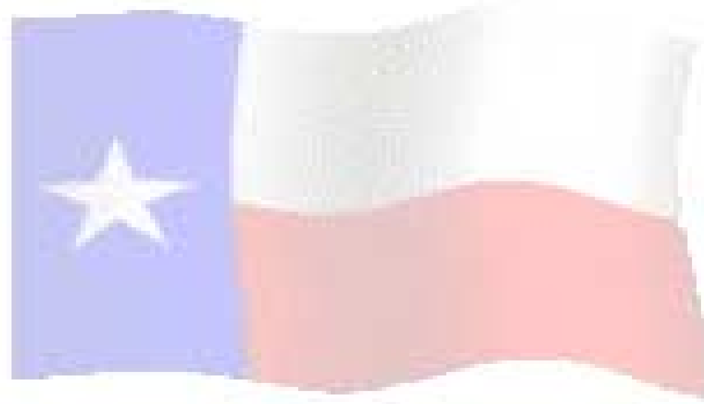
THE END STAGE RENAL DISEASE NETWORK OF TEXAS, INC. #14

1999 ANNUAL REPORT



The End Stage Renal Disease Network of Texas, Inc. (#14)
14114 Dallas Parkway #660
Dallas, Texas 75240

PREFACE

Introductory Statement of the Chairman

June 1999

As Chairman of the End Stage Renal Disease Network of Texas, Inc. it is my pleasure to endorse and submit the 1999 Annual Report of ESRD Network of Texas #14. This report provides data and narrative to chronicle the activities of the Network for the period January 1, 1999 through December 31, 1999.

On behalf of the members of the Executive Committee, I extend sincere appreciation to all individuals serving on the various committees for their active participation in developing and carrying out the projects and programs of Network #14. The staff and volunteers of the Network are to be commended for their continuing efforts to improve the care and quality of life of the ESRD patients in Texas.

Appreciation also goes to all the providers and patients who have maintained essential cooperation in working toward the successful accomplishment of the Network Goals for 1999. We recognize the spirit of cooperation of facility staff who provided data and information to the Network on a continuing basis.

1999 was a very active and productive year. Progress in the areas of Data and Quality Management continued. Quality Management activities were well received and created a greater awareness and utilization of outcomes management on a local and Network wide level. Enhanced data collection enabled the Network to perform profile and trend analysis and increase the timeliness and accuracy of data gathered. In 1999, the Network worked in a collaborative relationship with the Texas Department of Health to evaluate the care delivered in each dialysis facility.

The Networks goal is to function in a highly efficient and productive manner, fulfilling contractual obligations while responding to the needs and concerns of the providers and patients that comprise Network #14. It is by working together that the Network assists providers to assure that ESRD patients receive care that increases the likelihood of desired outcomes and is consistent with current professional knowledge. Through the continued cooperation of the Network council members, the Executive Committee, the Medical Review Board, the Texas Department of Health, and all of the individuals who volunteer their time and talents, the Network system will continue to be an efficient, effective, integral component of the ESRD Program.

We look forward to the coming year and the challenges it will bring.

John D. Bell, MD
Chairman, ESRD Network of Texas, Inc.

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The End Stage Renal Disease Network of Texas (#14) is under contract #500-97-EO32 with the Health Care Finance Administration, Baltimore Maryland.

II. INTRODUCTION

II. A. ESRD NETWORK OF TEXAS #14 DEMOGRAPHICS

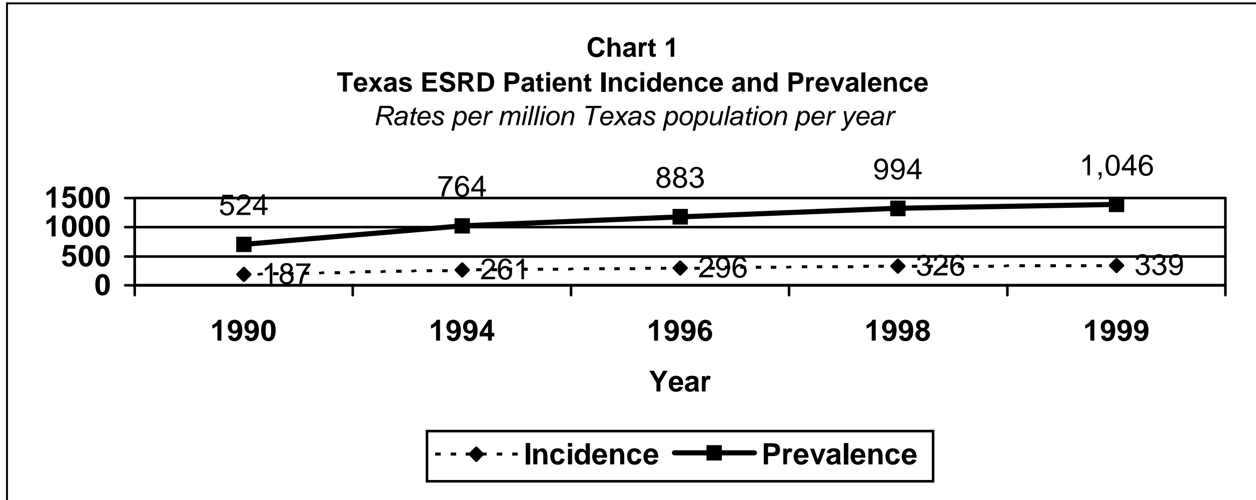
Texas Geography and Population Characteristics

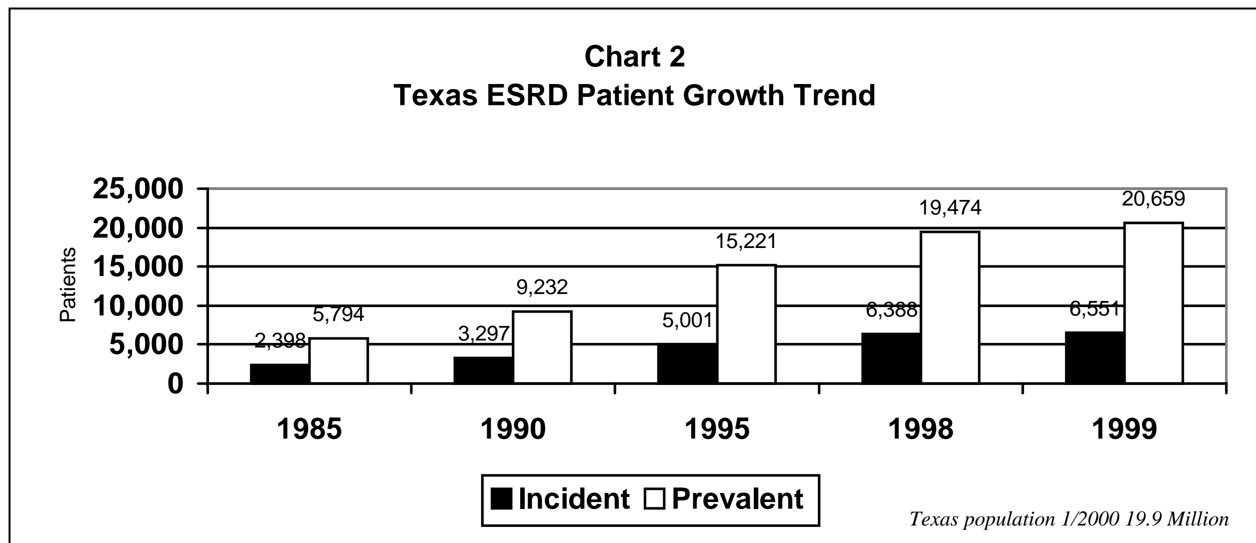
Texas received its statehood in 1865 as the 28th state. Texas has a rich history that includes the unique fact that six different flags have flown over Texas during its eight changes of sovereignty. No less than three countries have claimed ownership of Texas including Spain, France and Mexico in the past 300 years. Geographically, Texas is the second largest state in land area behind Alaska with 267 thousand square miles of land. Texas is also the second most populous state in the nation behind California with an estimated population of 19.9 million residents in 1999. In 1999, nearly 7 percent of the nations population resided in Texas. An estimated 20.3 million residents are expected to reside in Texas by the turn of the century. Although most rapid in Texas' largest urban centers (Houston, San Antonio, Dallas) and among areas that border Mexico (McAllen, Brownsville, Laredo), growth is occurring in nearly all size areas and regions of the state. The growth of the Texas population is projected to continue at a rate nearly twice as fast as that for the nation and to lead to a population that is older and more ethnically diverse.

All minority groups, except American Indians, will make up increasing percentages of the Texas population in the next three decades. According to state projections, whites, which made up 86 percent of the Texas population in 1999, will drop to 37 percent by the year 2010, while people of Hispanic origin are projected to become 46 percent of the population, up from 27 percent in 1993. Blacks are expected to make up 9 percent of the Texas population by the year 2010, down from 12 percent in 1998. Other ethnic groups are projected to comprise 8 percent of the state's population in 2010. The age of the general population is also expected to change. Currently about 8 percent of the Texas population is over the age of 65. By the year 2030, it is estimated that 17 percent of Texas residents will be over 65 years of age.

Incidence and Prevalence of End Stage Renal Disease (ESRD) in Texas

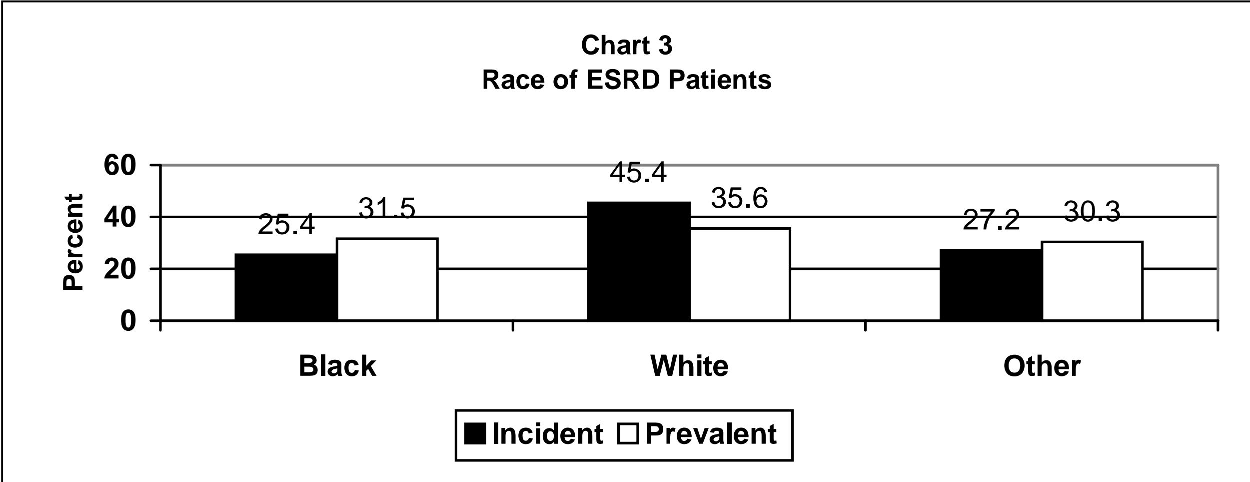
The incidence and prevalence of ESRD in Texas has been above the national average and trending upward since 1990. In 1990, the unadjusted incidence of ESRD in Texas was 187 per million population; by 1999 this had increased to 339 per million. The prevalence of ESRD in Texas has followed the same sharp upward trend. In 1990, 524 out of each million Texans had a diagnosis of ESRD, by 1999 the unadjusted prevalence rate for the Texas population had climbed to 1,046 per million (Chart 1).

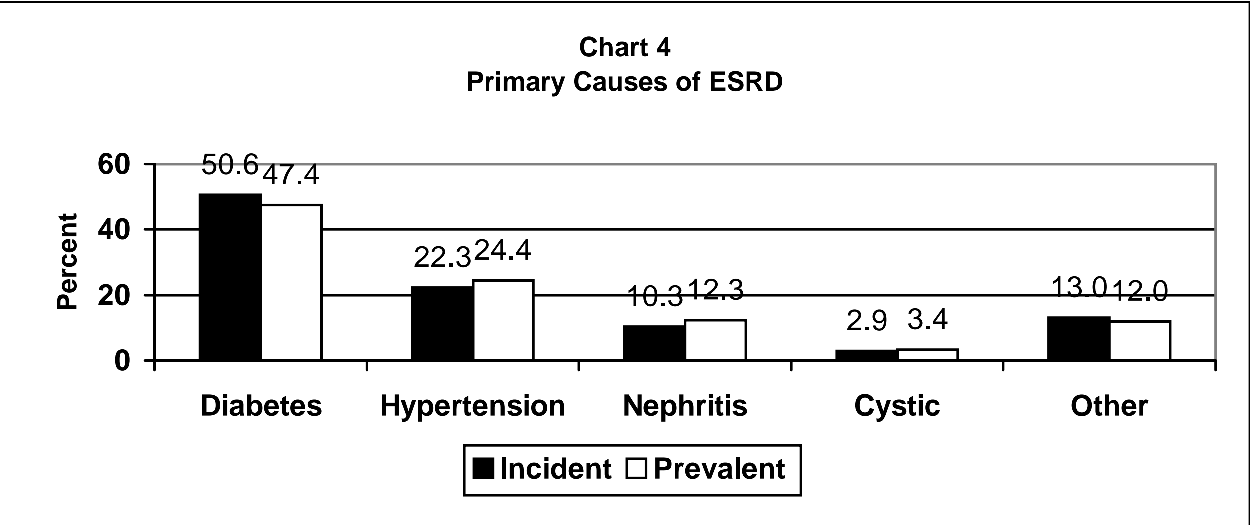




At the end of 1999, 27,129 persons were receiving renal replacement therapy (dialysis and transplant combined) in Texas. Of these 20,659 were either receiving hemodialysis or peritoneal dialysis, a 5.7 percent increase over 1998. In 1999, 6,551 newly diagnosed persons with ESRD began receiving dialysis. Both the incidence and prevalence rates have doubled when compared to the rates at the beginning of the decade. (Chart 2)

The majority of both the 1999 incident and prevalent patients were 60 years of age or older at 53 and 50.4 percent respectively, with males making up a slight majority of new and existing patients. This finding mirrors national ESRD statistics and documents an ongoing trend of an older ESRD population. The incident patients were 45.4 percent white and 25.4 percent black while the prevalent patient population is 35.6 percent white and 31.5 percent black (Chart 3).





Among incident ESRD cases the most frequently reported cause of ESRD was diabetes (50.6 percent) followed by hypertension (22 .3 percent). The leading cause of ESRD in the Texas prevalent ESRD population is diabetes at 47.4 percent followed by hypertension at 24.4 percent (Chart 4).

Location and Number of ESRD Facilities

At the end of 1999, Texas had a total of 261 Medicare approved dialysis facilities located in 87 of the 254 Texas counties. Thus, facilities are located in 34 percent of Texas counties, a 12 percent increase over 1997. Harris County (Houston area) has the most facilities (n=49), Bexar County (San Antonio area) the second highest number (n=28) and Dallas County (Dallas area) the third highest number (n=25). Since 1991 the number of Texas dialysis facilities has increased by 60 percent. Twenty-four transplant centers and one special renal children's' camp was also in operation. The Texas Department of Health Kidney Health Program reported that in 1999, 5,239 dialysis stations were available for use in dialysis facilities. This is double the number of stations in 1991.

