-making processes and capability to implement the CEMP in response to a wide area, extended power outage.

Business Continuity and Contingency Plan (BCCP)

As part of its emergency preparedness activities, the Network maintains a CMS Business Continuity and Contingency Plan (BCCP). The BCCP identifies personnel, contractors, and business processes necessary to return the Network data systems to operational readiness should an emergency cause the Network to be unable to operate for an extended period of time. The BCCP is reviewed at least annually.

The objectives of the primary functional components are to:

- Maximize the effectiveness of contingency operations that consist of the following phases:
    - ***Notification/Activation phase*** to detect and assess damage and to activate the plan
    - ***Damage Assessment*** to assess damage and determine recovery requirements
    - ***Recovery phase*** to restore temporary IT operations and recover damage done to the original system
- Identify the activities, resources, and procedures needed to carry out ESRD Network processing requirements during prolonged interruptions to normal operations.
- Assign responsibilities to designated ESRD Network personnel and provide guidance for recovering ESRD Network sites during prolonged periods of interruption to normal operations.
- Ensure coordination with other CMS QNet Complex Support staff who will participate in the contingency planning strategies.

Facility Resource Materials

The Network provides all new facilities a Facility Resource Materials packet. The resource

materials include the following items:

- Memorandum of Understanding (MOU) between the Network and the Facility - By completing this memorandum, the facility agrees to meet Network goals and participate in the activities of the Network, including data reporting, quality improvement activities, resolution of grievances, consultation on cases related to involuntary discharges, and special studies. The facility also agrees to use those treatment settings most compatible with the successful rehabilitation of the patient and improvement of their quality of life, and to promote the participation of suitable patients in vocational rehabilitation programs. The MOU provides information regarding the Network's availability to provide technical assistance to facilities and notice that participation in Network activities is a condition of approval to receive Medicare reimbursement for the provision of ESRD services. Failure to comply may result in sanctions by the Centers for Medicare & Medicaid Services.
- Network 7 Goals and Criteria and Standards
- Quality Improvement Plan template
- Facility contact information form to be returned along with the signed MOU
- Educational Posters – Facilities are required to display, in a location accessible to patients, the Network's posters, available in English and Spanish, containing information on how to contact the Network and file a grievance. Additional posters include information regarding Dialysis Facility Compare and Disaster Planning.
- New CROWNWeb User Training Checklist and link to the Project CROWNWeb website
- Link to register for a QIMS account for access to CROWNWeb

Network Website

The Network 7 website (www.fmqai.com) was developed to serve patients, families, dialysis and transplant providers, and the renal community at large. According to the Pew Research Center's Internet Project conducted from July 18 – September 2013, 86% of U.S. adults and 59% of U.S. adults age 65 and older are Internet users. This is a six-percentage point increase from 2012 for those adults over the age of 65. This data indicates that Internet adoption continues to increase and that web distribution is an effective way to engage the Network population.

The FMQAI website assists Network 7 in meeting its goal of improving the quality of healthcare services and quality of life for ESRD beneficiaries, as well as the CMS National Goal of increasing the independence, quality of life, and rehabilitation of individuals with ESRD. In an effort to promote use of the website, new content additions are announced to patients and providers via newsletters, fax blasts, and at community events. In addition, assistance with navigation of the website was provided via the Network help-line throughout 2013.

The FMQAI site meets federal guidelines for Section 508 compliance and strives to be as user-friendly as possible. To accomplish this task, the website is divided into several different

sections to ease the user's ability to find information. In 2013, these sections included:

- **About Network 7** – Information on Network Goals, and Criteria and Standards, as well as links to Network events, continuing education, the ESRD Statement of Work, and information on the Network's boards and committees.
- **For Patients and Families** –This section contains links to patient newsletters, patient education, and materials on emergency preparedness and going back to work. It includes helpful links such as the Dialysis Facility Compare (DFC) website. The Network website also includes information regarding the Network Grievance Process and a section for patient and family resources in Spanish.
- **Learning and Action Networks (LAN)** – This section was added in 2013 to support the Network's Patient Engagement and healthcare-acquired infection (HAI) LANs. This page includes LAN WebEx materials and educational materials developed for the Network's 2013 Campaigns.
- **ESRD Quality Incentive Program (QIP)** – This section includes links to the CMS QIP website, National Healthcare Safety Network (NHSN) resources, In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Services (ICH CAHPS) resources and dialysisreports.org.
- **Fistula First** – An overview of the Fistula First Breakthrough Initiative, as well as information and materials related to the Fistula First Focus Group.
- **Quality Improvement** – An explanation of quality improvement, detailed information on the Plan-Do-Study-Act cycle, as well as a link to download the quality improvement plan template utilized by the Network. This section also contains quality improvement and regulatory resources regarding the CMS Conditions for Coverage, Quality Assessment and Performance Improvement (QAPI), and Network hosted educational webinars.
- **Community Information and Resources** – Information on provider education, emergency preparedness, the grievance process, vocational rehabilitation, technical assistance, and patient education.
- **Data Management** – Links to Network Annual Reports, CMS reporting information and Special Quarterly Facility Roster Reports.
- **ESRD Emergency Information** – Links to the FKDC and the KCER Coalition. This section also offers downloadable emergency preparedness tools such as a patient "to do" checklist, tips for ESRD disaster planning, patient disaster posters, and Florida Emergency Operations Center contact information. In the event of an emergency or disaster, this page would also include the open and closed status of providers and other information to assist patients and providers.
- **Project CROWNWeb** – Links directly to education and training materials for the use of CROWNWeb.
- **Patient Care Technician (PCT) Certification** – PCT certification exam review materials and study tools.

Summary of Network-Specific Activities and Information

The Network's outreach activities focus on identifying the needs of ESRD patients and providers and employ multiple methods of dissemination. This outreach provides information, assistance, and education as directed by the responses and comments received in the Network Patient and Provider Needs Assessments. The Network also continues to assist ESRD providers and patients with emergency preparedness, including patient education handouts and staff training resources. The Network 7 website contains links for this information, as well as the other educational resources and materials described in this report.

CMS AIMS, DOMAINS & NETWORK ACTIVITIES

CMS AIMS, DOMAINS & Network Activities

INTRODUCTION

Network 7 supports the three Aims of CMS and its goal to foster health care transformation and find new ways to deliver services that improve care and lower costs. As partners in this change, the Network engaged in exciting new patient-centered initiatives that served to promote innovation and take ESRD care to the next level in quality outcomes, patient engagement, and community partnerships. The Network focused its efforts on identifying, developing, rapidly testing, and encouraging widespread adoption of innovative best practices, laying the groundwork for a broader transformation of our healthcare system to one that delivers better health care at lower costs.

AIM 1: BETTER Care for the individual through Beneficiary and Family Centered Care

INTRODUCTION

Beneficiary- and family-centered care can be described as an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among patients, their families, and healthcare providers (The Institute for Family-Centered Care). Per CMS direction, the Network has taken a two-tiered approach to incorporating the patient's voice in the activities of the Network and the renal community as a whole. The two tiers are: (1) engagement at the dialysis facility level to foster patient and family involvement; (2) development and implementation of a beneficiary and family centered care focused LAN to promote patient and family involvement at the Network level. Both tiers are essential and work together to promote beneficiary and family engagement to improve quality of care.

Network 7 Education and Marketing Plans

In addition to AIM 1 focused activities related to patient- and family-centered care, the Network also works with patients and providers in Florida to improve the quality of care and quality of life of ESRD patients by providing informational material and technical assistance on other ESRD-related issues, including those related to the other CMS AIMs. The Network accomplishes this through the development and implementation of the Network's Education and Marketing plans. Both plans are developed based on the results of the Network's Patient and Provider Needs Assessments.

Patient Needs Assessment

The Network updated the Patient Needs Assessment for 2013 through collaboration with the three ESRD Networks under FMQAI. The needs assessment was designed to gain an understanding of dialysis patients' educational needs, level of activity in the facility Plan of Care (POC) process, and knowledge of ESRD treatment options. It was shared with the Network

PAC which provided feedback.

Distribution
The Patient Needs Assessment was mailed as a separate document, along with the second quarter edition of the patient newsletter, to all dialysis facilities in Florida in June 2013. The needs assessments and newsletters were mailed to facility social workers with instructions requesting they distribute the documents and assist patients by faxing completed needs assessments back to the Network. The needs assessment is also posted on the Network website, with instructions for the patient to return by fax, regular mail, or via their dialysis social worker.

Analysis of Data
In 2013, the Network received 552 completed Patient Needs Assessments, either by fax or mail. Responses again revealed that the majority of respondents preferred to get their health education through face-to-face contact (verbal discussion) with dialysis staff or their doctor. Results also illustrated that 63% of respondents reported that they are given the opportunity to participate in a scheduled meeting at the facility to discuss their POC and 54% of these patients attended the meeting. Additionally, 60% of respondents reported that they are "knowledgeable" or "very knowledgeable" about treatment options for kidney disease. In addition to the Network's Marketing and Education Plans, the results of the needs assessments were utilized for development of the Network's 2013 LAN campaigns and additional Network educational materials. Full results from the 2013 Patient Needs Assessment are provided in Appendix A.

Provider Needs Assessment

The Network designed and distributed an updated dialysis Provider Needs Assessment in July 2013. The Provider Needs Assessment was distributed via e-mail. The Provider Needs Assessment was designed not only to ask providers what education and technical assistance they would like to receive from the Network, but also what education they needed for their patients and the level of patient engagement at the facility. The Network received 114 completed needs assessments and responses indicated providers would like more provider education regarding vascular access and dialysis adequacy and patient education materials regarding the QIP, self-care, independence, and patient rights. Responses also indicated 49% of providers invite patients to the facility QAPI meetings and approximately 33% invite patients to a POC meeting at their facility. Providers responded that their preference for receiving educational materials from the Network is as follows, in order, from first to fourth most preferred: e-mail, hard copy mail, provider eNewsletter, and fax blast/Network website. A full report of the Provider Needs Assessment results can be found in Appendix B.

Education Plan

This plan serves as a guide for conducting patient and provider education, and is updated annually, or as new information is available. The individual components of the plan reflect the Network Statement of Work and incorporate results of the feedback from ESRD patients, the Network's PAC, LAN participants, Patient SMEs, and members of the Network MRB and NC. The education plan is developed based on the results of the Network's annual patient and

provider needs assessments and reflects the specific needs of the ESRD patient population and the most effective strategies for the distribution of informational materials. Information provided to patients and providers per the education plan include the following:

- The role of the ESRD Network
- The Network's process for receiving, reporting, resolving, and tracking patient grievances
- The Network's role in facilitating patients' access to care
- Treatment options and new ESRD technologies available to patients, with an emphasis on those that have been shown to support patient independence (e.g., transplantation, home therapies, in-center self-care)
- Information to educate facilities/patients on the actions to take during emergency and disaster situations
- Information to encourage patients to achieve their maximum level of rehabilitation and to participate in activities that shall improve their quality of life
- Information on vascular access procedures
- The Network's toll-free number, mailing address, and website address
- Information on how to access and use the Dialysis Facility Compare website
- Information on how to interpret a facility's QIP Performance Score Certificate
- Information on all Network committees, including information on how to become a member of each committee
- Information on the importance of receiving vaccinations (including HBV, influenza, and pneumococcal vaccinations)
- Information related to the importance of disease management, the Welcome to Medicare Physical, heart-healthy living, diabetes self-management and training, and (if requested) smoking cessation
- Information on the benefits of the Medicare Prescription Drug Program (Medicare Part D) and on how to enroll

The Network's education plan also includes the provision of the Network ESRD Patient Orientation Packet (NEPOP). The mailing of the NEPOP was initiated in the fourth quarter of 2000 through a collaborative effort with CMS and the Network Coordinating Center (NCC). The NEPOP process entails identifying new ESRD patients upon entry into the Network data system (via the CMS-2728 Form) and sending out a package of orientation materials to their home addresses.

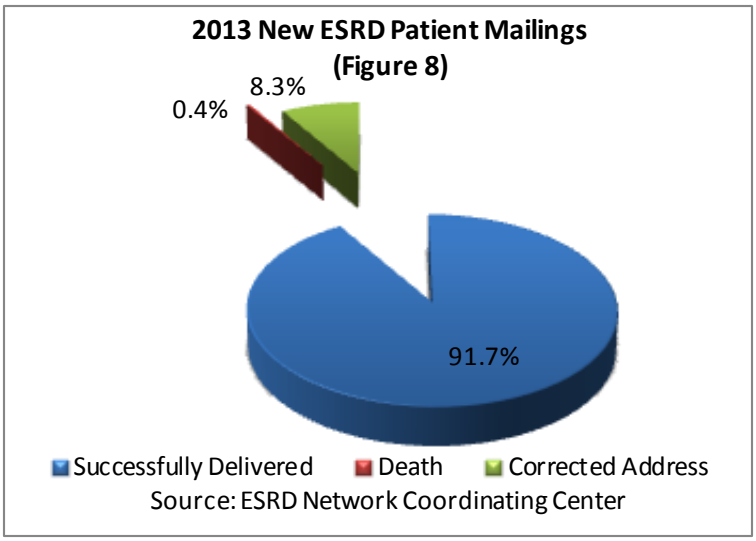
Each new chronic dialysis patient receives an introduction letter from the Network in the NEPOP within three months of initiation of dialysis in a chronic facility. The letter contains information on the Network's grievance procedure, the Network's toll-free number, services and assistance offered, available Network educational resources, and contact information/function of the State Survey Agency.

The NEPOP educational materials include the following:

- A Medicare beneficiary letter from the Administrator of CMS
- A letter from the Network Executive Director*
- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* (CMS booklet)*
- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services – 2013 Cost updates and Corrections* (CMS booklet)*
- *Preparing for Emergencies: A Guide for People on Dialysis* (CMS booklet)*
- *You Can Live: Your Guide for Living with Kidney Failure* (CMS booklet)*
- *Join Us: We Can Help* (National Kidney Foundation postcard)
- *Dialysis Facility Compare* (CMS brochure)*
- *Hemodialysis Vascular Access* (Fistula First Breakthrough Initiative flyer)*

**Materials available for the Spanish NEPOP mailing*

To ensure the process was effective in getting the materials to new patients, the Network tracked the percentage of NEPOP initial mailings returned due to error (e.g. mailing address) on a quarterly basis. In 2013, 8.3% of the NEPOP mailings were returned to the Network *(Figure 8)*, which was well within the Network target of a less than 10% return rate on initial mailings. The Network followed up on returned mailings to have the NEPOP sent to the correct addresses.



Marketing Plan

In addition to an Education Plan, the Network also developed and implemented a Marketing Plan specific to the topic of *Patient Engagement at the Facility Level* with the following objectives:

- Assess the current level of patient and family engagement at the facility level, from the perspective of both the provider and the patient.
- Increase patient and family engagement at the facility level through the distribution of resources, technical assistance, and education.
- Evaluate the effectiveness of, and make adjustments to, the plan based on re-measurement of the level of patient and family engagement at the facility level.

To assess the current level of patient and family engagement at the facility level, the Network utilized the results from both the patient and provider needs assessments. The Network was able to focus Patient Engagement messaging in the Patient and Provider Newsletters and through information provided by the Patient Engagement Learning and Action Network (LAN). The messaging encouraged facilities to assess their own level of patient and family engagement by reviewing and evaluating the following:

- Patient and family involvement in the facility's QAPI Program.
- The presence of patient and family meetings (e.g., patient council, support groups, vocational rehabilitation groups, new patient adjustment groups).
- Patient and family involvement in the facility's governing body.
- Policy and procedures related to family participation in the patient's care, such as involvement in the development of the individualized POC and cannulation.
- The percentage of patients and/or family members/caregivers who participate in POC meetings.

Patient and Provider Newsletters

During 2013, the Network shared the status of all AIM 1 activities, including results from the Network's LAN QIA and campaigns, statewide via the Network's quarterly newsletters for patients and providers. Additional topics for the newsletters included articles on vascular access, Medicare Part D, disaster preparedness, the Network grievance process, and treatment options. For each edition, the topics for the newsletters were developed to facilitate communication between patients and the providers that care for them. Patient newsletters also included an article titled "The Patient's Voice" which highlighted an important message the Network's Patient Advisory Members wanted to share patient-to-patient. Provider newsletters included important information regarding the CMS ESRD QIP, NHSN reporting, Patient Engagement, and CROWNWeb.

Patient Engagement Learning and Action Network (LAN)

A Learning and Action Network (LAN) is a mechanism by which large-scale improvement around a given aim is achieved through the use of various change methodologies, tools, and/or time-bounded initiatives. LANs manage knowledge as a valuable resource. They engage leaders around an action-based agenda. LANs create opportunities for in-depth learning and problem solving.

In 2013 the Network developed and facilitated a Patient Engagement LAN in the Network area to promote patient and family engagement. To begin LAN development, the Network recruited ESRD patients throughout Florida to volunteer as Network Patient Subject Matter Experts (Patient SMEs). Patient SME recruitment activities and materials were developed with input from the Network Patient Advisory Committee (PAC) and distributed to all Network dialysis facilities in January 2013. Packets also went to patients that had volunteered previously in the Network's Patient Coordinator program or had previously contacted the Network in prior recruitment efforts. The Patient SMEs are committed and informed patients who are representative of the demographic characteristics of the Network's service area and assiste the Network by providing the patient perspective for Network improvement activities.

The Patient SMEs met monthly during 2013 via conference call to share their stories, discuss identified areas of possible improvement at the patient and facility level, and provide direction

and feedback for Patient Engagement LAN activities. During the Patient SME call held in April 2013, the group decided the Patient Engagement LAN would focus on treatment options education and engaging patients in the POC process. The Network also recruited providers to join the Patient SME group on monthly conference calls starting in June 2013 to discuss LAN activities. The collaboration between committed patients and providers assisted the Network in ensuring both perspectives were considered in the development of LAN activities based on the topics chosen by the Patient SMEs.

Through the Patient Engagement LAN, the Network was tasked with implementing:

- A quality improvement activity (QIA) developed by the LAN impacting at least 10% of the Network population that promotes patient-centered care and protects the interest of beneficiaries; and
- At least two campaigns developed by the LAN that impact at least 20% of the Network population per campaign.

Patient Engagement LAN QIA

The LAN QIA included 36 facilities and 1,800 patients, and focused on provider education to increase the number of dialysis patients and/or their caregivers that are invited to attend a scheduled POC meeting with the facility Interdisciplinary Team (IDT). This focus was chosen by the Patient SMEs, with input from the provider work group.

QIA activities included the Focus Group facilities completing an environmental scan via a SurveyMonkey tool. The environmental scan assisted the Network in obtaining information from the Focus Group facilities regarding their POC process and established the baseline for the QIA primary measure. Interventions for the QIA included a Network-hosted orientation conference call for all focus group facilities, completion of an improvement plan (IP) by each facility, and provision of monthly educational resources by the Network to facilities specifically aimed at making the facility's POC process more patient-centered. The resources assisted facilities in engaging patients in understanding the POC process and becoming more active in their dialysis care. The facilities also completed and returned to the Network monthly attestations that the resource was received and described how the resource was utilized by facility staff. At the end of the QIA, 98.4% of patients scheduled for a POC meeting with the IDT were invited to participate. This was an increase of 47%. Additionally, at the end of the QIA, 49.2 % of patients from the QIA facilities attended their scheduled POC meeting. This was a 30% increase from baseline. QIA facilities completed an evaluation of the QIA as part of their November reporting, with 95% of the Focus Group responding that the QIA had a positive impact on their facility. The Network also provided a project completion letter to each facility, including final results of the QIA, and a summary was provided statewide to encourage adoption of QIA best practices.

Campaign 1: What's Your Plan?

Campaign 1 was implemented with 75 facilities and included 4,700 patients. The Campaign focused on patient education regarding participation in POC meetings with the facility Interdisciplinary Team (IDT) and included

dissemination of monthly Campaign materials to patients through the facilities. Before the Campaign began, 50% of the patients who responded to the Network's 2013 Patient Needs Assessment, from the Campaign region, reported they had participated in a scheduled meeting with the facility interdisciplinary team IDT to discuss their POC. At the end of the Campaign, 59% of patients who responded to the Campaign re-measurement tool reported that they had participated in a scheduled IDT meeting to discuss their POC. This 9% increase was the first step in increasing patient engagement in their dialysis treatment POC.

Campaign 2: Know Your Options

Campaign 2 was implemented with 70 facilities and included 4,200 patients.

The Campaign focused on patient education to increase patient knowledge of ESRD treatment options. Before the Campaign began, 60% of the patients who responded to the Network's 2013 Patient Needs Assessment from the Campaign region reported being "knowledgeable" or "very knowledgeable" regarding treatment options for End Stage Renal Disease (ESRD). At the end of the Campaign, 75% of patients who responded to the Campaign re-measurement tool reported being "knowledgeable" or "very knowledgeable" regarding treatment options for ESRD. This 15% increase was a positive step in ensuring all ESRD patients are knowledgeable regarding treatment options for ESRD.

Campaign educational materials were developed by the Network and patient SMEs, with feedback provided by the PAC. All of the Campaign materials, as well as other Network Patient Engagement LAN resources, are available on the Network website at http://fmqai.com/NW7-LANs.aspx.

Patient Experience of Care

Evaluate and Resolve Grievances

Network 7 maintained consistent efforts throughout 2013 to assist, facilitate, and educate ESRD patients and providers in resolving patient grievances. This was achieved by providing educational information to patients and providers, conducting trend analysis of reported situations to detect patterns of concern, and developing Network-specific policies and procedures for addressing patient grievances based on Chapter 9 of the Medicare ESRD Network Organizations Manual. In addition, the Network worked with its MRB to review and discuss grievances received and possible interventions to utilize with facilities receiving two or more grievances with the Network in any quarter of the year, or three or more grievances in a rolling year. These interventions may have included requiring a facility to complete an IP or staff education to address grievances reported.

Throughout 2013, the Network was available to receive grievances, and other contacts such as facility or patient inquiries, on a daily basis through phone calls, e-mail, and regular mail. Based on Chapter 9 of the Medicare ESRD Network Organizations Manual, evaluation and resolution

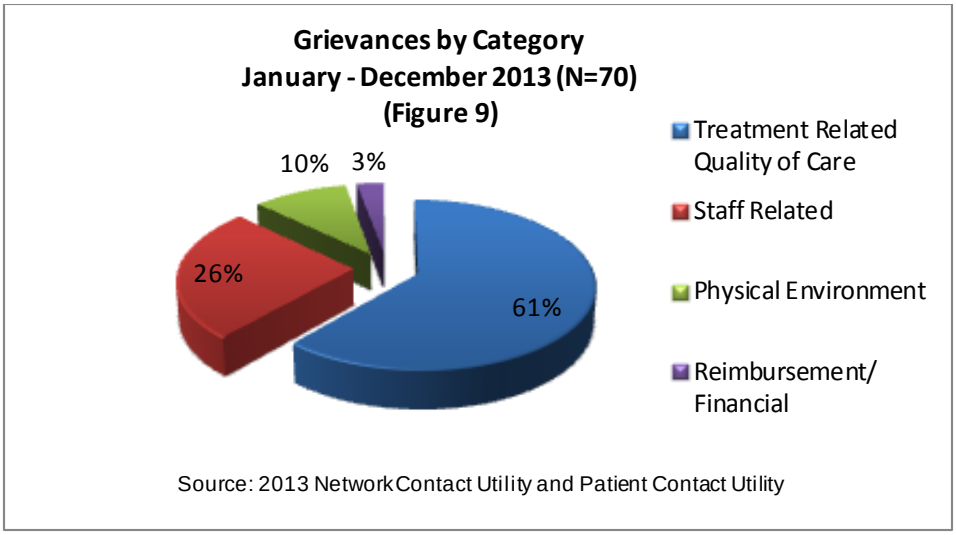
of grievances may include Immediate Advocacy or a Quality of Care Review. Immediate Advocacy is utilized by the Network and grievant to resolve a concern within three days. A Quality of Care Review involves review of documentation, including but not limited to medical records, facility policies, and procedures, and facility staffing plans; site visits; interviews with grievants, family members, facility staff, or others; requiring facilities to submit Corrective Action Plans; and other activities consistent with guidance provided by CMS.

The following is an overview of the Network's Quality of Care Review procedure. The Quality of Care Review process must be completed within 60 calendar days of receipt. The following steps are included in the grievance process:

1. A grievance is received at the Network office.
2. Network staff ascertains what steps the grievant has taken previously to resolve the problem and the patient's goal(s).
3. The Network staff notifies the grievant through the mail acknowledging receipt of the grievance.
4. Network staff notifies the ESRD provider or medical director's office of the grievance via phone and forwards a written request for a response to the grievance that includes a request for medical records or other documentation.
5. Network staff reviews the medical records and documentation, and when appropriate, forwards the information to members of the Network MRB for review and recommendations. All identifiers are removed from the information provided by all parties for the MRB review.
6. Network staff issues the facility or provider a final letter of findings for review and comment.
7. After the facility or provider has time to comment, the grievant is then issued a final letter of findings that includes the facility or medical director comments and the grievant's appeal rights.

A facility site visit may be necessary at any time during this process depending on the nature of the grievance. Matters serious enough to be an immediate threat to the patient or other patients' health and safety are referred immediately to the State Survey Agency for investigation. If a Quality of Care concern is identified, Network staff or the MRB may request an IP from the facility. If the facility is not successful in correcting the identified problem within the time frame of the IP, the MRB may recommend that CMS sanction the facility.

In 2013, the Network received a total of 70 grievances. Of the 70 grievances received, 70 (100%) were resolved. Of these, six (9%) were referred to the State Survey Agency for further investigation. The chart below demonstrates the grievances by category *(Figure 9):*



Grievance Quality Improvement Activity (QIA)

Per the 2013 ESRD Network Statement of Work (SOW), the Network was tasked with completing a focused audit of grievances received from January 1, 2013 – March 31, 2013 to identify a trend and implement a QIA with at least five facilities with the highest number of grievances in that trend area. Historically, Network 7 has completed grievance trending quarterly and reviewed this information with its Medical Review Board (MRB) Grievance Subcommittee to determine if specific facilities warranted quality improvement intervention or potential trends identified required additional review.

Based on the initial focused audit, the grievance category for Treatment Related/Quality of Care was identified to have the highest number of occurrences; however, further analysis identified a trend in only three facilities, each having a grievance related to fluid removal/dry weight. The Network conducted a second audit of Treatment Related/Quality of Care grievances from January 1, 2012 – December 31, 2012 to assess for additional grievances related to fluid removal/dry weight and identified an additional three facilities for inclusion for a total of six to participate in the QIA.

