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# FMQAI Access

The Florida ESRD Network

## Albumin: Why is it Important?

In monthly lab reviews, dialysis patients may be told that their albumin level is low and they need to eat more protein. What is albumin? Why is an albumin blood test important? What factors affect albumin? How can albumin levels be improved?

### What is Albumin?

Albumin is a major protein found in the blood. Protein plays a big role in fighting off infections and building or repairing muscle tissue. When a person does not eat enough calories or protein, the liver does not have enough protein to make new albumin, which causes lower albumin levels in the blood. Research has shown that patients with low albumin levels over time have a higher death risk. Testing albumin levels helps assess a person's nutritional status and risk for malnutrition.

### What is a good level for albumin?

The normal range for albumin is 3.5 – 5.5 g/dl (optimal level 4.0 g/dl). This may vary slightly between laboratories and the method the lab uses to process the blood sample. Check with your facility's renal dietitian to see what your goal for albumin should be.

### What other factors can affect albumin levels?

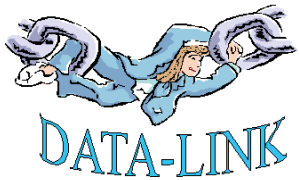
Albumin is a valuable test, but it is slow to change. It can

also be affected by a number of other health conditions. It can be low in persons with a history of liver disease, since albumin is made in the liver. It can also be low in persons with a history of nephrotic syndrome or certain kidney diseases that cause protein to be lost in the urine. Albumin levels can also drop quickly if an infection develops. Because it is hard to tell exactly what has caused the decrease, a healthcare team will use the albumin test along with other tools to monitor continued health. The dietitian will often ask about appetite, monitor weight and muscle tone and review other blood tests including those that measure adequate dialysis (Kt/V and URR).

### How much protein should patients eat to stay healthy?

Most people on hemodialysis should try for a goal of 8 – 10 ounces of protein each day, or 10 – 12 ounces for those on peritoneal dialysis. Check with your dietitian for your facility's specific protein goal. An easy way to estimate protein intake is to compare your portion size to the following objects: A matchbox is equal to 1 ounce of protein, a deck of cards is equal to 3 ounces of protein and a paperback book is equal to 8 ounces of protein.

*Thank you to Intermountain ESRD Network, Inc.  
(Network 15) for this excellent resource!*



# Compliance Requirements

## CMS Forms Compliance Requirements

There has been a significant drop in overall compliance rates during the last year. Believing this was largely because of the significant changes in the 2728 last June, we analyzed the compliance data from June 1, 2005 through May 31, 2006. The analysis showed that 33.3% of the forms with errors were because Field 18d was not filled out completely. This is the field that reports data on the vascular access used at onset, whether there is a maturing AVF present and if there is a maturing AVG present. Any time AVF is not the access being used for the first outpatient dialysis it is necessary to answer both of the additional questions. The field should look like this if the patient was dialyzed using a catheter on the first treatment and has a maturing AVF:

d. What access was used on first outpatient dialysis:	<input type="checkbox"/> AVF	<input type="checkbox"/> Graft	<input checked="" type="checkbox"/> Catheter	<input type="checkbox"/> Other
If not AVF, then:	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No		
Is maturing AVF present?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
Is Maturing graft present?				

Another 19.3% of the errors are for failing to fully complete Field 23. This is the field indicating the primary type of dialysis. When hemodialysis is selected it is required to indicate the number of sessions per week and the number of hours per session. When correctly completed the field should look something like this:

23. Primary Type of Dialysis
<input checked="" type="checkbox"/> Hemodialysis (Sessions per week <u>3</u> /hours per session <u>4</u> )
<input type="checkbox"/> CAPD <input type="checkbox"/> CCPD <input type="checkbox"/> Other

As many of you have become aware, CMS has very strict requirements for submitting Medical Evidence (2728) and Death Notification (2746) forms in a timely and accurate manner. Any units falling below the 90% average annual compliance level are reported to CMS. Those units falling below 80% for semi-annual compliance were required to attend a Data Training session, which was held in conjunction with this year's Annual Network Forum meeting on October 11, 2006.