II. B. Organizational Structure

B. Network Structure

The Network organizational structure is capable of supporting all activities of the Network, especially the comprehensive Quality Management Program. In addition to Network staff, there are three primary committees: the Network Council, Board of Directors (Executive Committee), and the Medical Review Board.

Staffing

- *Glenda Harbert, RN, CNN, CPHQ*, Executive Director
- *Nancy Carlson, BA,* Data Coordinator
- *Alex Rosenblum, BSRN, CNN, CPHQ,* Quality Management Coordinator
- *Debbie O'Daniel,* Administrative Assistant
- *Bobbie Knotek, BSN, CNN*, Quality Management Nurse
- *Ramiro Valdez, Ph.D.,* Patient Services Coordinator
- *Manuel Zapata, MBA,* ESRD Community Patient Representative
- *Arleene Thomas,* Assistant Data Coordinator
- *Georgia Brown,* Special Projects
- *Lakesha Johnson,* Data Specialist
- *Leigh Husni,* Project Assistant
- *Marianela Flores*, Clerk

Committee Function and Activity

Network Council

The Network Council is responsible for providing advice and assistance to the Board of Directors regarding the Network's activities and operations. The Council provides the mechanism for coordinated information exchange between the providers of ESRD services and the Network organization. It is the facilities in the Network that are responsible for carrying out the Network goals and objectives and adhering to the standards and criteria developed by the Medical Review Board. For effective Network operation, each ESRD facility in Network #14 has been invited to join the Network Council and has appointed a representative to the Council.

In order to ensure that all disciplines are represented on the Council, the Network can appoint individuals to represent any discipline that is not represented by the various facility appointments. The Network Council meets annually. Additional meetings of the Network Council may be held should the need be demonstrated.

Board of Directors (Executive Committee)

The Network organization activities are under the direction of a Board of Directors. The Board manages the business affairs of the corporation, establishes policy for Network Council consideration, establishes goals for the Network Council consideration, assesses each facility's progress in meeting the Network goals, and is responsible for the accomplishment of the contract through the Network organization.

Medical Review Board

The Medical Review Board is an eighteen member voluntary multidisciplinary advisory body appointed by the Executive Committee of Network #14. These appointments are based upon recommendations from the appropriate professional organizations. The Omnibus Budget Reconciliation Act of 1986 (OBRA) (Public Law 99-509) required the establishment of the Medical Review Board and that ESRD facilities and providers follow the recommendations of the Medical Review Board (Section 9335 {g}).

The purpose of the Medical Review Board is to assure, through the application of suitable procedures of health care review, that the care provided to ESRD patients within the Network #14 area is maintained at an optimal achievable level of quality. During 1999, the MRB members participated in six full day Board meetings and over twenty conference calls.

The Medical Review Board objectives are summarized as follows:

- To monitor the appropriateness and effectiveness of the long-term program proposed for the treatment of the ESRD patient.
- To evaluate professional performance and patient outcomes for consistency with expected and desirable standards and results that define quality care.
- To identify and evaluate patterns of care exhibited in the Network's facilities and compare such patterns, when possible, to local, regional, and national findings in an attempt to identify problems, inefficiencies, and/or areas of performance where improvements could be realized.
- On the basis of its review, to recommend or carry out actions indicated for improvements in the ESRD care of individual patients or groups of patients.

The Medical Review Board functions are summarized as follows:

- Serve as primary advisor to Network #14 for all medical matters.
- Review and expand criteria and standards to assess the quality and appropriateness of care patients are receiving.
- Review and expand criteria and standards to assess vocational rehabilitation potential.
- Review and expand criteria and standards to assess the placement of patients in the various treatment modality settings (self-care, in-center, transplantation).
- Identify both facility specific and Network-wide problems by routinely monitoring and reviewing Network data (facility specific and Network specific).
- Conduct review to assure:
    - The provision of high quality, comprehensive and appropriate medical care for patients in ESRD facilities.
    - Encourage, consistent with sound medical practice, the use of those treatment settings most compatible with the successful rehabilitation of the patient.
    - Encourage patient and provider participation in vocational rehabilitation programs.
    - Evaluate the procedure by which providers in the Network assess the appropriateness of patients for proposed treatment modalities and encourage the placement of patients in self-care settings and undergoing or preparing for transplantation.
    - Evaluate the accuracy and validity of the data supplied by the facilities.

- Compare Network #14 Clinical Process Measures outcomes to national results and make recommendations for further studies, trend analysis and facility education.
- Develop and analyze special studies for problems identified through the Clinical Process Measures Project, onsite facility case reviews, trend analysis, or data profiles.
- Develop and analyze the results of the Texas Department of Health Quality Of care Indicators Report and make recommendations for facility education.
- Develop a protocol for and recommend data abstraction processes on a percent of Network #14 dialysis patient records.
- Compare Network #14 Center for Disease Control (CDC) Dialysis Associated Diseases data and treatment variables to national results and make recommendations for further studies or education.
- Review medical evidence report (HCFA-2728) data and recommend action.
- Review, educate and identify opportunities for improvement in patterns of occurrence, care and outcomes to measurably improve the care and health outcomes for ESRD patients.
- Assist facilities in correcting identified problems within the Network.
- Assist facilities by recommending corrective actions for internal problems and improving care.
- Develop procedures for on-site visits as required for facility problems, assistance, or follow-up review of implementation and results of Corrective Action Plans.
- Identify recalcitrant facilities that consistently fail to comply with the program goals and objectives.
- Conduct patient and provider education and information activities to heighten awareness of alternative treatment modalities, technical advances, or other pertinent information relating to ESRD patients and providers.
- Assist providers establish and maintain effective facility specific quality management programs.
- Implement and maintain a patient grievance protocol and facilitate and mediate as necessary in the resolution of patient grievances.

Other Committees
In addition to the three primary committees, there are other committees and subcommittees that are utilized for Network operations and are activated or appointed as required.

- Nominating Committee
- Patient Advisory Committee
- Technical Subcommittee
- Social Services Committee
- Nutritional Committee

Committee Membership

Executive Committee

Chairman	*John Bell, MD* Nephrologist Bedford, Texas
Vice Chairman	*Richard Gibney, MD* Nephrologist Waco, Texas
Secretary	*Cleve Collins, MD* Nephrologist San Antonio, Texas
Treasurer	*Pat Dubose, RN* Nephrology Nurse Houston, Texas
Member at Large	*Dick Maggert* Patient Grandbury, Texas
Immediate Past Chairman	*Michael Stoltz, MD* Nephrologist Ft. Worth, Texas
MRB Chairman	*James Cotton, MD* Nephrologist Tyler, Texas

Medical Review Board

Nephrologists	Facility Location
James Cotton, MD, Chairman	Tyler, Texas
Robert Hootkins, MD, Vice-Chairman	Austin, Texas
James Lindley, MD, Immediate Past-Chairman	Austin, Texas
Lane Gober, MD	Victoria, Texas
Janis Birchall, MD	Corpus Christi, Texas
Steven Rosenblatt, MD	San Antonio, Texas
Ruben Velez, MD	Dallas, Texas
Pediatric Nephrologists	
Ronald Portman, MD	Houston, Texas
Mouin Seikaly, MD	Dallas, Texas
Transplant Surgeons	
Kristene Gugliuzza, MD	Galveston, Texas
Charles Van Buren, MD	Houston, Texas
Nurses	
Yolanda Solis, RN	San Antonio, Texas
Beverly Williams, RN, CNN	Abilene, Texas
Social Workers	
Mary Beth Callahan, MSW	Farmers Branch, Texas
Mary Havlovic, MSW	El Paso, Texas
Dietitians	
Louise Clement, MS, RD, LD	Lubbock, Texas
Mary Schanler, MS, RD, CNSD	Houston, Texas
Patients	
Thomas Brown	Bedford, Texas
Victoria Cummings, MPH	Austin, Texas

III. NETWORK GOALS AND ACTIVITIES

A. Network Goals and Objectives

1. National Goals

Network #14, consistent with all ESRD Networks, supports national goals included by the Health Care Financing Administration (HCFA) in the 1997-2000 Scope of Work for ESRD Networks. This provides the framework for developing Network specific goals that complement and achieves the following national goals:

- Improving the quality of health services and quality of life for ESRD beneficiaries;
- Improving data reporting, reliability, and validity between ESRD providers, networks, and HCFA (or other appropriate agency);
- Establishing and improving partnerships and cooperative activities among and between the ESRD Networks, Peer Review Organizations, State Survey Agencies, and ESRD providers.

In addition, a set of goals and responsibilities in support of HCFA's Health Care Quality Improvement Program (HCQIP) are articulated by HCFA in the 1997-2000 Scope of Work. The mission of HCQIP is to promote the quality, effectiveness, and efficiency of services to Medicare beneficiaries. This can be done by strengthening the community of those committed to improving quality, monitoring and improving quality of care, communicating with beneficiaries and healthcare providers in order to promote informed health choices, protecting beneficiaries from poor care, and strengthening the health care delivery system.

The Network's role in the HCQIP is to assess and improve the outcomes of care provided to Medicare ESRD beneficiaries by conducting quality improvement activities to assist the dialysis facilities and transplant providers. Quality improvement is a continuous process using information from data on processes and outcomes to recognize opportunities to improve care and to develop measurable improvement initiatives. The fundamental purpose of these activities is to assist the providers in improving the care provided to renal patients.

Network HCQIP responsibilities are as follows:

- Assist the renal community to measurably improve the quality of care and outcomes delivered to ESRD patients by developing, implementing, and evaluating Network quality improvement projects;
- Provide the renal community with information on patterns, processes, and outcomes of care to aid in identifying opportunities for improvement;
- Assist facilities and providers in evaluating information on processes used to deliver care to ESRD patients;

- Assist facilities and providers in developing, implementing, and evaluating their intervention strategies to improve patient care and outcomes;
- Evaluate the effectiveness of strategies the Network developed and implemented to stimulate the development of successful improvement efforts by facilities and providers that are focused on systemic changes in the organization;
- Assist facilities and providers to document the actions taken to:
  - Improve care and or make systematic changes;
  - Conform and measure their improvement changes;
  - Evaluate the effectiveness of their actions;
- Disseminate and share the results of QI strategies with all facilities and providers;
- Continually identify opportunities to improve care.

2. ESRD Network of Texas #14 Mission and Vision Statements

- ***Mission***

To improve the care of ESRD patients which is consistent with current professional knowledge and is medically necessary, efficient, high quality; to protect ESRD patients from harm, and to provide HCFA, the Texas Department of Health, and the renal community (USRDS, CDC, etc.) with quality information and data related to the Medicare ESRD Program and the ESRD Population.

- ***Vision***

Collect and transmit data electronically, resolve to set a new standard of excellence as the QM leader in our industry, and collaborate with agencies, providers, and patients to restore and/or improve the quality of life of ESRD patients.

3. ESRD Network of Texas #14-Specific Goals

The Executive Committee and Medical Review Board regularly review the ESRD Network of Texas #14 goals for 1997-2000 for continued appropriateness and feasibility. Goals and provider responsibilities are published annually and distributed to providers. Data collection processes track facility compliance and providers receive feedback reports and are asked for corrective action if they are noted to be delinquent, out of compliance or not meeting standards. Network #14 goals and objectives are organized into (6) general divisions that encompass the HCFA goals and objectives: These include:

- Assure the health care security for Medicare beneficiaries
- Improve the quality of health services to ESRD beneficiaries in the state of Texas
- Improve the quality of life for ESRD beneficiaries in the state of Texas
- Improve data reporting, reliability, and validity between ESRD providers, Networks, and HCFA, the Texas Department of Health and other related agencies; i.e., the United States Renal Data System, Centers for Disease Control.
- Establish and improve partnerships and cooperative activities among and between the ESRD Networks, Peer Review Organizations, State Survey Agencies, and ESRD providers.

- Establish and implement partnerships and cooperative projects

Each goal, developed during annual strategic planning sessions, has a corresponding set of objectives to guide the staff, Network boards, and the renal community toward successful implementation.

A. GOAL - ASSURE THE HEALTH CARE SECURITY FOR MEDICARE BENEFICIARIES

OBJECTIVE I

ACCESS TO APPROPRIATE QUALITY HEALTH CARE WHICH ACHIEVES DESIRED OUTCOMES

In support of this objective the Network performed the following during 1999:

A.
HCFA 2728 Medical Evidence Report

In 1995 HCFA revised the Medical Evidence Report (HCFA-2728) and requested that ESRD Network Medical Review Boards (MRB) review and make a determination of ESRD status of all incident patients not meeting the HCFA ESRD algorithm. The basis for the policy change was a concern that persons not meeting ESRD criteria were being placed on dialysis. In 1997, HCFA suspended the MRB review process, pending an alternative method to identify patients that are not ESRD.

During 1999, the Network and the Medical Review Board continued a Network #14 HCFA-2728 review process designed to monitor for appropriateness of initiation of ESRD treatment. The Network procedure included a mechanism for a nephrologist to offer written medical justification or remarks on a 2728 submitted that did not meet the HCFA ESRD algorithm and had an estimated or calculated creatinine clearance of greater than 20ml/min. In 1999, 6,831 HCFA-2728 forms were processed. Ninety-two percent (6,315) of forms processed passed the HCFA ESRD algorithm.

B.
Home Dialysis and Transplant Utilization

The Network goals for placing patients in self-care settings and transplantation are to encourage the use of medically appropriate treatment modalities and to place patients in those modalities, as established by the Medical Review Board, as equal to or above the Network average. These goals are based on prior years that have been taken from facility surveys. The Medical Review Board developed Criteria and Standards for the placement of ESRD patients in appropriate treatment settings that were sent directly to each facility. Each facility is further notified of the goal in a written statement of Network goals mailed annually and provided with their utilization rate compared to Texas.

Utilizing data profiles of home dialysis and transplant percentages, Network staff in consultation with the Medical Review Board, annually reviews facilities that fall significantly below the Network goal.

- For 1999 the percent of Network #14 ESRD patients receiving home dialysis was 8.5 percent compared to 10.0 percent in 1999. Nationally 12.0 percent of patients dialyzed at home in 1998. Nationally and in Texas the percentage of home dialysis patients is noted to be decreasing.

- For 1999, 990 kidney transplants were performed this is an increase of 3.6 percent from 1998.

The percent of Network #14 patients receiving a kidney transplant was 4.8 percent of the mean Network patient census. This compared to 5.1 percent and 5.4 percent in 1998 and 1997 respectively. The national average of patients transplanted was 5.7 percent in 1998. Nationally, the percent of prevalent ESRD patients receiving kidney transplants is decreasing due to increasing prevalence and a stagnant cadaver transplant rate primarily due to a lack of sufficient donors.

- Distribution of kidneys specific to the Texas African American population identified:
  - African Americans represent 32 percent of the Texas dialysis population and received 18 percent (182) of the 990 transplant performed in 1999.
  - African Americans received 20 and 14 percent of the total number of cadaver (735) and living related (255) transplanted organs respectively.