Furthermore, the Network reviewed state survey agency citation data for calendar years 2010 – 2012 which demonstrated that V-Tag 543*, Plan of Care – Manage Volume Status*, moved from the ninth highest V-Tag cited in 2010 to the number one citation in both 2011 and 2012. In June 2013, the QIA was formalized and approved by the Network's MRB.

Goal for Improvement

To determine the baseline percentage of patients, the Focus Group submitted one month's post-treatment summaries (May 2013) for all HD patients to the Network. The Network reviewed the summaries to calculate an average variance form the target dry weight for each patient and identified the 10% (subgroup) of patients from each facility with the highest average variance.

The Network then requested each facility to submit supporting documentation for the 10% of its

patients that the Network identified as having the highest average variances from their target dry weights during the month of May 2013. The Network then utilized the CMS Conditions for Coverage for ESRD Facilities regarding *Patient Plan of Care – Manage Volume Status* to develop the following criteria as an internal Network guideline for the QIA to assess if the facility met the goal of addressing a patient's dry weight variance:

- A target weight was identified.
- Staff acknowledged the dry weight variance.
- An assessment was completed to determine why the dry weight was not attained.
- A plan of action was developed and documented.

Interventions

Interventions for the QIA project included initial correspondence to the facility administrator and medical director regarding facility selection criteria, and required facility documentation to be provided to the Network to establish project baseline measurement; completion of an environmental scan by each facility and QIA related conference calls hosted by the Network. Each facility also received a Network developed report card regarding their facility's data reviewed and utilized by the Network for their baseline measurement and each facility submitted an RCA for Network review. The Network conducted three facility site visits focusing on records review, the facility dry weight management process and any new activities implemented since the start of the project. Additionally, facilities submitted a copy of their Quality Assessment Performance Improvement (QAPI) meeting minutes for one month in an effort for the Network to evaluate the interdisciplinary team's discussions regarding fluid removal and dry weight.

Project Measurement

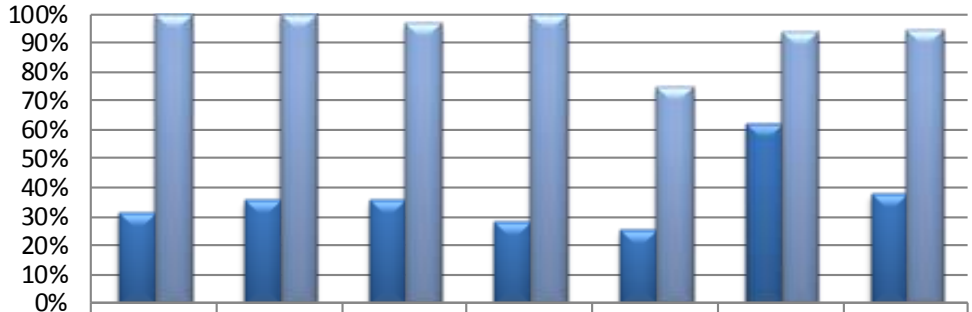
The Network utilized the same internal Network guideline criteria mentioned previously to evaluate the supporting documentation to determine facility pre and post QIA measurements.

- Numerator: Number of patients in the 10% subgroup that do not meet their established dry weight for fifty percent (50%) or more of their completed treatments during the baseline calendar month (May 2013) and do not have documentation in the medical record that the dry weight is being addressed.
- Denominator: Total number of patients in the 10% subgroup.

Results

The graph below *(Figure 10)* displays the Focus Group improvement of 57% for supporting documentation based on the QIA established criterion, which was structured in alignment with the ESRD Conditions for Coverage Patient Assessment requirements.

Grievance QIA - Improvement in Supporting Documentation
(Figure 10)



	Facility A	Facility B	Facility C	Facility D	Facility E	Facility F	All
Baseline	31.3%	35.7%	35.7%	28.1%	25.0%	62.5%	37.8%
Final	100.0%	100.0%	96.9%	100.0%	75.0%	93.8%	94.8%

Source: Facility Documentation

Focus Group participants attributed success to best practices including:

- Focusing on the patient's dry weight every treatment helped to determine patients' immediate needs, identify areas for educational opportunities, and prevent complications related to fluid overload
- Utilizing CRIT-Line patient monitoring and the Standing Order-Target Weight Tool
- Assigning an RN as Fluid Manager

Network correspondence sent to the Focus Group in December 2013 included the facility's average dry weight variance results for May (baseline) and October (final) as well as the facility's overall improvement.

In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS)

The In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey is a reporting measure contained in the ESRD QIP designed to measure the experiences of adults receiving in-center hemodialysis (ICH) care from Medicare-certified dialysis facilities. ICH eligible facilities must contract with an independent third party survey vendor that has been approved and trained by CMS and all approved ICH CAHPS Survey vendors are required to use the administration specifications developed by CMS. During 2013, the Network collected surveillance data reflecting the number of facilities that were utilizing the ICH CAHPS survey and provided that information to CMS on a monthly basis, via a Network developed data collection tool. Network staff, using e-mail, fax blasts and direct contact, also provided technical assistance to ICH CAHPS eligible facilities during the mandatory CROWNWeb attestation period, whereby the facility indicates its compliance with the ESRD QIP. After this intensive intervention, all but one eligible Network 7 facility completed the required attestation (373/374).

Patient-Appropriate Access to Dialysis Care

Access to Care

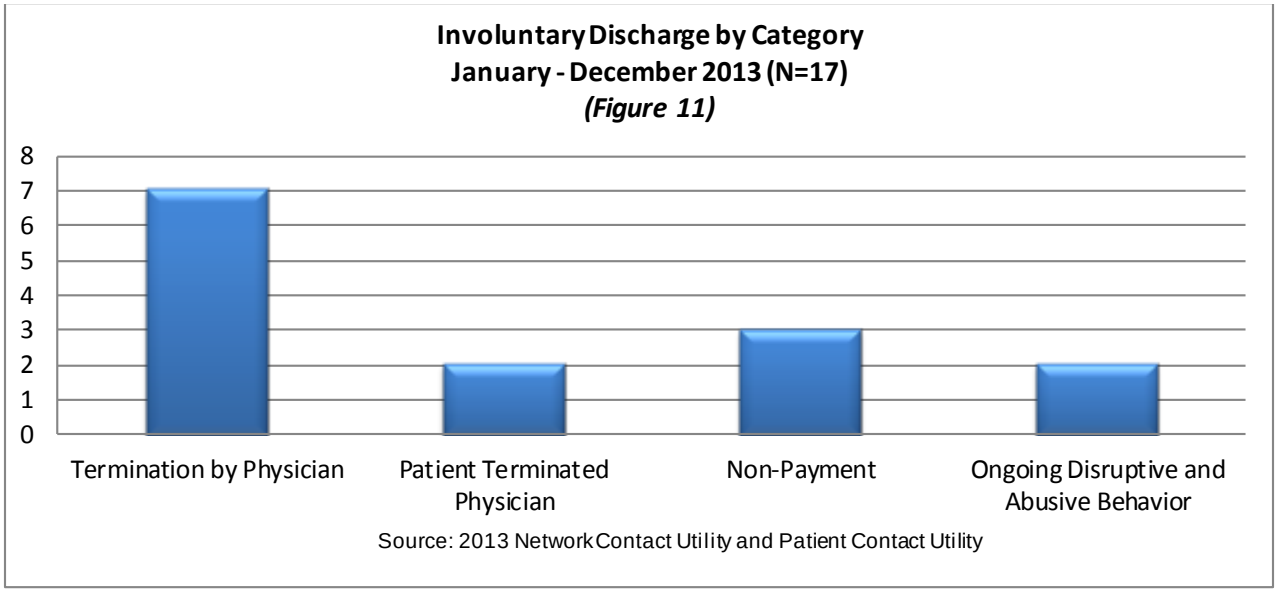
The Network strives to assure appropriate access to in-center dialysis care for ESRD patients who require life-sustaining dialysis treatment and who are not candidates for home modalities. The Network works with provider facilities to identify and address issues related to difficulties in placing patients in dialysis facilities, and in identifying patients at risk for involuntary discharge (IVD), involuntary transfer (IVT) or failure to place (FTP).

Involuntary Discharge (IVD), Involuntary Transfer (IVT), Failure to Place (FTP)

The ESRD Conditions for Coverage mandate that facilities provide patients with a 30-day written notice of an IVD and discontinuation of services. It also states that an order for discharge be signed by the facility's medical director and the patient's attending physician. The Network works with facilities to avert IVDs/IVTs whenever possible in order for patients to have appropriate access to in-center care.

Facilities are encouraged to contact the Network for support with difficult patient situations and patients who may become at-risk for IVD. It does this through making available the Network IVD Guidelines and Checklist in the Network provider newsletter, on the Network website, while exhibiting at provider events, via annual fax blast to all facilities, and through requests from facilities via calls to the Network. Additionally, the Network collaborates with the Florida State Survey Agency (SSA) regarding IVDs and periodically provides the SSA with reports of completed IVDs reported to the Network.

During 2013, the Network recorded 28 patients receiving a 30-day notice of IVD from a facility. Of the reported cases, 11 of them were averted and 17 resulted in a completed IVD. Of the 17 cases, the majority (41%) were due to care being terminated by the nephrologist, followed by non-payment (18%), and immediate or severe threat (18%). *(Figure 11)*



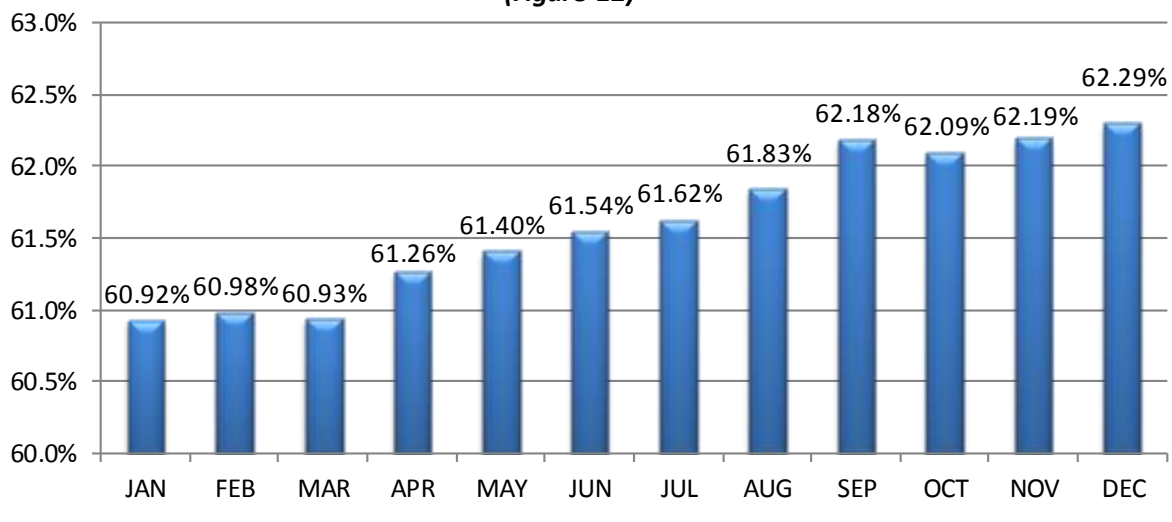
The Network also received, tracked, and reported cases of FTP and IVT to CMS monthly in 2013. FTP involves a situation in which no outpatient dialysis facility can be located that will accept a current or new ESRD patient for routine dialysis treatment. The Network received notice of four FTP cases in 2013 and provided technical assistance to all parties involved in each case. IVT involves a situation in which a patient who is registered to receive dialysis treatment at one facility is dissatisfied with being transferred to another dialysis facility when the transferring facility temporarily or permanently ceases to operate or exist. The Network did not receive notice of any IVT cases in 2013.

Vascular Access Management

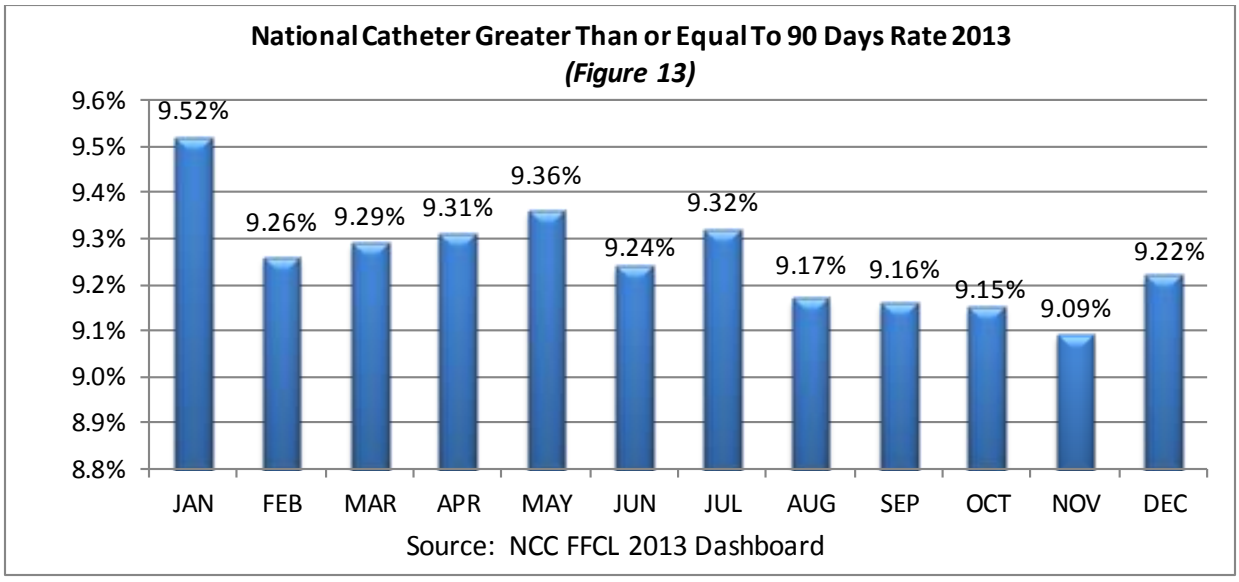
INTRODUCTION

In 2005, CMS introduced the Fistula First Breakthrough Initiative (FFBI), formerly called the National Vascular Access Improvement Initiative (NVAII). Fistula First is a nationwide initiative that promotes the adoption of recommended best practices in dialysis facilities. The goal of the FFBI is to address the urgent need to have safer, higher-quality access to hemodialysis through appropriate arteriovenous fistula (AVF) placement. Fistulas are considered to be the "gold standard" in vascular access, as they have demonstrated the ability to last longer, require less rework or repairs, and are linked with lower rates of infections, hospitalization, and death. The FFBI initiative has realized impressive gains in vascular access rates, both at the national and Network levels. *(Figures 12 and 13)*

National AVF Only Rate 2013
(Figure 12)

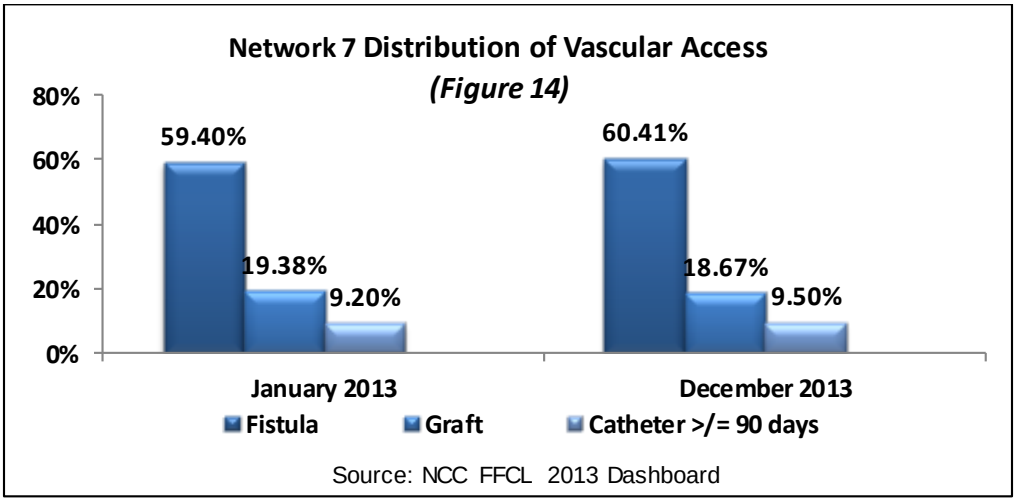


Source: NCC FFCL 2013 Dashboard



During its tenure, FFBI reported Network and national vascular access rates monthly via a dashboard, populated with vascular access rates from the FFBI data collection tool and posted on the Fistula First website. In support of the release of CROWNWeb in 2012 and ESRD Network Program's redesigned SOW in 2013, the FFBI enhanced its focus and data reporting to emphasize increasing AVF rates and decreasing catheter usages rates. In an effort to stress this enhanced effort, CMS introduced the Fistula First/Catheter Last (FFCL) focus to re-new commitment and focus on improving the AVF use while decreasing the reliance on catheters. The FFCL effort greatly expanded CROWNWeb data reports for use in Network quality improvement projects throughout 2013. To support the ESRD community, plans to develop a national FFCL Dashboard based on data captured in the CROWNWeb application are scheduled for release and posting in 2014.

Vascular access rates in Florida for January 2013 as compared to December 2013 are displayed in the following graph *(Figure 14).* During this period, the AVF in-use rate increased 1.01% and the catheter greater than 90 days rate increased 0.33%.

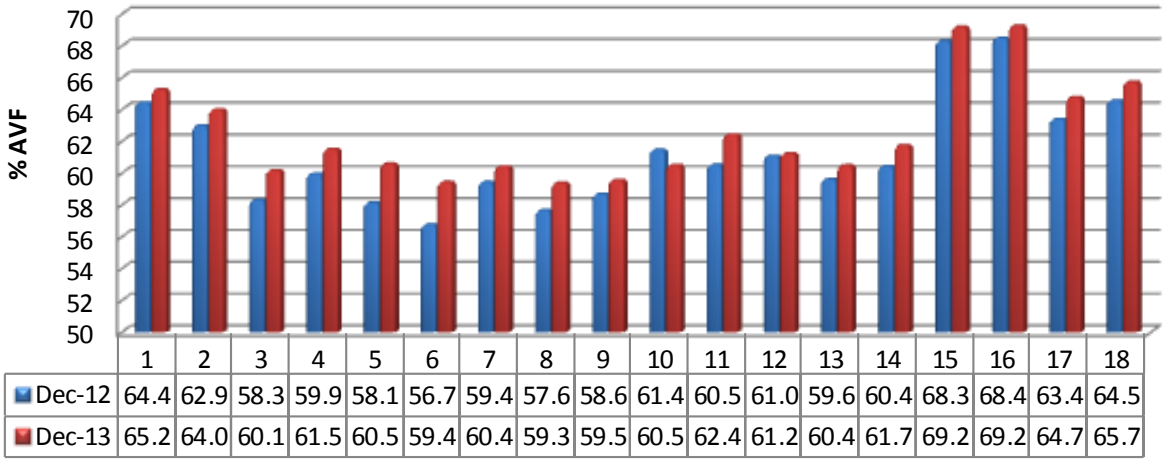


Improve AVF Rates for Prevalent Patients

Overall, since January 2004, the Network has achieved a statewide increase in AVF rates of 23.5%, increasing AVF in-use rates from 36.9% (January 2004) to 60.41% (December 2013). The facilities demonstrated positive improvements in their vascular access rates and developed effective processes for their vascular access management. Network 7 demonstrated a 2.01% increase in AV fistula in-use from 59.44% (December 2012) to 60.41% (December 2013).

As of December 2013, Network 7 ranked14th in AV fistula prevalence among all 18 Networks. The graph below depicts AVF comparison data by Network for December 2012 and 2013 (Figure 15). The CROWNWeb vascular access reporting rate for all 18 Networks was 93.83% (December 2012) and 94.75% (December 2013).

AVF Rate Comparison by Network
December 2012 - December 2013
(Figure 15)



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Dec-12	64.4	62.9	58.3	59.9	58.1	56.7	59.4	57.6	58.6	61.4	60.5	61.0	59.6	60.4	68.3	68.4	63.4	64.5
Dec-13	65.2	64.0	60.1	61.5	60.5	59.4	60.4	59.3	59.5	60.5	62.4	61.2	60.4	61.7	69.2	69.2	64.7	65.7

Source: NCC FFCL 2013

PERFORMANCE GOAL

The 2013 ESRD Network SOW charged the Networks with achieving and sustaining the CMS national goal of at least a 68% AV fistula-in-use rate for prevalent patients. The Network 7 goal was to reduce its AVF quality deficit by 20% by September, 2013. The quality deficit is calculated as the difference between the CMS goal of 68% and the Network 7 baseline AVF as of October 2012, which for Network 7 was 58.9%. If the amount of the quality deficit was less than 1% (floor) or more than 4% (ceiling), then the floor or ceiling would apply. Therefore, the goal for Network 7 was to improve the AVF in use rate by 1.82 percentage points, or to reach 60.7% by September 2013.

METHODS/IDENTIFICATION

In 2013 Network 7 instituted a two-pronged approach toward increasing fistula rates by utilizing

a statewide approach, as well as conducting more intensive interventions with an identified focus group of providers to improve AVF rates. The Focus Group method provided a systematic approach to health care quality improvement in which the dialysis focus group facilities were able to test and measure practice innovations. Focus Group facilities were also able to share experiences in an effort to accelerate learning and widespread implementation of best practices.

Utilizing the Network Vascular Access in-use Report in CROWNWeb (October 2012), the Network identified a total of ten Focus Group facilities to participate in the first period. At the end of the first period (June 2013), the Focus Group facilities were again evaluated for their progress, and based upon their performance; a determination was made as to whether the facilities would be released or continue in the project. During July 2013, the Network then identified new facilities for participation in the next Focus Group period by analyzing the CROWNWeb (April 2013) vascular access data.

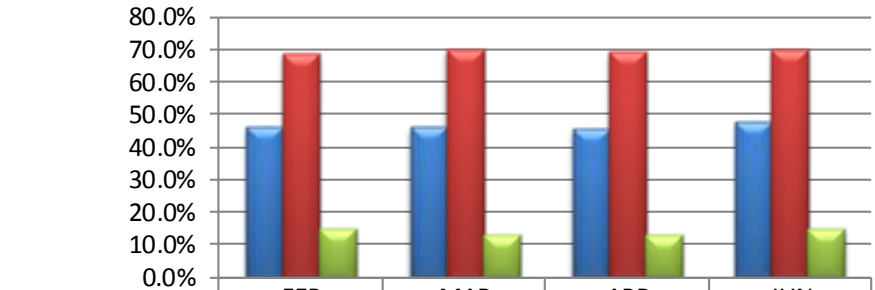
Interventions

- **Orientation –** Facility orientation to the vascular access projects was conducted by the Network via either teleconference or one-on-one communications and included a project overview, timeline, interventions, and monthly reporting requirements.
- **Root Cause Analysis** – Focus Group participants were required to submit evidence of a root cause analysis (RCA) conducted to guide development of a vascular access improvement plan.
- **Improvement Plan** – RCA documents and improvement plans were reviewed by Network staff with written feedback provided to all facilities within 30 days of submission of the plan.
- **Monthly Progress Reports** – In order to gauge monthly performance and conduct rapid cycle improvement, facilities were required to report their data on a monthly basis. The monthly self-report included the total number of patients dialyzing with an AVF, AVG, catheter in use for less than and greater than 90 days, and a breakdown of reasons for central venous catheter (CVC) use, as well as a breakdown of vascular access in-use on new/incident patients admitted to the facility. The Network analyzed the report monthly for positive/negative trends and provided each facility individualized technical assistance. Additionally, facilities were asked to report vascular access success they noted during the month, as well as any barriers they were currently experiencing. The Network utilized the barriers identified as topics of discussion during one-on-one communications with facilities. Additionally, the Network emphasized the QAPI concept in the monthly monitoring discussions to encourage facilities to identify relationships between improvement in AVF rates, or reduction in catheter rates, to a decrease in access infections and improvement in dialysis adequacy. To achieve this, the Network included an adequacy and vascular access infection reporting component into the monthly reporting tool. Facility reporting of the number of hemodialysis patients with URR less than 65 and vascular access related infection by specific access type was captured monthly.

AVF FOCUS GROUP RESULTS

The baseline AVF for the 10 facilities in Focus Group # 1 was 46.1%. By May 2013 this group improved by 1.6% achieving an overall AVF rate of 47.7% *(Figure 16)*. This group decreased the overall CVC ≥ 90 days rate from 15.1% to 14.7% during the same time period.

2013 AVF Focus Group # 1
(Figure 16)

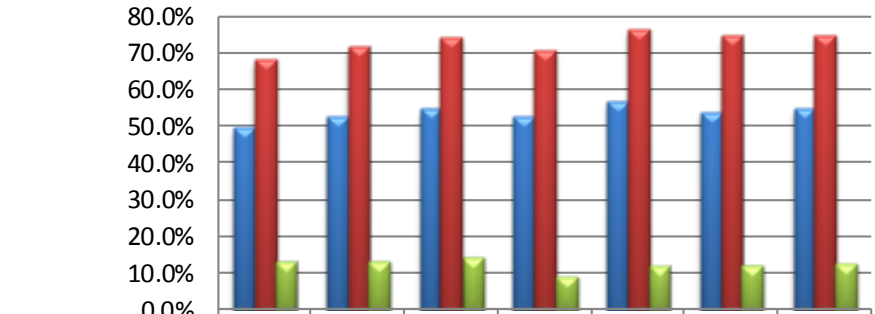


	FEB	MAR	APR	JUN
AVF	46.1%	46.5%	45.7%	47.7%
AVF + AVG	68.9%	70.3%	69.5%	70.3%
CVC >/= 90 days	15.1%	13.2%	12.8%	14.7%

Source: Facility Self-reported Data

Focus Group # 2 began the project with an overall self-reported AVF baseline rate of 49.3% (April 2013) and improved by 5.1% as of December 2013, reaching an overall AVF rate of 54.4%. The group also demonstrated a 6.3% improvement in permanent vascular access (AVF + AVG) in-use rates *(Figure 17).*

2013 AVF Focus Group # 2
(Figure 17)



	APR	JUL	AUG	SEP	OCT	NOV	DEC
AVF	49.3%	52.2%	54.4%	52.3%	56.6%	53.5%	54.4%
AVF + AVG	67.8%	71.2%	73.9%	70.2%	76.0%	74.6%	74.1%
CVC >/= 90 days	13.0%	12.9%	14.1%	8.8%	11.6%	11.9%	12.1%

Source: Facility Self-reported Data

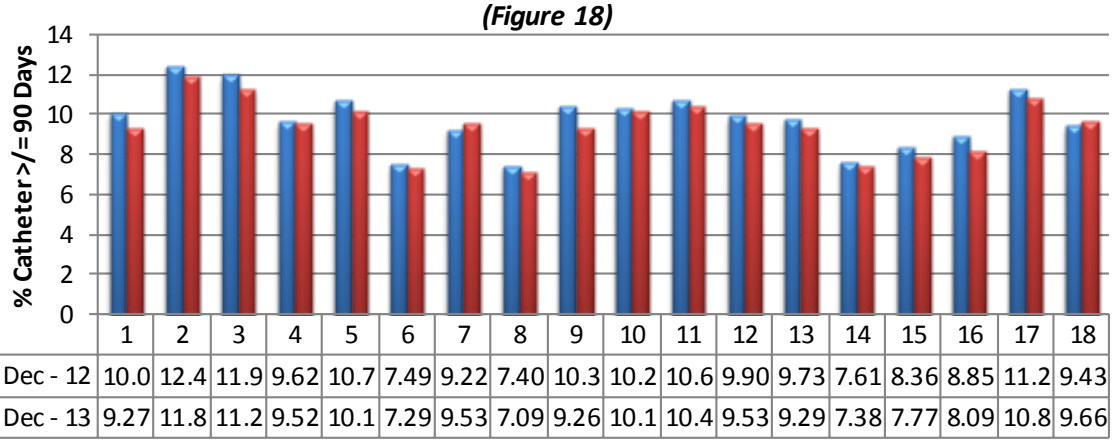
The goal for Network 7 was to improve the AVF in use rate by 1.82 percentage points, or to reach 60.7% by September 2013. The Network September 2013 final re-measurement AVF rate was 60.02% which was 0.6 percentage points short of achieving the CMS goal.

