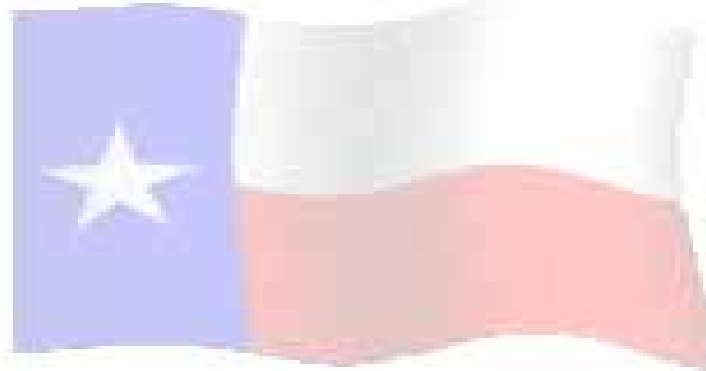


**THE END STAGE RENAL DISEASE
NETWORK OF TEXAS, INC. #14**

**2001
ANNUAL REPORT**



**The End Stage Renal Disease Network of Texas, Inc. (#14)
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The End Stage Renal Disease Network of Texas (#14) is under contract #500-00-NW14 with the Centers for Medicaid & Medicare Services, Baltimore Maryland

I. PREFACE

I.A Introductory Statement of the Chairman

June 2002

As Chairman of the End Stage Renal Disease Network of Texas, Inc. it is my pleasure to endorse and submit the 2001 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, 2001 through December 31, 2001.

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 2001. We recognize the spirit of cooperation of facility staff who provided data and information to the Network on a continuing basis.

2001 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 increased the timeliness and accuracy of data gathered. In 2001, the Network continued to work in a collaborative relationship with the Texas Department of Health to evaluate and improve 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.

**End Stage Renal Disease Network of Texas, Inc. (#14)
2001 Annual Report
I. B. Table of Contents**

I. Preface	
A. Statement of Chairman	2
B. Table of Contents	3
II. Introduction	
A. Network Demographics	4
B. Organizational Structure	7
III. Network Activities	
Goals and Objectives	11
Mission and Vision Statements	12
A. <i>Goal-Improving the Quality of Health Care Services and Quality of Life For ESRD Beneficiaries</i>	13
B. <i>Goal- Perform Special Studies Developed By The Medical Review Board, CMS, TDH, USRDS, And Other Agencies</i>	23
C. <i>Goal- Establishing and Improving Partnerships and Cooperative Activities Among and between the ESRD Networks, Peer Review Organizations, State Survey Agencies, ESRD facilities/ Providers, ESRD Facility owners, Professional Groups, and Patient Organizations.</i>	33
D. <i>Goal- Evaluating and resolving patient grievances as categorized in the Standardized Information Management System (SIMS)</i>	37
E. <i>Goal- Improving Data Reliability, Validity, and Reporting between ESRD Facilities/Providers, Networks and CMS and Other Related Agencies</i>	43
IV. Sanction Recommendations	45
V. Recommendations for Additional Facilities and Services	46
VI. Data Tables	48
A. Table 1: ESRD Incidence	49
B. Table 2: ESRD Dialysis Prevalence	51
C. Dialysis Patients Modality and Setting-Status on 12/31:	53
1. Table 3: Home	54
2. Table 4: In-Center	62
D. Renal Transplants	71
1. Table 5: Number by transplant State	
2. Table 6: Number by transplant type, age, race, sex, and primary diagnosis	72
E. Table 7: Dialysis Deaths	73
F. Table 8: Vocational Rehabilitation	75

II. INTRODUCTION

II. A. ESRD NETWORK OF TEXAS #14 DESCRIPTION

Texas Historical Highlights, 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.

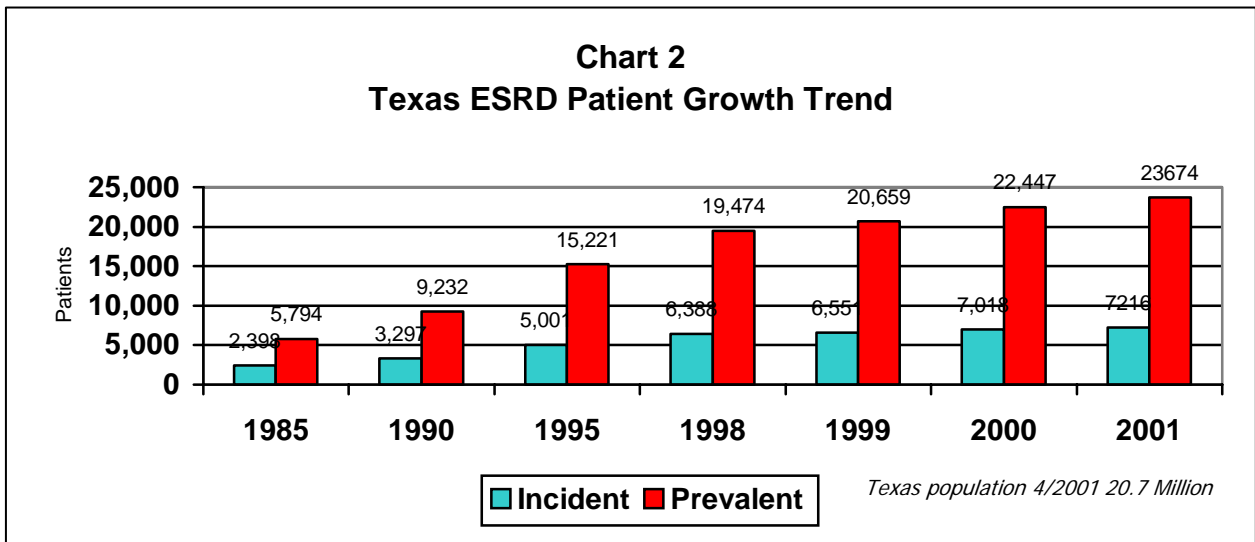
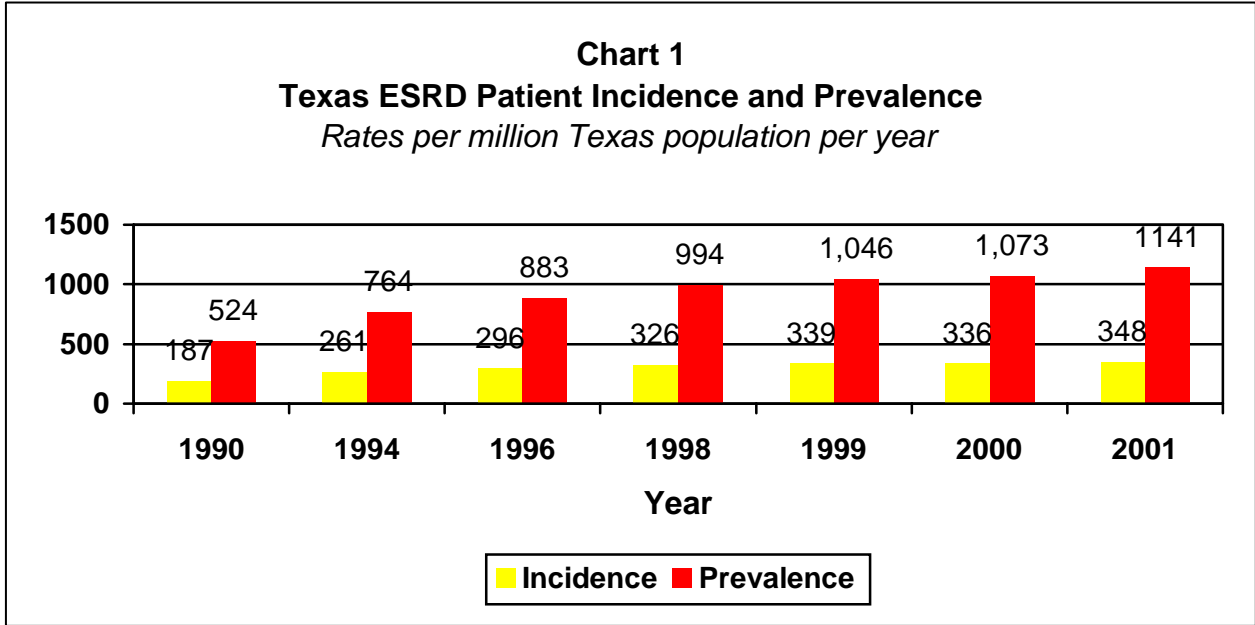
No less than three countries have claimed ownership of Texas prior to the US, including Spain, France and Mexico in the past 300 years. Geographically, Texas is the second largest state in land area behind Alaska with 267 thousand square miles of land. Texas is also the second most populous state in the nation behind California with an estimated population of 20.9 million residents in 2001. The state population increased 22.8 percent from 1990-2000, well above the 13.2 percent national population increase for this same period. In 2000, nearly 8 percent of the nation's population resided in Texas. Texas' metropolitan areas (Austin, Houston, San Antonio, Dallas) show fast population growth, while most of the non-metropolitan counties recorded either a slow growth or population decline. Three cities in Texas are among the largest ten cities in the US in 2000 (Dallas, Houston, San Antonio). Of the top ten fastest growing metropolitan areas from 1990-2000 in the US, three are in Texas; McAllen-Edinberg-Mission, Austin-San Marcos, Laredo. Two of these three areas border Mexico (McAllen, Laredo) where growth is occurring in nearly all areas. Nationwide, the population increased 21 percent in all counties bordering Mexico in the US from 1990-2000. 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.

Most minority groups will make up increasing percentages of the Texas population in the next three decades. Whites made up 71 percent of the Texas population in 2000, decreasing from 86% since 1999. According to state projections, by the year 2010, the white population will drop to 37 percent, while people of Hispanic origin, comprising 32 percent of the state population in 2000 are projected to comprise 46 percent of the population, increasing from 27 percent in 1993. In 2000, nearly one of five Hispanics in the country calls Texas home, with 18.9 percent (6.7 million) of the total U.S. Hispanic population residing in Texas, the third highest state for percent Hispanic population behind California and New Mexico. Hispanics were the majority population in 34 counties in Texas. The states Hispanic growth is fueled in nearly equal measure by immigration and natural increase. The immigration increase is of concern in the ESRD arena due to predictable problems for immigrants in obtaining health care, particularly in a population that is predisposed to Diabetes, and thus ESRD. Blacks, at 11.5 percent in 2000, are expected to make up 9 percent of the Texas population by the year 2010, decreasing 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. In 2000 9.9 percent of the Texas population was 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 2000 this had increased to 336 per million. The prevalence of ESRD in Texas has followed the same sharp upward trend. In 1990, **348** out of each million Texans had a diagnosis of ESRD, by 2001 the unadjusted prevalence rate for the Texas population had climbed to **1,141** per million (Chart 1).