- In 1999, the Network continued a process of collecting, profiling and reporting statewide and facility specific transplant activity data. Each facility is provided with a chart of their facility specific data compared to statewide averages. At the end of 1999, the Texas dialysis community self-reported the following transplant status activity outcomes as of December 31,1999 (Table 1).

Table 1 **Texas Transplant Status Activity** N=20,004	
Percent of Patients Referred for Transplant Consideration	**9.6% (1,915)**
Percent of Patients with a *WORK-UP* "In Progress"	**7.3% (1,470)**
Percent of Patients with a *WORK-UP* "On Hold"	**4.7% (931)**
Percent of Patients on a Transplant Center Waiting List	**9.9% (1,972)**
Percent of Patients Documented "Unsuitable for Transplant"	**42.5% (8,492)**
Percent of Patients Who Have "Refused a Transplant Evaluation", Were "Not Interested" as of Data Collection	**19.8% (3,960)**
"Not Known" as of Data Collection	**7.6% (1,522)**
**Total adds up to 101% due to patients being counted in multiple categories*	

Treatment Modality

C.

Network #14 encouraged selection of alternative modalities through the provision of information to all ESRD patients through a New Patient Book titled "Life Goes On" and patient newsletters. In 1999, nearly 6,400 new ESRD patients and their families received the Network #14 New Patient Book mailed directly to their home. Data profiles of self - care and transplantation were compiled for comparative review and presented to the Medical Review Board and Network Coordinating Council. Each facility is provided with a chart displaying their percent of patients in a self-care modality and percent of patients transplanted compared to the state.

D.

Patient grievances were profiled and examined by Network staff and the Medical Review Board. No

trends were identified indicating problems with access to self-care or transplantation by patient characteristic, facility, or Network. A review of the Network #14 grievance procedures and each grievance is detailed under Goal C Page 20.

E.

Network #14 financially supported, presented and publicized numerous regional and national patient meetings that included information on modality selection.

OBJECTIVE II

PROTECTION OF RIGHTS AND DIGNITY, CONSUMER SATISFACTION
PATIENT GRIEVANCE & RESOLUTION

In support of this objective the Network performed the following during 1999:

A.
As required by HCFA, Network #14 has implemented and maintained an effective patient grievance procedure to support patient's rights. The Network #14 Grievance Procedure and Patient Rights and Responsibilities document is included in the New Patient Packet and was mailed to over 6,400 patients' homes in 1999. The Network employs a *Patient Services Coordinator* who is a Ph.D. prepared social worker experienced in the care of ESRD patients. The Network Patient Services Coordinator has clinical expertise assessing, evaluating and counseling patients. The Patient Services Coordinator is responsible for the development and implementation of the Patients Services Program for the Network.

B.
A part-time position of *ESRD Community Representative (CR)* was maintained to assist both patients and professionals with ESRD related issues and concerns. The Executive committee designated that a individual with ESRD fill the position. Primary responsibilities include:

- Acting as a link with ESRD patients and provider community of the Network.
- Leadership of Patient Activity Committee.
- Visiting dialysis and transplant centers to inform patients and staff of the Networks role and responsibilities.
- Assisting with the development of information and providing education for patients and families.
- Coordinating production of patient newsletters.
- Coordinating the activities of the facility patient representatives.
- Assisting with patient grievances.
- Providing in-services and education to both patient and professional groups.

1999 Community Representative Activity Highlights

- Directed the reformation and restructure of the Network #14 Patient Advisory Committee (PAC) to provide input from ESRD patients to the Medical Review Board (MRB), the Executive Committee (EC) and Network staff. The PAC is made up of nine members. Five are from major metropolitan areas of the state. The other four are the patient representatives on the EC and MRB.
- Initiated a project to modify the Texas Medicaid Transportation system to improve services for dialysis patients who need transportation to and from dialysis on the weekends or after five pm

on weekdays. The CR formed a small committee of members of the ESRD community to present this problem to the Texas Department of Health (TDH), the agency in charge of the Medicaid Medical Transportation Program, and to request improvements. Upon review of the groups concerns, the TDH agreed to expand the schedule to enable dialysis patients to access the system to meet their unique travel needs.

- Participated as a member of the HCFA Consumer Information Reporting Workgroup. The group consists of eleven members of the renal community from across the nation. The group will report to HCFA with recommendations for facility specific information to be made available to the public. The primary purpose of this information will be to allow patients to evaluate facilities when making choices in selecting a facility for treatment.

- Participated as a member of the Texas Organ Allocation Taskforce. This group is charged by the legislature through a Texas Senate bill to complete a thorough review of the organ allocation system in Texas and to make recommendations for improvement. There are 11 members statewide, with representatives from the three OPO areas in Texas.

- Participated with many patient related groups in order to resolve problems and provide information. Worked closely with the American Association of Kidney Patients, both local and national office, the five National Kidney Foundation affiliates and the Texas Kidney Health Program.

C.

A poster is provided to each new facility for display in their waiting room that outlines the Network grievance process. The poster includes the phone number of both the ESRD Network and the Texas Department Health.

D.

With support from the Medical Review Board and a subcommittee, the Network produced and disseminates *A Treatment Agreement Guide-Guidelines and Resources to Improve Communications and Develop Expectations Between Renal Professionals and Their patients.* The booklet is designed to assist both professionals and patients reduce the occurrence of patient conflict and avoid negative experiences. The booklet is mailed to all new facilities and provided upon request.

E.

Network Patient Services Coordinator presented on methods to improve the patient staff relationship and professional ethics during the Network #14 Annual Meeting and during regional educational conferences.

F.

In 1999, Network #14 met the goal of maintaining a grievance system that was responsive to consumer needs. The Network adhered to the HCFA protocol and conducted thorough, objective investigations. The Network may receive referrals from patients, or a designated representative, medical personnel, renal organization and both state and federal agencies. Grievances and/or complaints may concern services provided in dialysis units, transplant centers, hospitals, or a

physician's office, but must be specifically related to ESRD services. Complaints about a reimbursement or survey and certification issue are referred to the Associate Regional Administrator, Division of Health Standards and Quality at the HCFA Regional Office or the Texas Department of Health (TDH) ESRD Facility Licensure Division.

An additional source of grievance activity referred to the Network office is from TDH referrals to the Network MRB for quality of care issues identified during state and Medicare survey activities. During 1999, numerous referrals included complaints involving patient rights and dignity issues. Examples include staff not responding to patients' request for help during treatment, unprofessional staff behavior, and failure to respond to patient complaints or grievances. The MRB included specific corrective actions for patient rights and dignity related deficiencies in their corrective action recommendation for facilities. (Refer to Goal C. Page 52.)

The number of written and phone contacts regarding quality or appropriateness of care issues from both patients and professionals is increasing; however, the number of facilities and patients is also increasing. In many cases patients or professionals simply request information or advice about an issue or concern. Either the Patient Services Coordinator or Network Quality Management staff address all patient complaints or grievances received. If needed, the Medical Review Board or Patient Subcommittee is consulted.

During 1999, the Network received a total of **ten** grievances requiring formal investigation.

- 48-99-01 The ESRD Network was forwarded written patient complaints that had been submitted to the Dallas HCFA Regional office by a dialysis patient. The grievance included concerns with access to a physician, patient care practices, facility grievance procedures, facility reuse policy and concerns with billing. Billing issues were to be reviewed by HCFA and Medicare intermediary. All other complaints were regulatory in nature and were referred to the Texas Department of Health for investigation with a request to offer assistance with the investigation.

- 49-99-02 The ESRD Network received a written unsigned grievance from a dialysis patient who reported complaints with his/her facility nurse staffing, unsafe facility structure, patient rights, hygiene and safety. No return address was provided. Based on the regulatory nature of the complaints the Network forwarded the complaint to the TDH for investigation along with an offer to provide assistance with the investigation. TDH investigated and validated the complaints.

- 50-99-03 The ESRD Network received a written grievance from an attorney representing a dialysis facility and their patients. The grievance-contained complaints that staff was repeatedly contacting patients by phone, letter and in person requesting that they transfer to newly opened dialysis clinics. The grievance included attestations from numerous patients detailing specific individuals, dates and comments. The grievance was referred to a patient committee of the Medical Review Board to review and provide recommendations. The committee directed that the Network evaluate whether solicitations were ongoing, inform the soliciting facility leadership

of the findings and language from the Texas Medical and Nurse Practice Act related to solicitation, and if needed report individuals to their appropriate licensing board for review. The Network did contact all patients listed in the grievance to verify whether or not they were still being contacted.

One patient reported a contact with the past 3-4 weeks. All other patients reported no recent contact. This information was shared with the soliciting facility. The Network also recommended that the grievance facility provide their patients with a form advising the new facility of their desire to remain at their original facility.

The new facility was informed that if patients were not interested in transferring they should not be contacted. Isolated incidents of patient contacts were reported, but no additional complaints were forwarded to the Network for investigation.

- 51-99-04 The ESRD Network received a written grievance from a dialysis patient reporting the following concerns regarding her facility: Staff slow to respond to patient requesting medical attention, delays in initiating treatment, patient rights, staff turnover and infection control. The complaint was referred to the TDH for investigation. The TDH initiated an investigation of the complaints and was able to validate many of the specific complaints. The facility was referred to the Network MRB for assistance with corrective action plan determination. Major changes were implemented by the facility ownership to correct the identified problems. The facility remains under ESRD Network and TDH corrective action monitoring into 2000.

- 52-99-05 A complaint from the Texas Department of Health was referred to the ESRD Network regarding a patient who believed he was being dismissed unfairly from his dialysis clinic. The Network investigated the patient's complaint and learned that he had a history of non-compliance to his treatment plan and periodically failed to attend his treatments for an extended period of time without notifying the facility. The facility had attempted to contract with the patient unsuccessfully and the Medical Director choose to withdraw his services from the patient. The Network was able to successfully locate a new facility for the patient and strongly encouraged the patient to follow his physician's treatment plan.

- 53-99-06 The ESRD Network received a written grievance from a dialysis facility healthcare professional regarding concerns that ESRD patients were being required to have $10,000-15,000 in the bank before they would be placed on the active transplant for a specific hospital. The healthcare professional submitted the grievance on behalf of two patients who requested anonymity. Based on the financial requirement the patients choose to select another hospital for their transplant service. The Network contacted the hospital transplant coordinator to review the allegations and investigate. It was learned that a misunderstanding had occurred. The transplant counselors stated that patients were told they should expect additional expenses after their transplant that will not be covered by insurance. This evidently was misunderstood and patients believed that they needed to have this money before the transplant and that it was a requirement. This was not as documents detailed. The Network asked that the program ensure that they explain more clearly the financial obligations of transplant.

- 54-99-07 The ESRD Network received a written complaint in follow-up to a phone call from the parent of a dialysis patient. The parent complained about the medical care provided to his daughter by her nephrologist, unsuccessful efforts to transfer his child to another clinic, staffing ratios and staff competence. The Network contacted the physician to discuss the allegations related to the medical care of the child. Some non-compliance was identified on the patient's part in regards to taking medications, but this information was evidently not shared nor known by the father, who had Power of Attorney for Health Care. The allegation was substantiated. Corrective action was requested to ensure that the father was an active participant in his daughter's medical care. The physician met with the father and worked out their differences and the father agreed to continue with the physician. The staffing and staff competence issues were regulatory in nature and were referred to the Texas Department of Health for investigation with an offer to provide assistance with the investigation. The TDH investigated the referred complaints and referred the facility to the MRB for assistance with corrective action plan development and monitoring. Facility monitoring ongoing into 2000.

- 55-99-08 The ESRD Network received a written complaint in follow-up to a phone conversation from the wife of a dialysis patient. The wife complained that her husband (who is on dialysis and positive for Hepatitis B) was being transferred to another dialysis facility for services, which was a considerable distance away from their current facility. A decision was made to transfer all hepatitis B positive patients to a single facility to allow for more uniform care. The wife stated that it will be a hardship to drive her husband to the new facility. The Network contacted the facility administrator to investigate the changes. The facility leadership stated that they had considered the impact on the patients and their family members, but felt that the plan would be of benefit to all patients. The facility administration was not willing to modify their plans for a single patient.

- 56-99-09 The ESRD Network received a written grievance from a dialysis patient who believed that she was being unfairly discharged from her dialysis facility. She stated that she was being discharged due to being rude and verbally abusive, not following physician's recommendations to seek psychological therapy, and not following the prescribed treatment plan. Due to the nature and complexity of the complaint the Network staff performed a medical record review and interviewed patient care staff over a two-day period at the facility. Upon completion of the investigation, a meeting with the patient and the treatment team was held to discuss the findings of the investigation. The investigation identified that the grievance was not valid. Medical records identified ongoing attempts by facility physician and treatment team to meet the needs of the complainant without satisfaction. The record also identified numerous documented episodes of treatment interference. The Network did identify irregularities with the facility's dismissal process. Specifically, staff assistance with locating a new facility for the complainant was fragmented and unorganized. As a result the Network recommended that the complainant be allowed to continue receiving treatment at the facility for a short period of time or until an alternative facility could be located, which ever occurred first. The Network assisted the patient to transfer to another facility.

G.

Network #14 continued documenting all "significant quality or appropriateness of care" phone contacts with the patient or professional community as a part of routine Network operations. Concerns are documented and coded onto a *Network Report of Contact Form*. Major information collected on the form includes: caller and facility name, description of the nature of the problem or concern, description of response and actions taken along with a code for the type of concerns or issues shared. In many circumstances the Network staff is able to meet the needs or concerns of callers and thus avoid the necessity for formal grievance activity.

Based on the concerns, questions or request, the Network staff will provide information, guidance, and if requested, intervene on the patient's behalf. During 1999, a total of **95** Report of Contacts that included **133** separate concern codes was documented (Table 2). The reasons for contacts are reviewed annually by the Network staff and Medical Review Board to identify trends and educational opportunities.

Complaints received by the Network office that are identified as regulatory in nature are referred to the Texas Department of Health (TDH) for investigation. All referrals include a request to include the ESRD Network staff in the investigation if needed. During 1999 the Network referred **8** complaints to the TDH for investigation of regulatory issues.

Table 2
1999 Report of Contact Concern Code Distribution

Percent (1998)	**Number Times Marked**	**Contact Code**
20% (26%)	27	Problematic patient or patient responsibilities
16% (8%)	21	Treatment plan does not meet patient specifications
15% (14%)	20	Medical staff behavior inappropriate
13% (18%)	18	Other (insurance, medical records, missing patient)
13% (14%)	17	Necessary facility personnel and or resources not available or adequate
12% (4%)	16	Beneficiary unable to locate physician or facility to receive care
5% (1%)	6	Facility/physician financial concern
3% (5%)	4	Facility is not sanitary
3% (9%)	4	Work issues/concerns

0%(1%)	0	Suspected fraud
0% (0%)	0	Personal belongings were disturbed or stolen
100%	#133	

OBJECTIVE III

DISSEMINATION OF CLEAR AND USEFUL INFORMATION TO ASSIST WITH HEALTH CARE DECISIONS

In support of this objective the Network performed the following during 1999:

A.