Reduce Catheter Rates for Prevalent Patients

Catheters have a significant association with morbidity and mortality in chronic hemodialysis patients (NKF KDOQI Guidelines Updates 2006). For the past eight years, the Network has developed a plan for QI activities based upon reducing the rate of catheters in use ≥ 90 days.

Overall since 2003, based on data from the FFBI, Network 7 achieved an 8.7% reduction in the percentage of patients utilizing long-term catheters ≥ 90 days, decreasing from a rate of 15.4% in July 2003 to 6.7% April 2012 (average yearly reduction of 0.99%). Data reporting transitioned to the CROWNWeb system in 2012 and is the source of data in the following sections.

Catheter >/= 90 Days Rate Comparison by Network
December 2012 - December 2013
(Figure 18)



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Dec - 12	10.0	12.4	11.9	9.62	10.7	7.49	9.22	7.40	10.3	10.2	10.6	9.90	9.73	7.61	8.36	8.85	11.2	9.43
Dec - 13	9.27	11.8	11.2	9.52	10.1	7.29	9.53	7.09	9.26	10.1	10.4	9.53	9.29	7.38	7.77	8.09	10.8	9.66

Source: NCC FFCL 2013 Dashboard

PERFORMANCE GOAL

In 2013, in addition to improving the statewide AVF rate, the Network's SOW included additional vascular access measures. The Network was charged with a goal to monitor facilities with long-term catheter (LTC) in-use rates (catheter ≥ 90 days) greater than 10%. The Network LTC goal was to achieve a two percentage point reduction in the baseline rate of LTC rates ≥ 90 days among prevalent patients in facilities with a baseline rate of > 10% (October 2012). The Network 7 baseline (October 2012) LTC rate was 14.68%. Therefore, the LTC in-use goal for these facilities was 12.68% by September 2013.

METHODS/IDENTIFICATION

The Network utilized the Focus Group approach allowing for rapid-cycle improvement over a shorter time frame (6-month time periods) and provided individualized quality improvement activities for facilities with LTC in-use rates above 10%. At the end of the first six-month period

(June 2013), the Focus Group facilities were again evaluated for their progress, and based upon their performance, a determination was made whether to continue in the Focus Group activity. The Network then identified new facilities for participation in the next Focus Group by analyzing the CROWNWeb (April 2013) vascular access data. A second Focus Group was identified for project inclusion.

Utilizing the Network Vascular Access in Use Report in CROWNWeb (October 2012), the Network identified 137 facilities with a catheter only ≥ 90 day rate above 10%. The aggregate LTC baseline rate for those 137 facilities was 14.9%. In September 2013, due to the closure of clinical data in CROWNWeb, the LTC rate was re-baselined and identfied 155 facilities with a LTC rate of > 10% with an aggreate LTC rate of 14.68%. The new LTC goal for the identfied 155 facilities was then therefore establised at 12.68%

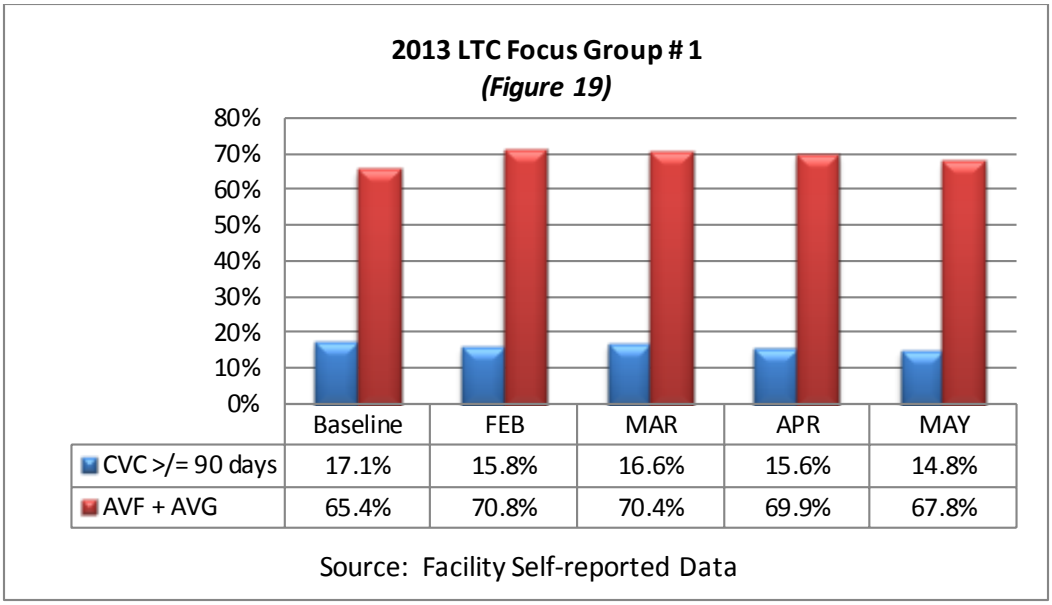
The Network utilized a statewide approach and conducted more intensive interventions with an identified Focus Group. The Network utilized a Focus Group approach as described above to work individually with selected facilities.

Interventions

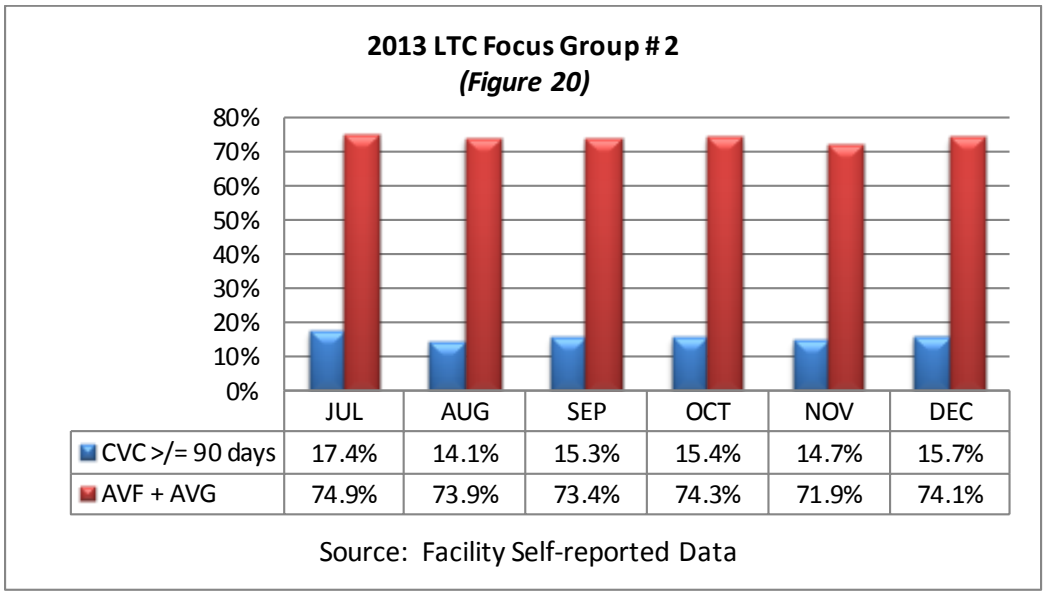
- **Orientation –** Facility orientation to the vascular access projects was conducted by the Network via teleconference or one-on-one communications and included a project overview, timeline, interventions, and monthly reporting requirements.
- **Root Cause Analysis** – Focus Group participants were required to submit evidence of a root cause analysis (RCA) conducted to guide development of a vascular access improvement plan.
- **Improvement Plan** – RCA documents and improvement plans were reviewed by Network staff with written feedback provided to all facilities within 30 days of submission of the plan.
- **Monthly Progress Reports** – Facilities were required to report monthly on their previous month's data via a Network specific self-reporting tool. The self-reporting template included the total number of hemodialysis patients, number of patients dialyzing with an AVF, AVG, catheter in-use for less than and greater than 90 days, and a breakdown for reasons for central venous catheter (CVC) use, as well as a breakdown of vascular access in-use on new/incident patients admitted to the facility. The monthly tool also included a component for monitoring hemodialysis adequacy and vascular access infection as described in the AVF Focus Group section. Additionally, the Network emphasized the QAPI concept with this group in the monthly monitoring to encourage facilities to identify relationships between improvement in AVF rates, or reduction in catheter rates, to a decrease in access infections and improved dialysis adequacy.

LTC Focus Group Results

The baseline rate CVC ≥ 90 days rate for the 10 facilities in Focus Group # 1 was 17.1%. As of May 2013, this group demonstrated a 2.3% improvement to an overall rate of 14.8% *(Figure 19).* An improvement in the permanent vascular access rate (AVF+AVG) of 2.4% was also achieved.



The 6 facilities in Focus Group # 2 began the project with an overall self-reported LTC baseline rate of 18% and demonstrated a 2.3% reduction in LTC to 15.7% by December 2013 *(Figure 20).*



Overall as of September 2013 for the 155 identified facilities, the LTC rate was 12.57%, exceeding the project LTC reduction goal (12.68%) by 0.11%.

MISSING VASCULAR ACCESS DATA

In 2013, the Network was tasked with monitoring vascular access data in CROWNWeb and supporting facilities to achieve a 100% CROWNWeb vascular access reporting rate. The Network provided technical assistance to facilities regarding their clinical information systems or

the manual data entry processes. The Network also provided support to corporate liaisons. In addition to the one-on-one technical support provided by the Network staff, the following communications were disseminated statewide pertaining to the timelines for closing of the clinical months in CROWNWeb:

- June 2013 – the Network sent notification to providers regarding the closing of the May – December 2012 clinical months in CROWNWeb and included instructions for verifying facility CROWNWeb Vascular Access data.
- May 2013 – the Network mailed correspondence to the facilities identified in the LTC subset group which included the facility's LTC rates for October 2012 – March 2013 as reported in CROWNWeb. Network correspondence included recommendations for facility monthly reporting and monitoring of vascular access data in CROWNWeb to ensure data accuracy, as well as resources available to guide facility improvement efforts for LTC reduction.
- August 2013 – the Network sent notification to providers regarding the closing of January – September 2013 clinical months in CROWNWeb.
- November 2013 – the Network sent notification to providers regarding the closing of October – December 2013 clinical months in CROWNWeb.

ADDITIONAL EDUCATIONAL MATERIALS PROVIDED

Presentations – The Network regularly provided vascular access updates including Fistula First during professional meetings throughout the state. During the presentations, statewide and Focus Group AVF and LTC data were provided, as well as an update on Network QI activities related to Fistula First and catheter reduction:

- Martha Hanthorn, MSW, Network 7 Executive Director presented "Destination Innovation: Transforming the Quality of ESRD Care" at the Florida Renal Administrators Association (FRAA) meeting during July 2013.
- Martha Hanthorn, MSW and Mark Russo, MD, PhD, welcomed 349 attendees to the 2013 Network 7 Annual Forum with a presentation titled "Destination Innovation: Transforming the Quality of ESRD Care. This multi-day event was held from October 28 – 30, 2013. The agenda for the 2013 Network Annual Forum meeting included vascular access presentations:
    - Dr. Fernando Kafie, MD, FACS presented "Vascular Access Creation and Management"
    - Dr. Daniel V. Patel, MD presented "Vascular Access and Interventional Nephrology"
- Interactive Workshop - The Network held a pre-conference Vascular Access Interactive Workshop in advance of the 2013 Annual Forum. Workshop sessions addressed:
    - Access complications affecting buttonhole sites;
    - Access complications affecting cannulation;
    - Assessing new fistula maturation and staff cannulation skills; and
    - Access assessment and indications for access evaluations.

The Network provided additional vascular access resources as follows:

- The Network's Provider *e*Newsletter (June 2013 – Edition 2) included the statewide AVF utilization rates for Q1 2013 (January – March), CMS Vascular Access Performance expectations for AVF use, and Network recommendations for monthly facility reviews of CROWNWeb to identify opportunities to improve reporting processes.
- "Missing Clinical Data in CROWNWeb" was addressed in the Network's Provider *e*Newsletter (September 2013 – Edition 3) and included contact information for Batch Submitting Organizations (BSOs) for assistance.
- Vascular access information was published in the Network's Patient Newsletter (Q2 2013) and included educational information on Hemodialysis Vascular Access Options including advantages and disadvantages for fistula, graft, and catheter.
- The Network statistician developed facility-specific vascular access trend reports for AVF and LTC in-use rates for the months of October 2012 – May 2013 utilizing CROWNWeb data. Recommendations to improve AVF in-use and catheter reduction rates were included in the report. The Network distributed the reports to the facility administrator and medical director statewide.
- Fistula First and quality improvement tools were posted to the website for review and download.

Summary

Overall Network 7 had a 2.14% increase in AV fistula in-use from 58.27% (May 2012) to 60.41% (December 2013). During 2013, the Network was able to realize improvements in both AVF and LTC rates statewide and with the facilities participating in the Focus Groups. Focus Group facilities' best practices and lessons learned will be utilized in the provision of vascular access technical assistance.

Patient Safety: Healthcare-Associated Infections

Healthcare-Associated Infections (HAI) Learning and Action Network (LAN)

The Network began the establishment and support of an HAI LAN by developing an HAI workgroup. The first HAI workgroup met on March 28, 2013 to form the framework for the HAI LAN. The Network invited stakeholders who had previously participated in the FMQAI Florida QIO LAN. The Network was also able to add representatives of Large Dialysis Organizations LDOs and independent dialysis facilities, as well as a hospital Clinical Practice Improvement consultant currently overseeing the hospital's compliance with the ESRD QIP to become core members of this HAI workgroup. The initial meeting was conducted using a didactic interactive model, with the following framing topics to assist attendees with discussions:

- Most common types of infection events
- Challenges and best practices
- Patient concerns
- Resources needed

- Other organizations or stakeholders that can assist in reducing HAIs
- Technical assistance the Network can provide to assist in reducing HAIs

A Network Patient Subject Matter Expert (SME) initiated the workgroup meeting by discussing his personal experience as a new dialysis patient who had three hospitalizations for catheter infections while his AV fistula was maturing. He provided his perspective and how most patients watch dialysis staff closely regarding infection control practices, especially hand washing after patient contact and when going between patients' dialysis machines. The patient prospective was based on his experience with two of the largest dialysis providers and their infection control programs.

Some of the key issues and recommendations from the initial workgroup meeting were to:

- Reduce/eliminate catheters;
- Address patient education needs;
- Create a culture of infection control in facilities that encompasses both staff and patients; and
- Share evidence-based best practices.

The Network conducted a second HAI workgroup meeting on June 6, 2013, to review and develop resources and tools for use during the Network HAI LAN. This call was held in collaboration with the Florida Department of Health HAI Prevention Program Manager. The workgroup identified primary areas of concern for the focus of the LAN: address the perceived/actual lack of adherence to standard infection control protocols, both from the provider and patient, and educate facility staff regarding the importance of consistent antibiotic stewardship.

The workgroup began the development of the following resources for possible use during the LAN:

- The promotion of the recommendations of the Centers for Disease Control and Prevention (CDC) collaborative which measured infection rates before and after the CDC nine core interventions
- Develop a medication cabinet sign/sticker to reinforce appropriate antibiotic stewardship
- Promote the use of the CDC website as a resource for knowledge and tools
- Develop additional tools to help educate providers and patients on infection control practices
- Utilize a provider needs assessment to determine additional educational needs

The final HAI workgroup was held on July 30, 2013 to finalize tools and the following agenda for the HAI LAN:

- Approve educational resources to provide to all LAN registrants and post to the Network website to spread statewide.
- Finalize the agenda for the Network HAI LAN meeting.
- Promote the CDC "Disinfection Checklist" during the HAI LAN. Have the nurse manager

from a dialysis provider who participated in the CDC dialysis collaborative and tested the CDC Disinfection Checklist present her experience of the rollout and use of the CDC Disinfection Checklist in five of their facilities. This will allow the HAI LAN workgroup members the opportunity to hear about this model and determine approaches to stimulating conversation among LAN participants.

The Network HAI LAN was held on August 22, 2013 with the following agenda and objectives:

Featured Speakers:

- A.C. (Anne-Carol) Burke, M.A., Healthcare-Associated Infection Prevention Program Manager, Florida Department of Health
- Peggy Bushey, RN, CDN, NM, CDC study participant for the CDC "Disinfection Checklist Trial: A Test of Change"

Meeting Objectives:

- Share experiences and knowledge between participants including ESRD providers, patients involved in facility level patient engagement efforts, and other community stakeholders
- Identify evidence-based practices and tools for use in the reduction of HAIs
- Promote improved antibiotic stewardship
- Identify opportunities to implement prevention strategies through culture change
- Support the ESRD QIP requirement for National Healthcare Safety Network (NHSN) reporting

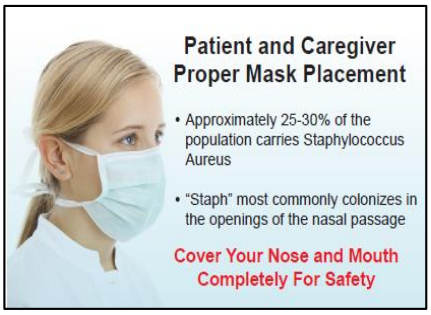
Target Audience:

- ESRD providers and corporate contacts
- ESRD patients and family members
- Network Patient Advisory Council (PAC) members and Patient SMEs
- Network Facility Ambassadors

Other Stakeholders:

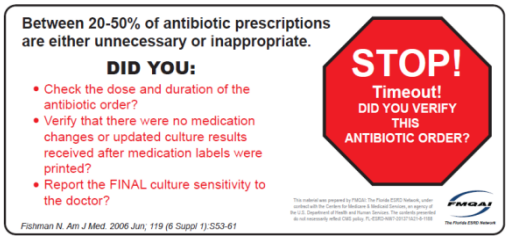
- State Survey Agency
- Florida Department of Health (FDOH)
- National Kidney Foundation of Florida (NKFF)
- American Association of Kidney Patients (AAKP)
- FMQAI QIO HAI LAN members

As a direct result of the HAI workgroup and LAN, on September 6, 2013 the Network was able to distribute the resources developed by the HAI LAN workgroup to all Florida dialysis facilities. The following resources were able to supplement the facilities current infection prevention programs:



The "Proper Mask Placement" card highlights the importance of both patients and caregivers covering their nose and mouth during catheter care. It also contains information for patients regarding how to contact Network 7. It is recommended that this card be distributed during facility education activities and to new patients. Recommendations include that facilities should stress the importance of patient participation in infection control and empower the patients to request proper mask placement by their dialysis provider.

The "Stop! Timeout!" sticker was designed to promote improved antibiotic stewardship. It is recommended that facilities place it on the medication cabinet or in an area where antibiotics are prepared for administration. The intent is that licensed personnel preparing medications are reminded to take a verification "time out" before initiating or continuing antibiotic therapy.



A survey/evaluation form was distributed to all HAI LAN participants; the intent was to provide the ability to submit feedback and recommendations related to the effectiveness and value of the resources and the HAI LAN. Overall the HAI LAN survey results were very positive and reflected an average satisfaction rating of 3.32 on a 4 point Likert scale (4 = very satisfied).

During the 2013 Network Annual Forum, Alicia Shugart, MA, from the CDC/NHSN provided a presentation on "NSHN Dialysis Event Surveillance Reports for the Florida ESRD Network," and A.C. Burke from the FDOH provided a presentation on "Keeping Dialysis Patients Safe from Multi-Drug Resistant Organisms."

Summary of Better Care for the Individual

The Network 7 community embraced the innovative activities with the LANs, QIAs and campaigns to improve the patient care experience and increase the level of inclusion of the patients' voice. The level of engagement at the facility level demonstrates that partnership and shared decision-making with patients and families improves health, quality, and value.

Aim 2: Better Health for the ESRD Population

INTRODUCTION

The Population Health Innovation Pilot Project presented new opportunities for the Network to improve the quality and efficiency of services rendered to our Medicare beneficiaries through learning activities associated with the review and analysis of data, input from providers, patients,

and other experts in the field, employment of proven quality improvement techniques, and identification and the spread of best practices. CROWNWeb data was the official data source for the project, provided by the ESRD Network Coordinating Center (NCC).

The bold and innovative approach to change involved in the Population Health Innovation Pilot Project aims to expand beyond traditional approaches to quality improvement with emphasis on engagement in collaborative partnerships to strive for maximum, sustainable improvement.

The Network reviewed and gained consensus for the selection of the Population Health Innovation Pilot Project with the MRB, NC, and PAC.

Population Health Innovation Project: Increasing Hepatitis B and Pneumococcal Vaccination Rates

In 2013, the Network initiated development of the Innovation Project to be fully implemented in 2014. The Network received data from the ESRD NCC, and conducted an analysis of patient pneumococcal and hepatitis B vaccination rates in Florida utilizing CMS criteria. The data were assessed for identification of an underserved population meeting project criteria to have ≤ 85% of the Florida target population not achieving the desired vaccination outcomes and identification of a disparity for both vaccination types of at least a combined 5% less than the non-underserved population (Table 1).

Table 1				
Disparity Race 12 Focus Facilities	Black or African American	White	Difference	
Number of Patients	494	364		
% of Patient Received Hepatitis	16.2%	31.0%	-14.8%	Sum
% of Patient Received Pneumococcal	10.3%	10.4%	-0.1%	-14.9%

Both of these requirements were met in the data analyses which demonstrated:

- The statewide pneumococcal vaccination rate was 62.0% and the hepatitis B vaccination rate was 60.5%.
- A race (African American vs. Caucasian) disparity was identified by meeting the project criteria of having at least a combined -5% total disparity for both vaccination types.

This project has applied the following provider and patient exclusions:

- Veterans Administration (VA) facilities
- Transplant facilities
- Special purpose facilities (e.g. prisons)
- ESRD patients below the age of 18

Using the above exclusion criteria, 12 facilities were identified with a combined race disparity rate of -14.9% and a total patient census of approximately 858.

This QIA has a primary and secondary measure. The primary measure is a one percent reduction in the identified disparity of race (Black or African American vs. White) for hepatitis B and pneumococcal vaccination rates. The secondary measure is an overall five percent vaccination rate increase of all patients within the project facilities, who have received the hepatitis B (minimum 1st of the series) and pneumococcal vaccinations.

The Network has also incorporated the following six attributes within the project plan interventions:

- Rapid Cycle Improvement
- Customer Focus & Value to Beneficiaries, Providers and CMS
- Sustainability
- Innovation
- Boundarilessness
- Unconditional Teamwork

The Rapid Cycle Improvement throughout the project will allow the Network to evaluate the value of the interventions and make interim adjustments as needed. The Network will continue to place the important role of the patient perspective as the foundation in all QIA. The Network will ensure there is an understanding of the patient experience of care and identifying successful ways to improve outcomes, as well the importance of the provider perspective in identifying barriers and realistic, actionable solutions. In order to maximize the project impact and long-term sustainability, the Network will use a multi-pronged approach to seek input from patients, providers, and other stakeholders; provide technical assistance with interventions and obtain feedback to ensure a patient-centered, customer-focused project that improves patient outcomes and brings value to the project participants and CMS.

Project facilities will be encouraged to share any innovative ideas they may have that could provide additional innovation to the project at any point. The Network has established new stakeholder relationships and partnerships for this project. Specifically the Network has begun collaborating with the FDOH and the Office of Minority Health to share resources and best practices to reduce healthcare disparities. In addition, the Network will engage multiple entities to impact improvement, and collaborate with patient SMEs, dialysis providers at the facility and corporate level, State agencies such as the Agency for Healthcare Administration (AHCA), the Centers for Disease Control and Prevention (CDC), and the Quality Improvement Organization (QIO) Prevention Team.

Summary

Utilizing the CMS AIM 2 Population Health Innovation Pilot Project Checklist and immunization data received from the ESRD NCC, the Network conducted analysis of patient pneumococcal and hepatitis B vaccination rates in Florida and identified a disparity for both vaccination types. Based on this analysis, the Network will begin project activities with 12 focus facilities in 2014, impacting a total patient census of approximately 858 individuals.

AIM 3: Reduce Costs of ESRD Care by Improving Care

INTRODUCTION

The ESRD QIP continues efforts by CMS to improve the quality of care for beneficiaries with ESRD. Since 1978, Medicare has worked through the ESRD Networks to monitor and improve the quality of care furnished to ESRD beneficiaries. Since 2001, CMS has published information for consumers about the quality of dialysis care on the Dialysis Facility Compare website at www.medicare.gov.

Section 153(c) of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires, among other things, that CMS select measures, develop a scoring methodology, and implement a payment reduction scale that relates to facility performance. A percentage of the facility's dialysis payment is contingent on the facility's actual performance on a specific set of measures. In support of the CMS AIM 3: Reduce Costs of ESRD Care by Improving Care, the Network provides technical assistance and education to facilities, beneficiaries, caregivers, and other stakeholders, on the ESRD QIP.