## Glomerular Filtration Rate (GFR) Criteria

As a reminder, Medical Review Board referral has been removed from the 2728 form. Instead, CMS has instructed Networks to review cases where facilities / physicians have 10% or more of new patients above the national threshold for Glomerular Filtration Rate (GFR). The GFR threshold is calculated annually and is set at two standard deviations above the previous year's national average GFR. The threshold for 2006 is 25.15. Additional information on GFR is available from our website at:

<http://www.fmqai.com/ESRD/pdf/GFR%20Criteria.pdf>.

## Quick Links

### Network Website

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

**Download 2728, 2746, and 2744 forms and instructions directly from CMS**

<http://www.cms.gov/CMSForms/CMSForms/list.asp> and do a search on the keyword ESRD.



In conjunction with the Fistula First Initiative, the Network has been monitoring vascular access rates for over two and a half years. As you can see, the state has made significant improvement in its fistula rates during that period. However, the national average continues to surpass the Network average. We must not let that continue!

The Centers for Medicare and Medicaid Services (CMS) has established the current Fistula First Breakthrough Initiative stretch goal as 66% AVF use as the primary access for hemodialysis patients by June 2009. We have significant work ahead of us, but the goal is achievable!

Continuing in its efforts to improve the quality of life and quality of care for ESRD patients in the state, Network 7 has re-initiated the Fistula First Mini-Collaborative. The Network 7 Fistula First Mini-Collaborative is modeled after the Institute of Healthcare Improvement (IHI) Breakthrough Series Collaboratives, which use the Model for Improvement, a “trial-and-learn” approach to quality improvement. The Model for Improvement couples three

fundamental questions with plan-do-study-act (PDSA) cycles:

- 1) What are we trying to accomplish?
- 2) How will we know that a change is improvement?
- 3) What changes can we make that will result in an improvement?

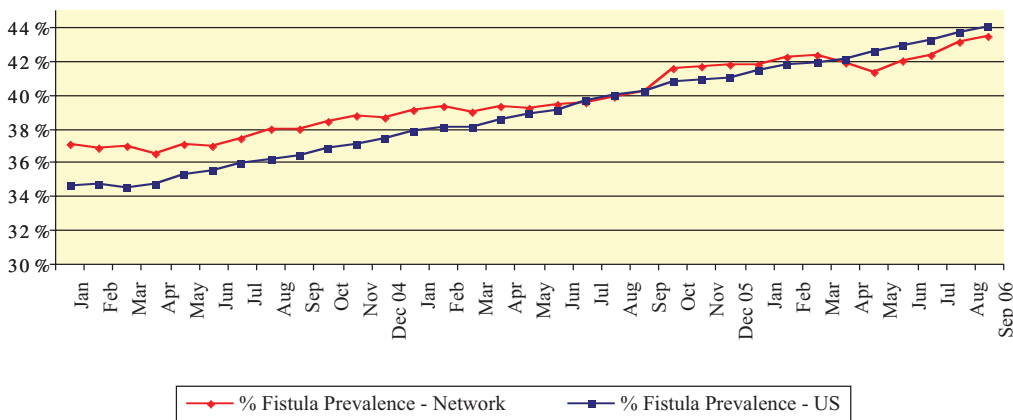
Using March 2006 data, all facilities with fistula rates below 30% were identified to participate in this rapid-cycle improvement project. These facilities will be working together during the next year to individually test system changes aimed at increasing the appropriate use of AVF for hemodialysis access and to collectively share learning.

During the coming year, forty-five dialysis facilities from across the state will be participating in monthly conference calls where “best practices” and “strategies to overcome barriers” will be discussed. The Network will also host three Learning Sessions where participants will have an opportunity to learn from faculty, receive individual coaching, gather knowledge on the subject matter and collaborate on improvement plans.