Beginning in 1999 all new ESRD patients entered into the HCFA data system by the filing of a HCFA-2728 were sent a copy of "Life Goes On… After Your Kidney Stop Working." Life Goes On… is disseminated to all dialysis facilities and each new patient. The 124 page softbound book was written with large print and easily readable language to improve readability. The contents provide new ESRD patients and their family/friends with information on such topics as helpful tips, patient rights and responsibilities, treatment choices, transplant options, maintaining current lifestyle, money, diet, medicines, the ESRD Network, problems and questions, advance directives, dealing with grievances and resources for more information about kidney disease and ESRD. Enclosed with a copy of the book during 1999, was a copy of the Lone Star Newsletter (Network #14 Patient Newsletter), Medicare Supplemental Handbook: Coverage of Kidney Dialysis and Kidney Transplant Services, copies of National Kidney Foundation Family Focus and American Association Of Kidney Patients periodicals.

B.

Network #14 published the Lone Star Newsletter (patient newsletter) twice in 1999 in both English and Spanish. The newsletter was mailed to each Texas ESRD facility for dissemination to patients by *the Facility Patient Representative* or facility staff. The spring issue included focus articles on patient success stories, AAKP organization, and vascular access information. The winter issue included articles on Y2K preparation, health quiz, patient success stories, Medicare fraud, Flu and Pneumonia prevention.

C.

Network #14 maintains a web site (www.esrdnetworks.org) for the dialysis community. The web site includes information and resources on ESRD outcome data, location of dialysis facilities, copies of Network #14 Professional Newsletters, links to all the major renal organizations including the National Kidney Foundation, and the NKF- Dialysis Outcomes Quality Initiatives Guidelines and the American Association of Kidney Patients.

D.
The Medical Review Board Nutrition Subcommittee developed a booklet titled *Why Am I So Thirsty.* The 11-page color booklet included information along with questions and answers about being thirsty on dialysis. The booklet was translated into Spanish and each facility received a supply of the booklets for distribution to facility patients. A related poster that reviewed the renal diet was also produced and distributed to each facility for patient education opportunities.

E.
HCFA Flu Vaccination Materials was disseminated to Texas dialysis facilities for distribution to each patient.
F.
HCFA/National Cancer Institute mammogram educational materials were disseminated to all Texas ESRD Facilities for distribution to each patient.

G.
HCFA *Know Your Number* brochure was disseminated to assist patients understand the importance of adequate dialysis.

H.
HCFA Preparing for Emergencies: For People on Dialysis brochure was disseminated to assist patients prepare for Y2K and other potential emergencies.

I.
Network # 14 staff participated on a national dialysis facility corporate committee to develop flu/pneumonia immunization materials for distribution to each of their facility patients. The goal of the project was to educate patients on the importance of immunization and to increase conformance to recommendations.

J.
A Patient Vascular Access Video developed by NW#6 was translated into Spanish for both Texas and National distribution.

K.
Network #14 maintains an extensive library of educational resources available upon request including pamphlets, articles and videos for both patients and professionals in English and Spanish. Materials available from the Network include:

- Centers for Disease Control National Surveillance of Dialysis Associated Infectious Diseases Report and Centers for Disease Control and Prevention
- ESRD Network of Texas Disaster Manual
- Renal Physicians Association Clinical Practice Guidelines and Position Papers
- HCFA Guide for Improving Care to ESRD patients
- Network #14 Treatment Agreement Guide

- Vascular access selection and care video
- Know Your Number brochure
- Preparing for Emergencies: For People On Dialysis
- National Kidney Foundation, American Association of Kidney Patients, American Kidney Fund pamphlets and periodicals
- National Kidney Foundation -DOQI Guidelines
- List of dialysis and transplant centers in Network #14
- Pamphlets on Kidney Disease
- Life Options Rehabilitation Council - Rehabilitation Resources
- HCFA National Core Indicator Reports
- Federal and State ESRD facility regulations

The goal of ensuring access to appropriate and quality health care, which achieves desired outcomes, has been met for 1999. Activities will continue to focus upon both patient and professional activities to achieve the listed objectives. Specifically, patient education initiatives and opportunities for improvement to increase both the numbers of patients dialyzing on a home modality and receiving a renal transplant will continue to be focused upon.

B. GOAL - IMPROVE THE QUALITY OF HEALTH SERVICES TO ESRD BENEFICIARIES

OBJECTIVE I

ASSIST PROVIDERS IN ESTABLISHING & MAINTAINING DYNAMIC, ONGOING QUALITY MANAGEMENT AND OUTCOMES ASSESSMENT PROGRAMS

In support of this objective the Network performed the following during 1999:

Quality management education has been an integral step in achieving the long-range quality management plan of Network #14. Guided by the Medical Review Board, this Network seeks to achieve a balance between the internal and external review approaches to the attainment of quality care and acceptable outcomes. The following activities were conducted in achieving the goal of assisting providers establish and maintain effective facility specific quality management programs.

A.

The Network#14 Quality Assurance/Improvement Manual was updated during 1999, and was provided to all facilities that opened in 1999 and to facilities requesting additional copies. The Network QM manual includes forty Quality Assurance/Improvement Studies, inclusive of instructions and forms, based upon the ESRD Network #14 Criteria and Standards.

B.

An updated and comprehensive set of run charts were developed and disseminated to each dialysis facility both on hard copy and on computer disk. The run charts included a state or national comparison and if applicable a NKF-DOQI recommended guideline. Facility Quality Management committees were directed to plot their facility outcomes on the charts and compare to the listed averages. If opportunities to improve were identified, it is expected that the facility implement a quality improvement project.

C.

HCFA –A Guide for Improving the Quality of Care for Dialysis Patients was provided to all new facilities and to existing facilities upon request.

D.

The Network provided phone and onsite consultation for dialysis facilities that requested assistance developing their quality management program or facilitating a quality management activity. The Network staff provided facility staff with community outcome data, copies of guidelines, advice on QI projects and QM program structure recommendations based on Network #14 Quality Management Criteria and Standards. Network staffs were invited to participate and facilitate quality improvement projects onsite with facilities during the year. Consultations included the subjects of hemodialysis adequacy, vascular access management and patient staff relations.

E.
Network QM staff was invited by a national dialysis chain to provide quality management principles and technique education to their corporate nurses, administrators and technical staff. Full day workshops were held in Houston, San Antonio and Lubbock, Texas. Over 300 supervisory staff members attended.

F.
Network staff prepared and presented over 50 presentations at both regional and national meetings on a wide variety of subjects including:

- Core Indicator Outcomes
- Understanding and Incorporating Quality Improvement
- Outcomes Management
- Professional Guidelines on the Care of ESRD patients
- NKF-DOQI Guidelines
- ESRD Network role and functions
- Completing HCFA and Network Data Collection forms
- Results of National Studies
- Results of Network Quality Improvement Projects
- Infection control recommendations for dialysis facilities
- Dealing with difficult patients
- Pharmacy implications for ESRD patients
- Legislative issues
- Patient/staff relationship building
- Ethics

G.
Executive Director and QM Coordinator met the continuing education requirements to maintain the national credential as *Certified Professionals in Healthcare Quality*.

H.
All corrective action plans (CAP) requested by the Medical Review Board included a requirement that facilities follow Network #14 QM Criteria and Standards and that the facility include copies of QM minutes and QI activities to demonstrate CAP compliance for Network review and intervention, if needed.

OBJECTIVE II

DEVELOP AND UTILIZE CRITERIA AND STANDARDS THAT ADDRESS THE QUALITY AND APPROPRIATENESS OF CARE FOR ESRD PATIENTS

In support of this objective the Network performed the following during 1999:

A.

Network #14 has developed and maintained criteria and standards to guide the ESRD community in providing appropriate and quality care. Network #14 criteria and standards are recommended practice standards within the Network and are utilized to:

- Create quality assurance/improvement studies
- Guide facility practice
- Provide standards to meet in medical review decisions
- Provide standards to meet in grievance investigations

Each new dialysis facility is provided with a copy of the Network #14 Criteria and Standards. Additional copies are provided upon request. The following areas of practice are addressed:

- Appropriateness of initiation therapy
- Selection of modality and appropriateness of modality
- Referral to vocational rehabilitation services
- Physician standards for care of ESRD patients (revision in progress)
- Standards of nursing practice
- Criteria and standard for Adult/pediatric hemodialysis and peritoneal dialysis
- Standards for social workers
- Criteria for Nutritional Care of ESRD patients
- Criteria to Monitor Mortality
- Criteria and standards for dialysis facility specific quality management programs
- Standards of Technical Care in ESRD facilities
- Criteria for adverse patient occurrences
- Criteria to monitor incidents
- Criteria for transplant

B.

Upon the recommendation of a Texas Department of Health (TDH) ESRD Task Force of dialysis professionals and patients, the TDH incorporated the Network #14 Quality Management Criteria and Standards and the Networks Standards of Technical Care into the revised TDH ESRD facility rules. Both had been developed and approved the Network Medical Review Board and Executive Committee.

C.

Physician and Social Worker Criteria and Standards revisions were initiated during 1999. Draft revisions are in development within the MRB.

D.

Network #14 staff and committee members participated as reviewers of a Renal Physician Association and American Society of Nephrology professional practice guideline titled *Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis.*

E.

All comparative data reports provided to facilities as part of the Network #14 vascular access quality improvement projects include references to NKF-DOQI™ Practice Guidelines.

F.

Network #14 immunization quality improvement project included references to HCFA Healthy People 2000 Goals, Centers for Disease Control and Prevention and National Coalition for Adult Immunization recommendations and goals.

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OBJECTIVE III

DISSEMINATE AND UTILIZE NATIONAL PRACTICE GUIDELINES TO ASSESS THE QUALITY OF CARE FOR ESRD PATIENTS AND PROVIDE PROFESSIONAL EDUCATION

In support of this objective the Network performed the following during 1999:

A.

In support of the *National Kidney Foundation – Dialysis Outcomes Quality Initiatives* (NKF-DOQI™) the Network highlighted NKF- DOQI recommendations in both professional and patient educational information. Specifically, the Network developed vascular access educational materials and tools that referenced the NKF-DOQI vascular access guidelines. These were disseminated to the Texas dialysis community and have been adopted for use nation-wide by one corporation. A Network patient newsletter highlighting the NKF-DOQI guidelines was published in both English and Spanish and is made available to both dialysis patients and staff.

B.

A statewide Network HCFA HCQIP Project titled: *Be-Wise-Immunize* was designed and implemented during 1998 and 1999 to increase the number of persons with ESRD receiving recommended influenza, pneumonia and hepatitis B immunizations. Vaccination schedule and administration guidelines included in the educational materials and tools were referenced from the HCFA Healthy People 2000, Centers for Disease Control and Prevention and the National Coalition for Adult Immunizations. (Refer to Goal B. Page 45.)

C.

A statewide Network HCFA HCQIP Project titled: *Operation Possible: Vascular Access* was designed and implemented during 1999 to decrease the utilization of hemodialysis catheters. NKF-DOQI™ Vascular Access guidelines were referenced. (Refer to Goal B. Page 49.)

D.

In collaboration with the Texas Department of Health (TDH), the Medical Review Board provided guidance and recommendations to the TDH regarding required corrective actions for appropriateness and quality of care related deficiencies identified during surveys. Recommended conformity with applicable guidelines were included in each corrective action plan.

E.

To assist facility infection control programs, the Network disseminated the *1998 Centers for Disease Control National Surveillance of Dialysis-Associated Diseases in the United States Survey Report.* The report includes important infection control precautions for dialysis units, recommendations for Hepatitis B vaccinations, and serologic surveillance in chronic hemodialysis patients and staff hepatitis B vaccine dosage schedules, and serologic testing schedule.

F.

In collaboration with the Texas Department of Health, Network #14 collected facility specific dialysis adequacy and anemia outcome data and peritonitis rates via a collection tool. Each Texas facility received a *Texas Department of Health Quality of Care Indicators Report* that included their facility specific data displayed in a graphic format allowing for comparison to national, state and recommended levels. NKF-DOQI™ recommendations were included in the report.

G.

The Network #14 Annual Coordinating Council meeting included presentations on Centers for Disease Control infection control recommendations, dialysis adequacy, nutrition and vascular access NKF-DOQI guidelines along with strategies for implementation into facility practice.

OBJECTIVE IV

COLLECT, ANALYZE AND DISSEMINATE FACILITY SPECIFIC, COMPARATIVE OUTCOME DATA

In support of this objective the Network performed the following during 1999:

A.

Network #14 produces an *Annual Facility Profile* for each Texas dialysis facility using data abstracted from the Annual Facility Survey and the Network database. The Profile includes facility and state comparative data and, if applicable, HCFA comparative data. The following facility specific charts were included:

- Standardized mortality rates
- Gross mortality rates
- Percent home and transplant patients
- Average living age, mean years on dialysis, average expired age, years on dialysis at death
- Cause of death
- Treatment modality
- Vocational rehabilitation
- Transplant referral activity

B.

Network #14 calculated and disseminated Compliance Reports that detailed each facility's timeliness and accuracy in completing HCFA 2728 and 2746 forms. Each report included a compliance rate compared to the Texas average and the HCFA compliance goal. Facilities falling significantly below expected compliance were required to develop corrective action plans for improvement. (Refer to Goal E. Page 62.)

C.

The Network specific HCFA HCQIP project titled: ***Be Wise-Immunize***, included a statewide sampling of all Texas dialysis facility immunization rates and practices reported from each facility via the ***Centers for Disease Control and Prevention Annual Facility Survey*** and a project specific data collection form. Charts were distributed detailing statewide facility vaccination averages in comparison to professional guidelines. Results were also highlighted in newsletters and at the Network annual meeting.

D.

The Network specific HCFA HCQIP project titled: *Mission Possible: Vascular Access* included a statewide sampling of all Texas dialysis facility vascular access rates and practices. Charts were distributed detailing statewide facility vascular access averages in comparison to professional guidelines. Results were also highlighted in newsletters and at the Network annual meeting.

E.
Starting in 1997, Network #14 has contracted with the Texas Department of Health (TDH) ESRD Facility Licensing Division to annually collect facility specific dialysis adequacy, anemia, albumin management core indicator data along with peritonitis rates from each Texas dialysis facility. The results are published as the *Quality of Care Indicator Report*. Each facility is provided facility specific data compared to state and national averages in run and bar chart form. The data presentation allows each facility the opportunity to compare outcomes to state and national averages.

The Network and TDH organized three regional seminars to review the findings of the annual *Quality of Care Indicator Report* and provide guidance and direction with implementing quality improvement activities.

F.
The *1999 USRDS Unit-Specific Reports* were disseminated that included facility specific Standardized Mortality, Hospitalization and Transplantation Ratios. Included in the report was facility specific information on the above ratios compared to Texas and the nation. The Network distributed the charts to the facility Medical Director, Head Nurse and Governing Body. Facility staff were requested to review their facility specific data and if opportunities to improve were identified, initiate a quality improvement project. Network #14 specific data was highlighted in the Networks professional newsletter.