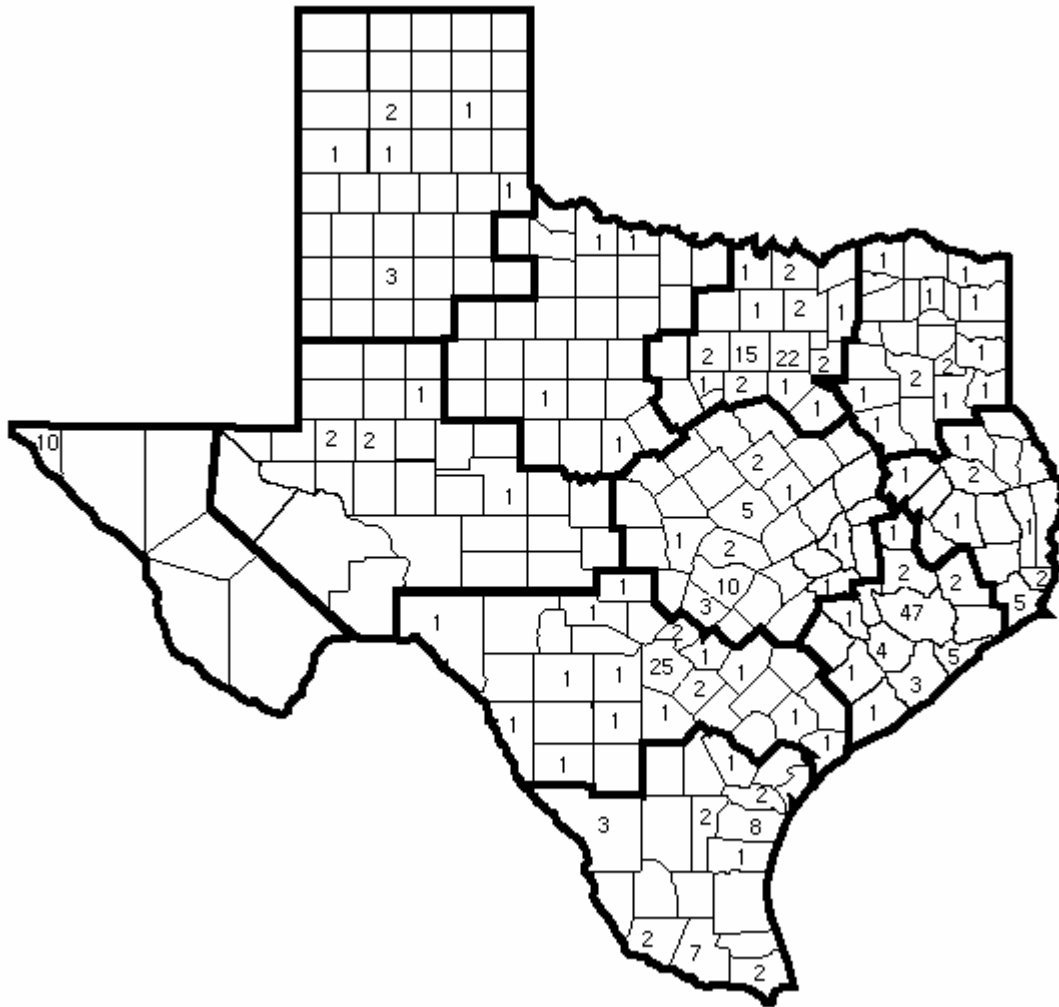
At the end of 2001, **30,047** persons were receiving renal replacement therapy (dialysis and transplant combined) in Texas. Of these **23,674** were either receiving hemodialysis or peritoneal dialysis, a **5.4 percent** increase over 2000. In 2001, **7,216** newly diagnosed persons with ESRD began receiving dialysis, a **3 percent** increase over 2000. Both the incidence and prevalence rates have doubled when compared to the rates at the beginning of the decade. (Chart 2)

Location and Number of ESRD Facilities

At the end of 2001, Texas had a total of **295** Medicare approved dialysis facilities located in **90** of the **254** Texas counties. Thus, facilities are located in **35.4** percent of Texas counties, a **13** percent increase over 1997. Harris County (Houston area) has the most facilities (**n=47**), Bexar County (San Antonio area) the second highest number (**n=25**) and Dallas County

(Dallas area) the third highest number (**n=22**).

Twenty-three transplant centers and **one** special renal children's' camp was also in operation. In 2001, **5,702** dialysis stations were available for use in dialysis facilities as reported in the SIMS system. The greatest availability of dialysis facilities are concentrated in highly populated urban areas, and also in some border counties. There are three VA, one military, and one criminal justice non-Medicare Certified dialysis facilities operating in Texas.



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, BSN, CNN, CPHQ,
Quality Management Coordinator

Debbie O'Daniel, Office Manager

Bobbie Knotek, BSN, CNN, Assistant
Quality Management Coordinator

Ramiro Valdez, Ph.D., Patient Services
Director

Arleene Thomas, Data Event Specialist

Gay Graeke, BS, QI & Social Services
Clerk

Terri Bollinger, RT, Data Clerk

Doris Wilson, Data Clerk

Leigh Husni, BS, Project Assistant

Joshua Conley, IT Services

Cindy Wright, RN, CNN, CCRN, USRDS
Nurse

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 (MRB) 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 MRB and that ESRD facilities and providers follow the recommendations of the MRB (Section 9335 {g}).

The purpose of the MRB 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 2001, the MRB members participated in six full day Board meetings and seven 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, 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 to 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	<i>John Bell, MD</i> Nephrologist Bedford, Texas
Vice Chairman	<i>Richard Gibney, MD</i> Nephrologist Waco, Texas
Secretary	<i>Cleve Collins, MD</i> Nephrologist San Antonio, Texas
Treasurer	<i>Pat Dubose, RN</i> Nephrology Nurse Houston, Texas
Member at Large	<i>Dick Maggart</i> Patient Granbury, Texas
Member at Large	<i>Susan Raulie, RN</i> Facility Administrator Corpus Christi, Texas
Member at Large	<i>Melvin Laski, MD</i> Nephrologist Lubbock, Texas
Immediate Past Chair	<i>Michael Stoltz, MD</i> Nephrologist Ft. Worth, Texas
MRB Chairman	<i>James Cotton, MD</i> Nephrologist Tyler, Texas

Medical Review Board

Nephrologists

James Cotton, MD, Tyler, Texas
Chairman

Robert Hootkins, MD, Austin, Texas
Vice-Chairman

James Lindley, MD, Austin, Texas
Immediate Past-Chairman

Fernando Raudales, MD El Paso, Texas

Janis Birchall, MD Corpus Christi, Texas

Steven Rosenblatt, MD
San Antonio, Texas

Ruben Velez, MD Dallas, Texas

Pediatric Nephrologists

Stuart Goldstein, MD Houston, Texas

Mouin Seikaly, MD Dallas, Texas

Transplant Surgeons

Kristene Gugliuzza, MD
Galveston, Texas

Charles Van Buren, MD
Houston, Texas

Nurses

Eva Garza, RN, CNN
Corpus Christi, Texas

Beverly Williams, RN, CNN
Abilene, Texas

Social Workers

Mary Beth Callahan, LMSW
Farmers Branch, Texas

Mary Havlovic, LMSW 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
Lewisville, Texas

III. NETWORK GOALS AND ACTIVITIES

National Network Goals and Objectives

Network #14, consistent with all ESRD Networks, supports national goals included by the Center for Medicare and Medicaid Services (CMS) in the 2000-2003 Statement of Work for ESRD Networks. These national goals provide 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 CMS (or other appropriate agency);
- Establishing and improving partnerships and cooperative activities among and between the ESRD Networks, Quality Improvement Organizations, State Survey Agencies, and ESRD providers, ESRD facility owners, professional groups and patient organizations;
- Evaluating and resolving patient grievances as categorized in the Standard Information Management System (SIMS).

In addition, a set of goals and responsibilities in support of CMS's Health Care Quality Improvement Program (HCQIP) were articulated by CMS in the 2000 –2003 Statement of Work that the Network supports. 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 assist providers in assessing and improving the care provided to Medicare ESRD beneficiaries by establishing a Network quality improvement program that includes quality improvements projects (QIPs), collection and monitoring of clinical performance measures (CPM's) at a regional (Network) and provider level, and conducting other quality improvement activities. 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.

**ESRD Network of Texas, Inc.
#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 CMS, 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

We will collect data and information electronically and support the community to transition to electronic data transmission, be a user friendly source of information for providers and patients that is available as needed, either directly or through links, provide timely meaningful and significant internet based information and tools regarding the provision and outcomes of ESRD care in Texas.

**ESRD Network of Texas, Inc. #14
Specific Goals**

The Executive Committee and Medical Review Board regularly review the ESRD Network of Texas #14 goals 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 CMS 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 CMS, 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.

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

III. A. GOAL – IMPROVING THE QUALITY OF CARE OF HEALTH SERVICES AND QUALITY OF LIFE FOR ESRD BENEFICIARIES

In support of this goal the Network performed the following during 2001:

Education Activities

A. Assisted in the development of CMS Patient Education Book

The Assistant Quality Management Coordinator served on the CMS national workgroup to develop the contents of the standardized New Patient Packet. A major component of the packet, the educational book, was partially adapted from the ESRD Network #14's patient book *Life Goes On... After Your Kidneys Stop Working.*"

At the request of CMS, Network #14 provided comments and suggestions on draft chapters of the book. Specifically the Network recommended that the book be written with large print and easily readable language to improve readability. In addition, the Network recommended increased focus on self-care responsibilities. The Network recommended that the lengthy safety component in the draft be deleted from this initial education book and developed into a separate publication. When a New Patient Packet is returned due to an undeliverable address, the Network identifies the patient's current facility and forwards the packet to the facility with the request that it be given to the patient.

The CMS New Patient Packet was sent to **7,216** patients in 2001. Between January 2001 and October 2001, the patient education component of the new patient packet was the AAKP Patient Plan – Phase 1. A letter from the ESRD

Network Executive Director included in the mailing by the Forum of Network office. is

The Network continues to provide two copies of the original Network #14 book, *Life Goes On...After Your Kidneys Stop Working*, to new facilities for placement in their patient education library. An order form for a copy-ready master of the book is included in this mailing. The book is provided to patients or family members as an educational resource.

B. Lone Star Newsletter- Patient Newsletter

Network #14 published the *Lone Star Newsletter* once in 2001 in both English and Spanish. The newsletter was mailed in bulk to each Texas ESRD facility for dissemination to patients by *the Facility Patient Representative* or facility staff. The issue included articles on:

- Texas ESRD patient success stories
- Review of AAKP organization
- Transportation information
- Dialysis and transplant websites
- CMS Dialysis Compare website
- How to handle complaints about care or services in clinic
- Patient resources

C. Lone Star Bulletin-Professional Newsletter

Network #14 published the *Lone Star Bulletin* once in 2001. Multiple copies of the newsletter were mailed to each Texas ESRD facility. Issues included articles on:

- Network #14 operations and personnel
- Patient safety
- Transplant referral activity
- CMS Dialysis Compare web site

- New federal regulations
- Network educational offerings
- Dialysis machine maintenance issues
- Tips for completing CMS forms
- Patient and professional resources

D. ESRD Network #14 Web Site

Network #14 maintains a web site (www.esrdnetwork.org) for the dialysis community. The web site includes information and resources on ESRD outcome data, location of dialysis facilities, Dialysis Facility Compare, copies of Network #14 Professional & Patient Newsletters, QM resources and links to all the major renal organizations including, the National Kidney Foundation, NKF-Dialysis Outcomes Quality Initiatives Guidelines and the American Association of Kidney Patients. The site was designed to assist individuals with reading disabilities and vision barriers to access the information.