The first Learning Session was held in Tampa on September 19, 2006 with approximately eighty people in attendance. During the meeting, attendees had the opportunity to share a Story Board, which they had previously prepared. The Boards were intended to enlighten the audience about the facility and its special characteristics. Storyboards have been known to help create an environment conducive to sharing and learning from the experiences of others.

*(continued on page 4)*

**AVF Prevalence – Network vs United States**



## Fistula First Update (continued)

The 66% stretch goal can be accomplished through better communication, education, vascular access monitoring, early referral for intervention and utilization of proper procedures. The Network quality improvement staff is always available to provide technical assistance. If you require support with your vascular access quality improvement initiatives, please don't hesitate to contact us at (813) 383-1530 ext 5.

### 2006 Network Annual Forum Meeting Fistula First Champions

#### Most Improved AVF Rate

- Renal Care Group – Destin
- RAI Care Centers – Clearwater
- Greater Miami Dialysis

#### Fistula First Breakthrough Initiative (AVF rate $\geq$ 66%)

- Atlantis Dialysis Center
- BMA – Boynton Beach
- Complete Dialysis Care South
- Fort Walton Beach Dialysis
- Pine Island Kidney Center
- RCG Fort Walton Beach
- Renal Care Group Destin
- Universal Kidney Center, Inc.
- Universal Kidney Center of Boynton Beach
- West Boca Dialysis Center

Newsletter  
Submittals

## TELL US WHAT YOU'RE DOING!

Are you implementing any QI projects that are having a positive impact on patient outcomes or internal processes? Let us showcase your successes in our newsletter.

Contact:

**Cindy Woodward**, QI/Community Services  
By phone: 813-383-1530 x3882 or  
E-mail: [cwoodward@nw7.esrd.net](mailto:cwoodward@nw7.esrd.net)

## What, exactly, does Kt/V mean?

- **K** represents clearance of urea – a function of the dialyzer. Dialyzers with a small surface area (amount of fibers) and small fiber pore size, clear less urea than dialyzers with a larger surface area (more fibers) and larger permeability. Therefore, one avenue to increase Kt/V is to increase dialyzer size and / or dialysate flow rate--a commonly used intervention.
- **t** represents time – the length of time during which urea can be removed. Logically, longer dialysis treatments allow for more urea removal, which is why physicians may opt to increase dialysis time.
- **V** represents volume – the body volume of distribution for urea--considered to be the same as total body water. Obese individuals have less total body water (fat tissue contains less water) while lean, muscular individuals have more total body water (muscle tissue contains more water).
- Based on the formula, a higher K or t, (the numerator) increases the product. Conversely, a higher V (the denominator) decreases the product. You may have noticed the change that volume makes in regard to young, muscular patients. Typically these patients (higher volume) must dialyze longer than patients with less muscle mass--if V is higher, either K or t must increase to yield a higher product. It is important to note, however, that volume "is what it is," manipulating the volume for on-line clearance measurements to increase Kt/V simply increases the number mathematically, not the actual clearance.