G.
The *1998 HCFA National Core Indicator Reports* were disseminated and Network #14 results were highlighted in professional newsletters and during presentations.

H.
Executive Director is participating as a workgroup member of the HCFA State Survey Reports Workgroup. This workgroup is developing ways to provide Medicare Surveyors with clinical data to assist them with their survey of dialysis clinics.

I.
Community Services Coordinator is participating as a member of the HCFA Consumer Reports Workgroup. This workgroup is developing ways to disseminate dialysis facility specific clinical information to the general public to help with medical care decisions.

OBJECTIVE V

PERFORM SPECIAL STUDIES DEVELOPED BY THE MEDICAL REVIEW BOARD, HCFA, TDH, USRDS AND OTHER AGENCIES

In support of this objective the Network performed the following during 1999:

A.

1999 HCFA ESRD Clinical Process Measures (CPM) Project

The HCFA ESRD CI Project transitioned to the CPM project in 1999. The project is an annual nationwide population based study to assess and identify opportunities to improve care of patients with ESRD. The project involves collecting data on measurable treatment outcomes to generate national and Network specific normative data for use in comparing performance. The purposes of the core indicator project are to:

- Assist ESRD providers in improving care delivered to dialysis patients.
- Compare the prevalence of important clinical measures and or characteristics of adult dialysis patients.
- Identify opportunities to improve care.

The ESRD Clinical Process Measures Project involves the joint efforts of HCFA, the Network and the dialysis community. Each year of the project, HCFA selects a random sample of adult in-center hemodialysis patients who were alive the previous December 31st. The sample is representative on the national and Network level with a sample size sufficient to provide statistical confidence.

The Network disseminated, collected, reviewed, corrected, and transmitted to HCFA on the contracted schedule, CPM Forms from 192 facilities on 498 hemodialysis patients and 98 peritoneal dialysis patients. Additionally, a data validation activity was conducted on a 5 percent sample.

Upon completion of the *HCFA ESRD CPM*, the Network disseminates a copy of the report to each dialysis facility. The 1999 Annual Report is the 6th report published to date. The 1999 annual report documents continued improvement in both Network #14 and national core indicator outcomes.

Facility Quality Management Committee members are urged to review and compare the findings included in the report to their facility specific outcomes. If opportunities are identified, facilities are encouraged to implement a quality improvement project. The Medical Review Board reviews the findings of the report annually and uses the information to identify possible quality improvement projects. HCFA and Network data from the CPM/ Core Indicators project are included in educational materials provided to each dialysis facility.

Listed below are selected Network #14 specific hemodialysis highlights from the 1999 annual report.

Hemodialysis Adequacy
- 81% of the Network #14 sample patients had a URR greater than or equal to 65%.
- When compared to the other 17 Network regions, Network #14 had the highest percent of patients with a URR greater than or equal to 65%.

Anemia Management
- 57% of the Network #14 sample patients had a Hematocrit between 33-36%.
- When compared to the other 17 Network regions, Network #14 had the 4th highest percent of patients with a hematocrit between 33-36%.

Albumin Management
- 84% of the Network #14 sample patients had a serum albumin greater than or equal to 3.5gm/dl (BCG method) or 3.2gm/dl (BCP method).
- When compared to the other 17 Network regions, Network #14 had the 2nd highest percent of patients with a serum albumin greater or equal to 3.5gm/dl (BCG method) or 3.2gm/dl (BCP method).

Vascular Access Management
- 20% of the Network #14 sample patients were utilizing a fistula.
- When compared to the other 17 Network regions, Network #14 had the third lowest percent of patients utilizing a fistula.
- 10% of the Network #14 sample patients were utilizing a catheter for 90 days or longer.
- When compared to the other 17 Network regions, Network #14 had the third lowest percent of patients utilizing a catheter for 90 days or longer.

B.

A *Centers for Disease Control and Prevention (CDC) National Surveillance of Dialysis Associated Diseases in the United States Survey* is distributed annually by the Network to each dialysis facility. The survey collects information on hemodialysis-associated diseases, certain hemodialysis practices, including measures designed to prevent disease and dialysis associated complications. The Network edits each survey and contacts facilities for missing or questionable data. The CDC produces an annual report highlighting the findings. The Network distributes the report along with charts comparing Texas data to national outcomes to each dialysis facility.

C.

Medical Review Board Special Study: Relationship Between Facility Standardized Mortality Rate (SMR) and Regulatory Survey Outcomes

During a *Forum of ESRD Network' s Medical Review Board Chairperson* Meeting in Philadelphia,

the Forum Medical Review Board Chairman informed the MRB members that HCFA was considering using USRDS calculated SMRs as a measure to select dialysis facilities for Medicare surveys. The members discussed the merits and concerns of using USRDS SMR data as a method for facility survey and certification activities by state surveyors and other regulators. The ESRD Network of Texas MRB Chair notified the members that based on the recent survey experience in Texas, some data was available to examine the relationship between facility SMR and the results of a state survey.

At the request of the Forum MRB committee, the ESRD Network of Texas and MRB performed a retrospective analysis of the relationship between the 33 facilities that had been referred to the MRB by the TDH during the 1996-1997 survey period.

Background

Beginning in September 1996, the Texas Department of Health (TDH) surveyed all Texas outpatient dialysis facilities for compliance to the recently enacted Texas ESRD Facility Rules and Standards. A total of 237 initial licensure facility surveys were performed between September 1996 and October 1997. Unique to the Texas rules is a relationship between the ESRD Network of Texas Medical Review Board (MRB) and the TDH ESRD Facility Licensing Division. The rules include a mechanism for results of TDH surveys that identify "significant problems potentially impacting patient outcomes" to be referred to the MRB for assistance in determining an appropriate corrective action.

During the 1996-97 survey period, the TDH forwarded 33 referrals to the MRB based on TDH surveyor assessment that deficient facility practices existed and that these practices presented real or potential risk to patient health and safety. The referred facilities represented 14% of the 237 facilities surveyed. In all 33 cases, the MRB concurred with the surveyor's decision to make the referral and recommended corrective actions.

The following are examples of deficient practices identified as not meeting TDH rules or community standards. The list is not all-inclusive, but represents common issues.
Failure to:

- Take appropriate infection control procedures for patients with unknown hepatitis B status upon admission to the facility.
- Assess patient status before treatment, resulting in negative patient outcome.
- Provide adequate dialysis and or appropriate anemia management.
- Ensure the provision of safe water for hemodialysis.
- Provide safe reuse of dialyzers.
- Provide sufficient qualified staff.

Using the 1996-1997 TDH survey data, an analysis was performed to compare the Network calculated SMR of the facilities that were referred to the MRB for quality of care concerns verses those that were not.

Findings
Correlations between SMR & Referral status were statistically significant and though associations indicated correlations between the variables, they were too small to have predictive value. Based upon the analysis as well as knowledge of actual serious practice deficiencies in facilities with excellent outcomes, the MRB concluded that regular routine surveys of all dialysis facilities should be conducted nationwide and recommended against use of SMR data to select facilities for survey.

OBJECTIVE VI

CONDUCT ACTIVITIES TO ASSIST PATIENTS AND PROVIDERS INCREASE UNDERSTANDING AND MEASURABLY IMPROVE ESRD CLINICAL OUTCOMES

In support of this objective the Network performed the following during 1999:

A.
Network #14 maintains a *Patient Advisory Committee* (PAC) and a *Patient Representative* in each dialysis facility. The PAC is composed of patients representative of all modalities, geographic areas of the Network and cultural diversity. The Chairperson is the Network ESRD Community Patient Representative. The PAC met three times in 1999 and was available by teleconference, or mail. The PAC provides patient focused input and suggestions on Network activities. These include review of the Network #14 patient education materials, newsletters and meetings topics. The process of requesting that facilities designate a patient representative was continued in 1999. During 1999, each representative was requested to distribute the biannual Network newsletters and communicate patient issues, concerns and needs to the Network.

B.
In support of the HCFA Health Care Quality Improvement Plan (HCQIP) and NKF–DOQI™ vascular access guidelines, the Network developed an educational initiative titled: Mission Possible*: Vascular Access.* The project goals were to:

- Decrease the prevalence of patients utilizing a hemodialysis catheter as their sole permanent access type when other options are available.
- Decrease the subclavian vein placement of catheters.
- Increase the use of vascular access data collection and outcome trending in dialysis facilities.
- Stimulate facilities to review and incorporate the NKF-DOQI™ vascular access. guidelines into their vascular access management programs.

With the assistance of the Medical Review Board, the Network:
- Organized regional education seminars focusing on methods to decrease catheter utilization.
- Collected and distributed facility specific vascular access management data and practice data.
- Provided each facility with educational materials and data collection tools to document individual patient access histories and facility specific outcome.
- Produced a patient education video on vascular access types and their care.
- Distributed NKF-DOQI™ vascular access practice guidelines to facilities and surgeons.

C.
In 1998, the Network began a major project to develop and publish a patient education book written

with large print and easily readable language. The book titled ***Life Goes On… After Your Kidney Stop Working*** was completed in early 1999. The 124 page softbound book includes the information previously provided to patients in the Network #14 ***New Patient Packet.*** The book includes a great deal of information about how a person with ESRD can improve their outcomes and lifestyle. A key section is a review of the NKF-DOQI™ guidelines and recommended strategies to meet the guidelines. Other sections expected to improve outcomes focus on the pros and cons of each vascular access, the importance of receiving recommended vaccinations and information on rehabilitation. An updated version was published in 1999 after critique and input from both the patient and professional ESRD community.

D.
Disseminated 1998 CDC National Surveillance of Dialysis Associated Disease in the United States. This document reports on infection control practices within the nations dialysis community. Also included are the CDC infection control practice recommendations.

E.
At the request of HCFA, the MRB Nutrition subcommittee developed culturally appropriate Hispanic food avoidance list and materials on thirst control in both English and Spanish. Poster and brochures were disseminated to each facility.

F.
A notice was broadcast faxed to all Texas dialysis facilities on the subjects of:

- FDA alert about possible blood contamination of dialysis machines using a specific brand of blood tubing.
- FDA alert regarding unexpected disconnections of a specific hemodialysis catheter that may result in blood loss.

G.
An updated and comprehensive set of run charts were developed and disseminated to each dialysis facility. The run charts included a state or HCFA CPM national comparison and if applicable a NKF-DOQI™ recommended guideline. Facility Quality Management committees were directed to plot their facility outcomes on the charts and compare to the listed averages. If opportunities to improve were identified the facility should implement a quality improvement project.

H.
Network staff participated in numerous educational programs designed to assist patients learn more about ESRD, it treatments and improve outcomes. Meetings included programs sponsored by the National Kidney Foundation, Polycystic Kidney Foundation, and the American Association of Kidney Patients. The Network also assisted many patients and family members by answering questions and providing information via phone calls, Internet and written request.

I.
Network staffs were invited to present at professional education meetings both in Texas and across the country. Presentation subjects included ESRD data review, Network operations, Quality Management, HCFA Forms Compliance, Vocational Rehabilitation, Texas ESRD Licensure Rules,

Network Quality Improvement Project results, and ESRD Program history.

J.
The Network acts as a clearinghouse to provide information to providers and patients concerning ESRD technology, guidelines, FDA alerts, outcomes and treatment advances as well as other pertinent information. The Network distributes notices and informational materials that are produced by government and renal organizations to appropriate parties.

K.
The Network published a patient newsletter (*The Lone Star Newsletter*) twice yearly and a professional newsletter (*The Lone Star Bulletin*) quarterly. The Network has found newsletters to be an effective way to routinely distribute educational information in a timely manner.

Major article subject highlights included in 1999 Professional Newsletters:

- Hemodialysis Adequacy project results
- Immunization Project Update
- Rehabilitation resources for ESRD facilities and patients
- Updates on Texas facility licensure process and referral activity
- Y2K disaster preparedness recommendations
- CDC VRE Study request for facility participants
- Transplant legislation
- Hurricane Bret review
- Texas Dialysis Facility Core Indicator Data
- Kidney transplant and vocational rehabilitation trends and patterns
- Upcoming educational opportunities
- Vascular access utilization in Texas dialysis facilities
- Patient education and support resources
- Facility quality management process recommendations
- Network and general information

Major article subject highlights included in 1999 Patient Newsletters:

- Review of the NKF DOQI Recommendations
- Patient stories detailing experiences with ESRD and rehabilitation
- Highlight on the American Association of Kidney Patients organization
- Patient support organization
- Information about vascular access
- Y2K preparations
- Review of vascular access selection and care
- Dialysis health quiz
- Information about Patient Advisory Committee
- Information about Medicare Fraud
- Flu/Pneumonia information

L.
Network #14 produces an annual educational meeting titled: *Nephrology-Today and Tomorrow* in

conjunction with the Coordinating Council Meeting. With the assistance of the renal community the program agenda is designed to offer educational opportunities that are both high interest and high quality. Breakout sessions are held to provide discipline specific education.

In 1999, nearly 500 participants had the option of attending presentations by noted presenters over the two days of the program. All disciplines were well represented. Presentation topics included:

- Patient centered nephrology
- Proactive approaches for dealing with non-compliant and aggressive patients
- Texas ESRD facility licensure program update
- HCFA Accountability Initiative
- Disaster preparedness
- Diagnostic and therapeutic problems with vascular access
- Antimicrobial resistance in dialysis facilities
- Herbal remedies impact on dialysis patients
- Overview of NKF-DOQI nutrition guidelines
- Non-nutritional causes of hypoalbuminemia
- Advanced psychiatric assessment of ESRD patients
- RPA/ASN guidelines on shared decision making in the appropriate initiation and withdrawal from dialysis
- Vocational rehabilitation issues
- Review of LORAC program resources
- Overview of renal disease management organizations
- SIMS update
- Methods to improve survey outcomes

The Network disseminated the following materials to all Texas ESRD facilities in 1999

- ESRD Network of Texas Facility Specific Annual Data Reports
- HCFA 1998 Clinical Process Measures Report
- 1999 Texas Department of Health Quality of Care Report
- Network#14 Goals and Objectives and List of Services
- 1999 USRDS Facility Specific Data Reports
- List of Texas dialysis and transplant facilities
- Network Patient Education Book, Life Goes on… After Your Kidney Stop Working
- 1999 Guide to Health Insurance for People With Medicare
- ESRD Network of Texas Run Charts
- LORAC New Life New Hope
- Why Am I Thirsty Booklets and Posters
- Texas ESRD Vocational Rehabilitation Activity Report
- Produced manuscript titled: Partnering to Improve Rehabilitation Opportunities for Persons with ESRD in Texas
- HCFA mammogram educational posters and brochures
- HCFA Flu and Pneumonia educational posters and brochures

- National Surveillance of Dialysis Associated Diseases in the United States, 1998
- HCFA Forms compliance reports
- AAKP Renal Life magazine
- National Kidney Foundation Family Focus Newspaper
- Fax Bulletin regarding contamination of dialysis machines
- Fax Bulletin regarding FDA warning on defective catheters

M.

The Network sponsored the two patient representative members of the Texas Department of Health (TDH) ESRD Facility Licensing Task Force. The patient representatives provided insight and opinion as to the impact of the current and proposed TDH rules for the Task Force.