Support for ESRD QIP and Performance Improvement on QIP Measures

The Network communicated ESRD QIP information throughout 2013 in a variety of ways. Facilities were notified via e-mail, fax, or individual phone contact of CMS notifications, upcoming deadlines, training vehicles, and available resources, regarding the QIP. Each of the Network's Quarterly Provider eNewsletters contained information about the program as well. Network staff also conducted activities to support facility data submission in CROWNWeb and the National Healthcare Safety Network (NHSN), both of which contain information and results that are part of the facility's QIP Total Performance Score (TPS). The Performance Score Certificate (PSC) displays the facility's TPS, scores on individual measures, and comparisons to the national average. Assisting dialysis facilities in understanding and complying with QIP processes and requirements, in turn improves facility performance on QIP measures and the TPS, which ultimately reduces the cost of ESRD care.

Beneficiaries, their families, and caregivers, were provided plain-language QIP information that explained the program's measures and the PSC, which is mandatorily displayed in each dialysis facility. The Network's PAC and SME groups collaborated and contributed to a PSC explanatory flyer that was sent for patient distribution in every QIP eligible dialysis facility in Network 7. The Network's Patient Newsletter also contained QIP information and a copy of the PSC with a detailed explanation:

The Network collaborates without boundaries while promoting the CMS ESRD QIP, demonstrated by its participation in the CDC HAI Prevention Collaborative, the NCC Community of Practice calls and webinars, partnership with the Florida Department of Health, attendance and subject matter expert input during provider teleconferences and meetings, and its on-going synergy with the State Survey Agency. The Network also facilitates a cohesive and productive Patient Engagement Learning and Action Network, whose primary focus is continuous quality

improvement, framed by the CMS Three Aims.

In further support of the CMS ESRD QIP, Network staff presented QIP information to invested stakeholders during in-person presentations, a few of which included: the ANNA Suncoast Chapter Summer Seminar, the FMC Regional Catheter Reduction Summit, and the ESRD Network 7 Annual Forum.

Facility Monitoring

The Network and MRB review the Standardized Mortality Ratio (SMR) data reported in the DFR, when available annually to identify facilities to participate in the monitoring project. The Network goals in working with these providers is to assist in facility development, implementation, maintenance, and evaluation of an effective data driven interdisciplinary program, focusing on indicators related to improved outcomes.

The Network process for monitoring facility compliance begins with the analysis of data, which are obtained from a variety of sources including Dialysis Facility Report (DFR) data, and complaints and grievances documented in the Patient Contact Utility. Once obtained, data are evaluated and facilities are considered to be out of range if they are not meeting the appropriate targets. When the Network identifies these facilities, it gives notice to the provider and allows for an opportunity to provide additional information. If an Improvement Plan (IP) is required, the Network provides technical assistance to the ESRD facility in the completion of this plan. The entire process results in a facility either being excused from monitoring, selected to participate in the monitoring project and submitting outcomes data as part of the IP, or being referred back to the MRB for the consideration of a sanction.

In late 2012, the Network began working with ten facilities with a greater than expected Standardized Mortality Rate (SMR) reported in the 2012 DFR. The Network provided quarterly updates to the MRB regarding the progress of the facilities in improving their patient care processes and self-reported monthly clinical outcome results.

Results

The monthly self-reporting for the Focus Group began in November 2012. The baseline average for the percentage of patients in the Focus Group facilities dialyzing with a catheter $\geq$ 90 days was 9.8%; six of the ten facilities reported rates below 10% (November 2012). For the adequacy component measure, the average percentage of hemodialysis patients in the Focus Group with Kt/V of less than 1.2 was 6.3% (November 2012). The Focus Group's average percentage of patients dialyzing with a catheter $\geq$ 90 days decrease slightly to 9.4%; with six of the ten facilities reporting rates of less than 10% in June 2013, in addition to a reduction in the average percentage of patients with a Kt/V of less than 1.2 to 4.3% in June 2013.

To determine participants for the 2013 – 2014 Focus Group, Network 7 first determined project release eligibility for the original ten facilities by analyzing SMR data reported in the 2013 DFR, facility self-reported monthly clinical outcomes data, and number of deaths. Based on this analysis, nine of the ten facilities were identified for release and one was targeted to continue. During October 2013, the MRB approved continuation of the project. Network 7 analyzed DFR

data for calendar year 2012 and the period of 2009-2012 to identify new facilities with a greater than expected SMR; four additional facilities met the inclusion criteria for a total of five facilities for the 2013 – 2014 facility monitoring group.

Data Collection and Entry

Veteran Health Administration dialysis facilities (VHA) are not required to use CROWNWeb for data submission. The Network continued to receive hard copies of Medical Evidence forms (CMS-2728), Death Notification forms (CMS-2746 Form), Annual Facility Survey forms (CMS-2744), and dialysis patient tracking forms from VHA facilities. Network staff submits these forms into CROWNWeb on behalf of the facilities on a daily basis. The Network staff submitted 105 forms and approximately 1,050 patient tracking updates on behalf of VHA facilities.

Use of CROWNWeb by kidney transplant facilities is not supported by CROWNWeb. As with VHA facilities, kidney transplant centers are not required to use CROWNWeb for data submission. The Network continued to receive hard copies of Medical Evidence forms (CMS-2728), Death Notification forms (CMS-2746 Form), Annual Facility Survey forms (CMS-2744), and dialysis patient tracking forms from VHA facilities. Network staff submits these forms into CROWNWeb on behalf of the facilities on a daily basis. The Network staff submitted 334 forms and approximately 3,040 patient tracking updates on behalf of kidney transplant centers.

Support Facility Data Submission for CROWNWeb, NHSN, and Other CMS Designated Data Systems

CMS Software Support

CMS and the ESRD Networks continued to work together to enhance the ESRD information system called Consolidated Renal Operations in a Web-enabled Network (CROWN). CROWN facilitates the collection and maintenance of information about the Medicare ESRD program, its beneficiaries, and the services provided to them. It allows dialysis facilities to submit information electronically. This information is immediately available to CMS and the appropriate ESRD Network. CROWN encompasses the following:

- The Renal Management Information System (REMIS), which determines the Medicare coverage periods for ESRD patients and serves as the primary mechanism to store and access ESRD patient and facility information;
- QualityNet Identity Management System (QIMS), the identity management system used to create and manage user accounts; and
- CROWNWeb, the single, web-enabled, national data warehouse for ESRD patient tracking, forms, and clinical data submission.

REMIS

REMIS determines the Medicare coverage periods for ESRD patients and serves as the primary mechanism to store and access ESRD patient and facility information in the ESRD Program Management and Medical Information System Database. REMIS combines read-only views of several CMS systems for information on ESRD patients. These systems include Medicare billing, Medicare Enrollment Database (EDB), data submitted via United Network of Organ

Sharing (UNOS), as well as views of the ESRD patient and facility tracking system CROWNWeb. REMIS also includes sophisticated data quality problem resolution support. Network 7 utilized REMIS to improve the accuracy, reporting, and reliability of ESRD data. For example, the Network utilized REMIS to reconcile discrepancies where multiple facilities claimed to have treated a patient during a specific time period. In addition, during the Annual Facility Survey (CMS-2744) preparation period, REMIS provided the Network with the ability to verify a patient's status when a facility reported a patient as "lost to follow-up."

QIMS

The QualityNet Identity Management System (QIMS) is the system that creates and manages User IDs and Passwords for multiple CMS applications, including CROWNWeb. QIMS simplifies the account activation process by enabling each facility's selected End User Manager (EUM) and Security Official to review, authorize, and activate account requests. QIMS also helps automate the account activation process by allowing users to initiate applications electronically and submit them to their EUM (End Users must also print and present the form to the EUM).

CROWNWeb Support

The Network utilized CROWNWeb reports to assist facilities in submitting data. Possible duplicate patient reports were reviewed monthly and necessary updates were made within CROWNWeb and/or submitted to the QualityNet Help Desk to resolve. Missing 2746 forms reports from the CDDS CROWNWeb contractor have been added to the Missing Forms notifications sent to facilities.

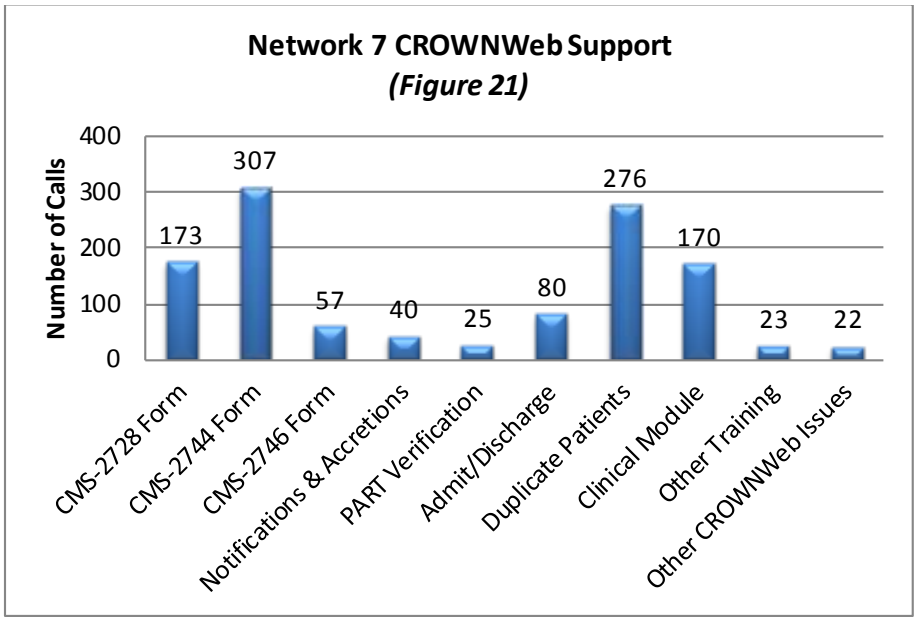
Twice monthly, the Network utilized the Missing Clinical reports provided by CDDS to notify facilities with less than 90% of their clinical data submitted for any collection type for open clinical months. Included in the notification were the number and percentage missing for each clinical collection type for all open clinical months. While working with facilities on the Annual Facility Survey, CMS-2744 form, the Network reviewed submission status for forms several times each week to identify facilities in need of assistance.

Facilities are provided with step-by-step instructions developed by the Network for completing the specific tasks in CROWNWeb. Facilities submitting data directly in CROWNWeb receive instructions on how to submit clinical information. Facilities associated with batch submitters receive instructions to contact the Help Desk for their batch submitter. On request, the Network provides facilities with lists of patients who are missing data allowing them to enter specific patients and/or work with their batch submitters to identify impediments to batch submission.

The Network worked directly with facilities experiencing issues with admitting out-of-scope patients by providing corrections to patient identifiers or admitting the patient on behalf of the facility, as appropriate. During 2013, the Network received 288 requests for assistance with out-of-scope patients. In addition to resolving 2,017 notifications and accretions assigned to the Network, the Network assisted facilities in resolving 277 notifications and accretions assigned directly to facilities.

In addition to notifications and reminders provided to facilities, the Network responded to 1,173

requests for assistance with CROWNWeb from facility users *(Figure 21)*.



CMS Forms

To register an ESRD patient, the treating dialysis facility or transplant facility must submit a Medical Evidence form (CMS-2728 Form) to the Network within 45 days of initiation of chronic treatment. The CMS-2728 Form serves two purposes:

- To provide medical evidence of an end stage renal condition for Medicare entitlement; and
- To enroll a patient in the national renal registry.

Upon the death of a patient, the provider must submit a Death Notification form (CMS-2746 Form) to the Network within 30 days of the patient's date of death.

To assist dialysis facilities in identifying missing forms, the Network augmented the *Missing Forms* and *Saved Status Forms* reports from CROWNWeb with the Gap Reports provided by the ESRD NCC to send lists of missing and un-submitted forms to facilities. These are e-mailed to all CROWNWeb users at the facility and include:

- CROWN UPI (Unique Patient Identifier)
- Type of Form Missing or Saved (CMS-2728, 2746)
- Admit or Death Date, as appropriate
- Due Date (admission date plus 45 days for 2728s or death date plus 30 days for 2746s)
- Step-by-step instructions on how to complete the form in CROWNWeb

In addition to the above reports, the Network worked one-on-one to support and mentor facilities needing assistance in submitting their forms.

NHSN Enrollment and Reporting

The Network provided facility monitoring with NHSN reporting on an ongoing basis throughout

2013. Network staff contacted facilities and provided technical assistance regarding missing or incorrect data in regards to their NHSN ESRD reporting. Network staff also distributed and encouraged the use of the ESRD CMS QIP Rule report to ensure accurate facility reporting in NHSN. The Network provided technical assistance to all newly certified facilities on the NHSN enrollment and reporting requirements and processes.

As of December 2013, the Network exceeded the CMS established goal that >80% of facilities were to be reporting Dialysis Facility Event data for at least six consecutive months with 322 of 336 (96%) eligible facilities in Network 7 having reported Dialysis Facility Event data in NHSN for at least six consecutive months.

Medicare Advantage

The Network also responded to inquiries from Medicare Advantage organizations regarding the status of CMS 2728 Forms and transplant status of ESRD Medicare beneficiaries who were members of Medicare Advantage organizations. In 2013, the Network responded to three inquiries regarding the ESRD status of three patients from Medicare Advantage organizations. Information included current dialysis or transplant function, first date of dialysis or transplant date, and the approximate date the CMS 2728 Form was submitted to CMS.

Summary

Through education, technical assistance, and spread of best practice methods, the Network strove to improve quality of care and reduce costs for people with ESRD. By supporting the QIP, CROWNWeb, and NHSN, the Network is promoting the efforts of CMS to move dialysis care toward a patient outcome-based system that focuses on quality assessment and performance improvement.

COLLABORATION WITH PATIENTS, PROVIDERS AND FACILITIES

INTRODUCTION

In addition to QIAs, the Network works with providers, patient groups, professional organizations, the State Survey Agency (SSA), the Florida QIO, and other appropriate groups to improve the quality of care and quality of life for ESRD patients. Below is a summary of the Network's collaborative activities.

Collaborative Activities with Kidney Patient Organizations

The Network partnered with patient and professional organizations throughout the state. These partners included, but were not limited to, NKF, American Association of Kidney Patients (AAKP), and the FFBI.

- The Network worked cooperatively with AAKP and NKF to promote the educational programs that each hosted throughout the state during 2013.
- In March 2013, the Network promoted World Kidney Day, a program held by Dialysis Patient Citizens in St. Petersburg, FL and presented to the group on Patient

Engagement.

- The Network collaborated with the NKF of Florida to promote and exhibit at the annual Renal Patient's Conference on Kidney Disease in Lakeland, FL in March 2013.
- The Network collaborated with the Tampa Bay Kidney Community patient group in recruitment for the Network's Patient SME program in January 2013.
- The Network provided materials for an Emergency Preparedness event hosted by the ESRD community in Jacksonville, FL in June 2013.

General ESRD Provider Collaborative and Educational Activities

Annual Forum

The Network hosted its 2013 Annual Forum from October 28 – 30, 2013 in Tampa at the Renaissance Hotel at International Plaza. Approximately 350 professionals attended this outstanding meeting, titled "Destination: Innovation." The Annual Forum provided presentations from both national and local speakers. Among some of the most thought-provoking topics and best evaluated speakers were "Increasing Patient Engagement: Vascular Access Creation and Management" by Fernando Kafie, MD, FACS; "Keeping Dialysis Patients Safe from Multi-Drug Resistant Organisms – It's More than Hygiene" by A.C. Burke, MA; "Talking Control Support Therapy" by Judy Beto, PhD, RD, FADA; and "Managing Personality Disorders in the Dialysis Unit" by Paul Gasser MS/LMFT, ICSW, CADC III and Deborah Evans, MA, MSW, LCSW.

In addition to the exceptional educational sessions that focused on improving the quality of life and quality of care for ESRD patients, FMQAI also presented its annual awards recognizing excellence in ESRD care. The event honored outstanding people, facilities, and organizations for their outstanding contributions during 2013. Awards were presented for Outcomes Excellence, Community Services, Volunteer of the Year, and Quality Improvement (Appendix E).

Additional General Provider Collaborative Activities

- February 17, 2013 – Network staff presentation at the Bonent 2013 Southeast Dialysis Seminar – "Meeting the Challenges for Compliance with the New ESRD Conditions for Coverage"
- May 2013 – FKDC participated in a statewide hospital webinar in collaboration with the FDOH to participate regarding the Piecing Together Preparedness Program.
- In addition to collaborating with the FDOH HAI Reduction Plan Program Manager, the FDOH Project Lead Epidemiologist has also joined the Network HAI LAN.
- May 22, 2013 – the Network QID and Quality Improvement Coordinator held a call with the FDOH HAI Reduction Plan Program Manager and the Project Lead Epidemiologist, to discuss the upcoming Network HAI LAN and the development of HAI LAN educational resources.
- June 2013 – The Network included an overview of the QIP in a local ANNA presentation.

- The Network QID and Quality Improvement Coordinators joined the CDC BSI Collaborative and participated on a Collaborative WebEx on May 22, 2013.
- July 2013 – Network Quality Improvement Coordinators (QICs) participated in an LDO regional Catheter Reduction Summit and provided recommendations on catheter reduction strategies and suggestions regarding facility evaluation of vascular access data accuracy in CROWNWeb.
- July 2013 – Executive Director presented at the Florida Renal Administrators Association annual conference, providing an overview of Network outcomes, activities underway related to the new SOW and CROWNWeb reporting and training.
- The QIO's Infection Prevention Coordinator collaborated with the Network and presented on the Comprehensive Unit Based Safety Program (CUSP) program at the HAI portion of the Network's in person LAN meeting on Oct 28, 2013.
- October 2013 – The Network held a Vascular Access Interactive Workshop at the 2013 Annual Forum. The workshop format included break-out sessions on the following topics:
    - Access complications affecting buttonholes
    - Access complications affecting cannulation
    - Assessing new fistula maturation and cannulation skills
    - Access assessment and indications for evaluations
- October 2013 – Network 7 Annual Forum, CDC/NHSN provided a presentation on "NSHN Dialysis Event Surveillance Reports for the Florida ESRD Network"
- October 2013 – Network 7 Annual Forum, FDOH presentation on "Keeping Dialysis Patients Safe from Multi-Drug Resistant Organisms"
- Network QI staff participated in quarterly DaVita-ESRD Networks Partnership conference calls

Targeted Collaborative Activities

- The Network collaborated with the SSA to discuss trends in facility citations and opportunities for provider education, as well as grievances and involuntary discharge situations. The Network hosts a bi-monthly collaborative call with SSA staff to further discuss concerns as a group and obtain feedback from each other regarding issues identified at the facility level, or new information from CMS regarding the dialysis community. In addition, the Network made seven referrals to the SSA for investigation concerns. The Network also provided the SSA with information regarding individual facility outcomes and participation in Network activities upon request. In 2013, the Network received 120 such requests.
- The Network collaborated with the NCC to provide Network feedback and Network SME participation on the NCC Patient and Family Engagement LAN.
- The Network's patient representative to the Forum of ESRD Network's Beneficiary Advisory Committee (BAC) continued to be an active participant bringing the patient's voice to Forum activities.
- ESRD NCC Data Committee – In May of 2013, the ESRD NCC Data Committee was created to guide decision-making and provide subject matter expertise on the generation

of data extracts or reports that are needed in order to complete tasks outlined in the Network SOW, but are currently not available from CROWNWeb. These data needs fall into, but are not limited to, the following major areas:
    - Data needed to complete the CMS ESRD Network Dashboard
    - Needs outlined in the CROWNWeb Gap Analysis
    - Clinical AIMS data
- The committee is comprised of two Network Data Managers from each of the ESRD Network Regional Offices (Boston, Dallas, Kansas City, and Seattle). Network 7 was selected as one of the representatives for the Dallas region. The committee assists the NCC with defining the data elements and logic for reports and helps prioritize support needs within the community. Between meetings, the committee members pilot test report and provide feedback to the NCC developers for enhancement needed to support the Network SOW activities.
- Network staff participates on the CDC HAI Prevention Collaborative webinar series, which features prominent speakers and sharing of resources.

Other Collaborative Activities

Network staff actively participated in the QIO cross-AIM LAN (HAI, Care Transitions, ADE, HAC), *Ordinary to Extraordinary*, on March 1, 2013. ESRD providers were invited and Network staff participated as facilitators and note takers during best practices sharing and "What can I do by Tuesday" round tables.

Summary

The Network is uniquely positioned to serve as a convener, organizer, motivator, and change agent by facilitating partnerships with beneficiaries, practitioners, healthcare providers, healthcare organizations, and other stakeholders. While securing these commitments and collaborative relationships, the Network provides outreach and education that is critical to achieving the CMS goals for healthcare transformation.

SPECIAL PROJECT

SPECIAL PROJECT: BUSINESS REQUIREMENTS FOR ESRD SYSTEMS (BRES)

PROJECT CROWNWeb

During 2013, Network 7 continued work on the Business Requirements for ESRD Systems (BRES) special project. This project has supported the development of the CROWNWeb application since the ESRD data system was officially launched by CMS in June 2012. CROWNWeb serves as the primary source of ESRD data collection from Medicare-certified dialysis facilities and ESRD Networks.

CROWNWeb Master Project Plan

The CROWNWeb Master Project Plan (MPP) is a formal, CMS approved document that is used to guide both project execution and project control to all stakeholders. The project plan is primarily used to document planning assumptions and decisions, facilitate communication among project stakeholders, document approved scope, and schedule baselines. The MPP provides detailed information on when releases will be deployed for the CROWNWeb application. This assures the CROWNWeb team has detailed steps in order to meet the production deployment.

CROWNWEB DATA

CROWNWeb continues to allow CMS, ESRD Networks, and dialysis providers to enter and view ESRD patient data through a secured web portal. Data submitted via CROWNWeb aids the ESRD community in assessing patient progress, measuring provider success, and gauging the overall success of the ESRD initiative through measures reporting and data availability. CMS uses the data from CROWNWeb to assess clinical performance on national, facility, state and Network levels. Additionally, the data can potentially establish policy and other measures for the application.

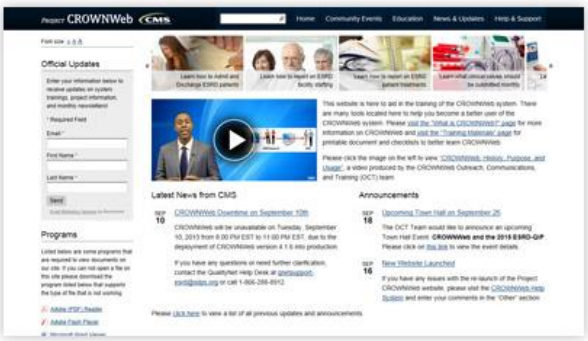
CROWNWeb Responsiveness and Feedback Tree

The CROWNWeb Responsiveness and Feedback Tree (CRAFT) continues to allow input and feedback from the Network and provider communities. This has been extremely successful since its launch in 2007. Staff on the Network 7 BRES team is dedicated to providing accurate and timely responses to the community. All inquiries received through CRAFT are indexed and prioritized and then provided to CMS on a weekly basis. CRAFT continues to provide an avenue of communication for CROWNWeb users and offers excellent customer service and responsiveness to the renal community. In addition, CRAFT serves as a method for renal community stakeholders to provide feedback into the CROWNWeb development process so that FMQAI/BRES can meet the needs of the community and enhance the CROWNWeb application experience.

PROJECT CROWNWEB WEBSITE

Information on CROWNWeb is also provided to the ESRD community through a project website (http://projectcrownweb.org/) and an e-mail distribution, which includes the CROWNWeb and CRAFT newsletters.

The newsletters, which are posted monthly on the website and e-mailed to those in the distribution, include updates on the latest CROWNWeb news, links to Web resources, details on the next scheduled CRAFT call, training information, and recognition of Networks participating in CROWNWeb workgroups.



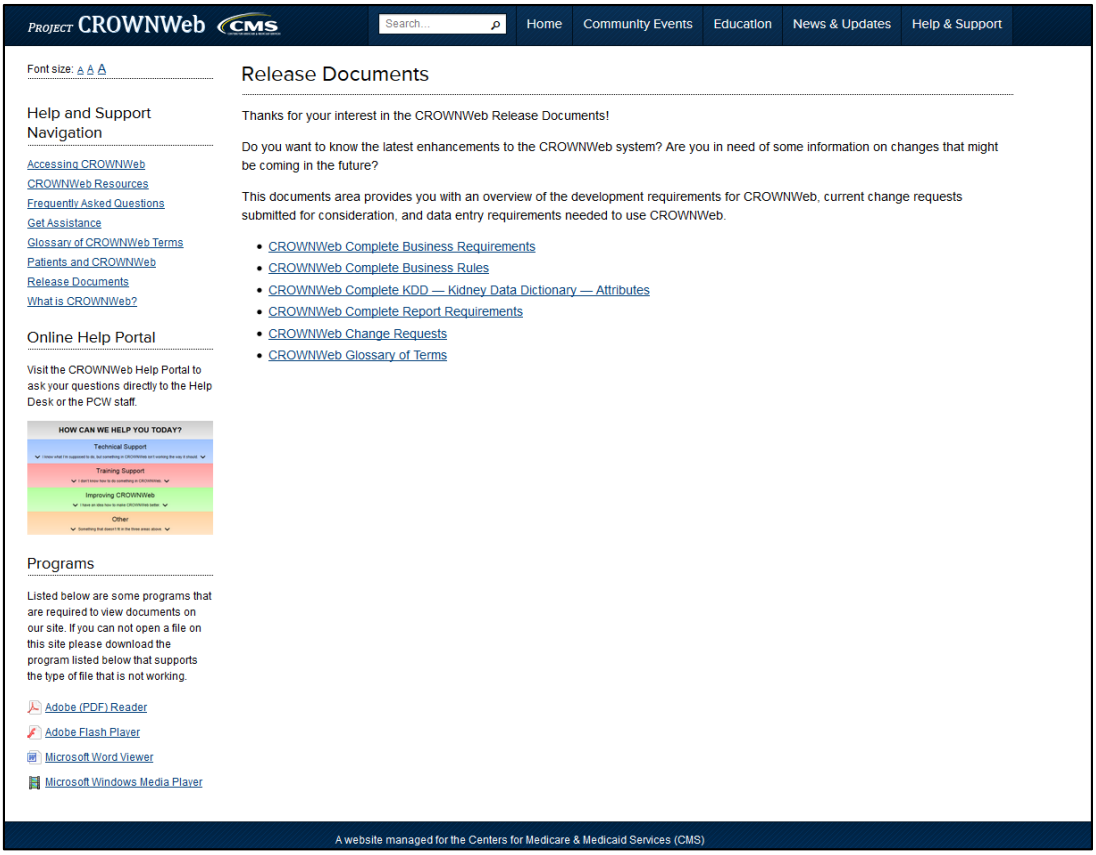
The website was modified greatly during the calendar year 2013, with some notable differences compared with the previous version. The above images compare the previous format with the dark blue background to the current improved version with the white background. The main differences are as follows:

- There is no login/user account requirement to view tutorials. Users will no longer need to create an account to access these tutorials, nor will they need to log in each time they access the website.
- A new Education page lists the different options for users to access education materials (e.g. live training schedules, tutorials, videos, and other resources).
- Website announcements are now featured on the home page along with official CMS updates. These announcements will pertain to Town Hall event updates, live courses, and similar events.
- All materials originally under "What Is CROWNWeb" can now be found under "Help & Support." This includes release documents, FAQs, glossaries, the online help, and other materials.
- The site has an all new design with emphasis on improved user flow (site navigation), user experience (larger, easier to read pages and presentations), and user retention (users can access what they need quickly and not lead them to use other resources).