# Vocational Rehabilitation Best Practices Checklist

- Upon admission meet with the patient and:
    - Encourage work retention
    - Educate about the benefits of employment
    - Engage in a discussion of personal rehabilitation goals, including but not limited to:
      - Vocational Rehabilitation programs
      - Activities that enhance independence and a higher quality of life, such as volunteer work or education
    - Offer to help with identified areas of need
    - Refer to resources as appropriate
    - Provide materials to aid in making important work, insurance and other lifestyle decisions, such as Network 7's 2006 Vocational Rehabilitation Toolkit – available at [www.fmqai.com](http://www.fmqai.com) or call 813-383-1530, ext. 3883
  - Provide patients with these tips about Vocational Rehabilitation (VR) services:
    - End Stage Renal Disease (ESRD) patients are eligible for VR counseling
    - VR can assist with training
    - VR offers help to individuals with keeping their current job
    - Be persistent with VR counselors
    - Inform the renal social worker if you need help
  - Patients who are already receiving SSDI or SSI may be referred to:
    - Social Security's Benefits Planning Assistance and Outreach (BPAO) program 866-352-2725
    - Maximus 866-968-7842 (Ticket to Work manager)
    - Local VR offices
    - Social Security Administration (SSA) *Working While Disabled* information
  - Prior to each Care Plan meeting, ask patients:
    - If they are satisfied with their current level of activity
    - If there have been any changes in their employment status
    - If they are interested in pursuing new educational interests
    - If they need assistance with their rehabilitation goals
  - Annually, per Network 7 Criteria & Standards:
    - Evaluate each patient age 18 through 54 for VR referral and make available to patients the VR resources obtainable in the area
    - Document VR status in the patient's medical record
- Resources**
- The Advocacy Center for Persons with Disabilities – Client Assistance Program (CAP) assists anyone with a disability that is interested in applying for and receiving services from Florida rehabilitation programs; CAP can investigate, negotiate and pursue administrative, legal and other remedies to ensure that client rights are protected 800-342-0823
  - Dialysis Facility Compare – Patients can find a center that meets their needs <http://www.medicare.gov/dialysis/>
  - Florida Alliance for Assistive Services and Technology (FAAST) – Provides hands on assistive technology demonstrations, training, access to personal computers and other items <http://www.faast.org/>
  - Florida Department of Education / Division of Vocational Rehabilitation (VR)
    - General information about VR including appeals rights can be found at [www.rehabworks.org](http://www.rehabworks.org)
    - Directory of VR offices <http://www.rehabworks.org/index.cfm?fuseaction=SubMain.Directory>
    - VR Ombudsman – will assist in resolving client services needs 866-515-3692
  - FMQAI: The Florida ESRD Network (Network 7) - Vocational Rehabilitation links and tools for download <http://www.fmqai.com/ESRD/CIR/Vocational%2DR%20ehabilitation/>
  - Home Dialysis Central – Information about home treatment modalities to suit individual schedule needs and enhance quality of life <http://www.homedialysis.org/>
  - Life Options Rehabilitation Program – Fact sheets about rehabilitation and other resources <http://www.lifeoptions.org/>

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# Q

## Quality Corner

### IMMUNIZATION AWARENESS

Medicare covers both the cost of pneumococcal and influenza vaccine and their administration by recognized providers. No beneficiary co-insurance or co-payment applies and a beneficiary does not have to meet his or her deductible to receive an influenza or pneumococcal immunization. Medicare also covers hepatitis B vaccination for persons at high or intermediate risk. The co-insurance or co-payment applies for hepatitis B vaccination after the yearly deductible has been met.

Despite Medicare coverage, the use of these benefits is not optimal. In 2004, Medicare survey data indicated a 73% influenza vaccination rate for facility and community-dwelling Medicare beneficiaries and a 67% pneumococcal vaccination rate for the same population. Additionally, dialysis patients are under-immunized. Vaccines are one of public health's great triumphs. With the exception of safe water, no other health strategy has had such a tremendous effect on reducing disease and improving health. Maintaining high immunization rates protects the entire community and is an important public health matter.

**Why Immunize Adults?** An average of 36,000 Americans die from influenza or its complications each year. The National Center for Health Statistics reported influenza and pneumonia to be the primary causes of death for more than 57,000 older adults in 2003. Pneumococcal disease occurs year round and accounts for approximately 40,000 cases of invasive disease and 5,000 deaths per year in the United States.

For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Medicare will cover a booster pneumococcal vaccine for high-risk persons if five years have passed since their last vaccination.

#### What's New?

- Nursing home residents are especially vulnerable to influenza and pneumonia and their complications. Beginning September 1, 2006, influenza and pneumococcal vaccination assessments will be included as part of the Minimum Data Set (MDS) for nursing homes.
- As of January 2005, all newly enrolled Medicare beneficiaries are covered for an initial physical examination that includes immunization for pneumococcal disease and influenza.
- As of January 2005, physicians can be paid for injections and immunizations administered to people with Medicare, even when administered during a visit that includes other Medicare-covered services.
- As of October 2002, hospitals, long-term care facilities and home health agencies participating in Medicare and Medicaid programs can administer influenza and pneumococcal vaccinations according to a standing orders protocol without the need for a physician's examination or direct order.
- Quality Improvement Organizations in each state are working to increase immunization rates in hospitals, physicians' offices, home health care settings and nursing homes.