OBJECTIVE VII

INITIATE QUALITY IMPROVEMENT PROJECTS ON TOPICS IDENTIFIED BY THE MEDICAL REVIEW BOARD AND THE TEXAS RENAL COMMUNITY AS A HIGH PRIORITY TO IMPACT SIGNIFICANT NUMBERS OF PATIENTS

In support of this objective the Network performed the following during 1999:

1998-1999 Network #14 Quality Improvement Project:
Be Wise - Immunize Cooperative Project

The Network #14 Quality Improvement Project is a Network specific activity within HCFA's Health Care Quality Improvement Program (HCQIP). HCQIP projects provide the opportunity for the Network to measurably improve patient outcomes.

In 1998, the Medical Review Board (MRB) of Network #14 joined with the Health Care Finance Administration (HCFA), Centers for Disease Control and Prevention (CDC) and the National Coalition for Adult Immunization to participate in an effort to meet the vaccination goals of ***HCFA's Pneumonia/Flu 2000*** campaign. Previously, the Network and the Texas Medical Foundation have worked in partnership to increase the number of ESRD patients receiving influenza vaccination. The Medicare Pneumonia/Flu 2000-campaign goal for ESRD patients is that 80 percent receive an influenza and pneumococcal disease vaccination (PPV) by the year 2000. The CDC recommends that all dialysis patients at risk of exposure be vaccinated against hepatitis B.

An ESRD Network of Texas (MRB) directed facility specific immunization survey identified that 99 percent of the Texas dialysis facilities reported offering influenza immunizations, while 15 percent of the facilities reported 50 percent or less of their patients received an influenza immunization during 1997.

A HCFA report, *National Highlights: Opportunities for Improving Pneumococcal and Influenza Vaccination Rates Among Medicare Beneficiaries*, reported that in 1996 45.6 of Texas and 39.2 percent of the nation's ESRD patients not enrolled in managed care, received a influenza vaccination. The same report identified that 4.8 of the Texas and 5.6 percent of the nations' ESRD patients received a pneumococcal vaccination. The MRB survey identified that 43 percent of Texas dialysis facilities offered pneumococcal immunizations, while 78 percent of Texas facilities reported that 50 percent or fewer of their patients received the immunization.

The project goal of the ***Be Wise-Immunize*** Quality Improvement Project is to increase the

conformance of the Texas ESRD providers to current influenza, pneumococcal and hepatitis B vaccination guidelines. It is believed that attainment of this goal will decrease both ESRD morbidity and mortality from preventable disease.

The expected outcomes of this project are to:

- Increase the total number of dialysis patients in Texas vaccinated annually against influenza and every 5 years for pneumococcal, and for HBV per CDC recommendations.

- Reduce the incidence of influenza, pneumonia, and hepatitis B (I-P-H) in the Texas ESRD population.
- Decrease patient morbidity and mortality from I-P-H, and reduce hospital and associated medical costs.

Sampling Strategy:
A pre and post measurement design was selected for this project. Billing claims for vaccinations are the direct measure to evaluate for success. A baseline state-wide vaccination rate was calculated by randomly selecting 5 percent (1,000) of all Texas ESRD patients alive and dialyzing as of 12/31/97 from the Network #14 database. With the assistance of the Texas Medical Foundation, the Medicare Part B billing database was queried and vaccination-billing information matched to each patient record. The Medicare Part B claims identified the following:

- 98% (978) of the baseline patient sample were reported valid

Influenza Vaccination

- 41% received a vaccination during 1997

Pneumonia Vaccination

- 12.7% (125) received the vaccination in the last 5 years (1993-1997)

Hepatitis B Vaccination

- 55% have received all three vaccine doses as of December, 1997

Interventions:
With the assistance of the Texas Medical Foundation, Texas Department of Health and infection control experts, Network #14 and the MRB designed educational materials for both patients and staff. The materials were mailed prior to the fall flu season to the facility Medical Director and Head Nurse. Materials developed include:

- Patient education flyer on the benefits of flu/pneumonia and Hepatitis B vaccination in both English and Spanish
- Poster encouraging patients to request vaccinations
- Professional education flyer providing information on:
  - Benefits of vaccinations
  - Common causes of under-utilization of vaccinations

- Tips to improve facility vaccination rates
- ESRD patient vaccination recommendations
- Questions and answers to common vaccination related issues
- A medical record form to assist facilities to track patient vaccinations

Follow-Up Measurements:
The Network duplicated the baseline sampling technique. With the assistance once again of the Texas Medical Foundation a 5 percent (1,166) sample of Texas dialysis patients who were receiving dialysis as of December 31,1998 was drawn from the Network data base. The Medical Information (PMMIS) and Medicare Part B billing database was queried to calculate the percentage of dialysis patients from the sample who billed for flu and pneumonia vaccinations during the last three months of 1998.
A separate data collection survey was also used to collect baseline and follow-up facility specific vaccination data. This secondary data collection source was implemented to collect immunization data that may not have been billed to Medicare. Baseline data was collected with the use of a Network specific survey, the follow-up data was collected utilizing the 1999 Centers for Disease Control National Surveillance of Dialysis–Associated Disease survey form which approximated the same data collection points.

Facility self reported Hepatitis B vaccination data was collected from the 1999 Centers for Disease Control National Surveillance of Dialysis –Associated Disease Survey form.

Chart 5 **Project Results** ***Medicare Billing Method***		
	1997	**1998**
Percent of patients receiving **flu** shot during year.	**44.8%**	**35.1%**
Percent of patients receiving **flu** shot during last three months of year.	**44.8%**	**35%**
Percent of patients receiving **Pneumococcal** shot during year.	**3.9%**	**12.5%**
Percent of patients receiving **Pneumococcal** shot during last three months of year.	**39.4%**	**97%**
Percent of patients receiving **Pneumococcal** shot during the past five-year period. (1997=1993-1997 1998 =1994-1998)	**12.7%**	**11.3%**

Chart 6 **Project Results** ***Network Specific Survey Method***		
	1997	**1998**
Percent of facilities offering flu immunizations.	**99%**	**100%**
Percent of facilities administering a flu immunization to **50% of more** of their patients	**85%**	**91%**
Percent of facilities offering Pneumovax immunizations.	**43%**	**73%**
Percent of facilities administering a Pneumovax immunization to **50%**	**26%**	**48%**

of more of their patients.		
Percent of patients who have received three Hepatitis B vaccinations doses as of December.	**55%**	**65.3%**

Project Conclusions:
Depending on the method used to evaluate the project, the results show an inconsistency. The Medicare billing data method shows that the percent of patients receiving a flu or pneumonia immunization decreased in 1998 compared to 1997, while the Network/CDC specific survey data demonstrates notable improvements in the percent of patients offered and receiving influenza or Pneumovax vaccinations.
An additional source of data is the HCFA National Immunization Billing data. In 1997, this database identified that 45 percent of Texas ESRD patients received a influenza immunization and 4.8 percent received a pneumococcal immunization. To date HCFA has not released 1998 data to allow for evaluation of changes in state or national ESRD rates.

Specifically when comparing improvement between 1997 and 1998, the percent of facilities offering influenza and Pneumococcal immunizations to their patients increased by 1 and 30 percent, respectively. The percent of facilities administering influenza or Pneumovax immunizations to 50 percent or more of their patients increased 6 and 22 percent, respectively. Lastly, the percent of patients who received all three hepatitis B vaccine doses increased by 10 percent.

Both ESRD Networks and Peer Review Organizations have communicated their concerns to HCFA regarding the low level of beneficiary immunization billing of Medicare. This appears to be an ongoing issue and concern with the community.

The Network's experience surveying the Texas dialysis community for facility specific self reported core indicators and clinical practices over the years has shown to be very reliable and reproducible, thus we are confident that the data collected using the Network specific data surveys is valid. As such, the expected project outcomes of increasing the percent of ESRD patients immunized and the concomitant effect of this activity have been met.

1999-2000 Network #14 Quality Improvement Project: *Mission Possible: Vascular Access*

Mission Possible: Vascular Access is the title of the 1999-2000 ESRD Network of Texas Quality Improvement Project. The project is the Network specific initiative in support of the Health Care Finance Administration's Health Care Quality Improvement Program (HCQIP). HCQIP projects concentrate on and improve the processes of care surrounding particular diseases. They are designed to identify opportunities for improvement in processes of care with the goal of improving the quality of care provided to Medicare ESRD beneficiaries

There are two types of permanent vascular access-the fistula and the graft. The fistula is considered the best access choice due to a superior patency rate and the need for fewer interventions. Another

access type is the catheter. The National Kidney Foundation–Dialysis Outcomes Quality Initiatives (NKF-DOQI™) Clinical Practice Guidelines for Vascular Access recommend that catheters be discouraged as permanent vascular access. As compared to grafts and fistulas, catheters have a higher incidence of complications, surgical intervention and hospitalization costs. Since 1995 the percent of Texas hemodialysis patients utilizing a catheter has increased 33 percent, resulting in an 18 percent prevalence rate as of October 1999.

Contributing factors for this increase in utilization of catheters are varied, multifaceted and complicated. Potential processes of care involved in this trend are:

- Late referral to the nephrologist and/or the vascular surgeon resulting in the need for an access type that provides immediate access to bloodstream.
- Medical constraints such as arteriosclerotic peripheral vascular disease, amputations or failed previous access.
- Surgeon/nephrologist communication and preference.
- Poor vascular access management at the facility level.
- Patient choice (lack of education, fear of needles).
- Health-care reimbursement issues.

Whatever the cause, the data clearly suggests the need for a Quality Improvement Initiative to educate and stimulate the dialysis community to focus attention on minimizing the utilization of catheters.

Objectives of the project:
The primary objective is to decrease the utilization of catheters for permanent vascular access in the Texas hemodialysis population.

Additional secondary objectives are to:

- Decrease the prevalence of patients utilizing a hemodialysis catheter as their sole permanent access type when other access options are available.
- Decrease the subclavian vein placement of catheters.
- Increase the use of vascular access data collection and outcome trending in dialysis facilities.

The project included all Texas outpatient dialysis facilities open as of October 1999. Each facility completed a survey in that month that collected information on facility specific vascular access utilization data and access monitoring processes. Significant baseline findings are shown below.

- As of October 1999: 3,233 (18%) hemodialysis patients were utilizing a catheter.
- The percent of hemodialysis patients utilizing catheters varies widely between facilities (range 0-60% of facility census).
- The percent of hemodialysis patients utilizing catheters varies widely between Texas counties (<10% Bexar county to >30% El Paso county).
- A total of 2,100 (65%) hemodialysis catheter patients were utilizing

a catheter with no other access placed or available.

- 1,390 (43%) were utilizing a subclavian catheter.
- 1,940 (60%) were utilizing a catheter for 90 days or longer.
- 85 (34%) facilities were not routinely monitoring AV grafts for stenosis.

Facilities identified as having superior (10% or less of the patients) catheter utilization rates were identified and asked to make available their vascular access management procedures as "benchmark" processes for the community. Network QM staff consulted with 15 facilities on site and via teleconference to review and document their vascular access processes.

All facilities were provided color feedback charts documenting their facility outcomes compared to the state that highlighted their conformance to NKF-DOQI vascular access guidelines. In addition each facility received a "tool box" that included the following items:

- Invitation to attend a half-day Network seminar on methods to minimize catheter utilization.
- Vascular access chart forms to assist facilities with collecting data on vascular access utilization and complications.
- Indications for catheter checklist.
- Patient education literature on recommended access type and their access care.
- A 15-minute video produced in both English and Spanish that discusses each access types, their pros and cons and their care.
- A copy of the NKF-DOQI™ vascular access guidelines.

Facilities identified as having an opportunity to improve their catheter utilization rates were strongly encouraged by the Network Medical Review Board to attend a complementary regional mentoring workshop titled *Solving the Catheter Conundrum*. The seminars were held in March and April 2000 in El Paso, Dallas, Houston and Corpus Christi. In partnership with benchmark facility staff, nephrologist, nurse and surgeon attendees were provided an opportunity to review specific vascular access management processes employed to attain low catheter rates and to learn additional methods of decreasing their catheter utilization rate. Nearly 80 percent of the intervention facilities attended and had physician representation at one of the meetings. Nearly 400 dialysis and surgical professionals attended.

At the conclusion of this two-year project, a follow-up survey will be distributed to evaluate changes in individual facility and Texas hemodialysis catheter utilization rates.

C. GOAL - ESTABLISH AND IMPLEMENT PARTNERSHIPS AND COOPERATIVE ACTIVITIES AMONG THE ESRD NETWORKS, PEER REVIEW ORGANIZATIONS, STATE SURVEY AGENCIES, ESRD PROVIDERS, RENAL ORGANIZATIONS, AND ESRD RELATED AGENCIES.

A.

Network #14 is an active participant in the Forum of ESRD Network activities. Network staff attended all Forum sponsored activities in 1999. The Network Executive Director, Data Coordinator and Quality Management Coordinator participated as members of the following committees:

- Standardized Information Management System (SIMS) development workgroups
- HCFA/Forum Annual meeting
- Quality Improvement Directors Committee

B.

Office of the Inspector General (OIG): Study of the HCFA Oversight of the ESRD Program

Representatives of the OIG visited the Network and interviewed members of the MRB, the Chairman, and nephrology patients, nurses, social workers, technicians and dietitians over a two-day period in July 1999. Interest was keen in the collaborative relationship between the State Agency and the Network and in particular the involvement of the MRB. (Refer to Goal B. Page 35.)
A report of the OIG study is expected to be published in 2000 that will most likely detail the Texas experience.

C.

General Accounting Office (GAO): Study of the ESRD Program at the request of the Senate Special Committee on Aging

The Network was contacted and a visit scheduled for early in 2000 to review the collaborative relationship between the State Agency and the Network.

D.

Network #14 and the Texas Medical Foundation (TMF) worked on a number of collaborative projects during 1999. TMF staff provided technical assistance with the ***Be–Wise Immunize*** Quality Improvement Project protocol, vaccination billing data and educational material design. The TMF provided the Network with copies of Medicare Mammogram educational materials for Network clearinghouse activities. TMF also provided assistance as needed with Network questions regarding Medicare policies and procedures.

E.

Network #14 and the Texas Department of Health (TDH) ESRD Facility Licensure and Certification Divisions continued a collaborative and collegial relationship in 1999. Eight complaints received by the Network that were regulatory in nature were referred to the Texas Department of Health for

investigation with an offer for Network assistance. Staff of both agencies have served as technical advisors as needed.

F.

Network #14 Executive Director and Quality Management Coordinator were included in a legislatively mandated ESRD Task Force of renal professionals and patients. The purpose of the Task Force was to review and revise the Texas ESRD Licensure Rules.

G.

The Network and TDH co-hosted regional seminars in Dallas, Houston and Austin to review the findings of the *1999 Quality of Care Indicator Report,* the revised TDH ESRD facility licensing rules and provide guidance and direction with implementing quality improvement activities. The complimentary seminars were attended by nearly 500 dialysis personnel representing over 75 percent of the states clinics.

H.