E. RPA/ASN Shared Decision– Making in the Appropriate Initiation of Withdrawal from Dialysis Clinical Practice Guidelines

Network #14 continues to disseminate the *Renal Physicians Association & American Society of Nephrology Shared Decision-Making in the Appropriate Initiation of Withdrawal from Dialysis Clinical Practice Guidelines* by providing a copy to all new facilities and distributing copies upon request.

F. Broadcast Fax/e-mail Education

Network #14 continues to use broadcast fax or e-mail to notify ESRD facilities of important patient care concerns, renal organization programs or general Network #14 education issues. Seventeen broadcast faxes were sent in

2001 by the QM department. Clinical alerts included:

- Texas Department of Health Preliminary Outcome Indicators Report
- Notice of upcoming Positive Professionals-Positive Patients meetings throughout Texas in 2001
- Announcement of Renagel assistance funds
- Baxter dialyzer recall
- A call for attendance at the patient conference scheduled in conjunction with the annual meeting
- Quality Improvement Project data

G. Resource List

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 include:

- AAKP Advisory on Inadequate Dialysis for HD & PD
- AAKP Patient Plan – Phases 1-4
- AKF pamphlets on kidney disease and treatment
- Centers For Disease Control National Surveillance Of Dialysis Associated Infectious Diseases Report and Centers For Disease Control Infection Control and Prevention Recommendations
- ESRD Network Forum Medical Record Model
- Federal And State ESRD Facility Regulations
- CMS Coverage of Kidney Dialysis and Kidney Transplant Services
- CMS Disaster Preparedness Manual
- CMS Hospice Benefits
- CMS Know Your Number Brochure
- CMS Mammograms
- CMS Preparing For Emergencies: For People On Dialysis
- CMS Preventive Services
- CMS Women with Medicare

- CMS Guide For Improving Care To ESRD Patients
- CMS National Core Indicator & Clinical Performance Measures Reports
- Life Options Rehabilitation Council - Rehabilitation Resources
- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services
- Network #14 Network of Texas Disaster Manual
- Network #14 List of Dialysis And Transplant Centers
- Network #14 Core Indicator Run Charts
- Network #14 Criteria and Standards
- Network #14 Facility Representative Job Description
- Network #14 Why Am I So Thirsty Booklet
- Network #14 Life Goes On...After Your Kidneys Stop Working
- Network #14 Treatment Agreement Guide
- Network #14 Disaster Preparedness For Dialysis Facilities
- National Kidney Foundation, American Association Of Kidney Patients, American Kidney Fund Pamphlets And Periodicals
- National Kidney Foundation-DOQI Guidelines
- National Kidney Foundation Pamphlets On Kidney Disease
- NIDDK Eat Right To Feel Right On Hemodialysis
- NIDDK Diabetes and Kidney Disease
- Renal Physicians Association Clinical Practice Guidelines And Position Papers
- RPA/ASN Shared Decision-Making in the Appropriate Initiation of Withdrawal from Dialysis Clinical Practice Guidelines
- Texas Department of Health Quality of Care Indicators Report
- Texas Rehabilitation Commission

Offices Locations

- Transplant Education Pamphlets from Fujisawa
- United Network Of Organ Sharing – What Every Patient Needs To Know
- Vascular Access Selection And Care Video

H. Network Annual Coordinating Council Meeting

A one and one-half day educational conference was conducted in November in Dallas for nearly 500 attendees that included plenary and discipline specific breakout sessions. Program presentations included the following titles:

- Positive Professionals - Positive Patients
- Management of Secondary Hyperparathyroidism in ESRD Patients: Updating the Use of Recently Developed Vitamin D Analogs
- Executive Director Report on Network Accomplishments and Goals
- Network Chairman Report
- Medical Review Board Report
- ESRD Patient Safety-A National Health Care Priority
- LORAC: Results of Network #14 Collaborative Study
- Avoiding Patient Dismissal
- Innovative Staffing Patterns
- Team Building
- The Care and Feeding of Nurses in a Supervisory Role
- PD Expert Panel
- Peritonitis Management
- Peritoneal Dialysis Show 'n Tell Exhibit
- ESRD Network of Texas, Inc. Revised Social Work Standards
- Completing HCFA/Network and Texas Kidney Health Care Forms
- Complaints/Grievances and the ESRD Network Grievance Process in Texas

- CMS Reimbursement for Diabetes and Renal Disease
- Clinical Strategies in Treating Low Bicarbonate Levels
- Diabetes Control in ESRD
- Enteral Nutrition for the ESRD Patient Through the Continuum of Care

I. Network Patient Care Technician Educational Workshops

In support of the Network's efforts to increase professionalism in unlicensed staff and to improve patient staff communications, Network #14 organized nine regional one-day workshops to provide education to unlicensed dialysis facility staff on understanding and responding to treatment non-compliance, professionalism and proactively recognizing and responding to escalating verbal and physical patient behaviors.

Assist Providers In Establishing & Maintaining Dynamic, Ongoing Quality Management & Outcomes Assessment Programs

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 to achieve the objective of assisting providers establish and maintain effective facility specific quality management programs.

A. The Network#14 Quality Assurance/Improvement Manual

The Network #14 Quality

Assurance/Improvement Manual was provided to all facilities that opened in 2001 and to facilities requesting additional copies. The Network QM manual includes numerous quality assurance/improvement studies, inclusive of instructions and forms, based upon the ESRD Network #14 Criteria and Standards.

B. Network #14 Core Indicator Run Charts

An updated and comprehensive set of run charts were developed and made available to each Texas dialysis facility in hard copy, computer disk or email. The run charts included a Texas or national comparison and, if applicable, the 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 was expected that the facility implement quality improvement activities.

C. Phone & Onsite Quality Management Consultations

Network #14 quality management personnel provided telephone and onsite consultation for numerous dialysis facilities requesting assistance developing their quality management program or facilitating a quality improvement activity. The Network 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 staff was also invited to participate in and facilitate quality

improvement projects onsite with facilities during the year. Consultations included the subjects of hemodialysis adequacy, peritoneal dialysis, vascular access management and patient/staff relations.

D. Educational Presentations

Network staff prepared and presented over 60 presentations at Network #14, regional and national meetings of renal professional organizations on a wide variety of subjects including numerous educational programs designed to assist patients and professionals learn more about ESRD, modality specific information and methods of improving outcomes. Meetings included programs sponsored by ESRD Networks, American Nephrology Nurses Association, American Association of Kidney Patients, American Kidney Fund, CMS, national dialysis corporations, and the National Kidney Foundation. *Refer to Page 36 that lists topics presented.*

E. Network #14 Criteria & Standards

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 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
- 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

F. Network #14 Social Work Criteria & Standards Revisions

The Social Work Standards revisions were completed in October 2001. The standards were distributed to every clinic in Texas, other Networks, renal corporation offices, and professional organizations such as LORAC and CNSW.

The Standards were developed under the leadership of the Social Worker representatives on the Medical Review Board. The Standards were exceptionally well received by social workers throughout Texas and nationally as noted by positive discussion on the National Kidney Foundation Council of Nephrology Social Worker list server.

While the Standards are a revision of the extant Standards, a new recommendation is for a ratio of 1 full time social worker to every 75- 100 hemodialysis patients unless the social worker has an assistant, when the recommended ratio is 1 to 125.

As is the case with all Network Criteria and Standards, the revised standards are merely a recommendation.

G. Support & Use of National Practice Guidelines

All comparative data reports provided to facilities as part of the Network #14 quality improvement projects and core indicator reporting include references to the *National Kidney Foundation – Dialysis Outcomes Quality Initiatives (NKF-DOQI™) Practice Guidelines* and other sources.

In addition, in support of the DOQI™, the Network highlighted DOQI recommendations in both professional and patient educational information. Specifically, the Network developed dialysis adequacy and vascular access educational materials and tools that referenced the DOQI guidelines. These were disseminated to the Texas dialysis community in conjunction with a quality improvement project.

A Network patient newsletter highlighting the NKF-DOQI guidelines previously published in both English and Spanish has been reprinted and is made available to both dialysis patients and staff.

H. Certified Professional in Health Care Quality

The Executive Director and QM Coordinator met the continuing

education requirements to maintain the national credential as *Certified Professionals in Healthcare Quality*.

I. Network #14 Medical Review Board Encouraged Use of Quality Management Activities

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.

J. Dissemination of 2001 Texas Department of Health Quality of Care Indicators Report

In collaboration with the Texas Department of Health, Network #14 collected facility specific dialysis adequacy, anemia, iron, renal osteodystrophy and peritonitis management outcome data utilizing a pilot data collection system developed by ESRD Network #11 to collect patient lab data electronically from the national dialysis facility laboratories. Facilities not associated with a national laboratory provided data via computer disk or hard copy.

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. DOQI™ recommendations were included in the report.

K. Dissemination of 2000 Unit-Specific Reports

The *University of Michigan Kidney Epidemiology and Cost Center 2000 Unit-Specific Reports* were disseminated during 2001. Included were facility specific Standardized Mortality, Hospitalization and Transplantation Ratios. Also 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, Governing Body, and corporate management.

Facility leadership was requested to review their facility specific data and if opportunities to improve were identified, initiate a quality improvement project.

L. Dissemination of 2000 CMS National Clinical Performance Measures Report

The 2000 *CMS National Clinical Performance Measures Reports* were disseminated and Network #14 results were highlighted in professional newsletters and during presentations.

M. Dissemination of 2000 Centers for Disease Control (CDC) National Surveillance of Dialysis Associated Diseases Report and Infection Control Recommendations

The 2000 CDC National Surveillance of Dialysis Associated Diseases Report and Infection Control Recommendations were disseminated along with comparison charts reflecting Texas dialysis community practices as compared to the nation.

Promote The Use of Medically Suitable Modalities

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 being equal to or above the Network average.

These goals are based on prior years that have been taken from yearly facility data collection. The Medical Review Board has 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. In 2001 access to transplantation as a modality was the focus of activity of the Medical Review Board. Network staff, in consultation with the Medical Review Board, reviewed facilities that fell significantly below the Network goals established by the MRB.

Additionally, a list of facilities offering home hemodialysis training and follow-up is maintained at Network #14. This facility list is provided upon request to patients and staff who request the locations of home hemodialysis training.

Patients who communicate with Network staff about difficulties with their current modality are counseled on alternative modalities, provided modality education resources and encouraged to discuss their potential for changing modalities with their nephrologists.