**How Can You Help?** As a trusted source, your recommendation is the most important factor in increasing immunization rates among adults.

For more information about Medicare's adult immunization benefits, billing Medicare for vaccinations, and other helpful information, visit the CMS Web site: [http://www.cms.gov/AdultImmunizations/01\\_Overview.asp](http://www.cms.gov/AdultImmunizations/01_Overview.asp).

# DID YOU KNOW???

*The ESRD Network of Florida is Available to Provide Technical Assistance!*

## Quality Improvement

- Assist, facilitate, educate and clarify CMS QI Projects for facilities as they implement the projects.
- Assist with the development/implementation of CQI Projects in facilities.
- Assist, clarify, educate on completion of QI related forms (CPM, CDC, etc.).
- Encourage the development of emergency preparedness policies & procedures at the facility level (to include a backup plan).
- Available to review Corrective Action Plans for completeness/accuracy before facilities submit them to AHCA.
- Available to educate on the Conditions of Coverage and its interpretation as well as the Network's Criteria & Standards.

## Information Systems

- Assist, educate, facilitate and clarify information for the completion of CMS Forms (2728, 2746, 2744, Patient Activity Report).
- Assist, facilitate, educate on reports sent to facilities from the Network (Missing Forms Report, Vocational Rehabilitation Survey, Compliance Report, etc.).
- Assist with data requests from facilities, insurance providers.
- Supply facilities, by request, with 2746 forms.

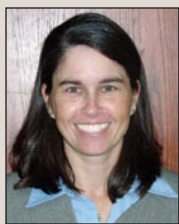
## Patient Services

- Assist, clarify and educate on grievance procedure & due process.
- Mediate between patients & facilities via telephone.
- Assist with the provision of community resource information and materials as available.
- Develop and host patient education workshops throughout the state.
- Provide Vocational Rehabilitation and emergency preparedness information to facilities and patients.
- Assist patients to locate facilities when traveling or as needed (we can not force a facility to accept a patient, just identify the ones available in the area).
- Maintain an 800 # for patient use throughout the state of Florida.
- *Accept collect calls from patients only.*

## Administrative

- Assist, clarify and educate facilities with CMS requirements.
- Communicate changes in CMS that will impact facilities via Fax Blast, e-mail (where available), informational mass mailings, workshops/professional meetings and Annual Meeting.
- Represent the needs of our community to CMS.
- Develop partnerships with organizations to address quality as an outcome in ESRD.
- Facilitate involvement in Network boards and activities from all aspects of the ESRD community.
- Involve the community proactively in the improvement of care in the state of Florida.
- Communicate with facilities on the status of the Network and its activities.

Contact the Network at (813) 383-1530 or [info@nw7.esrd.net](mailto:info@nw7.esrd.net)



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## FROM THE PROJECT DIRECTOR

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**A**s part of our efforts to provide professional education, the Network hosted its 2006 Annual Forum from October 11-13, 2006 in St. Petersburg at the Hilton St. Petersburg Bayfront. Almost 300 people attended this exceptional meeting, which focused on “Changing the Culture of ESRD Care.” The Annual Forum provided presentations from both national and local speakers. Among some of the most stimulating topics and best evaluated speakers were “Are You Prepared for a Pandemic?” by Michael Jacobs; “Pay for Performance” by Jeffrey Sands, MD; and “Debate: Evolving Issues in Living Donation” by Victor Bowers, MD and Thomas Peters, MD.