A new user feedback website, the CROWNWeb Help Portal (http://help.projectcrownweb.org/) was also created to guide user questions to the appropriate body to answer them.

Business Requirements and Kidney Data Dictionary

As part of the BRES Special Study, FMQAI developed and maintains the Business Requirements (BR), Kidney Data Dictionary (KDD), and Change Requests (CR) located at (http://projectcrownweb.org/help/release-documents/. These vital community reference documents provide a valuable source of information surrounding the background of CROWNWeb, and provide insight into future development of the system. The communication that is received via CRAFT as well as other elicitation sessions is sent to CMS and this in-turn potentially has an impact on how the BRs and KDDs are developed. Community comments regarding the BRs and KDD were received via the CRAFT e-mail account (mailto:craft@nw7.esrd.net).



CROWNWeb Training

The BRES team also participates in CRAFT calls and Community Town Halls sponsored by the CROWNWeb Outreach, Communication, and Training (OCT) team. These meetings and collaborative activities include participation in live presentations, as well as the provision of content for publications and newsletters.

FMQAI's web tutorials focused primarily on the visual and kinesthetic learning styles, allowing users to read (visual) through slides and click (kinesthetic) through quizzes and simulations en route to completing the training. Auditory learning styles are supported through the availability

of recorded instructor-led training sessions on http://www.projectcrownweb.org.

Patient CONTACT Utility

The Patient Contact Utility (PCU) was developed atop the Network Contact Utility (NCU) that was built in 2009. The NCU was developed leveraging the table structures from a legacy system called the Standard Information Management System (SIMS). It was offered, discussed and adopted as a stopgap measure to address the concerns expressed by key ESRD Network personnel during the initial SIMS-to-CROWNWeb migration period. Ultimately, the PCU is deemed an immediate solution for Network reporting of ESRD beneficiary complaints and grievances to CMS, until the centralized data repository is implemented.

Development work for the PCU began in early 2013 following the CMS approval of the associated definitions during the QualityNet 2012 conference. NCU-to-PCU trainings were held in June 2013 followed by the PCU 1.0 release on 7/1/2013. This initial release was delayed due to a national SDPS outage on 6/28/2013. Second phase development on the 2.0 version began in early 2014 followed by the release on 2/28/2014. BRES leverages the CRAFT inbox to field feedback and continues to work with the ESRD Network personnel to support the PCU.

SANCTION RECOMMENDATION

SANCTION RECOMMENDATION

Public Act 98-369 of Section 1881(c) of the Social Security Act states: the ESRD Network can recommend to CMS the imposition of an alternative sanction when the Network submits documents that an ESRD provider is not cooperating in achieving Network goals. The Federal Regulations that implement this statute are contained in 42 CFR §405.2181.

Network 7 strived to maintain a cooperative and collaborative partnership with ESRD providers in all activities. The Network regularly interacted with facilities related to quality improvement activities and projects, patient grievances, data reporting, and the provision of technical assistance and education.

In 2013, FMQAI: The Florida ESRD Network did not recommend sanctions to CMS of any facilities within its Network area.

RECOMMENDATIONS FOR ADDITIONAL FACILITIES

RECOMMENDATIONS FOR ADDITIONAL FACILITIES

FMQAI: The Florida ESRD Network did not recommend to CMS additional facilities within its Network area in 2013.

DATA TABLES

TABLE 1
Newly Diagnosed Chronic ESRD Patients

(ESRD Incidence)

Newly diagnosed chronic ESRD patients by state of residence, age, gender, race and primary diagnosis for calendar year 2013

Age Group	FL	Other	Total
00-04	17	3	20
05-09	11	1	12
10-14	13	2	15
15-19	29	2	31
20-24	64	2	66
25-29	108	3	111
30-34	113	3	116
35-39	168	4	172
40-44	276	4	280
45-49	353	7	360
50-54	556	15	571
55-59	694	18	712
60-64	836	20	856
65-69	843	30	873
70-74	904	26	930
75-79	826	28	854
80-84	676	17	693
>=85	538	14	552
Total	**7,025**	**199**	**7,224**

Gender	FL	Other	Total
Female	2,855	88	2,943
Male	4,170	111	4,281
Not Specified	0	0	0
Total	**7,025**	**199**	**7,224**

Race	FL	Other	Total
American Indian/Alaska Native	11	0	11
Asian	114	3	117
Black or African American	2,035	37	2,072
Multiracial	11	0	11
Native Hawaiian or Other Pacific Islander	42	0	42
White	4,773	159	4,932
Not Specified	39	0	39
Total	**7,025**	**199**	7,224

Primary Diagnosis	FL	Other	Total
Cystic/Hereditary/Congenital Diseases	206	10	216

Primary Diagnosis	FL	Other	Total
Diabetes	2,877	80	2,957
Glomerulonephritis	350	9	359
Hypertension/Large Vessel Disease	2,474	69	2,543
Interstitial Nephritis/Pyelonephritis	123	2	125
Miscellaneous Conditions	481	17	498
Neoplasms/Tumors	167	4	171
Secondary GN/Vasculitis	145	5	150
Not Specified	202	3	205
Total	**7,025**	**199**	**7,224**

Source of Information: CROWNWeb

Date of Preparation: April 2014

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

Primary Diagnosis: The categories are from the CMS 2728 Form.

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

This table includes 153 patients with transplant therapy as an initial treatment.
This table includes 105 patients receiving treatment at VA facilities.

TABLE 2

ESRD Dialysis Prevalence

All active dialysis patients by state of residence, age, race, gender and primary diagnosis as of 12/31/2013

Age Group	FL	Other	Total
00-04	19	2	21
05-09	13	1	14
10-14	29	2	31
15-19	80	1	81
20-24	190	4	194
25-29	366	5	371
30-34	594	10	604
35-39	785	12	797
40-44	1,335	16	1,351
45-49	1,711	17	1,728
50-54	2,352	27	2,379
55-59	3,023	47	3,070
60-64	3,224	78	3,302
65-69	3,227	80	3,307
70-74	2,887	115	3,002
75-79	2,474	123	2,597
80-84	1,924	100	2,024
>=85	1,492	66	1,558
Total	**25,725**	**706**	**26,431**

Gender	FL	Other	Total
Female	10,974	246	11,220
Male	14,751	460	15,211
Total	**25,725**	**706**	**26,431**

Ethnicity	FL	Other	Total
Hispanic or Latino	4,070	51	4,121
Not Hispanic or Latino	21,632	655	22,287
Not Specified	23	0	23
Total	**25,725**	**706**	**26,431**

Race	FL	Other	Total
American Indian/Alaska Native	40	0	40
Asian	404	6	410
Black or African American	10,592	137	10,729
More than one race selected	35	1	36
Native Hawaiian or Other Pacific Islander	129	4	133
White	14,505	558	15,063
Not Specified	20	0	20

Race	FL	Other	Total
Total	25,725	706	26,431

Primary Diagnosis	FL	Other	Total
Acquired obstructive uropathy	193	8	201
Acute interstitial nephritis	33	0	33
AIDS nephropathy	308	2	310
Amyloidosis	31	2	33
Analgesic abuse	30	1	31
Cholesterol emboli, renal emboli	50	6	56
Chronic interstitial nephritis	113	13	126
Chronic pyelonephritis, reflux nephropathy	68	3	71
Complications of other specified transplanted organ	3	0	3
Complications of transplanted bone marrow	6	0	6
Complications of transplanted heart	13	0	13
Complications of transplanted intestine	1	0	1
Complications of transplanted kidney	410	13	423
Complications of transplanted liver	29	1	30
Complications of transplanted lung	5	2	7
Complications of transplanted organ unspecified	12	0	12
Complications of transplanted pancreas	1	0	1
Congenital nephrotic syndrome	24	2	26
Congenital obstruction of ureterpelvic junction	20	0	20
Congenital obstruction of uretrovesical junction	7	1	8
Cystinosis	2	0	2
Dense deposit disease, MPGN type 2	5	0	5
Diabetes with renal manifestations Type 1	1,086	23	1,109
Diabetes with renal manifestations Type 2	9,402	249	9,651
Drash syndrome, mesangial sclerosis	4	0	4
Etiology uncertain	497	22	519
Fabry's disease	5	0	5
Focal Glomerulonephritis, focal sclerosing GN	691	23	714
Glomerulonephritis (GN) (histologically not examined)	724	22	746
Goodpasture's syndrome	37	0	37
Gouty nephropathy	3	0	3
Hemolytic uremic syndrome	24	0	24
Henoch-Schonlein syndrome	3	0	3
Hepatorenal syndrome	25	0	25
Hereditary nephritis, Alport's syndrome	34	1	35
Hypertension: Unspecified with renal failure	8,538	204	8,742
IgA nephropathy, Berger's disease (proven by immunofluorescence)	188	5	193
IgM nephropathy (proven by immunofluorescence)	8	0	8

Primary Diagnosis	FL	Other	Total
Lead nephropathy	1	0	1
Lupus erythematosus, (SLE nephritis)	408	7	415
Lymphoma of kidneys	2	0	2
Medullary cystic disease, including nephronophthisis	12	2	14
Membranoproliferative GN type 1, diffuse MPGN	79	5	84
Membranous nephropathy	130	3	133
Multiple myeloma	98	6	104
Nephrolithiasis	46	5	51
Nephropathy caused by other agents	69	2	71
Nephropathy due to heroin abuse and related drugs	4	0	4
Other (congenital malformation syndromes)	29	0	29
Other Congenital obstructive uropathy	41	2	43
Other disorders of calcium metabolism	1	0	1
Other immuno proliferative neoplasms (including light chain nephropathy)	18	0	18
Other proliferative GN	72	1	73
Other renal disorders	241	8	249
Other Vasculitis and its derivatives	37	3	40
Polyarteritis	6	0	6
Polycystic kidneys, adult type (dominant)	686	12	698
Polycystic, infantile (recessive)	11	0	11
Post infectious GN, SBE	20	0	20
Postpartum renal failure	5	0	5
Primary oxalosis	1	0	1
Prune belly syndrome	10	0	10
Radiation nephritis	4	0	4
Renal artery occlusion	32	1	33
Renal artery stenosis	99	15	114
Renal hypoplasia, dysplasia, oligonephronia	50	1	51
Renal tumor (benign)	5	1	6
Renal tumor (malignant)	92	6	98
Renal tumor (unspecified)	11	0	11
Scleroderma	8	0	8
Secondary GN, other	21	0	21
Sickle cell disease/anemia	28	0	28
Sickle cell trait and other sickle cell (HbS/Hb other)	1	0	1
Traumatic or surgical loss of kidney(s)	26	0	26
Tuberous sclerosis	9	1	10
Tubular necrosis (no recovery)	283	13	296
Urinary tract tumor (malignant)	13	0	13
Urinary tract tumor (unspecified)	5	0	5
Urolithiasis	11	0	11

Primary Diagnosis	FL	Other	Total
Wegener's granulomatosis	53	4	57
With lesion of rapidly progressive GN	33	0	33
Not Specified	281	5	286
Total	**25,725**	**706**	**26,431**

Source of Information: CROWNWeb

Date of Preparation: April 2014

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

Primary Diagnosis: The categories are from the CMS-2728 Form.

When a category count = 0, the category may not be displayed on the report.

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

TABLE 3

Dialysis Modality – Self Care-Settings Home

Number of living patients by modality by dialysis facility self-care settings as of December 31, 2012 and December 31, 2013

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
100001	0	0	7	7	23	21	0	0	30	28
100006	0	0	0	0	0	0	0	0	0	0
100007	8	8	0	0	0	0	0	0	8	8
100022	0	0	0	0	3	2	0	0	3	2
100038	0	0	0	0	0	0	0	0	0	0
100088	0	0	0	0	0	3	0	0	0	3
10009F	1	0	0	0	7	10	0	0	8	10
100113	0	0	0	0	7	4	0	0	7	4
10011F	0	0	0	0	0	0	0	0	0	0
100128	0	0	0	0	3	4	0	0	3	4
100288	0	0	3	0	15	16	0	0	18	16
10061F	0	0	4	5	7	7	0	0	11	12
10065F	0	0	0	0	0	0	0	0	0	0
102501	0	1	7	6	33	35	0	1	40	43
102502	6	8	1	3	13	15	0	0	20	26
102503	0	0	0	0	0	0	0	0	0	0
102504	0	0	0	0	0	0	0	0	0	0
102505	0	0	4	2	35	45	0	0	39	47
102506	1	2	1	4	12	12	0	0	14	18
102510	0	0	0	0	0	0	0	0	0	0
102511	2	3	3	3	18	18	0	0	23	24
102512	0	4	5	6	19	15	0	0	24	25
102513	0	0	5	3	35	33	0	0	40	36
102514	4	7	10	10	23	24	0	0	37	41
102517	0	0	2	0	2	3	0	0	4	3
102518	0	0	2	0	39	0	0	0	41	0
102519	0	0	3	0	3	4	0	0	6	4
102520	0	0	4	3	7	16	0	0	11	19
102521	10	17	6	4	55	68	0	0	71	89
102522	0	0	0	0	0	0	0	0	0	0
102524	0	0	0	0	0	0	0	0	0	0
102525	0	0	0	1	0	3	0	0	0	4
102527	0	0	0	0	3	5	0	0	3	5
102528	0	0	0	0	0	0	0	0	0	0
102529	17	9	0	0	2	2	0	0	19	11
102530	0	0	0	1	3	5	0	0	3	6

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
102531	1	1	3	2	38	36	0	0	42	39
102532	3	4	13	14	24	24	0	0	40	42
102534	0	1	0	1	2	4	0	0	2	6
102536	0	0	0	0	0	0	0	0	0	0
102538	0	0	0	0	1	0	0	0	1	0
102542	0	0	3	3	3	7	0	0	6	10
102543	0	0	0	0	0	1	0	0	0	1
102544	0	0	10	14	13	22	0	0	23	36
102545	0	0	9	5	30	32	0	0	39	37
102546	0	0	1	0	5	4	0	0	6	4
102547	0	0	3	0	5	0	0	0	8	0
102548	0	0	5	5	14	12	0	0	19	17
102549	0	0	0	0	0	0	0	0	0	0
102551	0	0	3	4	10	6	0	0	13	10
102553	8	5	1	1	13	15	0	0	22	21
102554	0	1	3	2	19	13	0	0	22	16
102555	0	0	0	0	0	0	0	0	0	0
102557	0	0	1	2	4	0	0	0	5	2
102558	81	76	3	2	0	0	0	0	84	78
102559	0	0	1	2	3	2	0	0	4	4
102563	0	0	0	0	0	0	0	0	0	0
102564	0	0	2	2	3	2	0	0	5	4
102565	0	0	2	1	10	9	0	0	12	10
102566	0	0	0	0	0	0	0	0	0	0
102569	0	0	0	0	0	0	0	0	0	0
102571	0	0	1	0	3	3	0	0	4	3
102573	0	0	1	1	25	36	0	0	26	37
102574	5	8	0	0	6	5	0	0	11	13
102576	0	0	0	0	15	20	0	0	15	20
102578	0	0	0	0	0	0	0	0	0	0
102579	0	0	1	1	4	3	0	0	5	4
102581	0	0	0	0	0	1	0	0	0	1
102582	0	0	0	0	0	0	0	0	0	0
102583	0	0	0	0	0	0	0	0	0	0
102584	0	0	0	2	1	6	0	0	1	8
102585	0	0	0	0	0	0	0	0	0	0
102586	11	8	6	8	14	12	0	0	31	28
102587	0	0	0	0	2	3	0	0	2	3
102589	0	0	0	1	0	1	0	0	0	2
102590	6	12	6	3	18	9	1	1	31	25
102591	0	0	4	2	10	3	0	0	14	5
102592	0	0	0	0	0	0	0	0	0	0
102593	0	0	3	2	21	18	0	0	24	20
102594	4	10	0	0	6	8	0	0	10	18

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
102595	0	0	0	0	0	0	0	0	0	0
102596	4	6	2	3	15	20	0	0	21	29
102597	0	0	6	2	0	4	0	0	6	6
102598	7	12	2	1	4	9	0	0	13	22
102601	0	0	0	0	0	0	0	0	0	0
102602	0	0	8	6	21	18	0	0	29	24
102603	0	0	0	0	0	1	0	0	0	1
102604	5	3	0	0	12	18	0	0	17	21
102605	0	0	0	0	0	0	0	0	0	0
102609	0	0	0	0	1	4	0	0	1	4
102610	1	3	4	3	9	6	0	0	14	12
102612	0	0	8	6	20	20	0	0	28	26
102613	0	0	0	0	0	0	0	0	0	0
102614	0	0	0	0	0	0	0	0	0	0
102615	0	0	1	0	11	13	0	0	12	13
102616	0	1	1	0	3	3	0	0	4	4
102617	0	0	0	0	0	0	0	0	0	0
102618	0	0	0	0	0	0	0	0	0	0
102619	0	0	0	0	0	0	0	0	0	0
102623	0	0	0	0	0	0	0	0	0	0
102624	0	0	0	0	0	0	0	0	0	0
102626	0	0	0	0	0	0	0	0	0	0
102627	0	0	0	0	0	0	0	0	0	0
102628	0	0	5	5	11	11	0	0	16	16
102629	0	0	0	0	0	0	0	0	0	0
102630	0	0	0	0	0	0	0	0	0	0
102632	0	0	0	0	0	0	0	0	0	0
102634	6	12	2	1	14	12	0	0	22	25
102635	0	0	3	1	0	3	0	0	3	4
102636	0	1	1	1	3	0	0	0	4	2
102637	3	0	1	0	6	11	0	0	10	11
102638	0	0	0	0	0	0	0	0	0	0
102639	0	0	0	0	0	0	0	0	0	0
102642	2	1	0	0	6	6	0	0	8	7
102645	24	18	2	6	8	10	0	0	34	34
102646	3	0	0	1	2	4	0	0	5	5
102647	0	0	0	0	0	0	0	0	0	0
102648	0	0	0	0	3	2	0	0	3	2
102649	0	0	0	0	0	0	0	0	0	0
102651	0	0	0	0	0	0	0	0	0	0
102652	0	0	0	0	0	0	0	0	0	0
102653	0	0	1	0	1	2	0	0	2	2
102654	0	0	0	0	0	0	0	0	0	0
102655	0	0	0	0	0	0	0	0	0	0

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
102656	10	7	0	2	0	0	0	0	10	9
102658	0	0	1	1	3	5	0	0	4	6
102659	1	1	0	1	18	18	0	0	19	20
102660	0	0	0	0	0	0	0	0	0	0
102662	0	0	0	0	0	0	0	0	0	0
102664	0	0	0	0	0	0	0	0	0	0
102665	0	0	0	0	0	0	0	0	0	0
102666	0	0	1	0	4	10	0	0	5	10
102668	0	0	0	0	0	0	0	0	0	0
102670	0	0	0	0	0	0	0	0	0	0
102673	9	7	1	1	50	53	0	0	60	61
102674	0	0	0	0	0	0	0	0	0	0
102675	0	0	2	1	0	0	0	0	2	1
102676	0	0	1	1	4	8	0	0	5	9
102678	0	0	0	0	0	0	0	0	0	0
102679	0	0	0	0	4	1	0	0	4	1
102680	0	0	11	15	3	7	0	0	14	22
102681	0	0	0	0	0	0	0	0	0	0
102683	0	0	0	0	0	0	0	0	0	0
102684	0	0	2	2	8	7	0	0	10	9
102687	0	0	0	0	0	0	0	0	0	0
102689	0	0	0	0	0	0	0	0	0	0
102690	0	0	0	0	0	0	0	0	0	0
102692	0	0	0	0	0	8	0	0	0	8
102693	2	4	0	1	3	5	0	0	5	10
102694	0	0	0	0	0	0	0	0	0	0
102695	0	0	0	0	0	0	0	0	0	0
102696	0	0	0	0	0	0	0	0	0	0
102697	0	0	0	0	0	0	0	0	0	0
102699	0	0	0	0	0	0	0	0	0	0
102700	0	0	0	0	0	0	0	0	0	0
102701	0	0	6	2	30	38	0	0	36	40
102702	0	0	0	0	0	0	0	0	0	0
102703	0	0	0	0	0	0	0	0	0	0
102704	0	0	0	0	0	0	0	0	0	0
102705	2	3	21	11	22	27	1	0	46	41
102706	8	5	3	3	13	15	0	0	24	23
102707	0	0	0	0	0	0	0	0	0	0
102708	0	0	0	0	0	0	0	0	0	0
102709	0	0	0	0	0	0	0	0	0	0
102710	0	0	0	0	4	2	0	0	4	2
102712	0	0	0	0	0	0	0	0	0	0
102714	0	0	0	0	0	0	0	0	0	0
102715	0	0	0	0	0	0	0	0	0	0

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
102716	0	0	0	0	0	0	0	0	0	0
102717	0	0	0	1	11	15	0	0	11	16
102718	0	0	0	0	0	2	0	0	0	2
102719	0	0	0	0	0	1	0	0	0	1
102720	0	0	11	7	8	13	0	0	19	20
102721	0	0	0	0	0	0	0	0	0	0
102722	0	0	4	0	7	8	0	0	11	8
102726	11	13	0	0	0	0	0	0	11	13
102727	0	0	1	2	7	4	0	0	8	6
102728	0	0	3	3	12	13	1	0	16	16
102731	0	0	0	0	0	0	0	0	0	0
102732	0	0	0	0	0	0	0	0	0	0
102733	0	0	0	0	0	0	0	0	0	0
102736	0	0	0	0	0	0	0	0	0	0
102737	0	0	0	0	0	0	0	0	0	0
102738	0	0	0	0	0	0	0	0	0	0
102739	0	0	0	0	0	0	0	0	0	0
102740	30	27	0	0	0	0	0	0	30	27
102741	0	0	0	0	0	0	0	0	0	0
102742	0	0	3	3	4	6	0	0	7	9
102743	0	0	0	0	0	2	0	0	0	2
102744	0	0	0	0	1	2	0	0	1	2
102745	0	0	0	0	0	0	0	0	0	0
102746	0	0	0	0	0	0	0	0	0	0
102747	0	0	0	0	0	4	0	0	0	4
102748	0	0	2	0	15	11	0	0	17	11
102749	0	0	0	0	0	0	0	0	0	0
102750	0	0	0	0	0	0	0	0	0	0
102751	0	0	0	0	0	0	0	0	0	0
102752	0	0	0	0	0	0	0	0	0	0
102754	0	0	1	0	15	16	0	0	16	16
102756	0	0	2	2	8	8	0	0	10	10
102757	0	0	0	0	0	0	0	0	0	0
102759	0	0	0	0	0	0	0	0	0	0
102760#	0	0	0	0	0	0	0	0	0	0
102761	5	4	0	0	13	12	0	0	18	16
102762	0	0	0	2	3	4	0	0	3	6
102763	0	0	0	0	0	0	0	0	0	0
102764	0	3	0	0	0	0	0	0	0	3
102765	0	0	0	0	0	0	0	0	0	0
102766	0	0	0	0	2	1	0	0	2	1
102767	0	0	0	0	0	0	0	0	0	0
102768	0	0	0	0	0	0	0	0	0	0
102769	2	0	2	1	6	16	0	0	10	17

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
102770	0	0	0	0	0	0	0	0	0	0
102771	0	0	0	0	0	0	0	0	0	0
102772	0	0	2	2	70	76	0	0	72	78
102773	0	0	0	0	12	7	0	0	12	7
102774	0	0	1	4	6	8	0	0	7	12
102775	0	0	0	0	0	0	0	0	0	0
102776	0	0	0	0	0	0	0	0	0	0
102777	0	0	1	1	3	3	0	0	4	4
102778	0	0	0	0	0	0	0	0	0	0
102779	0	0	0	0	4	1	0	0	4	1
102782	0	0	0	0	0	0	0	0	0	0
102783	0	0	0	4	10	14	0	0	10	18
102784	0	0	0	0	0	0	0	0	0	0
102786	0	0	0	0	0	0	0	0	0	0
102787	0	0	2	2	13	13	0	0	15	15
102788	0	0	0	0	0	0	0	0	0	0
102789	0	0	4	9	0	0	0	0	4	9
102790	0	0	0	0	0	0	0	0	0	0
102791	0	0	4	7	1	10	0	0	5	17
102792	0	0	6	4	29	20	0	0	35	24
102793	0	0	0	0	0	0	0	0	0	0
102794	1	2	13	10	16	21	0	0	30	33
102795	0	0	0	0	0	0	0	0	0	0
102796	0	0	0	0	0	0	0	0	0	0
102800	16	9	0	0	0	0	0	0	16	9
102801	0	0	0	0	0	0	0	0	0	0
102802	0	0	0	0	2	3	0	0	2	3
102803	9	9	0	0	0	0	0	0	9	9
102804	0	0	0	0	0	0	0	0	0	0
102805	0	0	9	6	14	25	0	0	23	31
102806	1	1	1	0	5	1	0	0	7	2
102807	0	0	0	0	0	0	0	0	0	0
102808	0	0	0	0	0	0	0	0	0	0
102809	0	1	2	0	6	6	0	0	8	7
102810	0	0	0	0	0	0	0	0	0	0
102811	0	0	0	0	3	1	0	0	3	1
102812	0	0	0	0	0	0	0	0	0	0
102813	0	0	0	0	0	0	0	0	0	0
102814	0	0	0	0	0	0	0	0	0	0
102815	0	0	0	0	0	0	0	0	0	0
102816	0	0	0	1	10	11	0	0	10	12
102817	0	0	2	0	8	12	0	0	10	12
102818	0	0	0	0	0	0	0	0	0	0
102819	0	0	0	0	0	0	0	0	0	0