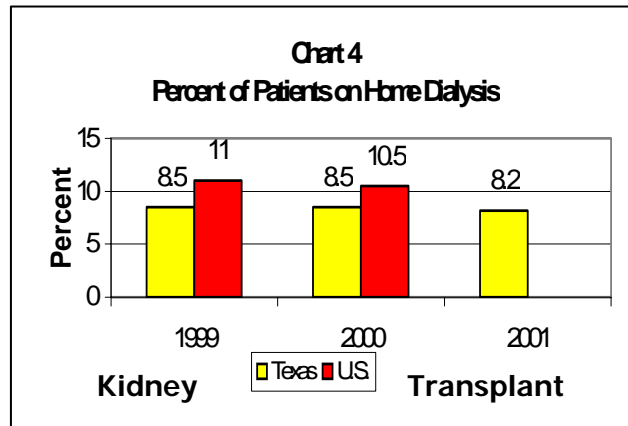
A Peritoneal Dialysis breakout session was added to the Network Annual meeting in 2001.

Special Project in Access to Care

At the request of a public hospital, the ESRD Network and Medical Review Board collaborated to expedite the transfer of several newly diagnosed ESRD patients who were unable to be placed into community facilities due to reported staff shortages. Due to increased numbers and acuity of patients at the public hospital, these patients awaiting placement were limited to one to two dialysis sessions per week. This treatment frequency placed the patients at increased risk of morbidity. The Network communicated with local dialysis facilities and arranged for a physician mediator to expedite the placement of patients. The community supported the Networks requests for patient placement and many patient placements occurred.

newsletters. The New Patient Book is mailed directly to the patients home.

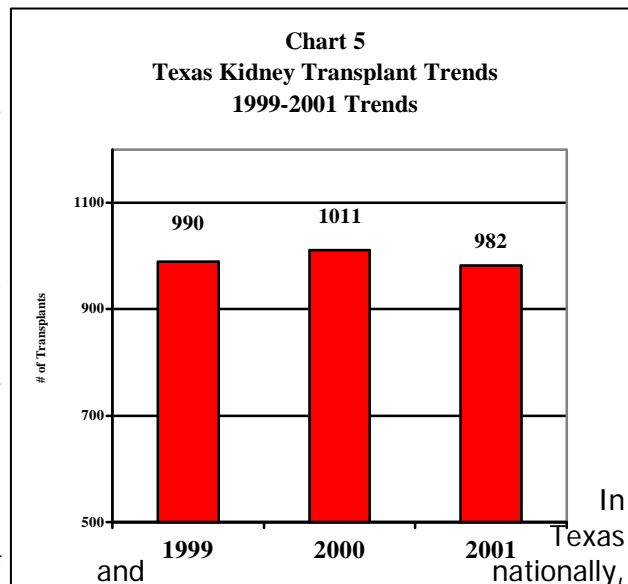
Network #14 financially supported and presented at numerous publicized regional and national patient meetings that included information on modality selection.



Home Peritoneal & Hemodialysis Utilization

The percent of Network #14 ESRD patients receiving home dialysis (hemodialysis and peritoneal dialysis combined) in 2001 was **8.2** percent compared to **8.5** percent in 2000. Nationally **10.2** percent of patients dialyzed at home in 2000. No national data for 2001 has been published to date. Nationally and in Network #14, the percentage of home dialysis patients continues to decrease; however, new therapies related to home dialysis are emerging and may reverse this downward trend. (Chart 4)

Network #14 encouraged selection of alternative modalities by providing all ESRD patients the use of the Network #14 New Patient Book titled "Life Goes On," the CMS new patient book, "You Can Live," American Association of Kidney Patients Patient Plan and patient



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. (Chart 5)

Transplant Modality Initiatives

In 2001, the Network continued a process of collecting, profiling and reporting statewide and facility specific transplant activity data. Each facility is provided with facility specific data charts compared to statewide averages.

Based on concerns with a small cohort of facilities reporting a higher than expected number of patients transplant status as *unknown*, *refused* transplant or *unsuitable* during 2000 the MRB initiated a quality improvement project to focus attention on Texas dialysis facility patient education and referral practices.

The MRB selected facilities that reported referring less than 20 percent of patients for transplantation or greater than or equal to 70 percent of patients reported as *status unknown*, *refused* transplant or *unsuitable*.

In the opinion of the MRB, not more than 10 percent of a facility's patients should be reported as status *unknown*. Facility Medical Directors were asked to submit to the Network facility policy and procedures, transplant program exclusion criteria and an explanation of their reported data. The results identified that many of the facilities often did not report accurate data and/or acknowledged that their facility did not have an organized process to educate and refer patients.

To help promote referral and kidney transplantation in the Texas dialysis community, the Network continued to invite transplant specific organizations to answer questions and provide educational resources for attendees of the Network annual meeting.

In addition, the Network distributes transplant related educational materials designed for both professionals and patients at Network meetings and upon request.

Rehabilitation Initiatives

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.

Vocational Rehabilitation data are collected from each facility via the use of the Annual Vocational Rehabilitation Activity Report. The form was reviewed and revised by a MRB subcommittee of Texas Social Workers in 2001. The report collected the following information on facility patients 18-55 as of the last day of the year:

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

The Network and the MRB annually review the Vocational Rehabilitation (VR) Activity Report. The 2001 data displayed in Table 1 reveals that Texas facilities reported that **23.7 percent** of patients between the years of 18 and 55 years of age, as of 12/31/01, were employed or attending school full or part time and **10.5 percent** were referred for vocational rehabilitation services. Nationally, **24.7 percent** of

patients were working or in school and **12.3 percent** were referred for vocational rehabilitation services.

To help promote rehabilitation in the Texas dialysis community, the Network partnered with the Texas Rehabilitation Commission (TRC) to offer a complimentary educational session during the ESRD Network annual meeting for TRC counselors on the subject of ESRD, treatment and developing collaborative relationship with dialysis facilities in their work area. Unfortunately, only one counselor registered to attend which caused the meeting to be cancelled.

The Network continues to distribute rehabilitation and quality of life educational materials designed for both professionals and patients at Network meetings and upon request.

Activities conducted have achieved the goal of improving the quality of care of health services and quality of life for ESRD beneficiaries.

	1999	2000	2001
Number of patients 18-55 Years of age	8,782	8,943	9,604
Percent of patients working or in school full or part time	23	25	23.7
Percent patients referred to Texas Rehabilitation Commission (TRC) or other VR agency	8	8	10.5
Percent of patients accepted by TRC or other VR agency	2	2	2.5
Percent of patients reported to be retired due to <i>disability</i>	67	78	48.7
Percent of patients reported to be retired due to <i>age or preference</i>	18	18	5.5
Percent patients who are homemaker or not choosing a vocational rehabilitation referral	24	24	22
Totals may not equal 100% due to multiple category reporting			

III.B. GOAL-Perform Special Studies Developed By The Medical Review Board, CMS, TDH, USRDS, And Other Agencies

A. 2001 CMS ESRD Clinical Performance Measures (CPM) Project

This 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 Performance Measures Project involves the joint efforts of CMS, the Network and the dialysis community. Each year of the project, CMS selects a random sample of over 8,000 adult in-center hemodialysis and 1,000 peritoneal dialysis patients. The sample is representative on the national and Network level with a sample size sufficient to provide statistical confidence.

In 2001, the Network disseminated, collected, reviewed, corrected, and transmitted to CMS on the contracted schedule, CPM Forms from **223** facilities on **585** hemodialysis patients and **84** peritoneal dialysis patients. Facility CPM forms were collected on **10** facilities.

Additionally, a data validation activity was conducted on a 5 percent sample. In 2001, the Network also disseminated, collected, reviewed, corrected and transmitted to CMS on the contracted schedule, CPM forms from 3 Veteran's Administration Hospitals on **195** hemodialysis patients and **18** peritoneal dialysis patients. Each VA facility completed a facility CPM.

The 2001 *CMS ESRD CPM Report* was disseminated to each dialysis facility. The 2001 Annual Report is the 8th report published to date and documents continued improvement in both Network #14 and national 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. CMS and Network data from the Clinical Performance Measures project are included in educational materials provided to each facility.

Highlights of Texas 2001 ESRD CPM Outcomes

Hemodialysis Patients

Hemodialysis Adequacy

88% of the Network #14 sample patients had URR greater than or equal to 65% compared to the Network national average of **82%** (78-88%).

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

76% of the Network #14 sample patients had hemoglobin greater than or equal to 11gm/dl compared to the Network national average of **74%** (69-76%).

When compared to the other 17 Network regions, Network #14 had the second highest percent of patients with hemoglobin greater than or equal to 11gm/dl.

Albumin Management

29% of the Network #14 sample patients had a serum albumin greater than or equal to 4.0gm/dl (BCG method) or 3.7gm/dl (BCP method) compared the Network national average of **29%** (23-34%).

When compared to the other 17 Network regions, Network #14 had the seventh highest percent of patients with a serum albumin greater than or equal to 4.0gm/dl (BCG method) or 3.7gm/dl (BCP method).

Vascular Access Management

22% of the Network #14 sample prevalent patients were using a fistula

compared to the Network national average of **30%** (22-42%).

When compared to the other 17 Network regions, Network #14 had the lowest percent of patients utilizing a fistula.

59% of the Network #14 sample prevalent patients were using a graft, and **19%** a catheter to compared to the Network national average of **46%** (31-59%) and **24%** (16-30%) respectively.

Peritoneal Dialysis Patients

No Network to nation specific comparative peritoneal dialysis adequacy, anemia or albumin data is published.

B. Texas Department of Health Quality of Care Indicators Report

The *Texas Department of Health Quality of Care Indicators Report (QIR)* is a major component of an ongoing collaborative effort between Network #14 and the Texas Department of Health ESRD Licensing Program (TDH). Since 1996, the QIR has provided an opportunity for Texas dialysis facilities to compare core indicators and patient care processes to statewide and, whenever possible, national averages or clinical practice guidelines. The project involves collecting patient specific core indicator data from each Texas dialysis facility to generate facility and Network specific normative data for use in comparing performance. The purposes of the QIR are to compare and trend facility specific and statewide clinical core indicator measures and facility processes and to identify opportunities and assist facilities with improving their quality of care.

In 2001, **273** hemodialysis facilities provided patient specific data on **14,671** hemodialysis patients, and **97** peritoneal facilities provided data on **1,070** peritoneal patients.

At the completion of the data collection process, an annual report is produced displaying Texas dialysis community core indicators outcomes along with recommended areas for needed improvement. In addition, each facility is provided with detailed colored charts displaying their facility's core indicator outcomes compared to statewide averages and national CPM data.

The Network directs that each facility's QM committee review its data for opportunities to improve. Facilities

reporting below average outcomes are notified of their status and offered the opportunity to request QM assistance from Network #14 QM nurses. Lastly, the Network #14 Medical Review Board reviews the data and offers recommendations to the TDH for survey activity based on facility core indicator outcomes. Table 2 highlights QIR outcome trends.