In addition to the outstanding educational sessions, FMQAI also presented its annual awards, recognizing excellence in ESRD care. The event honored several outstanding people and facilities for their exceptional work during 2006. Awards were presented for Fistula First Champions, Data Achievement, Community Services, Outcomes Excellence and Volunteer of the Year. A unique award was also presented this year to honor the life and work of a Network staff member that passed away in May 2006.

### **Fistula First Champions**

As part of the Centers for Medicare and Medicaid Services Fistula First Breakthrough Initiative, the Network continues to work with dialysis facilities, nephrologists, surgeons and other key partners to reach the goal of 66% of patients with AV fistulas. Network 7 recognized ten facilities that have already reached the “Breakthrough Initiative” goal. Additionally, the Network was pleased to honor three facilities, which showed the greatest AVF improvements during the last 12 months.

### **Data Achievement Award**

This award was given to thirty-seven ESRD facilities exemplifying excellence in data management. Fifteen of those facilities were receiving the Data Achievement Award for the second year in a row. Criteria for consideration included the consistent submission of 100% accurate and timely data for all CMS forms (2728s and 2746s) and the Patient Activity Reports.

### **Community Services Award**

The Community Services Award was developed to honor an organization or individual who had made an outstanding effort to improve the quality of services for Florida kidney patients. The Network was pleased to recognize Laurie Shore, MSW, LCSW from the LifeLink HealthCare Institute for her dedication and collaboration with the Florida renal community to ensure that all ESRD patients have the skills and knowledge to help themselves, be knowledgeable about their care and improve their level of independence. Additionally, through her ability to establish partnerships in the renal community and the general public, she has made positive impacts, both in Florida and nationwide, on topics including disaster preparedness and Medicare Part D.

### **John Cunio, MD Memorial Award for Excellence**

The criteria used in assessing potential candidates for this award were: standardized mortality and hospitalization ratios, anemia management, adequacy of dialysis and AVF rates. Four facilities received honorable mention for their outstanding achievements – RCG – Sacred Heart – Pediatric Dialysis, University Artificial Kidney Center, Renal Care Group – Destin, and BMA – Boynton Beach. Then, the Network presented the John Cunio, MD Memorial Award for Excellence to Complete Dialysis Care South for its excellence in the management of patient outcomes for Florida ESRD patients.

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## From the Project Director ...continued from page 8

### **Volunteer of the Year Award**

In appreciation for her valuable leadership, and in grateful acknowledgement of her talents and service so freely and unselfishly given, FMQAI: The Florida ESRD Network presented Linda Carroll, RN with the Volunteer of the Year Award. Her contributions include many aspects of the Network program, which are not traditional ESRD activities. With her extensive renal experience and the talent for collaboration, Linda has worked diligently to increase the number of working patients in our state. Additionally, as a leader of the Florida Kidney Disaster Coalition, she has focused on the development of tools and resources to ensure patients receive dialysis treatments, especially during emergencies.

### **Susan V. McGovern, ARNP, MS Memorial Award**

As announced earlier this year, the Network staff lost a key member of its team – Susan McGovern -- after a two-year battle with breast cancer. Susan made a tremendous difference to our staff and to our community. To honor her memory, the Network created an annual award “honoring the quest for continuous quality improvement, the desire to teach others, and the willingness to serve the renal community at the highest level.” With Susan’s mother, Marie McGovern, and sister, Diane Holmes in attendance, the Network was pleased to present Norma Gomez, MBA, RN, CNN with the inaugural Susan V. McGovern, ARNP, MS Memorial Award. Norma truly defines the uniqueness that Susan portrayed in her work. Both statewide and nationally, she has worked for the constant improvement in patient care, the education of nephrology nurses and the development of disaster preparedness best practices. Her invaluable knowledge and unflinching dedication has improved the quality of care and quality of life for kidney patients.

Overall, FMQAI: The Florida ESRD Network has continued to show improvement in patient outcomes, but this success wouldn’t be possible without all of you. The Network thanks you for your cooperation and support. Together, we improve the quality of care and quality of life for our Florida ESRD patients.