Network #14 sponsored the two patient representative members of the Texas Department of Health (TDH) ESRD Facility Licensing Task Force. The patient representatives provided insight and opinion as to the impact of the current and proposed TDH rules for the Task Force.

I.

Network #14 assisted with the program development and registration of American Nephrology Nurses Association Statewide meeting held in Galveston, Texas.

J.

Network #14 QM nurse continued in the position as National Kidney Foundation (NKF)-Council of Nephrology Nurse and Technicians Region 4 Vice Chair with responsibilities of helping to develop NKF national educational programs. In addition, QM nurse monitors and moderates the NKF CyberNephrology listserve.

K.

Network #14 QM nurse assisted the American Kidney Fund with revising of their *Treatment Options for Kidney Disease* pamphlet.

L.

Network #14 Executive Director served on editorial board of the American Association of Kidney Patients professional newsletter.

M.

Network #14 QM Coordinator served as a member on Blue Cross/Blue Shield of Texas Part A Advisory Committee.

N.
Network #14 Patient Services Coordinator participated as a workgroup member revising HCFA booklet, *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services: A Supplement to Your Medicare Handbook.*

O.
Network #14 Executive Director participated in American Nephrology Nurses Association Ethics Subcommittee.

P.
Network #14 and the Texas Rehabilitation Commission (TRC) continued a partnership. The objectives of the partnership were to allow the Network staff the opportunity to meet with and educate TRC counselors about:

- Causes of ESRD
- Treatment of ESRD
- ESRD Vocational Rehabilitation Data
- Initiatives to increase ESRD vocational rehabilitation
- Recommendations to improve referral process between facilities and TRC

During 1999, the TRC invited Network staff to provide in-services to TRC counselors during regional TRC meetings. The results of the partnership are expected to increase referrals and the number of patients working or in school.

Q.
Network #14 staff participated in numerous educational programs designed to assist patients learn more about ESRD, it treatments and improve outcomes. Meetings included programs sponsored by the National Kidney Foundation, Polycystic Kidney Foundation, and the American Association of Kidney Patients.

R.
One unique aspect of the relationship between Network #14 and the TDH is the inclusion of the Network #14 Medical Review Board in the state ESRD facility licensing law. A provision within the enforcement subchapter of the state licensure rules allows the TDH to refer results of facility surveys to the MRB for recommendation and determination of corrective action requested. The Network contracts with the TDH to collect facility specific quality indicator data through the use of the *Texas Department of Health Quality of Care Survey* and produces both facility specific reports and an *Annual TDH Quality of Care Indicators Report*.

During 1999, sixteen facility referrals were made to the MRB by the TDH. The MRB identified “serious or life threatening” quality of care deficiencies in eight facilities and “potentially serious or life threatening” deficiencies in the other eight. One of the facilities identified as having serious or life threatening” quality of care deficiencies was recommended to be closed to the TDH and HCFA.

Life threatening quality of care deficiencies were cited in the following areas:

- Water treatment testing/dialyzer reuse practices
- Vascular access related infection control practices
- Facility staffing ratios
- Nursing management
- Nursing practices
- Medical Director supervision
- Untrained or unsupervised dialysis technicians
- Vascular access management
- Anemia management, dialysis adequacy practices outside the standard of practice
- Use of malfunctioning dialysis machines for treatment
- Lack of oversite and management of patient care by physicians
- Infection control practices
- Low potassium dialysate bath monitoring

Potentially serious or life threatening deficiencies were cited in the following areas:

- Patient monitoring
- Machine safety and maintenance
- Technical staff competency
- Quality Management program
- Pre-treatment patient assessments not performed
- General infection control practices
- Patient care planning

All referred facilities were asked to provide protocol changes, education initiatives, audits and quality management minutes to the MRB for review for period of six months. If TDH required the use of temporary facility monitors or managers the MRB requested periodic updates on their assessment of corrective actions. At the request of facility leadership, the Network assists with development of corrective actions, provides education and supports facility quality management activity.

S.

Network staff worked cooperatively and participated with many organizations involved with the various aspects of ESRD. In addition, the Network staff volunteered time and expertise as board and committee members for the National Kidney Foundation, the American Association of Kidney Patients, and the American Nephrology Nurses Association. The Network provided technical assistance to the following organizations thus helping meet their need or goals:

- American Diabetes Association
- American Nephrology Nurses Association - National and Texas Chapters
- American Kidney Fund

- American Association of Kidney Patients
- Centers for Disease Control and Prevention
- NKF Council of Renal Dietitians
- NKF Council of Nephrology Social Workers
- Forum of ESRD Networks
- Health Care Finance Administration
- Life Options Rehabilitation Council
- National Kidney Foundation, Texas and National Affiliates
- National Renal Administrator Association
- National Association of Nephrology Technicians
- Polycystic Kidney Foundation
- Renal Physicians Association
- State of Texas - Emergency Planning Division
- Texas Department of Health- Health Facility Licensure & Certification Divisions
- Texas Department of Health-Kidney Health Care Program
- Texas Medical Foundation
- Texas Rehabilitation Commission
- Texas Renal Administrators Council
- Texas Transplant Society
- United Network for Organ Sharing

The goal of *e***stablishing and implementing partnerships and cooperative activities among the ESRD Networks, Peer Review Organizations, State survey agencies, ESRD providers, renal organizations, and ESRD related agencies** has been met for 1999. Partnership and collaborative activities will continue to be pursued for the benefit of patients, professionals and organizations.

D. GOAL - IMPROVE THE QUALITY OF LIFE FOR ESRD BENEFICIARIES IN THE STATE OF TEXAS

OBJECTIVE I
FACILITATE ASSESSMENT OF QUALITY OF LIFE

In support of this objective the Network performed the following during 1999:

The rehabilitation of ESRD patients was an original goal of the Medicare ESRD program. There is growing scientific support that the key to patient wellness is the optimizing of patient functioning. The reported benefits associated with successful rehabilitation include better quality of life, reduced health care costs, and fewer demands for support from care providers.

A.

The Rehabilitation Program of Network #14 is aimed at ensuring that rehabilitative opportunities are presented and available to all suitable ESRD patients. The Medical Review Board has developed and adopted Criteria and Standards to identify suitable vocational candidates.

B.

Network #14 and the Texas Rehabilitation Commission (TRC) continued a partnership. The objectives of the partnership is to allow the Network staff the opportunity to meet with and educate TRC counselors about:

- Causes of ESRD
- Treatment of ESRD
- ESRD Vocational Rehabilitation Data
- Initiatives to increase ESRD vocational rehabilitation
- Recommendations to improve referral process between facilities and TRC

During 1999, the TRC invited Network staff to provide in-services to TRC counselors during regional TRC meetings. The results of the partnership are expected to increase referrals and the number of patients working or in school.

C.

Network #14 published a manuscript titled *Partnering to Improve Rehabilitation Opportunities for Persons with End Stage Renal Disease in Texas* in the October 1999 issue of Advances in Renal Replacement Therapy. The article highlighted the collaborative activities with the TRC to increase the numbers of ESRD patients working or in school. A copy of the article was disseminated to all dialysis facilities.

D.

The Network continues its efforts to promote patient and facility rehabilitation activities. In support of the ***Life Options Rehabilitation Council*** (LORAC) goals the Network distributed LORAC patient and facility education materials. The Network maintains a supply of LORAC educational materials and disseminates them as requested to professionals and patients in the renal community.

E.
The Network annual meeting included presentations on both vocational rehabilitation and quality of life topics designed to educate and encourage facility professionals.

F.
The Network maintains a library of the ESRD related QOL instruments for facilities to review and consider for implementation. The PSC assisted facilities with the selection and implementation of QOL tools.

G.
The Network #14 patient newsletter included articles on the subject of patient empowerment and the importance and medical benefits of staying physically and mentally active. In addition, professional newsletters included articles encouraging professionals to encourage ESRD patients to participate in renal related community activities including the U.S. Transplant Games.

OBJECTIVE II
COLLABORATE WITH THE RENAL COMMUNITY AND REHABILITATION AGENCIES TO PROMOTE REHABILITATION

In support of this objective the Network performed the following during 1999.

A.
Refer to Goal C. Page 51.

B.
A TRC ESRD specific counselor provides the Network with consultations related to TRC and vocational rehabilitation. In addition, the counselor provides consultations to facility staff upon request.

OBJECTIVE III
PROMOTE THE USE OF MEDICALLY SUITABLE MODALITIES

In support of this objective the Network performed the following during 1999:

A.
Refer to Goal A. Objectives 1,2, 3

B.
The Network collects, analyzes, and disseminates facility specific, comparative vocational rehabilitation and modality utilization data including transplant referral and use of home dialysis.

C.
Vocational Rehabilitation data are collected from each facility via the use of the Annual Vocational Rehabilitation Activity Report. The report collects the following information on facility patients 18-55 as of the last day of the year:

- Employed full or part time
- Student full or part time
- Referred to VR agency
- Accepted by VR agency
- Working or student as a result of VR agency acceptance
- Retired due to age or disability
- Chooses not to seek employment or VR referral

The Network and the MRB review the Vocational Rehabilitation (VR) Activity Report annually. The 1999 data displayed in Table3 revealed that Texas facilities self reported that 22.8 percent (1,992) of their patients between the years of 18 and 55 years of age as of 12/31/99 were employed or attending school full or part time. Network #14 data compared favorably to the limited statistics published on VR rates. Eighty-seven percent (691) of the reported eligible patients (796) were referred to a VR agency. Of these, 24 percent (169) were accepted by a VR agency for training or assistance. A total of 70 patients were reported working or in school as a result of recent assistance from a VR agency in 1999.

Table 3: Texas Vocational Rehabilitation Activity N=8,713 patients 18-55 as of 12/31/99	
Percent of patients 18-55 years of age working or in school full or part time	22.8% (1,992)
Retired due to age, preference or disability	66.8% (5,825)
Homemaker or not choosing a vocational rehabilitation referral	24% (2,092)
*Total add up to greater than 100% due to multiple category reporting	

The goal of i**mproving the Quality of Life for ESRD Beneficiaries in the State of Texas** has been met for 1999. Ongoing activities will continue to assist ESRD patients. Based on a review of the activities designed to meet this goal the Network Executive Committee has recommended the

implementation of additional activities to meet patient needs in 2000.

E. GOAL - IMPROVE DATA REPORTING, RELIABILITY, AND VALIDITY BETWEEN ESRD PROVIDERS, NETWORKS, AND HCFA, THE TEXAS DEPARTMENT OF HEALTH AND OTHER RELATED AGENCIES AND ORGANIZATIONS; I.E. USRDS, CDC

OBJECTIVE I
PROVIDE INFORMATION ON PATTERNS, PROCESSES, AND OUTCOMES OF CARE TO SUPPORT QUALITY ACTIVITIES

In support of this objective the Network performed the following during 1999:

A.
Refer to Goal A. Objectives I A, B; Goal B. Objective III C, E, F
Objective IV A, B, C, D and Objective VII A, B.

B.
The Network prepared various statistical charts, graphs and presentations for reporting to the Network Coordinating Council. Presentations prepared included Incidence, Prevalence, Gross Mortality Rates, Adjusted Mortality Rates, Home Patient Percentages, and Percent of Patients Transplanted.

OBJECTIVE II
PROVIDE DATA TO SUPPORT THE NATIONAL MEDICAL INFORMATION SYSTEM IN A TIMELY MANNER AS DEFINED BY HCFA

In support of this objective the Network performed the following during 1999:

A.
During 1999, Network #14 processed and validated 7,338 Chronic Renal Disease Medical Evidence Reports (HCFA Form - 2728), and 4,279 ESRD Death Notifications (HCFA Form - 2746). There were 3,490 facility generated Monthly Patient Activity Reports processed validating new patients, expired patients, tracking patient transfers and changes in modality. Two hundred seventy - seven facility (277) surveys were processed, validated, and transmitted to HCFA.

B.
The Network has developed a *Monthly Patient Activity Report* that each provider submits to the Network office by the 10th of every month, along with the HCFA forms for the month's activities. Additionally, a Missing Forms Report is generated quarterly to notify providers out of compliance in submitting the required forms.

C.
Data infrastructure was maintained to collect the requested data from 261 Medicare approved dialysis facilities, 24 transplant centers, and one special provider for a children's' camp at year-end.

There were 20,975 dialysis patients in Medicare approved facilities throughout the Network's geographic area for the period ending December 31,1999. In addition, there are five Veterans Administration, one military, and one Department of criminal justice prison units in the Network that are not Medicare approved.

D.
The Network data system is configured under the Novell Networking environment and consists of a 486, 100 MHz dedicated server with 3-2 GB hard drives. 2-Pentium 233 MHz with 1.2 GB hard drive, 1-Pentium 100MHZ with 6 GB hard drive, 3-Pentium 133 MHz with 1.2GB hard drive, 1-Pentium 133 MHz with 6GB hard drive, 3-Pentium 166 MHz with 1 GB hard drive. The software currently installed is DBASE IV, Clipper Compiler, DOS version 6.2, , WordPerfect version 5.1,6.1,7.0, PC SAS, Anywhere, version 4.5, ProComm, Seagate Backup 3.2 GB version 4.5, Microsoft Office 95, Windows 97, and "Network Manager" (developed for Network #14 patient data base).

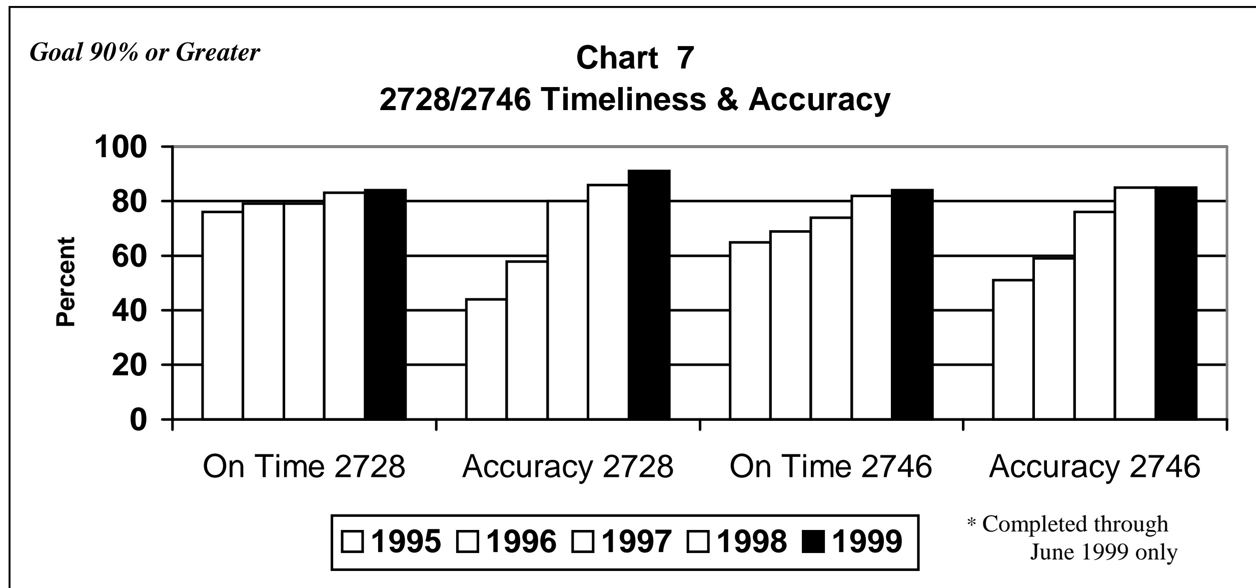
E.
In June 1999, HCFA delivered a Compaq server and installed internet service. In October 1999, HCFA delivered ten complete Dell computers, for the Network workstations. This equipment will be used to operate the SIMS application beginning January 2000.