Table 2			
Texas Department of Health Quality Indicator Report Trends			
Facility Average Data (273 facilities –14, 671 patients)			
	1999	2000	2001
Percent of hemodialysis patients with URR \geq 65%	91.2	92.3	90.5
Percent of peritoneal CAPD patients with Kt/V \geq 2.0	68.4	75.2	76.0
Percent of peritoneal CCPD patients with Kt/V \geq 1	65	77.2	77.1
Percent of hemodialysis patients with HGB \geq 11	74.9	80.2	78.3
Percent of peritoneal dialysis patients with HGB \geq 11	70.2	67.4	73.8
Percent of hemodialysis patients with albumin \geq 3.8	53.2	55.1	59.7
Percent of peritoneal patients with albumin \geq 3.8	26.7	29.9	40.8
Total (New + Relapsing) peritonitis episodes per months	13.3	18	12.2
Percent hemodialysis patients with calcium \geq 8.5mg/dl	nr	85.9	81.5
Percent hemodialysis patients with phosphorus \geq 6.0mg/dl	nr	45.1	45.4
Data is reported as statewide facility average nr =not collected/reported			

C. The Centers for Disease Control and Prevention (CDC) National Surveillance of Dialysis Associated Diseases in the United States Survey

The *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.

D. Unit Specific Reports of Standardized Mortality, Hospitalization and Transplant Produced by the University of Michigan Kidney Epidemiology and Cost Center

In 2001, the Unit Specific Reports of Standardized Mortality, Hospitalization and Transplant were distributed to each facility medical director and to the regional dialysis corporate offices upon request.

In 2001, for the first time the mailing included facility data reports for the state surveyors and dialysis facility compare quality measures report to be reviewed for accuracy by facility management.

CMS Quality Improvement Projects (QIP) Summary and Results

2001-2002 QIP

Can a URR of 65% be delivered to 100% of Hemodialysis Patients in Texas?

The Texas dialysis community is a leader in providing the recommended levels of hemodialysis (URR of $\geq 65\%$ or Kt/V of ≥ 1.2), as defined by the National Kidney Foundation Dialysis Outcomes Quality Initiatives (DOQI)

Practice Guidelines on Adequacy of Hemodialysis (HD). Over the past five years, the percent of patients in Texas meeting DOQI HD adequacy guidelines has increased to over 90%.

Based on trends in historical data, the percent of patients meeting DOQI goals should continue to increase. However, it is unclear if 100% of the Texas hemodialysis patient population will be able to meet DOQI guidelines or if this is an unrealistic expectation. The concern is that numerous studies have identified that patients not meeting DOQI HD guidelines may be at increased risk of hospitalization or death due to the effects of underdialysis.

Based on the 2000 CPM Report, the adequacy of hemodialysis outcomes in Texas exceed the CMS national hemodialysis goal. However, a small subgroup of Texas patients, estimated at about 1,500 patients (8%), did not achieve a URR of $\geq 65\%$ as of 12/31/2000. While the ESRD Network Medical Review Board (MRB) expects that additional patients will attain a URR of 65%, it is believed that the goal of 100% of Texas hemodialysis patients with a URR of ≥ 65 is untenable.

This opinion is based upon MRB empiric knowledge that numerous patient barriers and technical limitations exist to the delivery of adequate hemodialysis. Examples are patient non-compliance, vascular access and large body weight (>83 KG). Patient related barriers and technical limitations that impede the attainment of URR > 65% for a month or longer are real factors that may never be entirely eliminated. In addition, in the opinion of the MRB, for some patients a URR of < 65% may in reality be adequate given the inherent limitations of the URR model.

For the purposes of this project, CU was defined as having a URR less than 65% for three months or longer. It appears that in most cases, underlying factors are being diagnosed and resolved within a month or two, resulting in achievement of adequate dialysis. However, it was estimated that approximately 450 of these patients might be CU due to factors such as poorly functioning vascular access, large body weight, non-compliance that may or may not be correctable or acceptable to the patient.

Potential For Change

Based on this information the Network and MRB sought to examine the relationship between the CU subgroup of patients and barriers to the delivery of adequate dialysis. In the fall of 2000, the Network initiated a Quality Improvement Project (QIP) with the following objectives:

- Identify the unique patient characteristics and causes for underdialysis within the CU subgroup.
- Educate and assist facilities with developing strategies to minimize underdialysis within the CU subgroup.
- Distribute information to the dialysis community and CMS on the causes for underdialysis and potential interventions to achieve URR > 65% within the CU subgroup.
- Decrease the incidence of CU

Methods

This QIP was proposed in December 2000, approved February 2001 and completed November 2001. All adult Texas in-center Medicare approved dialysis clinics open as of September 2000, participated in the project. The project was undertaken in three phases

(baseline data collection, education/intervention activity and follow-up data collection). Initial data collection consisted of two survey instruments completed by facility personnel.

Data Collection Baseline Measurement

Two hundred seventy-two facilities completed a baseline facility specific data collection form for the period September-November 2000, that collected hemodialysis facility specific data and information on the following process and outcome indicators:

- Number/percent of patients with URR \geq 65% for the months September-December 2000. (*Outcome indicator*)
- Number of patients meeting CU criteria (*Chronic patient at least 90 days prior to data collection and URR < 65% for three consecutive months*). (*Outcome indicator*)
- Dialysis prescription and monitoring processes. (*Process indicator*)
- Processes for evaluating ongoing indications for hemodialysis catheter use. (*Process indicator*)

All facilities reporting one or more patients meeting the CU criteria were required to complete a Patient Specific Data Collection form that collected the following information:

- Dialysis prescription
- Pre/post bun and URR
- Pre/post weight
- Delivered treatment time
- Months with URR <65%
- Vascular access type
- List of perceived reasons for URR <65%
- List of interventions attempted to improve URR

Prescribed Kt/V was calculated using the prescribed dialyzer manufacturer's

clearance specifications (KOA), prescribed treatment time and dry weight. Delivered Kt/V was calculated using the prescribed dialyzer manufacturer's clearance specifications (KOA), delivered treatment time, blood flow rate, and patient dry weight.

Patient demographic (age, sex, race) and medical characteristics (cause of renal failure, number of months on dialysis, co-morbid conditions) information was obtained from the ESRD Network SIMS database by matching patient Medicare number, date of birth and date of first dialysis submitted on HCFA Form 2728.

Two certified nephrology nurses with extensive training and experience with medical record review and data collection reviewed data forms. Facilities were contacted for missing or unclear data. Ten percent of imputed facility and patient data was compared to hard copy data for reliability of data input.

For the purposes of this project, facilities not reporting a CU patient at baseline were considered to be "quasi control" units by virtue of not being provided with any direct requests by the MRB to review a specific CU patient's treatment plan and implement corrective actions.

Interventions

A Survey Results and Practice Recommendations Report was produced. The 24-page color report was developed from the survey data and distributed to all Texas dialysis facilities. The report contained charts and graphs that displayed:

- Demographics of CU patients compared to the Texas hemodialysis population.
- Notable differences in demographics

and dialysis treatment variables between CU patients and Texas hemodialysis population.

- Reported causes and interventions for underdialysis in CU patients
- Percent of facilities that:
- Calculate a prescribed Kt/V for each new patient.
- Evaluate for ongoing indications for continued hemodialysis catheter use and how often they evaluate.
- Have a written process to intervene for patients who do not run prescribed time or miss treatments.

The report also included a list of proactive strategies and associated tools to assist facility staff correct current and minimize underdialysis. MRB developed tools included an assessment tool for use with patients who shorten or skip treatments, prescribed hemodialysis adequacy worksheet, indicators for continued hemodialysis catheter use checklist. In addition, a patient/staff education video titled *What is Adequate Dialysis?* was distributed along with a copy of the NKF-DOQI Hemodialysis Adequacy Clinical Practice Guideline. Lastly, a survey was included to evaluate the report, proactive strategies and associated tools.

Facilities that reported having a CU patient were provided with the patient name(s) and reported cause(s) along with a directive from the MRB and Network to review the patient's prescribed and delivered dialysis prescriptions, evaluate the proactive strategies provided and implement a process improvement plan. Network staff and MRB members were available to provide education or consultation to facility staff upon request. A supplemental mailing was made to each facility three months following initial intervention supporting ongoing efforts to focus attention on minimizing CU and

using the Network provided tools and resources.

An additional 240 patients were identified as meeting the CU criteria on follow-up. These patients were noted to have similar demographic and treatment characteristics of the baseline patient group. (Table 2)

Table 2. Highlight Differences between Baseline & New CU Patients	Baseline CU Patients N=#207	New CU Patients N=#239	P-value
Average months on dialysis	45.8 (±51.3)	40.3(±12.7)	0.0021
Average dry weight	104.5(±33.0)	97.6(±30.6)	0.0247
Average prescribed blood flow rate	413(±70.7)	397.5 (±65.4)	0.0163
Continuous data is mean (standard deviation ±)			

Table 3. Baseline Pre-Intervention CU Patient Demographic & Dialysis Treatment Characteristics Compared to Network #14	CU HD Patient Cohort November 2000	Network #14 HD Cohort December 2000
Facilities	117	285
Patients	207	22,000
Average Age (years)	49.7 (±13.3)	60
% Male	84.1	50
Average Months on HD	45.8 (± 51.3)	42
% African-American	51.2	31.5
% Diabetic	45.4	47.4
Dry Weight (kg)	104.5 (± 33.0)	75.1 ¹
% Greater than 83 kg	72.8	nr
Average delivered treatment minutes	235.2(± 41.2)	214 ¹
% Prescribed Kt/V ≥ 1.2	71.9	90 ¹
% Delivered Kt/V ≥1.2	63.8	nr
Average URR	57 (± 6.1)	68.2
% Pts with URR <65% for ≥ 6 months	52.2	nr
Weight loss during Tx.(kg)	4.0(± 2.1)	nr
% Catheters	31.4	17.4
% Fistulas	36.7	20.5
Source: ESRD Network #14 database ¹ Other source: 2000 CPM Annual Report nr = data not reported Continuous data is mean (standard deviation ±) Categorical data is n (%) with property		

Table 4. Highlight Patient Demographic and Treatment Comparisons at Follow-up	Unresolved CU Patients with URR <65% N=#55	Resolved CU Patients with URR ≥65% N=#91	P-value
Dry weight (kg)	120.8 (±36.8)	95.5 (±28)	0.0001
% Greater than 83KG	47(88.7)	56(63.6)	0.0015
Months on dialysis	53.1 (±48)	39.8 (±45.4)	0.0559
Male (%)	92.7	81.3	0.0867
Age Group			0.0122
0-45	27(50)	35 (38.5)	-
46-60	23 (42.6)	32(35.2)	-
61+	4(7.4)	24(26.4)	-
Average months on dialysis	46.5 (±10.7)	50.9 (±14.1)	0.0326
Diagnosis			0.0957
Diabetes	17(31.5)	48(52.8)	-
Access			0.0798
Catheters	20(37.7)	17(19.3)	-
Prescribed minutes	263(±34.7)	251.5(±26.1)	0.0378
% Pts URR <65% for >6 Months	34(61.8)	43 (47.2)	0.1233
% Prescribed Kt/V ≥ 1.2	27(61.4)	64 (82)	0.0168
% Delivered Kt/V ≥1.2	21(46.7)	59 (76.6)	0.0014
Reasons for CU²			
Large body weight	41(74.6)	43(47.2)	0.0018
Requested shortened treatment	26(47.3)	29(31.9)	0.0784
Inadequate VA blood flow	18(32.7)	50(55.0)	0.0105
Prescribed Kt/V <1.2	10(18.2)	13(14.3)	0.6401
Actions² to correct CU			
Changed to higher clearance dialyzer	18(32.7)	34(37.4)	0.5975
Increased Treatment Time	18(32.7)	32(35.2)	0.8577
Revised/New Vascular Access	12(21.8)	31(34.1)	0.1360
Education/Behavior Contracting	27(49.1)	31(34.1)	0.0827
Increased Blood Flow Rate	16(29.1)	27(29.7)	1.0000
<i>Categorical data is n (%) with property More than one reason or intervention could have been reported ²Reasons and actions for CU for resolved patients collected at baseline only</i>			

Table 4 highlights the common demographic characteristics of the baseline patients who remained CU. Included were majority male, large body weight, many prescribed a Kt/V ≤ 1.2 and high catheter use.