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
102820	0	0	0	0	0	0	0	0	0	0
102821	0	0	1	0	12	13	0	0	13	13
102822	0	0	0	0	0	0	0	0	0	0
102823	0	0	1	0	39	49	0	0	40	49
102824	2	2	2	1	24	23	0	0	28	26
102825	18	20	33	32	95	86	0	0	146	138
102826	0	0	0	0	9	7	0	0	9	7
102827	0	0	0	0	0	0	0	0	0	0
102828	1	0	0	0	8	11	0	0	9	11
102829	0	0	0	0	0	0	0	0	0	0
102830	0	0	0	0	0	0	0	0	0	0
102831	0	0	0	0	0	0	0	0	0	0
102832	0	0	5	0	70	14	0	0	75	14
102833	0	0	11	12	18	20	0	0	29	32
102834	0	0	0	0	0	0	0	0	0	0
102835	0	0	0	0	0	0	0	0	0	0
102836	0	0	0	1	4	2	0	0	4	3
102837	0	0	0	0	0	0	0	0	0	0
102838	0	0	1	1	7	7	0	0	8	8
102839	0	0	0	0	0	0	0	0	0	0
102840	0	0	0	0	0	0	0	0	0	0
102841	0	0	0	0	0	0	0	0	0	0
102843	0	0	0	0	0	0	0	0	0	0
102844	2	4	3	1	3	6	0	0	8	11
102845	0	0	0	0	0	0	0	0	0	0
102847	7	3	4	3	9	21	0	0	20	27
102848	0	1	1	0	21	23	0	0	22	24
102849	0	0	1	1	17	16	0	0	18	17
102850	3	2	2	1	6	3	0	0	11	6
102851	0	0	3	2	18	21	0	0	21	23
102853	0	0	2	4	8	13	0	0	10	17
102854	0	0	2	0	2	2	0	0	4	2
102855	5	8	2	0	11	7	0	0	18	15
102856	0	0	0	0	0	0	0	0	0	0
102857	0	0	0	0	0	0	0	0	0	0
102858	0	0	0	0	0	0	0	0	0	0
102859	0	0	0	0	0	0	0	0	0	0
102860	0	0	0	0	0	0	0	0	0	0
102861	0	0	3	2	13	13	0	0	16	15
102862#	0	0	0	0	0	0	0	0	0	0
102863	0	0	0	0	0	0	0	0	0	0
102864	0	0	3	1	3	3	0	0	6	4
102865	0	0	0	0	0	0	0	0	0	0
102866	0	0	0	0	0	0	0	0	0	0

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
102867	0	0	0	0	1	2	0	0	1	2
102868	0	0	0	0	0	0	0	0	0	0
102869	0	0	0	0	0	0	0	0	0	0
102870	0	0	0	0	0	0	0	0	0	0
102871	2	4	0	0	0	0	0	0	2	4
102872	0	0	0	0	0	0	0	0	0	0
102873	2	8	0	0	9	9	0	0	11	17
102874	0	0	0	0	0	0	0	0	0	0
102875	0	0	0	0	0	0	0	0	0	0
102876	0	0	0	0	12	9	0	0	12	9
102877	0	0	0	0	0	0	0	0	0	0
102878	0	0	0	0	0	0	0	0	0	0
102879	0	0	0	0	0	0	0	0	0	0
102880	0	0	0	0	0	0	0	0	0	0
102881	0	0	0	0	1	1	0	0	1	1
102882	0	0	0	1	17	14	0	0	17	15
102883	1	0	0	0	0	0	0	0	1	0
102884	0	0	0	0	0	0	0	0	0	0
102885	22	17	1	2	15	25	0	0	38	44
102886	0	0	0	0	0	0	0	0	0	0
102887	5	6	0	1	7	6	0	0	12	13
102888	0	0	0	0	0	0	0	0	0	0
102889	0	0	0	0	3	5	0	0	3	5
102890	0	0	0	0	0	0	0	0	0	0
102891	0	0	0	0	0	0	0	0	0	0
102892	0	0	0	0	0	0	0	0	0	0
102893	0	0	0	0	0	0	0	0	0	0
102894	14	18	0	1	0	0	0	0	14	19
102895	0	0	0	0	0	0	0	0	0	0
102896	2	1	2	1	27	30	0	0	31	32
102897	0	0	3	2	9	8	0	0	12	10
102898	0	0	0	0	3	0	0	0	3	0
102899	0	0	0	0	0	0	0	0	0	0
103300	0	0	1	1	3	6	0	0	4	7
103301	0	0	0	0	9	7	0	0	9	7
103502	2	3	5	2	4	3	0	0	11	8
103503	2	2	2	2	4	5	0	0	8	9
108812^	0	0	0	0	0	0	0	0	0	0
682500	0	0	1	2	5	8	0	0	6	10
682501	0	0	0	0	0	0	0	0	0	0
682502	0	0	0	0	0	9	0	0	0	9
682503	2	1	0	0	2	1	0	0	4	2
682504	0	0	1	1	2	3	0	0	3	4
682505	0	0	0	0	0	0	0	0	0	0

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
682506	1	0	2	3	7	7	0	0	10	10
682507	10	17	0	0	0	0	0	0	10	17
682508	1	0	1	1	3	2	0	0	5	3
682509	0	0	0	0	0	0	0	0	0	0
682510	0	0	0	0	0	0	0	0	0	0
682511	16	23	0	0	0	0	0	0	16	23
682512	0	0	0	0	0	0	0	0	0	0
682513	6	11	1	0	0	0	0	0	7	11
682514#	0	0	0	0	0	0	0	0	0	0
682515	0	0	2	1	5	5	0	0	7	6
682516	0	1	0	1	3	4	0	0	3	6
682517	0	0	0	0	0	6	0	0	0	6
682518	0	0	1	1	2	7	0	0	3	8
682519	0	0	0	0	0	0	0	0	0	0
682520	0	0	0	0	0	0	0	0	0	0
682521	0	0	0	0	0	0	0	0	0	0
682522	0	0	0	1	21	26	0	0	21	27
682523	3	4	2	2	0	1	0	0	5	7
682524#	0	0	0	0	0	0	0	0	0	0
682525	0	0	0	0	0	0	0	0	0	0
682526	0	0	0	0	1	5	0	1	1	6
682527	0	0	0	0	0	0	0	0	0	0
682528	0	0	0	0	0	0	0	0	0	0
682529	0	0	0	0	0	0	0	0	0	0
682530	0	0	0	0	0	0	0	0	0	0
682531	0	3	0	1	1	11	0	0	1	15
682532^	0	0	0	0	0	2	0	0	0	2
682533^	0	0	0	1	0	4	0	0	0	5
682534^	0	2	0	5	0	39	0	0	0	46
682535	0	0	0	0	0	0	0	0	0	0
682536	0	0	0	0	0	0	0	0	0	0
682537	0	0	0	0	0	0	0	0	0	0
682538^	0	0	0	8	0	80	0	0	0	88
682539^	0	0	0	1	0	1	0	0	0	2
682540^	0	0	0	0	0	0	0	0	0	0
682541^	0	0	0	0	0	2	0	0	0	2
682542^	0	0	0	1	0	1	0	0	0	2
682543^	0	1	0	1	0	5	0	0	0	7
682544^	0	0	0	0	0	0	0	0	0	0
682545^	0	0	0	0	0	0	0	0	0	0
682546^	0	0	0	0	0	0	0	0	0	0
FL0ORP	0	39	0	9	0	0	0	0	0	48
FL Totals	**459**	**539**	**429**	**401**	**1,902**	**2,157**	**3**	**3**	**2,793**	**3,100**

	Hemo		CAPD		CCPD		Other		Total	
Facility CCN	2011	2013	2012	2013	2012	2013	2012	2013	2012	2013
Network Totals	**459**	**539**	**429**	**401**	**1,902**	**2,157**	**3**	**3**	**2,793**	**3,100**

Source of Information: Facility Survey (CMS 2744) and CROWNWeb

Date of Preparation: April 2014

This table includes 19 Veterans Affairs Facility patients for 2012 and 22 Veterans Affairs Facility patients for 2013

^ Facility not operational in 2012

Facility not operational in 2013

* Facility does not have a generated 2744 in 2013

Table 4
Dialysis Modality – In-Center

Number of living patients by modality by dialysis facility in-center as of December 31, 2012 and December 31, 2013

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
100001	198	192	1	0	199	192	229	220
100006	6	8	0	0	6	8	6	8
100007	8	6	0	0	8	6	16	14
100022	31	33	0	0	31	33	34	35
100038	7	7	0	0	7	7	7	7
100088	4	4	0	0	4	4	4	7
10009F	34	37	0	0	34	37	42	47
100113	7	9	0	0	7	9	14	13
10011F	43	44	0	0	43	44	43	44
100128	9	9	0	0	9	9	12	13
100288	83	89	1	0	84	89	102	105
10061F	26	25	0	0	26	25	37	37
10065F	33	23	0	0	33	23	33	23
102501	102	101	0	0	102	101	142	144
102502	100	104	1	0	101	104	121	130
102503	68	65	0	0	68	65	68	65
102504	167	186	0	0	167	186	167	186
102505	139	135	0	0	139	135	178	182
102506	51	63	0	0	51	63	65	81
102510	52	49	0	0	52	49	52	49
102511	0	0	0	0	0	0	23	24
102512	76	78	0	0	76	78	100	103
102513	109	112	0	0	109	112	149	148
102514	93	88	0	0	93	88	130	129
102517	92	90	0	0	92	90	96	93
102518	82	77	0	0	82	77	123	77
102519	86	87	0	0	86	87	92	91
102520	31	25	1	1	32	26	43	45
102521	76	76	0	0	76	76	147	165
102522	103	96	0	0	103	96	103	96
102524	83	44	0	0	83	44	83	44
102525	98	88	0	0	98	88	98	92
102527	75	84	1	0	76	84	79	89
102528	60	64	0	0	60	64	60	64
102529	35	38	0	0	35	38	54	49
102530	68	77	0	0	68	77	71	83
102531	93	100	0	0	93	100	135	139

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
102532	98	91	0	0	98	91	138	133
102534	48	42	0	0	48	42	50	48
102536	110	98	0	0	110	98	110	98
102538	58	51	0	0	58	51	59	51
102542	50	57	0	0	50	57	56	67
102543	37	41	0	0	37	41	37	42
102544	72	84	0	0	72	84	95	120
102545	90	101	0	0	90	101	129	138
102546	74	89	0	0	74	89	80	93
102547	119	118	0	0	119	118	127	118
102548	96	91	0	0	96	91	115	108
102549	62	71	0	0	62	71	62	71
102551	61	57	0	1	61	58	74	68
102553	149	143	1	0	150	143	172	164
102554	70	63	0	0	70	63	92	79
102555	88	86	0	0	88	86	88	86
102557	63	57	0	0	63	57	68	59
102558	105	99	0	0	105	99	189	177
102559	149	145	0	0	149	145	153	149
102563	35	38	0	0	35	38	35	38
102564	86	79	0	0	86	79	91	83
102565	110	121	0	0	110	121	122	131
102566	93	88	0	0	93	88	93	88
102569	88	88	0	0	88	88	88	88
102571	75	78	0	0	75	78	79	81
102573	74	95	1	0	75	95	101	132
102574	56	76	0	0	56	76	67	89
102576	86	83	0	0	86	83	101	103
102578	87	81	0	0	87	81	87	81
102579	70	64	0	0	70	64	75	68
102581	68	62	0	0	68	62	68	63
102582	36	36	0	0	36	36	36	36
102583	128	132	0	0	128	132	128	132
102584	48	49	0	0	48	49	49	57
102585	57	58	0	0	57	58	57	58
102586	109	108	1	0	110	108	141	136
102587	32	31	0	0	32	31	34	34
102589	27	19	0	0	27	19	27	21
102590	133	141	0	0	133	141	164	166
102591	71	82	0	0	71	82	85	87
102592	45	47	0	0	45	47	45	47
102593	98	122	0	0	98	122	122	142
102594	64	80	0	0	64	80	74	98

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
102595	103	93	0	0	103	93	103	93
102596	141	139	0	0	141	139	162	168
102597	64	65	0	0	64	65	70	71
102598	68	59	1	0	69	59	82	81
102601	88	71	0	0	88	71	88	71
102602	109	109	0	3	109	112	138	136
102603	37	47	0	0	37	47	37	48
102604	35	38	0	1	35	39	52	60
102605	89	92	0	0	89	92	89	92
102609	67	62	0	0	67	62	68	66
102610	140	137	0	0	140	137	154	149
102612	47	46	0	0	47	46	75	72
102613	76	83	0	0	76	83	76	83
102614	72	76	0	0	72	76	72	76
102615	114	118	0	0	114	118	126	131
102616	53	46	0	0	53	46	57	50
102617	54	64	0	0	54	64	54	64
102618	31	43	0	0	31	43	31	43
102619	78	78	0	0	78	78	78	78
102623	75	94	0	0	75	94	75	94
102624	70	71	0	0	70	71	70	71
102626	51	56	0	0	51	56	51	56
102627	79	77	0	0	79	77	79	77
102628	0	0	0	0	0	0	16	16
102629	45	54	0	0	45	54	45	54
102630	70	75	0	0	70	75	70	75
102632	63	66	0	0	63	66	63	66
102634	90	91	0	0	90	91	112	116
102635	105	106	0	0	105	106	108	110
102636	129	134	0	0	129	134	133	136
102637	82	74	0	0	82	74	92	85
102638	68	71	0	0	68	71	68	71
102639	83	84	0	0	83	84	83	84
102642	49	49	0	0	49	49	57	56
102645	90	93	1	0	91	93	125	127
102646	21	23	0	0	21	23	26	28
102647	98	94	0	0	98	94	98	94
102648	103	100	0	0	103	100	106	102
102649	75	71	0	0	75	71	75	71
102651	96	92	0	0	96	92	96	92
102652	64	56	0	0	64	56	64	56
102653	89	98	0	0	89	98	91	100
102654	65	68	0	0	65	68	65	68

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
102655	60	63	0	0	60	63	60	63
102656	152	148	0	0	152	148	162	157
102658	90	96	0	0	90	96	94	102
102659	118	134	0	0	118	134	137	154
102660	98	115	0	0	98	115	98	115
102662	92	91	0	0	92	91	92	91
102664	87	86	0	0	87	86	87	86
102665	90	93	0	0	90	93	90	93
102666	76	81	0	0	76	81	81	91
102668	44	45	0	0	44	45	44	45
102670	92	82	0	0	92	82	92	82
102673	75	88	0	0	75	88	135	149
102674	53	55	0	0	53	55	53	55
102675	57	56	0	1	57	57	59	58
102676	78	76	0	0	78	76	83	85
102678	157	119	0	0	157	119	157	119
102679	56	60	0	0	56	60	60	61
102680	101	110	0	0	101	110	115	132
102681	82	88	0	0	82	88	82	88
102683	96	98	0	0	96	98	96	98
102684	82	96	0	0	82	96	92	105
102687	91	81	0	0	91	81	91	81
102689	43	33	0	0	43	33	43	33
102690	45	46	0	0	45	46	45	46
102692	58	50	0	0	58	50	58	58
102693	56	58	0	0	56	58	61	68
102694	80	78	0	0	80	78	80	78
102695	13	13	0	0	13	13	13	13
102696	36	32	0	0	36	32	36	32
102697	98	90	0	0	98	90	98	90
102699	31	33	0	0	31	33	31	33
102700	51	47	0	0	51	47	51	47
102701	77	62	0	0	77	62	113	102
102702	31	39	0	0	31	39	31	39
102703	37	27	0	0	37	27	37	27
102704	35	54	0	0	35	54	35	54
102705	137	154	0	1	137	155	183	196
102706	61	65	0	0	61	65	85	88
102707	37	37	0	0	37	37	37	37
102708	62	66	0	0	62	66	62	66
102709	50	55	0	0	50	55	50	55
102710	60	61	0	0	60	61	64	63
102712	37	41	0	0	37	41	37	41

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
102714	60	62	0	0	60	62	60	62
102715	21	24	0	0	21	24	21	24
102716	54	69	0	0	54	69	54	69
102717	42	39	0	0	42	39	53	55
102718	73	70	0	0	73	70	73	72
102719	39	40	0	0	39	40	39	41
102720	75	67	0	0	75	67	94	87
102721	119	111	0	0	119	111	119	111
102722	44	42	0	0	44	42	55	50
102726	32	26	0	0	32	26	43	39
102727	42	52	0	0	42	52	50	58
102728	70	73	1	0	71	73	87	89
102731	94	90	0	0	94	90	94	90
102732	47	45	0	0	47	45	47	45
102733	47	62	0	0	47	62	47	62
102736	30	34	0	0	30	34	30	34
102737	42	42	0	0	42	42	42	42
102738	37	29	0	0	37	29	37	29
102739	28	23	0	0	28	23	28	23
102740	75	81	0	0	75	81	105	108
102741	33	29	0	0	33	29	33	29
102742	88	82	0	0	88	82	95	91
102743	40	38	0	0	40	38	40	40
102744	48	54	0	0	48	54	49	56
102745	78	70	0	0	78	70	78	70
102746	67	70	0	0	67	70	67	70
102747	65	70	0	0	65	70	65	74
102748	102	103	0	0	102	103	119	114
102749	4	10	0	0	4	10	4	10
102750	58	55	0	0	58	55	58	55
102751	41	33	0	0	41	33	41	33
102752	42	42	0	0	42	42	42	42
102754	107	103	0	0	107	103	123	119
102756	69	59	0	0	69	59	79	69
102757	44	45	0	0	44	45	44	45
102759	18	19	0	0	18	19	18	19
102760#	0	0	0	0	0	0	0	0
102761	107	102	0	0	107	102	125	118
102762	82	83	1	1	83	84	86	90
102763	53	48	0	0	53	48	53	48
102764	0	60	0	0	0	60	0	63
102765	74	77	0	0	74	77	74	77
102766	135	136	1	1	136	137	138	138

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
102767	89	80	0	0	89	80	89	80
102768	52	44	0	0	52	44	52	44
102769	82	85	0	0	82	85	92	102
102770	72	69	0	0	72	69	72	69
102771	46	51	0	0	46	51	46	51
102772	0	0	0	0	0	0	72	78
102773	70	66	0	1	70	67	82	74
102774	86	85	0	0	86	85	93	97
102775	71	72	0	0	71	72	71	72
102776	88	88	0	0	88	88	88	88
102777	62	63	0	0	62	63	66	67
102778	69	57	0	0	69	57	69	57
102779	100	93	20	26	120	119	124	120
102782	37	38	0	0	37	38	37	38
102783	91	84	0	0	91	84	101	102
102784	83	88	0	0	83	88	83	88
102786	39	53	0	0	39	53	39	53
102787	94	91	0	0	94	91	109	106
102788	62	66	0	0	62	66	62	66
102789	77	91	0	0	77	91	81	100
102790	20	22	0	0	20	22	20	22
102791	43	42	0	0	43	42	48	59
102792	114	110	0	0	114	110	149	134
102793	64	66	0	0	64	66	64	66
102794	101	94	0	0	101	94	131	127
102795	54	45	0	0	54	45	54	45
102796	22	21	0	0	22	21	22	21
102800	85	86	0	0	85	86	101	95
102801	29	36	0	0	29	36	29	36
102802	52	61	0	0	52	61	54	64
102803	55	55	0	0	55	55	64	64
102804	28	28	0	0	28	28	28	28
102805	89	80	0	0	89	80	112	111
102806	102	116	0	0	102	116	109	118
102807	32	36	0	0	32	36	32	36
102808	36	31	0	0	36	31	36	31
102809	41	39	0	0	41	39	49	46
102810	82	80	0	0	82	80	82	80
102811	28	26	0	0	28	26	31	27
102812	86	92	0	0	86	92	86	92
102813	79	80	0	0	79	80	79	80
102814	34	38	0	0	34	38	34	38
102815	55	60	0	0	55	60	55	60

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
102816	41	42	0	0	41	42	51	54
102817	70	64	0	0	70	64	80	76
102818	63	61	0	0	63	61	63	61
102819	30	30	0	0	30	30	30	30
102820	62	73	0	0	62	73	62	73
102821	0	0	0	0	0	0	13	13
102822	58	60	0	0	58	60	58	60
102823	0	0	0	0	0	0	40	49
102824	87	83	0	1	87	84	115	110
102825	0	0	0	0	0	0	146	138
102826	57	49	0	0	57	49	66	56
102827	81	80	0	0	81	80	81	80
102828	38	35	0	0	38	35	47	46
102829	87	84	0	0	87	84	87	84
102830	50	45	0	0	50	45	50	45
102831	27	33	0	0	27	33	27	33
102832	112	111	0	0	112	111	187	125
102833	0	0	0	0	0	0	29	32
102834	51	40	0	0	51	40	51	40
102835	76	83	0	0	76	83	76	83
102836	59	68	0	0	59	68	63	71
102837	94	95	0	0	94	95	94	95
102838	63	57	0	0	63	57	71	65
102839	87	93	0	0	87	93	87	93
102840	90	78	0	0	90	78	90	78
102841	48	50	0	0	48	50	48	50
102843	68	70	1	0	69	70	69	70
102844	104	88	0	0	104	88	112	99
102845	64	56	0	0	64	56	64	56
102847	80	68	0	0	80	68	100	95
102848	48	60	0	0	48	60	70	84
102849	65	68	0	0	65	68	83	85
102850	88	68	0	0	88	68	99	74
102851	65	68	1	1	66	69	87	92
102853	71	72	0	0	71	72	81	89
102854	74	77	0	0	74	77	78	79
102855	121	104	0	0	121	104	139	119
102856	62	80	0	0	62	80	62	80
102857	71	70	0	0	71	70	71	70
102858	101	107	0	0	101	107	101	107
102859	35	39	0	0	35	39	35	39
102860	25	27	0	0	25	27	25	27
102861	94	101	0	0	94	101	110	116

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
102862#	0	0	0	0	0	0	0	0
102863	19	17	0	0	19	17	19	17
102864	71	79	0	0	71	79	77	83
102865	22	23	0	0	22	23	22	23
102866	53	57	0	0	53	57	53	57
102867	15	18	0	0	15	18	16	20
102868	55	71	0	0	55	71	55	71
102869	45	44	0	0	45	44	45	44
102870	96	102	0	0	96	102	96	102
102871	27	42	0	0	27	42	29	46
102872	104	101	0	0	104	101	104	101
102873	54	65	0	0	54	65	65	82
102874	51	54	0	0	51	54	51	54
102875	52	57	0	0	52	57	52	57
102876	51	42	1	0	52	42	64	51
102877	48	50	0	0	48	50	48	50
102878	84	85	0	0	84	85	84	85
102879	38	37	0	0	38	37	38	37
102880	44	44	0	0	44	44	44	44
102881	10	9	0	0	10	9	11	10
102882	79	84	0	0	79	84	96	99
102883	43	55	0	0	43	55	44	55
102884	70	78	0	0	70	78	70	78
102885	0	0	0	0	0	0	38	44
102886	74	91	0	0	74	91	74	91
102887	0	0	0	0	0	0	12	13
102888	23	22	0	0	23	22	23	22
102889	32	32	0	0	32	32	35	37
102890	21	17	0	0	21	17	21	17
102891	26	34	0	0	26	34	26	34
102892	42	49	0	0	42	49	42	49
102893	40	60	0	0	40	60	40	60
102894	4	4	0	0	4	4	18	23
102895	19	15	0	0	19	15	19	15
102896	88	94	0	0	88	94	119	126
102897	48	67	0	0	48	67	60	77
102898	78	81	0	0	78	81	81	81
102899	42	48	0	0	42	48	42	48
103300	3	5	0	0	3	5	7	12
103301	13	14	0	0	13	14	22	21
103502	60	51	0	0	60	51	71	59
103503	78	87	0	0	78	87	86	96
108812^	0	3	0	0	0	3	0	3

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
682500	32	39	0	1	32	40	38	50
682501	29	48	0	0	29	48	29	48
682502	32	38	0	0	32	38	32	47
682503	18	29	0	0	18	29	22	31
682504	0	0	0	0	0	0	3	4
682505	29	31	0	0	29	31	29	31
682506	27	30	0	0	27	30	37	40
682507	41	55	0	0	41	55	51	72
682508	52	65	0	1	52	66	57	69
682509	22	24	0	0	22	24	22	24
682510	70	57	0	0	70	57	70	57
682511	16	23	0	0	16	23	32	46
682512	24	13	0	0	24	13	24	13
682513	10	18	0	0	10	18	17	29
682514#	0	0	0	0	0	0	0	0
682515	32	31	0	0	32	31	39	37
682516	42	37	0	0	42	37	45	43
682517	94	83	0	0	94	83	94	89
682518	20	35	0	0	20	35	23	43
682519	40	50	0	0	40	50	40	50
682520	29	60	0	0	29	60	29	60
682521	17	30	0	0	17	30	17	30
682522	82	94	2	1	84	95	105	122
682523	3	5	0	0	3	5	8	12
682524#	0	0	0	0	0	0	0	0
682525	18	33	0	0	18	33	18	33
682526	14	25	0	0	14	25	15	31
682527	12	31	0	0	12	31	12	31
682528	0	0	0	0	0	0	0	0
682529	0	21	0	0	0	21	0	21
682530	0	60	0	0	0	60	0	60
682531	0	0	0	0	0	0	1	15
682532^	0	12	0	0	0	12	0	14
682533^	0	0	0	0	0	0	0	5
682534^	0	0	0	0	0	0	0	46
682535	0	34	0	0	0	34	0	34
682536	0	11	0	0	0	11	0	11
682537	0	7	0	0	0	7	0	7
682538^	0	0	0	0	0	0	0	88
682539^	0	0	0	0	0	0	0	2
682540^	0	11	0	0	0	11	0	11
682541^	0	27	0	0	0	27	0	29
682542^	0	10	0	0	0	10	0	12

	Hemo		PD		Total		Total In-Center & Home[1]	
Facility CCN	2012	2013	2012	2013	2012	2013	2012	2013
682543^	0	0	0	0	0	0	0	7
682544^	0	1	0	0	0	1	0	1
682545^	0	1	0	0	0	1	0	1
682546^	0	0	0	0	0	0	0	0
FL0ORP	0	39	0	0	0	39	0	87
FL Totals	22,512	23,240	38	42	22,550	23,282	25,343	26,382
Network Totals	22,512	23,240	38	42	22,550	23,282	25,343	26,382

Source of Information: Facility Survey (CMS 2744) and CROWNWeb

Date of Preparation: April 2014

[1] The last column of the report displays the total from Table #3 plus total from Table #4

This table includes 136 Veterans Affairs Facility patients for 2012 and 129 Veterans Affairs Facility patients for 2013

^ Facility not operational in 2012

Facility not operational in 2013

* Facility does not have a generated 2744 in 2013

Table 5
Renal Transplant by Transplant Center

Number of transplants performed by transplant center
calendar year 2012 and calendar year 2013

Transplant Center	Total Transplants Performed		Patients Awaiting Transplant	
	2012	**2013**	**2012**	**2013**
109801	196	216	0	215
109802	180	165	511	517
109803	89	94	425	473
109804	280	275	0	0
109806	160	160	1,078	973
109807	17	13	45	43
109809	38	36	114	210
FL Total	**960**	**959**	**2,173**	**2,431**

Source of Information: Facility Survey (CMS 2744) and CROWNWeb

Date of Preparation: April 2014

Some patients may be placed on more than one waiting list.