OBJECTIVE III

MAINTAIN A 90% REQUIRED TIMELINESS AND ACCURACY COMPLIANCE RATE FOR ALL PROVIDERS

In support of this objective the Network performed the following during 1999:

During the first six-months of 1999, the Network mailed to each facility a listing of all forms (2728/2746) and any missing or inaccurate data fields that had been sent to the Network during the last six months of 1998. Percentages for timeliness and accuracy were also printed on each report for each facility as well as Network average, helping the facility to compare themselves with the entire Network. The facility percentages were stratified into quartiles, and the bottom quartile of facilities (n=51) was notified to prepare a Corrective Action Plan for timeliness, accuracy or both. Additionally, mentor facilities were made available to assist with education and process advice. Corrective Action Plans were sent into the Network in a timely manner; one CAP from each category was chosen to use for education purposes during 1999 in services. Improvements from April 1995 to June 1999 are shown in Chart 5.



OBJECTIVE IV

FOSTER ELECTRONIC TRANSMISSION OF DATA

In support of this objective the Network performed the following during 1999:

The Network Executive Director, Data Coordinator and Quality Management Coordinator participated as workgroup members in the development of the Standardized Information Management System (SIMS). During 1999, Network staff participated in the Data Elements, Standard and Portability and Output and Reporting Workgroups. The SIMS software is currently undergoing testing by individual Network offices and will be implemented January 3,2000.

IV SANCTION RECOMMENDATIONS

During 1999, the Texas Department of Health (TDH) identified a facility with serious or life threatening deficiencies during a survey. The Network #14 Medical Review Board reviewed the results of the survey and concurred that the circumstances described by the TDH were serious and life threatening. In the opinion of the MRB, the practices in the facility over time did not meet the standard of care and observed that the standardized mortality rate was consistently higher than the state average. The MRB expressed serious concern for the health and welfare of the patients due to the serious nature of the unmet safety measures common to dialysis procedures in multiple care delivery areas.

The MRB recommended facility closure and Medicare desertification. The TDH reported that no authority existed for this action in the TDH licensure program. Due to TDH Certification Division policy a Medicare survey was not performed in association with the TDH Licensure survey. The Network forwarded a letter to the HCFA Dallas Regional Office that contained the MRB's determination and the TDH actions. The facility was not closed, but was required by TDH rules to hire a temporary manager and discipline specific monitors to correct the deficiencies.

V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES

Although the Network has no official role in the approval process for new or expanded facilities with HCFA, the Network does monitor and review the overall capabilities within the area. The Network is fortunate in that any perceived need for additional or alternative services or facilities in order to meet Network goals is met immediately with an appropriate response from the provider community.

The Network received numerous contacts during the year from patients who stated that they were experiencing difficulty locating a facility after being dismissed due to attitude, behavior or non-compliance to physician's orders. Incidents of patients being dismissed from their facilities are a growing problem in the dialysis community. Upon Network investigation, the majority of patients that have been discharged have been provided adequate opportunities to correct the offending action prior to dismissal. In many cases, the facility is able to orderly locate a new facility for the patient to transfer.

In other cases (i.e., physically aggressive) such patients are dismissed prior to acceptance to another facility. This situation often results in patients needing assistance with locating a new facility. Under this scenario, patients often experience rejection from facilities under the same physician or corporate group. If this occurs, these patients must rely on hospitals to provide treatment on an emergent basis until a new facility is located. The Network is aware of a growing number of patients relaying on hospitals to receive their treatments due to the inability to locate an outpatient clinic for treatment.

Recommendations for alternative services

The Network recommends that HCFA foster the establishment of special needs dialysis facilities in the major metropolitan areas to serve displaced patients that require chronic dialysis yet do not have a chronic provider. It is anticipated that these special needs facilities would require at least the following special services to meet the needs of this increasing population of patients:

- Security guards & metal detectors
- Social Workers on staff whenever patients dialyzing
- Registered Nurses on staff whenever patients dialyzing
- Lower patient care staff to patient ratio
- Higher hourly pay rate for all staff; high risk/ hazard pay
- Psychological counseling on site

These additional services would certainly inflate the cost of delivering services to this population thus a higher reimbursement rate would be required for such facilities. Establishment of these special needs facilities could be fostered through:

- A HCFA sponsored demonstration project
- Waived requirement to justify higher reimbursement rate with historical costs for initial set

up of facilities

VI. DATA TABLES

END-STAGE RENAL DISEASE NETWORK #14
FACILITY SURVEY TOTALS FOR 1999

	TOTAL	IN-CENTER	HOME
Patients at beginning of year	19,160	17,392	1,768
		-35	35**
ADDITIONS during year:			
New Starts	6,395	5,973	422
Re-starts	135	128	7
Transferred from other units	4,009	3,594	415
Returned after transplant	364	337	27
Total additions	10903	10032	871
LOSSES during year:			
Deaths	4,233	3,911	322
Recovered Function	337	321	16
Received Transplant	874	722	152
Transferred to other units	4,005	3,568	437
Discontinued Dialysis	0	0	0
Lost of follow - up	2	2	0
Total losses	9451	8524	927
Total Patients at year end:	20612	18,865	1,747
Hemodialysis	18,924	18,858	66
Peritoneal	5	1	4
CAPD	690	3*	687
CCPD	993	3*	990

*Represents self-dialysis training patients.
** Patients reclassified from 1998
Note: Due to movement of home patients among home dialysis, self-care training and outpatient dialysis, accurate counts are not always available.

NEWLY DIAGNOSED CHRONIC ESRD PATIENTS

TABLE #1 **(ESRD INCIDENCE)**

Newly Diagnosed Chronic ESRD Patients by Age, Sex, Race & Primary Diagnosis for Calendar Year 1999

AGE:	TEXAS	OTHER*	TOTAL	PERCENT OF TOTAL
0-4	19	1	20	0.3%
5-9	11	1	12	0.2%
10-14	22	0	22	0.3%
15-19	44	1	45	0.7%
20-24	69	1	70	1.1%
25-29	154	2	156	2.3%
30-34	203	1	204	3.1%
35-39	310	1	311	4.7%
40-44	373	5	378	5.7%
45-49	496	8	504	7.6%
50-54	652	6	658	9.9%
55-59	694	10	704	10.6%
60-64	750	11	761	11.4%
65-69	836	13	849	12.8%
70-74	758	13	771	11.6%
75-79	630	8	638	9.6%
80-84	338	6	344	5.2%
> 85	179	8	187	2.8%
UNKNOWN	13	0	13	0.2%
TOTALS:	6551	96	6647	100.0%
RACE:				
Black	1676	13	1689	25.4%
White	2946	69	3015	45.4%
Native American	15	11	26	0.4%
Asian/Pac Islander	92	2	94	1.4%
Other	1807	1	1808	27.2%
Unknown	15	0	15	0.2%
TOTALS:	6551	96	6647	100.0%
SEX:				
Male	3360	45	3405	51.2%
Female	3191	51	3242	48.8%
Unknown	0	0	0	0.0%
TOTALS:	6551	96	6647	100.0%
PRIMARY DIAGNOSIS:				
Diabetes	3308	54	3362	50.6%
Hypertension	1463	19	1482	22.3%
Glomerulonephritis	678	9	687	10.3%
Cystic Kidney	194	2	196	2.9%
Other	844	12	856	12.9%
Unknown	64	0	64	1.0%
TOTALS:	6551	96	6647	100.0%

Date Prepared: 6/07/2000
Source of Information: Network Database

This table cannot be compared to the HCFA Facility Survey because the HCFA Facility Survey is limited to only outpatient dialysis patients initiating ESRD treatment in Medicare approved facilities. * Patients outside Network area

LIVING ESRD DIALYSIS PATIENTS

TABLE #2 (ESRD PREVALENCE)

All Active ESRD Patients by Age, Sex, Race & Primary Diagnosis on Calendar Year 1999

AGE:	TEXAS	OTHER*		TOTAL	PERCENT OF TOTAL
0-4	34	2		36	0.2%
5-9	21	0		21	0.1%
10-14	35	0		35	0.2%
15-19	87	0		87	0.4%
20-24	237	1		238	1.1%
25-29	491	2		493	2.4%
30-34	714	4		718	3.4%
35-39	1050	5		1055	5.1%
40-44	1380	12		1392	6.7%
45-49	1785	14		1799	8.6%
50-54	2158	24		2182	10.5%
55-59	2251	19		2270	10.9%
60-64	2418	23		2441	11.7%
65-69	2584	22		2606	12.5%
70-74	2390	22		2412	11.6%
75-79	1730	7		1737	8.3%
80-84	857	4		861	4.1%
> 85	435	5		440	2.1%
UNKNOWN	2	0		2	0.0%
TOTALS:	20659	166		20825	100.0%
RACE:					
Black	6522	44		6566	31.5%
White	7345	79		7424	35.6%
Native American	60	14		74	0.4%
Asian/Pac Islander	296	0		296	1.4%
Other	6281	28		6309	30.3%
Unknown	155	1		156	0.7%
TOTALS:	20659	166		20825	100.0%
SEX:					
Male	10412	82		10494	50.4%
Female	10247	84		10331	49.6%
Unknown	0	0		0	0.0%
TOTALS:	20659	166		20825	100.0%
PRIMARY DIAGNOSIS:					
Diabetes	9781	82		9863	47.4%
Hypertension	5044	41		5085	24.4%
Glomerulonephritis	2559	13		2572	12.4%
Cystic Kidney	696	6		702	3.4%
Other	2520	24		2544	12.2%
Unknown	59	0		59	0.3%
TOTALS:	20659	166		20825	100.0%

Date Prepared: 6/07/2000
Source of Information: Network Database

This table cannot be compared to the HCFA Facility Survey: The HCFA Facility Survey is limited to dialysis patients receiving outpatient services from Medicare approved facilities. These numbers may not reflect the true point prevalence.

TABLE #5 RENAL TRANSPLANTS PERFORMED
by Transplant Center for Calendar Years 1998 & 1999

Transplant Center	Total Transplants Performed		Patients Waitlisted*	
	1998	1999	1998	1999
450015	36	36	140	160
450018	71	88	205	183
450021	86	138	314	139
450040	N/A	8	N/A	15
450051	63	62	171	208
450054	24	32	38	39
450068	124	120	106	184
450083	27	21	49	47
450124	7	11	29	18
450135	64	41	37	32
450193	87	64	100	146
450213	46	47	46	236
450237	N/A	13	N/A	9
450358	30	36	57	110
450457	37	7	13	15
450563	N/A	20	N/A	20
450631	171	136	371	350
450647	N/A	4	N/A	7

460668	26	29	58	92
450686	12	15	12	9
450809	20	25	65	59
453300	3	7	7	1
453302	8	10	6	7
453304	12	20	10	6

TOTALS:	954	990

Date Prepared: 06/07/2000
Source of Information: 1998 & 1999 Facility Surveys
*These numbers are not added to State or Network totals as some patients may be placed on more than one waiting list.

TABLE #6

RENAL TRANSPLANT RECIPIENTS BY AGE, RACE, SEX & PRIMARY DIAGNOSIS NETWORK 14 TRANSPLANT CENTERS, CALENDAR YEAR 1999

AGE:	CADAVER	LIVING RELATED	LIVING UNRELATED	UNKNOWN
0-4	9	3	0	0
5-9	4	6	0	0
10-14	15	7	2	0
15-19	21	10	0	0
20-24	24	21	1	0
25-29	47	20	3	0
30-34	53	24	2	0
35-39	67	22	7	0
40-44	105	23	2	0
45-49	94	21	6	0
50-54	92	34	5	0
55-59	71	13	5	0
60-64	75	6	1	0
65-69	43	10	0	0
70-74	11	1	0	0
75-79	2	0	0	0
80-84	1	0	0	0
> 85	1	0	0	0
UNKNOWN	0	0	0	0
TOTALS:	735	221	34	0
RACE:				
Black	146	32	4	0
White	416	121	28	0
Native American	1	1	0	0
Asian/Pac Islander	16	2	1	0
Other	156	65	1	0
Unknown	0	0	0	0

TOTALS:	735	221	34	0
SEX:				
Male	421	126	22	0
Female	314	95	12	0
Unknown	0	0	0	0
TOTALS:	735	221	34	0
PRIMARY DIAGNOSIS:				
Diabetes	236	48	10	0
Hypertension	114	32	7	0
Glomerulonephritis	186	63	7	0
Cystic Kidney	92	26	8	0
Other	62	40	2	0
Unknown	45	12	0	0
TOTALS:	735	221	34	0

Date Prepared: 06/07/2000

Source of Information: Network Database

TABLE # 7

DIALYSIS DEATHS

Deaths of Dialysis Patients by Age, Sex, Race, Primary Diagnosis and Causes of Death for Calendar Year 1999

AGE:	TEXAS	OTHER*		TOTAL	
0-4	4	0		4	
5-9	1	0		1	
10-14	3	0		3	
15-19	8	0		8	
20-24	16	0		16	
25-29	27	0		27	
30-34	51	0		51	
35-39	104	0		104	
40-44	162	1		163	
45-49	222	0		222	
50-54	291	2		293	
55-59	385	9		394	
60-64	478	10		488	
65-69	601	9		610	
70-74	686	11		697	
75-79	623	5		628	
80-84	343	3		346	
> 85	241	7		248	
UNKNOWN	2	0		2	
TOTALS:	4248	57		4305	
RACE:					
Black	1114	10		1124	
White	2053	38		2091	
Native American	14	4		18	
Asian/Pac Islander	36	0		36	
Other	996	5		1001	
Unknown	35	0		35	
TOTALS:	4248	57		4305	
SEX:					
Male	2109	16		2125	
Female	2139	41		2180	
Unknown	0	0		0	
TOTALS:	4248	57		4305	
PRIMARY DIAGNOSIS:					
Diabetes	2295	27		2322	

Hypertension	977	8		985	
Glomerulonephritis	359	5		364	
Cystic Kidney	70	4		74	
Other	532	16		548	
Unknown	12	0		12	
TOTALS:	4245	60		4305	
CAUSE OF DEATH:					
Cardiac	1910	28		1938	
Vascular	406	9		415	
Infection	695	6		701	
Liver Disease	42	0		42	
Gastrointestinal	55	0		55	
Other	1078	8		1086	
Unknown	62	6		68	
TOTALS:	4248	57		4305	

Date Prepared: 06/07/2000
Source of Information: Network Database
This table cannot be compared to the HCFA Facility Survey; the HCFA Facility Survey is limited to those ldeaths reported by Medicare approved facilities. *Patients outside Network area