Implementation of facility processes to identify and minimize underdialysis was evaluated. At baseline, 47% of facilities reported calculating a prescribed Kt/V for each new patient; this improved to 66% at follow-up. No change was noted in the percent of facilities evaluating ongoing hemodialysis catheter use. The number of facilities with a written process to intervene for patients who do not run prescribed time or miss treatments increased at follow-up to 54%.

Results

The results of the QIP were positive in that each objective was met. The QIP identified the number, demographics and characteristics of a CU patient cohort in Texas. This type information has not been documented to date in the literature and will serve as a significant resource for QI and research efforts related to improving dialysis adequacy. In addition, the dialysis community will be able to focus additional QI attention on patients who may be at risk of underdialysis. This project identified that in Texas, the patients at greatest risk of CU are individuals who are of large body weight, have difficulties with their vascular access and may have issues with compliance with treatment plan. The QIP also documented that some patients may be unable to attain a URR of 65% as a result of uncorrectable clinical or technical barriers.

Facilities were able to correct CU in nearly half (98/207) of the baseline patients. The majority of these patients had been reported to have URR of <

65% for six months or longer. The QIP also identified on follow-up continued incidence of CU patients.

Lessons Learned

This quality improvement project identified that even though greater than 90% of the Texas hemodialysis patient population has attained recommended adequacy levels, a small percentage (<1%) of Texas hemodialysis patients have significant barriers to attaining a $URR \geq 65\%$.

Characteristics of patients at greatest risk of CU are:

- Under the age of 50
- African-American
- Large body weight
- Hemodialysis catheter as vascular (indent all)access
- Prescribed a Kt/V of less than 1.2
- Unable or unwilling to fulfill prescribed time

At follow-up many patients remained at risk for CU. However, nearly half attained a $URR \geq 65\%$ as a result of one or more interventions. The primary interventions responsible for the attainment of $URR \geq 65\%$ in these patients were revising/replacing vascular accesses, patient education and increasing treatment time.

One possible explanation for why some patients remained at risk for CU at follow-up can be attributed to the group's higher percentage of patients with one or more of these factors: weight greater than 83Kg body weight, reliance on catheters or the inability or unwillingness to fulfill prescribed treatment time.

Each of the above barriers has its own set of potential causes within individual facilities. For example, patient barriers

for large body weight individuals include: unwillingness to lose weight, be treated for longer than 4-5 hours or be scheduled for more than three weekly treatments. Patients using catheters may be reluctant to have a permanent access placed or may have exhausted all graft/fistula sites. Shortened treatment time may be attributable to a lack of understanding of benefits of full treatment time, psychosocial factors or transportation/scheduling limitations.

Facility barriers may include inability or unwillingness on the part of the facility to extend dialysis treatment time for large body weight patients or to provide more than three weekly treatments due to operational and financial constraints. Increased catheter utilization may be a result of facility staff not referring patients in a timely manner for permanent access placement and/or failure to educate patients on the benefits of permanent access. Shortened treatment times may be due to staff failure to identify and resolve patient medical concerns during treatment and/or lack of facility processes for addressing the issue of patients who consistently sign off early. Failure to adequately prescribe dialysis may be a factor not only in patients with large body weight, but also in patients with inadequate vascular access.

One of the goals of the QIP was to assist facilities in the recognition and implementation of processes that are beneficial in minimizing the incidence of chronic underdialysis in their patient population. Network #14 and MRB-developed quality improvement tools to address the most likely causes of CU were distributed to all facilities. These tools included a catheter indication checklist, interventions for shortened treatment worksheet and a Kt/V

calculation template. On the follow-up data collection and Network #14 QIP QI tool evaluation, the majority of intervention and non-intervention facilities reported adoption of the QIP quality improvement tools for use with CU patients.

Activities conducted achieved the goal to perform special studies developed by the Medical Review Board, CMS, TDH, USRDS, and Other Agencies.

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

In support of this goal the Network performed the following during 2001:

A. Network #14 Committee Participation

Network #14 is an active participant in the Forum of ESRD Network and CMS collaborative activities. Network staff attended all Forum and CMS sponsored activities in 2001. The Network Executive Director, Data Coordinator, Quality Management Coordinator and Patient Services Coordinator participated as members of the following committees:

- Forum Board of Directors Treasurer
- Standardized Information Management System (SIMS) Workgroups
- CMS/Forum Annual Meeting Planning Committee
- CMS New Patient Packet Committee
- Quality Improvement Directors Committee
- CMS Consumer Reports Workgroup
- CMS Grievance Process Revision Workgroup
- CMS Quality Improvement Project Fistula Template Team
- CMS Quality Improvement Project Stenosis Template Team
- CMS Quality Improvement Project Catheter Template Team (MRB Chairman)
- CMS/ NW Patient Safety Team

B. Collaborative Activities with Other ESRD Networks

Network #14 collaborated with other ESRD Networks to share QM project documents, CMS/SIMS data collection/analysis tools and patient and staff education materials. In 2001, Network #14 made available to all Networks, quality management/data collection tools, newsletters and quality improvement project materials. In addition, the Network Director of Patient Services (DPS) presented at the annual meetings of seven other Networks, as well as, regional patient meetings. The DPS provided written and verbal Spanish translation services to other Networks.

C. Collaboration with Peer Review Organizations

Network #14 continues a partnership with the Texas Medical Foundation to educate ESRD patients and professionals about the importance of receiving recommended vaccines during the fall and winter months. The Network distributes TMF education materials and refers dialysis facilities to their organization for additional vaccination related materials.

D. Collaboration with Regional Medicare Intermediary

QMC presented an inservice to Trailblazers on Network QIP activities. Executive Director and QMC serve on advisory committees to the FI.

E. Collaboration with Texas Department of Health

Network #14 and the Texas Department of Health (TDH) ESRD Facility Licensure and Certification Divisions continue a collaborative and collegial relationship in support of Texas ESRD Facility Licensing Rules. The Network QM staff works closely with TDH ESRD surveyors

providing technical information and facility specific and national core indicator outcome data to assist with the evaluation of quality of care. Refer to page 26 for additional information.

In 2001, the TDH referred eight facilities to the Network #14 Medical Review Board as a result of concerns of potential or serious issues with facility quality and appropriateness of care issues. The MRB assisted the TDH by reviewing the concerns and recommending directed corrective actions including the use of monitors and managers. Life threatening quality of care deficiencies were cited by the MRB and TDH in the following areas:

- Hemodialysis and peritoneal dialysis adequacy
- Anemia management
- Peritonitis
- Water treatment testing/dialyzer reuse practices
- Machine maintenance
- Infection control practices
- Facility staffing ratios
- Nursing management
- Nursing practices
- Medical Director supervision
- Training or supervision of dialysis technicians
- Vascular access management
- Oversight and management of patient care by physicians

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

- Patient monitoring
- Physician oversight
- Machine safety and maintenance
- Technical staff competency
- Quality Management program
- Patient assessments
- General infection control practices
- Patient care planning

All referred facilities were required to provide protocol changes, education initiatives, audits and quality management minutes to the MRB for review for a 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, Network #14 assisted with development of corrective actions and provided education and support of facility's quality management program.

The Network also provided ongoing education to the TDH ESRD surveyors by providing Network project results and educational materials. Annually the Network provides an opportunity for the TDH to present survey findings and recommendations to the Network Council to minimize survey deficiencies.

Routine concerns/complaints received at the Network #14 office that were regulatory in nature were referred to TDH for survey activity. In 2001, the Network referred ten concerns to the TDH for investigation and participated in joint survey activity and phone consultations with surveyors.

In addition, the MRB recommended TDH survey activity for **63** facilities with TDH Quality of Care Core Indicator outcomes that were not consistent with current professional knowledge.

F. Collaboration with Federal Government Agencies

QMC participates on the United States Renal Data Systems Special Studies Workgroup and will be attending USRDS Steering Committee meetings as the ESRD Network Forum representative.

G. Life Options Rehabilitation Council

Network #14 partnered with the Life Options Rehabilitation Council (LORAC) and the Council of Nephrology Social Workers of North Texas to develop a study to evaluate the relationship between a dialysis facility's rehabilitation interventions and facility level patient outcomes. Facility demographics, rehabilitation efforts and core indicator outcomes were collected and analyzed. The results and recommendations presented at the Network annual meeting in 2001. LORAC investigators report that the article is expected to be published in a summer 2002 issue of the American Journal of Kidney Disease.

H. Patient and Professional Renal Organization Educational Meeting Assistance

Network #14 assisted with the program development and publicizing of national and regional National Kidney Foundation, American Kidney Fund, American Nephrology Nurses Association and American Association of Kidney Patients meetings. In many cases, Network staff also presented at the meetings.

I. Patient and Professional Renal Organization Educational Technical Assistance

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 Nephrology Nurses Association - National and Texas Chapters
- American Kidney Fund
- American Association of Kidney Patients
- Centers for Disease Control and Prevention
- Center for Medicare and Medicaid Services
- NKF Council of Renal Dietitians
- NKF Council of Nephrology Social Workers
- NKF Council of Nephrology Nurses and Technicians
- Forum of ESRD Networks
- Life Options Rehabilitation Council
- National Kidney Foundation, Texas and National Affiliates
- National Renal Administrator Association
- National Association of Nephrology Technicians
- 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 Rehabilitation Commission
- Texas Transplant Society
- United Network for Organ Sharing

Network Staff Positions and responsibilities with organizations included:

Assistant Quality Management Coordinator served as:

- National Kidney Foundation (NKF)- Council of Nephrology Nurses and Technicians Region 4 Vice Chair, responsible to assist in the development of the NKF national educational programs, moderate the NKF CyberNephrology listserve and

write a quarterly update for NKF's Professional Council Newsletter, Renalink

- ANNA Peritoneal Dialysis Special Interest Group Member
- NKF "Family Focus" newspaper Nursing Editor, with quarterly contributions on issues of interest to patients.
- Co-Chair NKF Professional Council Meeting in San Francisco 2001.