*Kelly M. Mayo, MS*

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## **FREE CEU OFFERINGS!**

### **Implementation and Use of the DCP Toolbox - 1 Free CEU**

The Decreasing Patient/Provider Conflict (DPC) ToolBox was created by the ESRD community as a resource for Dialysis and Transplant Centers. Using the DPC ToolBox assists providers of dialysis and transplant services to better cope with the issue of conflict. This class “trains the trainer” to use the DPC ToolBox and implement the three training steps of the DPC project.

### **Water Treatment for Dialysis - 1 Free CEU**

This course examines the need for pure water and the function of a water treatment system necessary to produce hemodialysis quality water. This course can be taken by nurses, technicians, physicians, social workers and administrators that are involved with dialysis patient care. The emphasis will be to provide the individual with a brief overview of why water quality is important. It also identifies and explains the key components that are contained within a water treatment system.

Access these online education courses at:

<http://learning5.flqio.org/course/category.php?id=7>



## Tools and Resources for Assessing Functional Status of ESRD Patients

FMQAI: The Florida ESRD Network (NW7) Criteria & Standards require that the MSW recommend to the physician, patients with severe psychological problems or difficulty in coping [with the complexities of ESRD] for referral to appropriate psychosocial resources in the community. Use of quality of life assessment tools can be an important step in improving patient health, decreasing hospitalization, increasing adherence, improving rehabilitation potential and decreasing mortality rates. Many corporate dialysis organizations have a tool that they recommend and make available to staff for implementing and scoring. The following are some additional resources and tools that can aid renal social workers in the assessment of the functional status of patients:

- **The Kidney Disease Quality of Life survey (KDQOL)** is a disease-specific survey that includes a generic functioning and well-being survey plus questions related to kidney disease like burden of illness, satisfaction with care, sexual functioning and more. You can find a couple of versions of the survey and associated scoring templates online at the KDQOL website (both are free, but you must register to download them) at <http://www.gim.med.ucla.edu/kdqol/>
- **The SF-36** is a Quality of Life (QOL) instrument available at <http://www.sf-36.org/>. This website has both the SF-36 and SF-12 samples. Before administering these forms, registration and licensing fees are required.
- **The Geriatric Depression Scale** (short form) is available at <http://www.stanford.edu/~yesavage/GDS.html> and can be downloaded for your use free of charge. It is easy to score, and scores can be prorated to remove the somatic components such as energy, appetite, etc. A Spanish version is also available.
- **The Beck Depression Inventory Fast Screen** for medical patients is copyrighted and is available for a fee. The BDI Fast Screen was constructed to reduce the number of false positives for depression in patients with known biological, medical or substance abuse problems.
- **The Physicians Health Questionnaire (PHQ-9)** is copyrighted, and is available in English and Spanish. To read and agree to the terms of usage, locate scoring instructions and register for download go to <http://www.depression-primarycare.org/clinicians/toolkits/>
- **The Council of Nephrology Social Workers (CNSW)** has a listserv where social workers can join and request peer input on difficult cases: <http://www.kidney.org/professionals/CNSW/>

Additional resources are available for patients:

- **Coping Effectively: A Guide for Patients and Their Families** is a booklet available through the National Kidney Foundation at [www.kidney.org](http://www.kidney.org)
- **Just the Facts: Dealing with Depression** is a two-page fact sheet on depression available at [www.lifeoptions.org](http://www.lifeoptions.org)
- **American Association of Kidney Patients (AAKP)** provides information and support to patients. Log on at [www.aakp.org](http://www.aakp.org)

For further information about assessing the functional status of patients, contact:

Lisa Drossos, MSSW, LCSW  
FMQAI: The Florida ESRD Network  
[Ldrossos@nw7.esrd.net](mailto:Ldrossos@nw7.esrd.net)  
813-383-1530, ext. 3883  
[www.fmqai.com](http://www.fmqai.com)