TABLE 6

Renal Transplant Recipients

Renal transplant recipients by transplant type, age, race, gender and primary diagnosis for calendar year 2013

Age Group	Transplant Type				Total
	Deceased	Living Related	Living Unrelated	Unknown	
00-04	9	1	0	0	10
05-09	6	3	0	0	9
10-14	6	1	0	0	7
15-19	15	2	2	0	19
20-24	12	19	0	0	31
25-29	26	14	6	0	46
30-34	26	15	6	0	47
35-39	43	16	6	0	65
40-44	68	13	6	0	87
45-49	72	16	9	0	97
50-54	78	18	14	0	110
55-59	80	19	8	0	107
60-64	100	18	10	0	128
65-69	83	14	5	0	102
70-74	47	7	4	0	58
75-79	22	3	4	0	29
80-84	5	0	1	0	6
>=85	1	0	0	0	1
Total	**699**	**179**	**81**	**0**	**959**

Gender	Transplant Type				Total
	Deceased	Living Related	Living Unrelated	Unknown	
Female	293	82	29	0	404
Male	406	97	52	0	555
Total	**699**	**179**	**81**	**0**	**959**

Race	Transplant Type				Total
	Deceased	Living Related	Living Unrelated	Unknown	
American Indian/Alaska Native	0	0	0	0	0
Asian	20	6	3	0	29
Black or African American	235	29	12	0	276
Multiracial	1	3	1	0	5
Native Hawaiian or Other Pacific Islander	4	0	0	0	4
White	423	135	64	0	622
Not Specified	16	6	1	0	23

Race	Transplant Type				Total
	Deceased	Living Related	Living Unrelated	Unknown	
Total	699	179	81	0	959

Primary Diagnosis	Transplant Type				Total
	Deceased	Living Related	Living Unrelated	Unknown	
Acquired obstructive uropathy	5	2	0	0	7
Acute interstitial nephritis	0	0	0	0	0
AIDS nephropathy	1	1	0	0	2
Amyloidosis	0	1	0	0	1
Analgesic abuse	1	0	0	0	1
Cholesterol emboli, renal emboli	0	0	0	0	0
Chronic interstitial nephritis	4	3	1	0	8
Chronic pyelonephritis, reflux nephropathy	2	3	2	0	7
Complications of other specified transplanted organ	0	0	0	0	0
Complications of transplanted bone marrow	0	0	0	0	0
Complications of transplanted heart	1	2	0	0	3
Complications of transplanted intestine	3	0	0	0	3
Complications of transplanted kidney	23	0	1	0	24
Complications of transplanted liver	3	0	0	0	3
Complications of transplanted lung	1	0	0	0	1
Complications of transplanted organ unspecified	1	0	0	0	1
Complications of transplanted pancreas	0	0	0	0	0
Congenital nephrotic syndrome	6	1	0	0	7
Congenital obstruction of ureterpelvic junction	1	0	0	0	1
Congenital obstruction of uretrovesical junction	0	0	0	0	0
Cystinosis	1	0	1	0	2
Dense deposit disease, MPGN type 2	0	0	0	0	0
Diabetes with renal manifestations Type 1	50	4	1	0	55
Diabetes with renal manifestations Type 2	139	18	13	0	170
Drash syndrome, mesangial sclerosis	0	0	0	0	0
Etiology uncertain	20	7	2	0	29
Fabry's disease	0	0	0	0	0
Focal Glomerulonephritis, focal sclerosing GN	51	16	6	0	73
Glomerulonephritis (GN) (histologically not examined)	31	18	2	0	51
Goodpasture's syndrome	1	1	0	0	2
Gouty nephropathy	0	0	0	0	0
Hemolytic uremic syndrome	1	0	0	0	1
Henoch-Schonlein syndrome	0	0	0	0	0
Hepatorenal syndrome	7	0	0	0	7
Hereditary nephritis, Alport's syndrome	2	0	2	0	4

Primary Diagnosis	Transplant Type				Total
	Deceased	Living Related	Living Unrelated	Unknown	
Hypertension: Unspecified with renal failure	165	34	16	0	215
IgA nephropathy, Berger's disease (proven by immunofluorescence)	18	10	5	0	33
IgM nephropathy (proven by immunofluorescence)	0	1	0	0	1
Lead nephropathy	0	0	0	0	0
Lupus erythematosus, (SLE nephritis)	19	9	2	0	30
Lymphoma of kidneys	0	0	0	0	0
Medullary cystic disease, including nephronophthisis	2	2	0	0	4
Membranoproliferative GN type 1, diffuse MPGN	5	1	1	0	7
Membranous nephropathy	7	1	0	0	8
Multiple myeloma	0	0	0	0	0
Nephrolithiasis	1	0	1	0	2
Nephropathy caused by other agents	1	1	1	0	3
Nephropathy due to heroin abuse and related drugs	0	0	0	0	0
Other (congenital malformation syndromes)	3	1	0	0	4
Other Congenital obstructive uropathy	1	1	1	0	3
Other disorders of calcium metabolism	0	0	0	0	0
Other immuno proliferative neoplasms (including light chain nephropathy)	0	0	0	0	0
Other proliferative GN	3	1	0	0	4
Other renal disorders	10	5	0	0	15
Other Vasculitis and its derivatives	3	0	0	0	3
Polyarteritis	0	0	0	0	0
Polycystic kidneys, adult type (dominant)	50	14	17	0	81
Polycystic, infantile (recessive)	4	1	0	0	5
Post infectious GN, SBE	0	1	0	0	1
Postpartum renal failure	0	0	0	0	0
Primary oxalosis	1	0	0	0	1
Prune belly syndrome	0	0	0	0	0
Radiation nephritis	0	0	0	0	0
Renal artery occlusion	0	0	0	0	0
Renal artery stenosis	2	0	0	0	2
Renal hypoplasia, dysplasia, oligonephronia	9	3	1	0	13
Renal tumor (benign)	0	0	0	0	0
Renal tumor (malignant)	1	0	1	0	2
Renal tumor (unspecified)	0	0	0	0	0
Scleroderma	1	0	1	0	2
Secondary GN, other	0	1	0	0	1
Sickle cell disease/anemia	0	1	0	0	1
Sickle cell trait and other sickle cell (HbS/Hb other)	0	0	0	0	0
Traumatic or surgical loss of kidney(s)	1	1	0	0	2

Primary Diagnosis	Transplant Type				Total
	Deceased	Living Related	Living Unrelated	Unknown	
Tuberous sclerosis	0	0	0	0	0
Tubular necrosis (no recovery)	5	0	0	0	5
Urinary tract tumor (benign)	0	0	0	0	0
Urinary tract tumor (malignant)	0	0	0	0	0
Urinary tract tumor (unspecified)	1	0	0	0	1
Urolithiasis	2	0	0	0	2
Wegener's granulomatosis	4	2	0	0	6
With lesion of rapidly progressive GN	1	0	0	0	1
Not Specified	24	11	3	0	**38**
Total	**699**	**179**	**81**	**0**	**959**

Source of Information: CROWNWeb

Date of Preparation: April 2014

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

Primary Diagnosis: The categories are from the CMS-2728 Form.

Table 7
Dialysis Deaths

Deaths of dialysis patients by state of residence, age, race, gender, primary diagnosis and cause of death for calendar year 2013

Age Group	FL	Other	Total
00-04	2	0	2
05-09	2	0	2
10-14	1	0	1
15-19	4	0	4
20-24	12	0	12
25-29	26	0	26
30-34	33	1	34
35-39	40	1	41
40-44	96	0	96
45-49	160	0	160
50-54	244	4	248
55-59	360	3	363
60-64	432	1	433
65-69	599	8	607
70-74	695	13	708
75-79	728	14	742
80-84	609	10	619
>=85	679	13	692
Total	4,722	68	4,790

Gender	FL	Other	Total
Female	1,967	20	1,987
Male	2,755	48	2,803
Not Specified	0	0	0
Total	**4,722**	**68**	**4,790**

Race	FL	Other	Total
American Indian/Alaska Native	8	0	8
Asian	44	0	44
Black or African American	1,345	10	1,355
Multiracial	5	0	5
Native Hawaiian or Other Pacific Islander	18	0	18
White	3,296	58	3,354
Not Specified	6	0	6
Total	**4,722**	**68**	**4,790**

Primary Diagnosis	FL	Other	Total
Cystic/Hereditary/Congenital Diseases	77	2	79
Diabetes	2,099	27	2,126
Glomerulonephritis	218	2	220
Hypertension/Large Vessel Disease	1,575	24	1,599
Interstitial Nephritis/Pyelonephritis	104	0	104
Miscellaneous Conditions	331	8	339
Neoplasms/Tumors	168	4	172
Secondary GN/Vasculitis	81	1	82
Not Specified	69	0	69
Total	**4,722**	**68**	**4,790**

Primary Cause of Death	FL	Other	Total
Cardiac	2,225	32	2,257
Gastro-Intestinal	33	1	34
Infection	332	5	337
Liver Disease	41	1	42
Not Specified	101	1	102
Other	1,106	16	1,122
Unknown	746	9	755
Vascular	138	3	141
Total	**4,722**	**68**	**4,790**

Source of Information: CROWNWeb

Date of Preparation: April 2014

Race: The categories are from the CMS-2728 Form

Primary Diagnosis: The categories are from the CMS-2728 Form

Primary Cause of Death: The categories are from the CMS-2746 Form

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

This table includes 29 Patients receiving treatment at VA facilities.

TABLE 8
Vocational Rehabilitation

Beginning Through End of Survey Period 2013

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
102518	23	0	0	0
102501	51	0	4	0
102514	43	2	13	2
102512	38	0	5	0
102548	28	0	0	0
102551	15	0	0	0
100001	101	1	12	1
102531	49	1	13	2
102521	50	0	5	5
102557	11	0	0	0
102573	42	0	4	0
102519	28	0	2	0
102528	18	0	5	1
102529	7	0	2	0
102506	31	0	7	0
102542	17	0	1	0
102538	12	0	0	0
102547	34	0	1	0
102563	5	0	0	0
102554	22	0	2	0
103300	3	1	0	2
100007	5	0	0	0
102505	89	3	18	2
102517	22	0	4	0
102511	13	0	6	2
102546	53	0	3	0
102553	40	0	11	0
102569	28	0	1	0
102513	56	0	4	0
102524	10	0	0	0
102534	11	0	2	0
102549	10	0	0	0
102545	46	0	6	1
102564	16	0	2	0
102520	12	0	3	0
102525	18	0	2	0

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
102527	12	0	4	0
102510	11	0	1	0
100288	43	0	6	0
102571	26	0	2	0
102555	32	0	1	0
100038	3	0	0	2
102536	32	0	2	0
102559	41	0	12	2
102504	63	0	2	2
102544	34	0	6	3
102718	18	1	4	0
102503	18	0	0	0
102530	23	0	6	0
102532	43	3	11	3
102502	34	0	10	3
102543	12	0	1	0
102558	29	0	3	0
102565	53	0	5	0
102566	22	3	10	3
102574	29	0	1	0
102576	23	0	2	0
102578	16	0	3	0
102579	11	0	1	0
102581	27	1	4	1
102582	8	0	1	0
102583	40	1	8	2
102584	16	0	3	0
102585	22	0	1	0
102586	71	6	32	4
102587	4	0	0	0
102589	9	0	1	0
102590	48	0	4	0
102591	27	0	3	0
102592	12	0	1	0
102593	33	0	8	0
102594	36	0	11	4
102595	19	2	7	1
102596	36	0	9	0
102597	10	0	2	0
102598	16	0	1	0
102601	17	0	0	0
102602	42	0	1	0
102603	12	0	2	0

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
102604	24	0	1	0
102605	25	0	2	0
102609	19	0	3	1
102610	47	0	7	0
102689	11	0	0	0
102612	28	2	5	3
100022	18	0	3	0
100113	4	0	0	0
100128	9	1	1	1
109802	0	0	0	0
109804	0	0	0	0
109803	0	0	0	0
109801	0	0	0	0
102616	18	0	0	0
102618	19	0	7	0
102613	29	1	4	0
102614	24	0	1	0
102615	37	0	0	0
102619	15	0	2	0
102617	19	0	2	0
102623	30	2	5	2
102624	24	0	5	0
109809	0	0	0	0
102626	19	0	0	0
102627	23	0	1	0
10061F	4	0	0	0
10011F	9	0	0	0
102629	8	0	1	0
102630	23	0	3	0
102632	16	0	0	0
102635	26	0	3	0
102634	35	0	5	0
102636	52	0	8	0
102558	4	0	0	0
102638	22	0	2	0
102637	28	0	0	0
102628	5	0	2	0
102639	31	1	5	3
102642	13	0	2	0
102647	26	0	6	0
102646	9	0	1	0
103301	6	1	0	1
102645	49	1	16	0

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
102648	24	0	10	0
102649	11	0	4	0
102652	13	0	0	0
102651	17	0	2	1
102653	19	0	3	0
102656	74	3	6	3
102654	10	0	3	0
102655	14	0	1	0
102658	13	0	5	0
102662	20	1	0	0
102659	53	0	4	1
102660	30	0	4	2
102664	30	0	0	0
102665	17	0	2	1
10009F	8	0	0	0
102529	0	0	0	0
102666	24	2	7	1
102670	11	0	0	0
102668	9	0	0	0
102695	3	0	0	0
102674	17	0	2	0
102673	69	0	17	0
102675	5	0	0	0
102683	23	0	1	0
102676	28	0	1	0
102678	23	0	1	0
102679	20	0	1	0
102684	36	1	8	1
102687	12	1	3	1
102680	36	0	6	1
102681	35	0	4	0
102692	10	0	1	0
102690	7	0	0	0
10065F	2	0	0	0
102693	21	1	3	1
102705	50	1	18	1
102694	19	0	1	0
102696	8	0	0	0
102699	6	0	0	0
102697	39	0	1	0
102702	11	0	1	0
102708	21	1	5	0
102701	29	0	4	0

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
102715	8	0	1	0
102700	13	0	1	0
102704	26	0	6	1
102719	8	0	1	0
102707	14	0	4	0
102710	14	0	1	0
102712	9	0	0	0
102716	23	0	0	0
102714	16	0	1	0
102717	8	0	0	0
102720	11	0	0	0
102721	34	2	20	2
102722	10	0	0	0
102733	9	0	0	0
102703	8	0	0	0
102726	5	0	1	1
102728	16	0	1	0
102709	10	0	2	0
102748	38	0	5	1
102731	14	0	2	0
102727	4	0	0	0
102737	13	0	0	0
102732	7	0	2	0
102739	7	0	0	0
102736	6	0	0	0
102746	14	1	6	0
100088	0	0	0	0
102740	33	2	7	2
102738	6	1	1	1
102741	12	0	0	0
102893	20	1	8	1
102742	23	0	4	0
102744	7	2	3	1
102743	9	0	1	0
102756	21	1	3	3
102752	6	0	0	0
102750	9	0	1	0
102745	25	0	2	0
102749	2	1	0	1
102747	19	0	0	0
102751	16	0	1	0
102522	16	1	11	1
102706	13	1	1	0

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
102759	3	0	2	0
102757	14	1	2	0
102763	3	0	0	0
102766	27	1	6	0
102764	20	0	0	0
102768	14	1	2	1
102754	36	1	4	2
102761	45	4	7	3
102767	27	0	10	0
102762	24	0	2	0
102765	24	0	3	0
102770	16	0	0	0
102772	27	0	9	4
102769	38	0	3	0
102773	25	0	1	0
102774	7	0	3	0
102776	26	1	5	0
109806	0	0	0	0
102771	14	0	2	0
102775	14	1	1	1
102778	13	0	0	0
102783	26	0	6	0
102782	12	0	0	0
102777	29	0	3	0
102779	40	0	14	0
102784	45	0	6	6
102792	25	0	5	2
102786	14	1	2	1
102790	5	0	0	0
102789	16	1	5	1
102788	11	0	0	0
102787	22	1	3	0
102791	9	0	1	0
102793	24	0	5	0
102794	55	0	13	2
102795	14	2	6	0
102801	12	0	2	0
102796	2	0	0	0
102800	26	0	5	1
102805	42	0	4	0
102811	4	0	2	0
102803	25	0	0	0
102804	9	0	1	0

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
FL0ORP	56	0	0	0
102806	20	0	1	0
102808	6	0	1	0
102807	6	0	2	1
102802	18	0	0	0
102812	30	1	2	0
102809	4	0	0	0
102810	22	0	1	0
102813	26	0	2	0
103502	18	0	2	0
102815	28	0	2	0
102814	10	0	1	0
102817	23	0	3	1
102818	9	0	0	0
102819	9	0	3	0
102820	36	0	5	0
102816	15	0	1	0
102856	34	0	4	1
102832	32	0	0	0
102823	16	0	5	0
102825	41	2	13	1
102824	26	2	7	2
102828	19	0	2	0
102826	11	0	1	2
102827	15	0	1	0
102821	3	0	0	0
102822	16	0	0	0
102829	24	0	1	0
102830	15	0	1	0
102831	6	0	0	0
102834	11	0	0	0
102833	8	0	4	0
102835	18	0	3	0
102860	7	0	0	0
102836	14	0	7	0
102838	7	0	0	0
102839	33	0	4	0
102840	20	0	1	0
102841	14	0	3	0
109807	0	0	0	0
102843	7	0	0	0
102844	8	0	2	0
102845	12	11	2	0

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
102883	13	0	1	0
102851	20	0	1	0
103503	52	0	2	0
102848	17	0	1	1
102849	17	1	3	1
102850	29	0	3	1
102847	18	0	1	0
102853	18	0	1	0
102855	32	0	0	0
102861	24	0	6	0
102837	32	2	3	2
102854	4	1	1	0
102885	22	0	9	0
102857	12	0	0	0
102858	30	0	2	1
102859	7	0	0	0
102874	12	0	2	1
682504	1	0	0	0
102875	10	0	2	0
102873	22	0	6	0
102881	4	0	1	0
102871	15	0	7	0
102863	4	0	1	0
102864	22	0	0	0
102865	7	1	1	0
102876	15	1	2	0
102866	15	1	8	0
102867	4	0	1	0
102868	19	0	1	0
102869	6	0	1	0
102870	33	6	8	4
102890	8	0	0	0
102880	11	0	5	2
102879	17	0	2	0
102884	25	0	4	0
102872	17	0	3	0
102882	27	0	3	0
102877	11	3	1	0
102887	2	0	0	0
102878	31	0	0	0
102888	6	0	1	0
102886	34	0	4	0
102892	8	1	4	1

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
102894	5	0	0	0
102889	7	0	2	0
682500	19	0	3	0
102895	6	0	0	0
102891	9	0	2	0
102896	60	0	16	2
102897	14	0	1	1
682513	9	0	0	0
682501	10	0	0	0
682502	17	0	4	0
102898	18	0	0	0
682511	10	0	0	0
682503	6	1	1	0
682507	13	0	1	0
682508	27	0	1	0
102899	9	0	1	0
682505	9	0	0	0
682509	3	0	0	0
682506	17	0	1	0
682510	16	1	2	3
682512	4	0	0	0
682515	6	0	3	0
682525	11	1	1	0
682516	13	0	1	1
682523	8	0	3	0
682517	31	0	0	0
682527	4	0	2	0
100006	1	0	0	1
682520	10	0	4	0
682521	9	0	1	0
682518	11	0	2	1
682528	0	0	0	0
682519	10	0	0	0
682522	34	0	3	0
682526	18	0	2	0
682536	5	0	0	0
682530	23	1	0	0
682529	6	0	0	0
682535	17	0	1	0
682531	9	0	4	2
682534	16	0	0	0
682532	4	0	0	0
682538	28	0	8	0

Facility CCN	Aged 18 through 54	Patients Receiving Services from Voc Rehab	Patients Employed Full-Time or Part-Time	Patients Attending School Full-Time or Part-Time
108812	0	0	0	0
682540	1	0	0	0
682539	1	0	0	0
682537	2	0	1	0
682541	7	0	1	0
682533	1	0	0	0
682543	7	0	1	0
682546	0	0	0	0
682545	1	0	0	0
682542	0	0	0	0
682544	0	0	0	0
FL Total	**7,459**	**110**	**1,066**	**145**

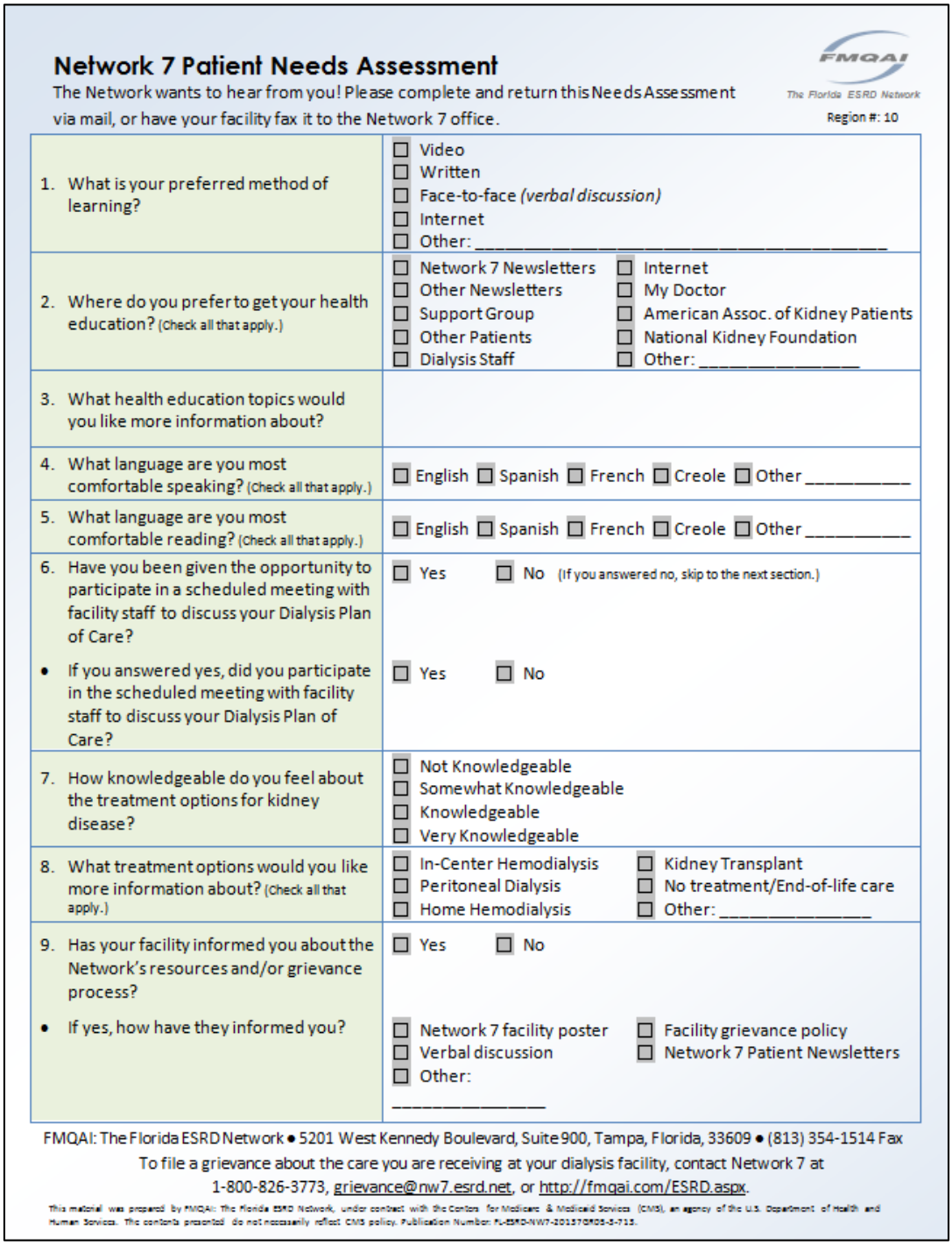
Source of Information: CROWNWeb

Date of Preparation: April 2014

APPENDICES

APPENDIX A. PATIENT NEEDS ASSESSMENT AND RESULTS

The Patient Needs Assessment was updated with feedback from the Network PAC and mailed to all Florida dialysis facilities in June 2013. The table below summarizes the results from the 552 completed needs assessments received by the Network.



Network 7 Patient Needs Assessment

The Network wants to hear from you! Please complete and return this Needs Assessment via mail, or have your facility fax it to the Network 7 office.