Executive Director served as:

- Chairperson of the Ethics Subcommittee of the American Nephrology Nurses Association (ANNA)
- Member of the ANNA Professional Practice Committee
- Member and treasurer of the Forum of ESRD Networks Board of Directors
- Medicare FI Trailblazers Part B Advisory Committee

Quality Management Coordinator served as:

- Medicare FI Trailblazers Part A Advisory Committee
- Dallas Chapter ANNA Board member

Patient Services Director served as:

- American Kidney Fund Advisory Board Member
- National Kidney Foundation of Texas Patient Services Representative

J. Network Staff Presentations

Network #14 personnel presented at over 60 national and regional National Kidney Foundation, American Kidney Fund, American Nephrology Nurses Association and American Association of Kidney Patients and other ESRD related organizations and group meetings. Topics that were presented included:

- Medical Insurance and dialysis
- Patient Centered Nephrology
- Dealing with Difficult Patients

- Professionalism
- Patient Safety Initiative
- Understanding and Facilitating Patient Non-compliance
- Humor in Dialysis
- Onsite facility in-services on clinical concerns and patient staff relationships
- Patient Issues
- ESRD Network QIP Activities
- Social Work Concerns
- Social Work Roles and Responsibilities

- Professional Growth
- Professional Ethics
- Network Grievance Procedures
- Resolving Grievances
- Cultural Diversity
- Dialysis Care
- Vascular Access
- Network Functions
- Difficult Staff
- Personality Disorders on Dialysis
- Effective Clinical Management

K. Texas Rehabilitation Commission

Network #14 and the Texas Rehabilitation Commission (TRC) continued a partnership. The objectives of the partnership are 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

Activities conducted have achieved the goal to establish and implement partnerships and cooperative activities among the various ESRD organizations and agencies.

III. D. GOAL-EVALUATING AND RESOLVING PATIENT GRIEVANCES AS CATEGORIZED IN THE STANDARD INFORMATION MANAGEMENT SYSTEM

In support of this goal the Network has performed the following during 2001:

In 2001, Network #14 met the goal of maintaining a grievance system that was responsive to consumer needs. Information on Grievance Procedure and Patient Rights and Responsibilities are included in the New Patient Packet that was mailed to 7,216 new patients' homes in 2001. The Network continues to disseminate a colorful poster to each new facility and to extant facilities upon request that outlines the Network grievance process. The poster includes the phone number of both the ESRD Network and the Texas Department Health. Facilities are asked to place the poster in the patient waiting area.

The Network employs a *Director of Patient Services* (DPS) who is a social worker licensed to practice in Texas, and has over 15 years experience in ESRD. The Network DPS also has clinical expertise in assessing, evaluating and counseling patients. The DPS is responsible for the development and implementation of the Patients Services Program for the Network.

The Network adhered to the CMS protocol and conducted thorough, objective investigations. The Network may receive referrals from patients, family members or other designated representatives, medical personnel, renal organizations, 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 reimbursements or survey and certification issues are referred to the Associate Regional Administrator, Division of Health Standards and Quality at the CMS Regional Office or the Texas Department of Health (TDH) ESRD Facility Licensure Division.

An additional source of grievance activity is from TDH referrals to the Network MRB for quality of care issues identified during state and Medicare survey activities. During 2001, several referrals included complaints involving patient rights and sensitivity issues. Examples include: staff not responding to patient's request for help during treatment, unprofessional behavior by staff, 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 recommendations for facilities and required clinics to perform patient satisfaction surveys on a prescribed time frame.

The number of written and phone contacts increased dramatically in 2001. The majority of these are from clinic staff seeking guidance and assistance with difficult patient situations. Because Network staff has been able to assist in these situations, the number of formal grievances and complaints has declined during the year 2001. Either the DPS or Network Quality Management staff address all patient complaints and grievances as well as facility requests for assistance. The Network staff strives to resolve complaints and intervene with clinics to *keep* complaints from going to the Medical Review Board. However, in some cases, the Medical Review Board

or Patient Subcommittee is consulted. During 2001, the Network received a total of five formal grievances requiring formal investigation. They are:

Case # 1400362484: A patient's daughter complained that the patient care technicians (PCTs) were not following the doctor's orders to give her mother normal saline every hour. The orders had been temporarily suspended while the patient received treatments at the hospital and then were reinstated when she returned to the outpatient setting. The PCT could not read the doctor's notes, and, rather than ask the charge nurse, he disregarded the orders. The patient's catheter clotted as a result.

Resolution: Referred to Texas Department of Health.

Case #1400372470: A patient complained that his facility decided to cut all patients' treatments by one hour because of shortage of staff. The patient had already complained to the administrator that his URRs were dropping, but his treatment time was not reinstated.

Resolution: Network staff contacted the clinic and expressed concern regarding inadequate dialysis. Information on the National Practice Guideline regarding Adequacy of Hemodialysis was provided. Data on dialysis adequacy was requested. Additional staff were hired and adequate dialysis prescriptions were reinstated.

Case #1400376161: A patient's husband called with several complaints. He alleged that the staff were insensitive and uncaring and did not respond to patient requests for help during treatments. He stated that the chairs were all broken and had duct tape on them. He stated that he

complained to the clinic manager, and she got angry and wrote a letter to all patients telling them they were the reason the nurses were leaving. Additionally, the complainant stated that the scales were broken and that they opened the clinic about a half hour after the first patient is supposed to be on the machine. Reportedly, the patients were upset and afraid to say anything.

Resolution: Referred to MRB. The clinic was placed on a corrective action plan monitored by the MRB.

Case #1400377959: A patient called and complained that staff was rude and unprofessional claiming that the staff "horse play" in the clinic, disregard patient requests, and use profanity with patients who complain. The complainant alleged that the manager only came to the clinic two or three times a month and stated that when she did come to the clinic, the staff behaved appropriately. However, when she is not there (which is most of the time), the staff act unprofessionally. The charge nurse cannot control them. The caller stated that the Social Worker only came to the clinic every two weeks and is no help.

Resolution: DPS made a site visit to the clinic and interviewed all patients and staff. The manager was asked to write a plan of correction. Three months later the patient called again and said nothing had changed.

Resolution: Referred to the Texas Department of Health.

Case #1400379694: A patient's daughter called and complained that her mother was receiving poor care at the clinic. The patient complained of chest pain during the treatment, and the staff said it was due to her having a heart problem. The daughter stated that the cardiologist denied that the patients'

heart caused the chest pain, stating instead that the dialysis caused the pain. She told the nephrologist what the cardiologist said, and she alleged that the nephrologist became angry and told her if they did not like his care they could switch to another clinic. As a result, the patient was given a 30-day notice of dismissal.

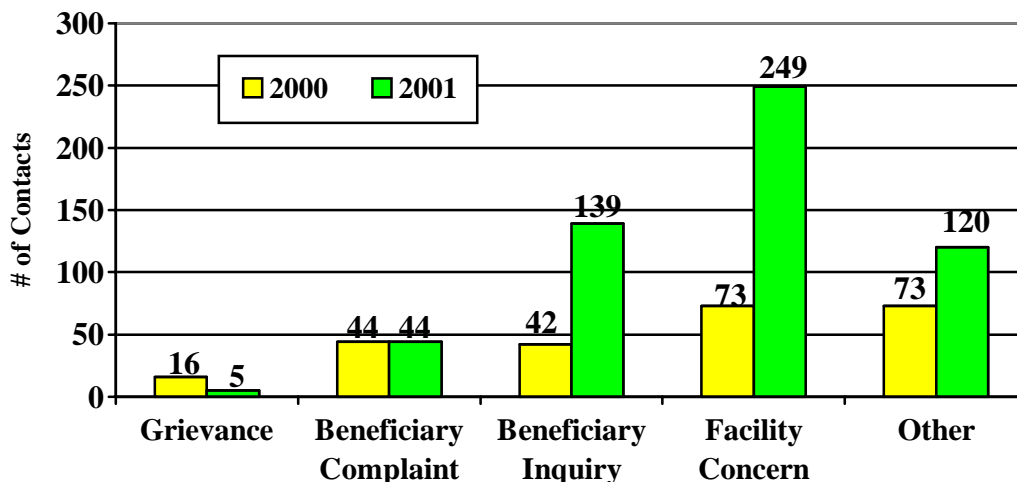
Resolution: Network staff intervened with the facility and physician to delay the dismissal. Network staff met with representatives from CMS, the patient's insurance company, the dialysis corporation and the physician group. Discussions centered upon ways to help the patient. Agreement was obtained to work with patient and family. Placement at another area dialysis facility was arranged; however, the family suddenly relocated to Florida. The case was closed.

Network #14 continued documenting all significant appropriateness of care or quality of care phone calls, faxes, and e-mails with patients or with the renal professional community as part of

routine Network operations. Concerns are documented and coded into the SIMS system. Reports are produced from this data system for review and profiling. Usually 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 requests, the Network staff will provide information, guidance, and if requested, intervene on the patient's behalf. As stated previously, there was a dramatic increase in the number and type of contacts from 2000 to 2001. During 2001, a total of 557 reports were entered into SIMS compared with 249 for the year 2000. This included five formal grievances for 2001 compared to sixteen in 2000. There were 44 beneficiary complaints in 2001, which is exactly the same number as 2000. However, in 2001 the Network received 139 beneficiary inquiries compared to only 42 in the year 2000. During the year 2001, the Network received 249 inquiries from facilities compared to 73 facility inquiries in 2000.

**Chart 6. SIMS Report of Contact
2000-2001 Trends**



In 2001, the Network received no data inquiries compared to one in 2000. Finally, in 2001 the Network received 120 "other" inquiries compared to 73 in 2000(Chart 6).

The Network observed an increase in patients dismissed from dialysis facilities both with and without a 30 day notice. Some patients were dismissed without placement for chronic dialysis. Data on patient dismissal was collected and analyzed and presented to both the Medical Review Board and the Network Council. A new field was added to the Monthly Patient Activity Report to routinely track involuntary dismissals along with causes and placement data. The Medical Review Board continues to review the data for possible action in 2002.

Aggregate and facility specific contacts are reviewed quarterly by the Network staff and Medical Review Board to identify trends and educational opportunities. Patient grievances were profiled and examined by Network staff and the Medical Review Board. There were two clinics that were identified as having a pattern of patient complaints. Network staff contacted the clinic managers and found that in both cases the managers were aware of the many complaints. In one clinic the manager did not have the leadership skills to resolve the complaints about staff behavior. In the second clinic the manager had been instructed by the corporation not to hire much needed staff. In both cases the Network worked with the regional vice-presidents to correct the situation, and the Network continues to monitor the clinic. No trends were identified indicating problems with access to self-care or transplantation by patient characteristic, facility, or Network.

Complaints received by the Network office 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 2001, the Network referred five complaints to the TDH for investigation of regulatory issues.

Proactive Activities To Prevent Complaints and Grievances

A. Assessment Tool for Use with Patients Who Skip or Shorten Dialysis Treatments

With support from the Medical Review Board and a subcommittee, the Network produced a tool that was distributed to all attendees at the Network's Annual Meeting. The Network continues to provide the tool to clinics when calls are received for help with non-compliant patients. The tool offers practical suggestions for intervention into non-compliance that any member of the treatment team can follow.

B. Sample Contract for Continued Provision of Dialysis Services

Known as the "behavior contract," this document written by an attorney, offers a generic guide which clinics can use to engage a patient to change his/her behavior rather than rush to dismissal.

C. Behavior Contracts as a Positive Patient Experience

An article published in Nephrology News & Issues has been sent to clinics that need more guidance to help patients change problematic behavior.