## Voc Rehab Checklist *(continued from page 5)*

- Social Security Administration - *Working While Disabled* information <http://www.ssa.gov/pubs/10095.html> Spanish Version <http://www.ssa.gov/espanol/10995.html>
- Social Security's Benefits Planning Assistance and Outreach Program (BPAO) - Assists individuals with

questions, resources and support related to returning to work; a locator map for Florida Outreach offices is available at <http://www.goodwilljax.org/BPAO.pdf>

- United Network for Organ Sharing (UNOS) – Provides transplantation and donation information <http://www.unos.org/>

## Organ Donation: Common Questions & Answers

*Each day, about 74 people receive an organ transplant. However, seventeen people die each day waiting for transplants that can't take place because of the shortage of donated organs.*

### **Who can become a donor?**

All individuals can indicate their intent to donate (persons under 18 years of age must have parent's or guardian's consent). Medical suitability for donation is determined at the time of death.

### **Why is it important for minorities to donate?**

The need for transplants is unusually high among some ethnic minorities. Some diseases of the kidney, heart, lung, pancreas and liver that can lead to organ failure are found more frequently in ethnic minority populations than in the general population. For example, Native Americans are four times more likely than Whites to suffer from diabetes. African Americans, Asians, Pacific Islanders and Hispanics are three times more likely than Whites to suffer from kidney disease. Many African Americans have hypertension, which can lead to kidney failure. Some of these diseases are best treated through transplantation; others can *only* be treated through transplantation.

The rate of organ donation in minority communities does not keep pace with the number needing transplants. Although minorities donate in proportion to their share of the population, their need for transplants is much greater. African Americans, for example, are about 13 percent of the population, about 12 percent of donors, and about 23 percent of the kidney waiting list.

Successful transplantation is often enhanced by matching of organs between members of the same racial and ethnic group. Generally, people are genetically more similar to people of their own ethnicity or race than to people of other races. Therefore, matches are more likely, and more timely, when donors and potential recipients are members of the same ethnic background.

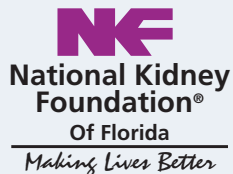
Minority patients may have to wait longer for matched kidneys and therefore may be sicker at the time of transplant or die waiting. With more donated organs from minorities, finding a match will be quicker and the waiting time will be reduced.

### **Can a person with a previous medical condition donate an organ?**

Even if you have any pre-existing medical circumstances or conditions, determination of suitability to donate organs or tissue may be based on a combination of factors that take into account the donor's general health and the urgency of need of the recipient. This determination is usually done by the medical staff that recovers the organs or by the transplant team that reviews all of the data about the organ(s) or tissue that have been recovered from the donor.

### **If a person decides to donate, will that affect the quality of care received in the hospital?**

No, every effort is made to save your life before donation is considered.



NATIONAL KIDNEY  
FOUNDATION  
OF FLORIDA

**2007 Miami Kidney Walk**

Sunday, February 11, 2007 Bayfront Park  
Registration 9:00 am • Walk begins at 10:30 am

The Kidney Walk is a 2 mile non-competitive walk to raise money and awareness about kidney disease. It is an occasion for dialysis patients, organ transplant recipients, living donors, donor families, the medical and business communities and the general public to come together to celebrate life and create lasting community advocacy.

***Kidney Facts:***

- More than 20 million people have kidney disease--most don't know it--and at least 20 million more are at risk.
- Nearly 90,000 people are waiting for organ transplants; 17 people die every day while they wait.
- Of every NKF dollar, 83 cents goes directly to programs and services, exceeding industry standards.



**New WebEx Session on the ESRD Network Website!!**

***Best Practices to Maximize Arteriovenous Fistula (AVF)  
Through Joint Initiatives***

***Presented by:  
Marwan Tabbara, MD, FACS***

The session may be found on the Network website at [www.fmqai.com/ESRD/About-Network-7/Events/](http://www.fmqai.com/ESRD/About-Network-7/Events/)  
If you have questions regarding this material, you may direct them to the attention of Kim Schroeder at (813) 383-1530 ext. 3822.



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