FMQAI The Florida ESRD Network

Region #: 10

1. What is your preferred method of learning?	☐ Video ☐ Written ☐ Face-to-face *(verbal discussion)* ☐ Internet ☐ Other: _____
2. Where do you prefer to get your health education? (Check all that apply.)	☐ Network 7 Newsletters ☐ Internet ☐ Other Newsletters ☐ My Doctor ☐ Support Group ☐ American Assoc. of Kidney Patients ☐ Other Patients ☐ National Kidney Foundation ☐ Dialysis Staff ☐ Other: _____
3. What health education topics would you like more information about?	
4. What language are you most comfortable speaking? (Check all that apply.)	☐ English ☐ Spanish ☐ French ☐ Creole ☐ Other _____
5. What language are you most comfortable reading? (Check all that apply.)	☐ English ☐ Spanish ☐ French ☐ Creole ☐ Other _____
6. Have you been given the opportunity to participate in a scheduled meeting with facility staff to discuss your Dialysis Plan of Care?	☐ Yes ☐ No (If you answered no, skip to the next section.)
• If you answered yes, did you participate in the scheduled meeting with facility staff to discuss your Dialysis Plan of Care?	☐ Yes ☐ No
7. How knowledgeable do you feel about the treatment options for kidney disease?	☐ Not Knowledgeable ☐ Somewhat Knowledgeable ☐ Knowledgeable ☐ Very Knowledgeable
8. What treatment options would you like more information about? (Check all that apply.)	☐ In-Center Hemodialysis ☐ Kidney Transplant ☐ Peritoneal Dialysis ☐ No treatment/End-of-life care ☐ Home Hemodialysis ☐ Other: _____
9. Has your facility informed you about the Network's resources and/or grievance process?	☐ Yes ☐ No
• If yes, how have they informed you?	☐ Network 7 facility poster ☐ Facility grievance policy ☐ Verbal discussion ☐ Network 7 Patient Newsletters ☐ Other: _____

FMQAI: The Florida ESRD Network • 5201 West Kennedy Boulevard, Suite 900, Tampa, Florida, 33609 • (813) 354-1514 Fax

To file a grievance about the care you are receiving at your dialysis facility, contact Network 7 at 1-800-826-3773, grievance@nw7.esrd.net, or http://fmqai.com/ESRD.aspx.

This material was prepared by FMQAI: The Florida ESRD Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication Number FL-ESRD-NW7-20137DMS-5-715.

2013 Network 7 Patient Needs Assessment Results

Total number of respondents: 552
(Figure 1)

	# of Responses	% of All Responses	% of Respondents
What is your preferred method of learning?			
Video	95	14.55%	17.21%
Written	145	22.21%	26.27%
Face-to-face *(verbal discussion)*	353	54.06%	63.95%
Internet	53	8.12%	9.60%
Other	7	1.07%	1.27%
Where do you prefer to get your health education? (Check all that apply.)			
Network 7 Newsletters	63	5.50%	11.41%
Internet	121	10.56%	21.92%
Other Newsletter	36	3.14%	6.52%
My Doctor	341	29.76%	61.78%
Support Group	45	3.93%	8.15%
Other Patients	48	4.19%	8.70%
Dialysis Staff	365	31.85%	66.12%
American Assoc. of Kidney Patients	45	3.93%	8.15%
Support Group	0	0.00%	0.00%
National Kidney Foundation	72	6.28%	13.04%
Other	10	0.87%	1.81%
What language are you most comfortable speaking? (Check all that apply.)			
English	457	86.06%	82.79%
Spanish	51	9.60%	9.24%
French	9	1.69%	1.63%
Creole	10	1.88%	1.81%
Other	4	0.75%	0.72%
What language are you most comfortable reading? (Check all that apply.)			
English	439	85.24%	79.53%
Spanish	52	10.10%	9.42%
French	10	1.94%	1.81%
Creole	10	1.94%	1.81%
Other	4	0.78%	0.72%

Have you been given the opportunity to participate in a scheduled meeting with facility staff to discuss your Dialysis Plan of Care?			
Yes	346	69.06%	62.68%
No (If you answered no, skip to the next section.)	155	30.94%	28.08%
If you answered yes, did you participate in the scheduled meeting with facility staff to discuss your Dialysis Plan of Care?			
Yes	183	53.67%	33.15%
No	158	46.33%	28.62%
How knowledgeable do you feel about the treatment options for kidney disease?	# of Responses	% of All Responses	% of Respondents
Not Knowledgeable	31	6.10%	5.62%
Somewhat Knowledgeable	146	28.74%	26.45%

Knowledgeable	222	43.70%	40.22%
Very Knowledgeable	109	21.46%	19.75%
What treatment options would you like more information about? (Check all that apply.)			
In-Center Hemodialysis	139	29.57%	25.18%
Peritoneal Dialysis	57	12.13%	10.33%
Kidney Transplant	170	36.17%	30.80%
Home Hemodialysis	61	12.98%	11.05%
No treatment/End of Life care	23	4.89%	4.17%
Other	20	4.26%	3.62%
Has your facility informed you about the Network's resources and/or grievance process?			
Yes	367	75.67%	66.49%
No	118	24.33%	21.38%
If yes, how have they informed you?			
Network 7 facility poster	57	11.54%	10.33%
Facility grievance policy	112	22.67%	20.29%
Verbal Discussion	274	55.47%	49.64%
Network 7 Patient Newsletters	42	8.50%	7.61%
Other	9	1.82%	1.63%

APPENDIX B. PROVIDER NEEDS ASSESSMENT RESULTS

2013 Network 7 Provider Needs Assessment Results Total number of respondents: 114			
	Response %	Response Count	
1. Where do you obtain patient education materials? (Check all that apply.)(n=114)			
Network 7 Patient Newsletter	50.9%	58	
Network 7 Provider eNewsletter	31.6%	36	
Network 7 Website	33.3%	38	
Patient organization websites (e.g., NKF, AAKP, RSN)	59.6%	68	
My dialysis company	71.9%	82	
Other (Please specify)			
2. How does the facility distribute the Network 7 Newsletter? (Check all that apply.) (n=114)	Response %	Response Count	
The newsletter is given to individual patients	50.0%	57	
Copies are placed in the facility waiting room	79.8%	91	
A copy is posted in the facility waiting room	21.9%	25	
Copies are distributed by the Network patient	6.1%	7	
Other (Please specify)		3	
3. What educational topics would you find useful for your patients? (Ranked the top three topics.) (n=114)	Count ranked #1	Count ranked #2	Count ranked #3
Patient rights	20	18	12
Patient responsibilities	10	20	15
Patient engagement	13	13	17
Self-care and independence	23	11	9
Home dialysis modality options	5	11	8
Transplant options	8	3	10
Nutrition/diet	13	14	10
Vocational rehabilitation	1	1	5
Patient satisfaction	7	7	11
Emergency preparedness for patients	6	8	10
Advanced directives/end of –life care	6	6	5
4. Are there other topics you would like information about for your patients? (Check all that apply.) (n=31)	Response %	Response Count	
Open Ended Question (Top 3 choices) • Treatment Related: self-care, infection control, access choice • Coping Strategies • QOL	 32.3% 19.3% 9.7%	 10 6 3	

5. In What language(s) other than English would you like to receive patient educational materials? (n= 104)	Response %	Response Count	
Spanish	98.1%	102	
French	9.6	10	
Creole	34.6	36	
Other		6	
6. Does your facility have the ability to play videos for individual patients via the facility TV system or an individual DVD player during dialysis treatments? (n=114)	Response %	Response Count	
Yes	68.4%	78	
No	31.6%	36	
7. Does your facility have the ability to play videos for patients in the facility waiting area? (n=114)	Response %	Response Count	
Yes	58.8%	67	
No	41.2%	47	
8. How often is education on ESRD treatment options provided to patients in your facility? (Check all that apply.) (n=110)	Response %	Response Count	
Upon admission	82.7%	91	
Annually	57.3%	63	
Monthly	34.5%	38	
As needed	81.8%	90	
Other		16	
9. How does the facility provide ESRD treatment options education to patients? (Please select all that apply.) (n= 113)	Response %	Response Count	
One-on-one discussion	92.9%	105	
Written handouts	85.8%	97	
DVD	38.1%	43	
Online resources	27.4%	31	
Group classes	23.9%	27	
Facility-specific program	11.5%	13	
Corporate-wide program	25.7%	29	
Other (please specify)		7	
10. In your facility, who provides the patients with education regarding ESRD treatment options? (Please select all that apply.) (n=113)	Response %	Response Count	
Nurse	82.3%	93	
Social Worker	91.2%	103	
Dietitian	34.5%	39	
Administrator	43.4%	49	
Patient Educator	24.8%	28	
Other (please specify)			
11. Does your facility invite patients to attend the facility's Quality Assessment Performance Improvement (QAPI) meetings? (n=108)	Response %	Response Count	

Yes	49.1%	53	
No	50.9%	55	
12. Does your facility involve patients in the governing body (Board of Directors) for your facility? (n=108)	Response %	Response Count	
Yes	10.2%	11	
No	89.8%	97	
13. Does your facility offer patients the opportunity to participate in any other facility related meeting or committee? Please explain. (n=46)	Response %	Response Count	
Open Ended Question • No • Care Plan • Support Group/Focus Group • Patient Advocacy/Political Action • Other	 32.6% 32.6% 15.2% 8.7%	 15 15 7 4	
14. Does your facility host a patient support group? (n=108)	Response %	Response Count	
Yes	17.6%	19	
No	83.3%	90	
15. Does your facility host other patient groups (e.g., vocational rehabilitation, patient advisory, etc.)?(n=108)	Response %	Response Count	
Yes	10.2%	11	
No	89.8%	97	
If yes, please specify: Kidney Smart, Kidney Care, PD Day, Voc Rehab, Caregiver Support		9	
16. How do you prefer to receive education materials/resources from the Network? (Please select all that apply.) (n=104)	Response %	Response Count	
Provider eNewsletter	47.1%	49	
E-mail	61.5%	64	
Fax	26.0%	27	
Mail	58.7%	61	
Network website	26.0%	27	
Other (please specify)		5	
17. On what topics related to the Centers for Medicare & Medicaid Services (CMS) ESRD Quality Incentive Program (QIP) would you like to receive additional information and/or education? (Check all that apply.) (n=96)	Response %	Response Count	
National Healthcare Safety Network (NHSN) reporting	54.2%	52	
In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) administration	41.7%	40	

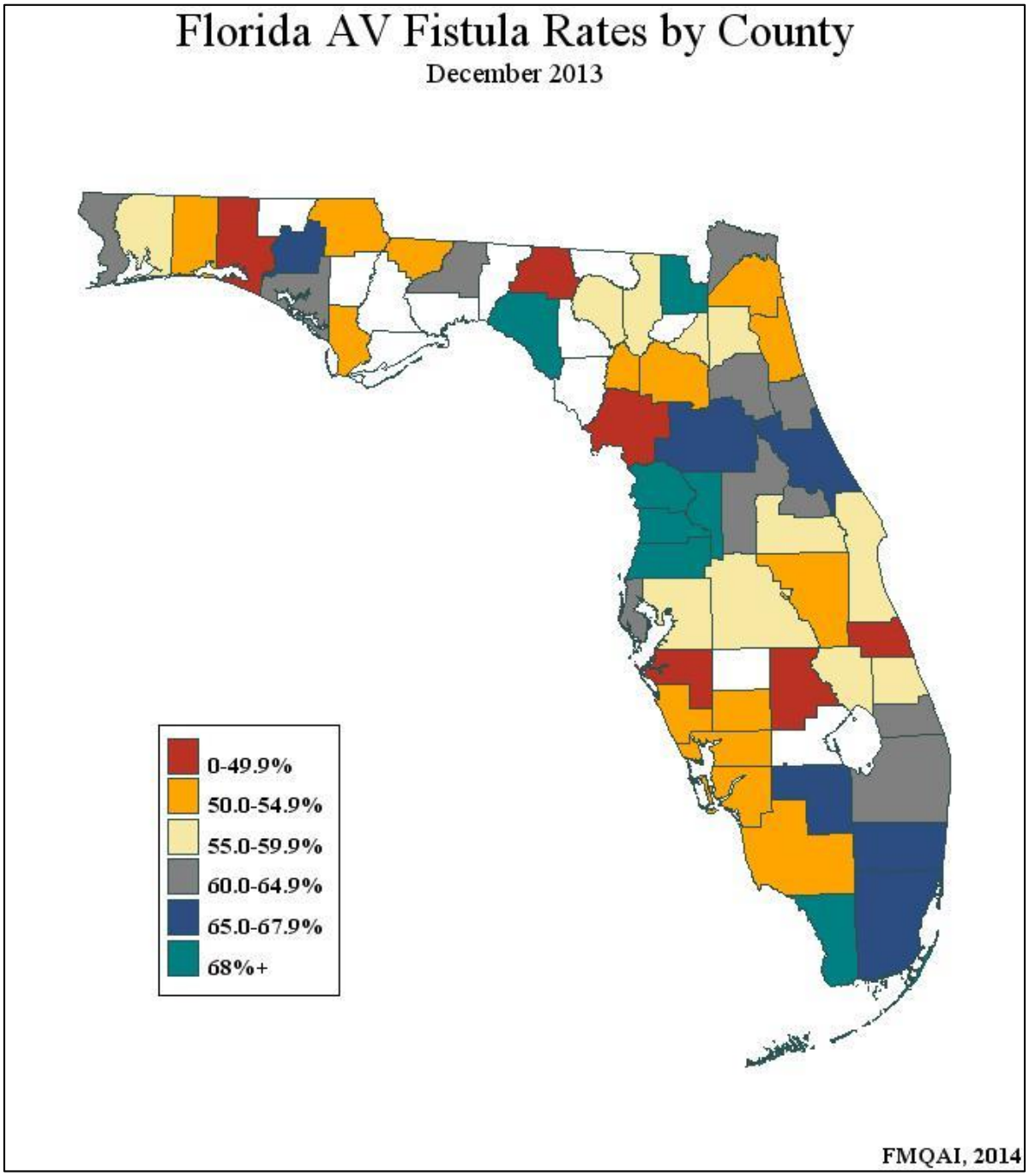
Hemodialysis adequacy	56.3%	54	
Peritoneal dialysis adequacy	35.4%	34	
Pediatric dialysis adequacy	9.4%	9	
Vascular access	68.8%	67	
Hemoglobin greater than 12 g/dl	39.6%	38	
Mineral metabolism	55.2%	53	
Anemia management	53.1%	51	
Facility data submission to CROWNWeb	37.5%	36	
ESRD QIP Performance Score Reports (PSRs)	47.9%	46	
ESRD QIP Performance Score Certificates (PSCs)	37.5%	36	
Patient education regarding the QIP	66.7%	64	
Other (please specify)		4	
18. Do you receive the quarterly Network 7 Provider eNewsletter? (n=104)	Response %	Response Count	
Yes	85.6%	89	
No	14.4%	15	
19. If you answered no to #19 and would like to receive the quarterly Provider eNewsletter, please enter your e-mail address:	Response %	Response Count	
NA			
20. If you answered yes to #19, how valuable do you find the Provider eNewsletter articles? (n=89)	Response %	Response Count	
Extremely valuable	25.8%	23	
Valuable	60.7%	54	
Somewhat valuable	13.5%	12	
Of little value	0.0%	0	
21. What topics would you like to see in the Network 7 Provider eNewsletter? (n=21)	Response %	Response Count	
Topics listed: • Treatment Related information • Best Practices • Quality of Life • Compliance/Behavior • Other	 29.0% 14.0% 14.0% 14.0%	 6 3 3 3 6	
22. Are there needs or comments that were not addressed that you would like to add to this needs assessment? (Please specify.) (n=8)			
Topics listed • Medical coordination of treatment for multiple diagnosis patients • Getting the Nephrologist involved in education to patient • Ethics • Adequacy • Surgeons • Finding qualified access surgeons • Sensitivity education for staff • Caretaker burnout			

23. Please describe your role at the facility: (n=104)	Response %	Response Count	
RN	17.3%	18	
LPN	1.0%	1	
Social Worker	21.2%	22	
Patient Care Technician	1.9%	2	
Dietitian	7.7%	8	
Administrator	51.0%	53	
Other		17	

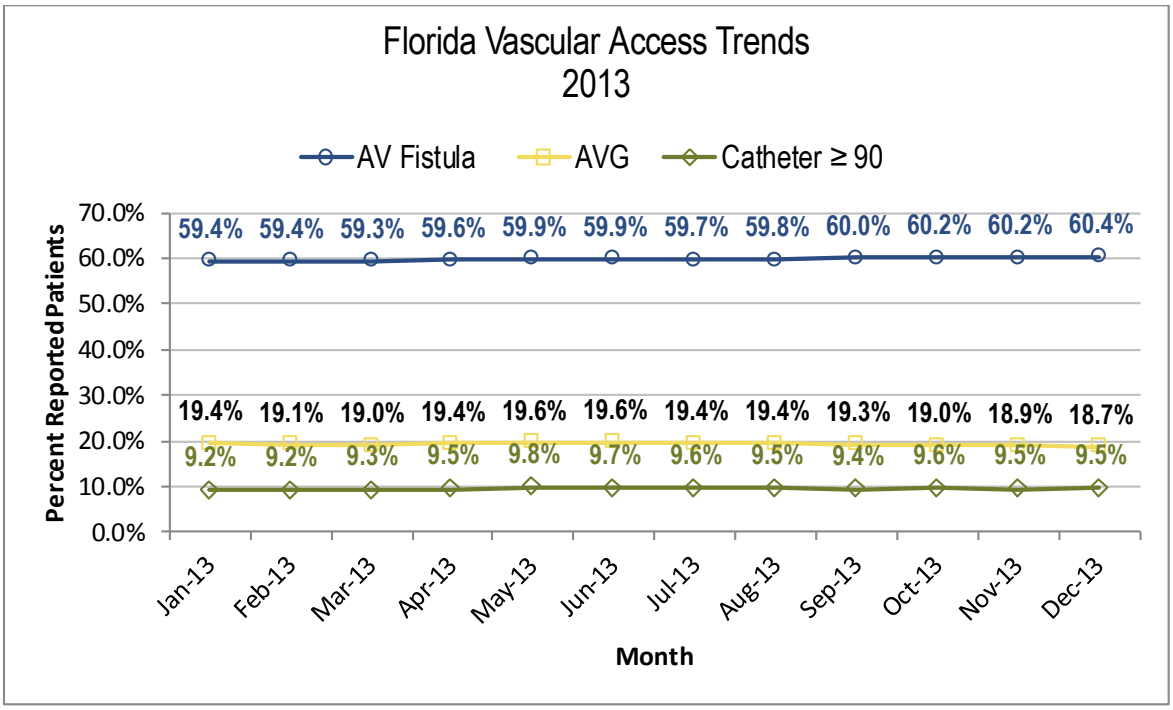
APPENDIX C. FACILITY VASCULAR ACCESS REPORTING

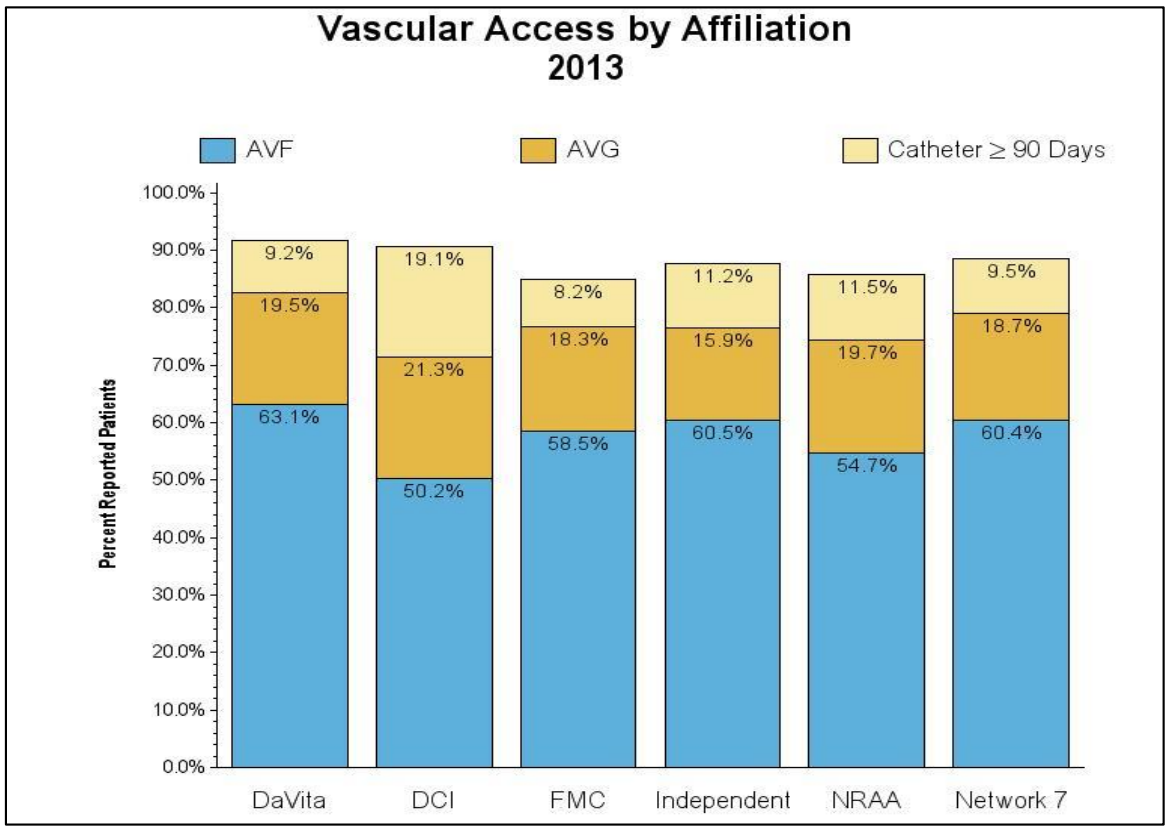
Region, State, and Facility-Specific Reports

As of December 2013, seven of Florida's 67 counties had an average AVF rate of 68% or greater for prevalent patients. Of the 67 counties, 22 demonstrated an average AVF rate above 60% for all prevalent hemodialysis patients reported in CROWNWeb.



The following graph depicts Florida's 2013 Vascular Access Trends for AV fistula, AV graft, and Catheter ≥ 90 days in-use for prevalent hemodialysis patients reported in CROWNWeb.





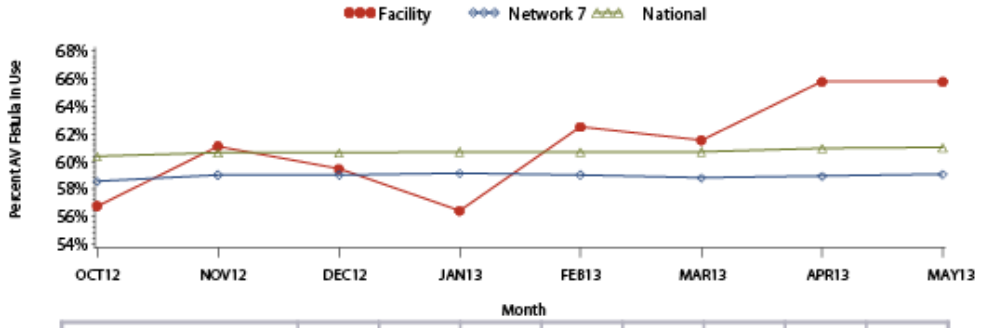
2013 Vascular Access Provider Report

The Facility Vascular Access Trends report distributed to all Florida dialysis facilities portrayed a comparison of the facility's AV Fistula in-use and Catheter ≥ 90 Days in-use Rates to Network 7 and U.S.

Facility Vascular Access Trends

FMQAI
The Florida ESRD Network

AV Fistula In Use Rate
CMS Goal: 68% or Higher



	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013
	56.8%	61.1%	59.5%	56.4%	62.5%	61.5%	65.8%	65.8%
Network 7	58.5%	59.0%	59.0%	59.1%	59.0%	58.8%	58.9%	59.1%
Nation	60.4%	60.6%	60.6%	60.7%	60.7%	60.7%	60.9%	61.0%

Catheter ≥90 Days In Use Rate
CMS Goal: 10% or Less

	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013
	16.2%	11.1%	13.5%	12.8%	7.5%	12.8%	10.5%	10.5%
Network 7	10.1%	9.9%	10.1%	10.0%	9.9%	10.0%	10.3%	10.9%
Nation	10.1%	10.0%	10.3%	10.3%	10.1%	10.1%	10.3%	10.5%

Data Source: July 2013 CROWNWeb Network Vascular Access In Use Report.

APPENDIX D. NETWORK 7 ANNUAL FORUM – AWARD RECIPIENTS

John Cunio, MD, Memorial Award for Excellence

The John Cunio, MD, Memorial Award for Excellence is presented to the ESRD facility exemplifying excellence in the management of patient outcomes. Dr. Cunio was a long-time volunteer of the Network, a past president, and with Dr. Bill Anderson, opened the first dialysis center in Florida. This Award for Excellence serves to acknowledge his contribution to the care of ESRD patients. The criteria used in assessing potential candidates for the award were: standardized mortality and hospitalization ratios, anemia management, adequacy of dialysis, and AVF rates. Four facilities received an honorable mention for their outstanding achievements and one facility was presented the Award for Excellence. The award read: "*FMQAI: The Florida ESRD Network, John Cunio MD Memorial Award for Excellence, presented to FMC Tradition (102891) for your excellence in the management of patient outcomes for Florida ESRD patients. October 2013.*"

Community Services Award

The Community Services Award is presented annually to the organization or individual who has made an outstanding effort to improve the quality of services for Florida kidney patients. The 2013 award was presented to Joe Karan for his significant contributions in his work on behalf of Florida kidney patients in his Network 7 role as a Patient Subject Matter Expert, as well as his community work with the National Kidney Foundation of Florida. He has provided a voice for Florida patients and assisted the Network in ensuring the patient perspective is included in our activities, thereby impacting patient-centered care for all Florida ESRD facilities. The award read: *"FMQAI: The Florida ESRD Network, Community Services Award, presented to Joe Karan. In appreciation for your dedication and collaboration with the Florida renal community to ensure that ESRD providers have access to the education needed to provide quality care. October 2013."*

Volunteer of the Year Award

Florida renal professionals play an important role in the success of Network 7. The Volunteer of the Year Award is presented to an individual who has contributed significantly with their valuable leadership, dedication, and commitment to the Florida renal community. In 2013, the Network was pleased to honor a dedicated individual for his efforts to improve the lives of Florida's kidney patients. The award read: *"FMQAI: The Florida ESRD Network, Volunteer of the Year Award, presented to Avon Doll, MD. In grateful acknowledgement of your valuable leadership, talents, and dedicated willingness to serve. October 2013."*

Susan V. McGovern, ARNP, MS, Memorial Award

Seven years ago, the Network staff lost a key member of its team—Susan McGovern—after a two-year battle with breast cancer. Susan made a tremendous difference to our staff and to our community. To honor her memory, the Network created an award in her name. The Susan V.

McGovern Memorial Award is presented annually to an individual who has demonstrated the qualities and skills that represented Susan's contribution to our community—continuous quality improvement, teaching, and service.

In 2013, the Network was pleased to honor a dedicated volunteer who, through her expertise and passion, has improved the quality of care and quality of life for kidney patients. The award read: "*FMQAI: The Florida ESRD Network, Susan V. McGovern, ARNP, MS, Award, presented to Rose Ann Patt. Honoring the quest for continuous quality improvement, the desire to teach others, and the willingness to serve the renal community at the highest level. October 2013.*"