D. Positive Professionals-Positive Patients Educational Workshop Series

The Network continued to produce regional workshops titled *Positive*

Professionals-Positive Patients to an intended audience of unlicensed chair side care givers. The workshop objectives are to enhance the understanding of dialysis patient stressors, provide knowledge of the benefits of working within professional boundaries and instruct in advanced skills and techniques that may be used to improve patient-staff communications along with proactive strategies to positively impact patient and staff interactions. These workshops were conducted in recognition of increasing reports of difficult patients and a directive from CMS in the 2000-2003 Statement of Work for efforts in this area. Cities where the workshops were presented were Dallas/Ft. Worth, San Antonio, Houston, and Nacogdoches. The workshop will be presented in other cities in 2002. When all major metropolitan areas have been served, the cycle will be repeated in the year 2003.

E. Professional Ethics Education for Social Workers

The Patient Services Director presented on professional ethics in the renal setting for renal social workers in many sessions. The social workers obtained .3 continuing education units from the Texas State Board of Social Work Examiners at these workshops. All licensed social workers in Texas are required to have .3 CEUs in ethics continuing education every year, and the Network has made it possible for social workers to do this at very little cost while providing education specifically related to the renal setting.

F. Clinic Workshops on Patient Sensitivity

The Director of Patient Services continues to lead workshops for clinics on patient sensitivity, dealing with

difficult patients, proper documentation, cross-cultural issues, and prevention of staff burnout. These workshops are presented at the local clinics for local staff at no cost other than the travel expenses for the DPS.

G. Patient Meetings at the Clinic

The DPS meets routinely with patients in the waiting rooms of clinics and informs patients about the Network and services available to patients. Frequently asked questions deal with transplants, scheduling problems, eating during dialysis, and the staff bringing water to patients during their dialysis treatments.

H. Network "Rounds" at local clinics.

The DPS regularly goes to dialysis clinics, introduces himself to patients while they are dialyzing and gives the following speech in English or in Spanish: "Hi. My name is __. I work with the End Stage Renal Disease Network of Texas, which is under Medicare. As you know Medicare pays for dialysis for most patients. They spend a lot of money each year on you. Because they spend so much money they want to be sure you are well taken care of. For this reason they appoint the Network to oversee the dialysis clinics and transplant centers in Texas. We keep tabs on patient care, on quality, and handle complaints. If you ever have a question, need some information, or have a complaint, here is my name and number." They are then given a business card with the Network's address and phone number on it.

I. National Publications by DPS made available locally

During the year 2001, the Network's DPS had four articles published in national magazines. These were

handed out to local patients. Publications are: "Patient-Centered Nephrology: the balance of life" Clinical Strategies of American Kidney Fund, April 2001; "The Intolerance of Zero Tolerance" Dialysis & Transplantation September 2001; "Death with Dignity on Dialysis" Renalink, Winter 2001; "Things to do to Expedite a Transplant" For Patients Only, November 2001.

discussed in Section VI. Recommendations for additional facilities.

J. Patient Education Resources

The Network patient newsletter, *The Lone Star Newsletter*, highlighted steps for patients to take whenever concerns or complaints arise. This is repeated in every issue. These steps direct patients and families to the local provider as a first step in preventing the escalation of concerns and moving toward resolution efforts.

K. Patient Representatives

Each facility is asked to appoint at least one patient representative to help the clinic staff members disseminate information from the Network to patients, to mentor new patients and to act as a liaison between patients and facility administration and the Network.

L. Patient Advisory Committee

A ten member committee representative of the ethnic, modality and geographic diversity of the state was maintained to advise the Network on matters of importance to the patient community. The committee met twice in 2001.

The multifaceted efforts and activities of Network #14 have met the goal of evaluating and resolving patient grievances. As expected more activity is noted due to an increase in both the incidence and prevalence of dialysis patients and providers. Network #14 has increasing concerns regarding zero tolerance policies in dialysis facilities as

III. E. GOAL - IMPROVING DATA RELIABILITY, VALIDITY AND REPORTING, BETWEEN ESRD FACILITIES/ PROVIDERS, NETWORKS, AND CMS, THE TEXAS DEPARTMENT OF HEALTH AND OTHER RELATED AGENCIES.

In support of this goal the Network performed the following during 2001:

Provided Information on patterns, processes, and outcomes of care to support quality activities.

A. Collaboration with Texas Department of Health

Refer to pages 18, 33 & 34 that describe the collaborative activities with the Texas Department of Health.

B. Texas ESRD Data Reporting

The Network prepared various statistical charts, graphs and presentations for reporting to the Network Coordinating Council. Presentations included: Incidence, Prevalence, Percentages, and Percent of Patients Transplanted.

C. Facility Specific Transplant Data

Refer to page 21 that describes the trended facility specific comparative transplant data provided to each facility.

D. Facility Specific ESRD Data

Refer to page 33 & 34 that describes the production and dissemination of facility specific comparative data regarding vascular access and dialysis adequacy.

Provided data to support the Standard Information System (SIMS) in a timely manner as defined by CMS

A. Survey Activity

During 2001, Network #14 processed and validated 7851 Chronic Renal Disease Medical Evidence Reports (CMS Form - 2728), and 4,842 ESRD Death Notifications (CMS Form - 2746). There were 3,876 facility generated Monthly Patient Activity Reports processed validating new patients, expired patients, tracking patient transfers and changes in modality. Three hundred and sixteen facility (316) surveys were processed, validated, and transmitted to CMS.

B. Monthly Patient Activity Report

Network #14 has developed a *Monthly Patient Activity Report* that each provider submits to the Network office by the 8th of every month along with the CMS forms for the month's activities.

C. Data Infrastructure

Data infrastructure was maintained to collect the requested data from 290 Medicare approved dialysis facilities, 23 transplant centers, and one special provider for a children's camp at year-end. There were 23,674 dialysis patients in facilities throughout the Network's geographic area for the period ending December 31, 2001. In addition, there are three Veterans Administration, 2 military, and 1 Department of criminal justice prison units in the Network that are not Medicare approved.

D. Data System Configuration

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, for file management.

E. Computer and Server

In June 1999, CMS delivered a Compaq server and installed Internet service. In October 1999, CMS delivered ten complete Dell computers, for the

Network workstations. This equipment was used to operate the SIMS application beginning January 2000.

Maintained a 90% required timeliness and accuracy compliance rate for all providers

For the year ending 2001, Network #14 sent to each facility a listing of all 2746 and 2728 forms received by Network 14. Percentages for timeliness and accuracy were included in each report for each facility, as well as Network average, to facilitate comparative analysis. Corrective Action Plan for timeliness, accuracy or both, was required for facilities falling below the 90% CMS guideline. The combined accuracy and timeliness for Network 14 for the year 2001 was 90.6%. Additionally, the Data Coordinator presented a seminar during the Network's Annual Meeting to educate providers regarding the accurate completion of the CMS forms. Also, a representative from the Texas Kidney Health state agency presented information demonstrating the use of the 2728 form for state funding for beneficiaries.

member in the development of the Standardized Information Management System (SIMS) on the following committees: Patient Termination File Committee, Provider Numbering and Dialysis Compare Utility Committee, and all SIMS-CMS conference calls.

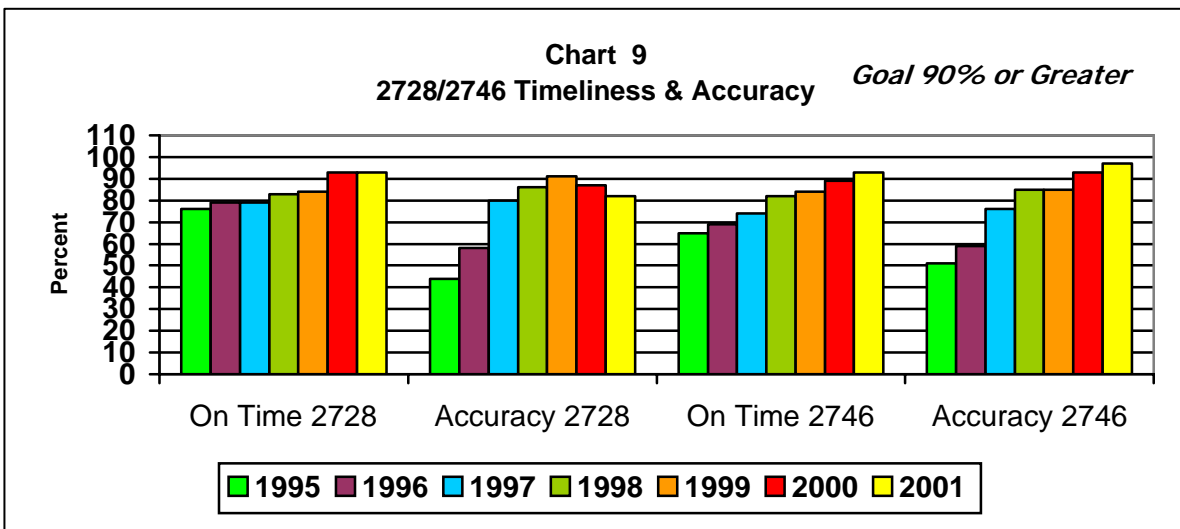
B. Facilities were encouraged to use an Excel spreadsheet for patient tracking to facilitate completion of the annual facility survey.

C. Facilities were encouraged and an increased number used a diskette to provide Quality Indicator data for other Quality Improvement Activities.

The goal of improving data reliability, validity, and reporting between ESRD facilities/providers, Networks, and CMS has been met as demonstrated by a continued several year trend of improvements in compliance.

Foster Electronic Transmission Of Data

A. During the year, the Data Coordinator participated as a workgroup



IV. SANCTION RECOMMENDATIONS

During 2001, 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. 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 decertification to the TDH. The TDH worked with the facility owners and the facility was voluntarily closed.

V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES

Although the Network has no official role in the approval process for new or expanded facilities with CMS, the Network does monitor and review the overall capabilities within the area.

The Network continued to receive increased contacts during the year 2001 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, many of these patients that have been discharged have been provided adequate opportunities to correct the offending action prior to dismissal. In some cases, the facility is able to locate a new facility for the orderly transfer of the patient. A disturbing trend in the increase of patient discharge for treatment noncompliance was observed and is under review by the Medical Review Board.

In other cases (i.e., physically aggressive) such patients are dismissed prior to acceptance to another facility. In 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 relying on hospitals to receive their treatments due to the inability to locate an outpatient clinic for treatment.

There appears to be an increased use of "Zero Tolerance" policies regarding any

behavior that is perceived as threatening to other patients or staff. Facilities report a sense of duty to act proactively to prevent acts of violence. The publication of the Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis Practice Guideline in February 2000, may have encouraged institution of such policies as various approaches to dealing with the difficult patient are explored. Additionally, federal OSHA requirements regarding workplace violence prevention programs may also have a role in the utilization of such policies.

The Network recommends that CMS 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 CMS sponsored demonstration project

- Waived requirement to justify higher reimbursement rate with historical costs for initial set up of facilities

The Network also recommends that CMS convene a national consensus conference to explore the complex issues surrounding the treatment or lack of treatment for challenging ESRD patients.

