

Conflicting
Information
Reports
...page 2



Monitoring &
Surveillance
...page 3



Hospice &
ESRD
...page 5



Anemia
Guidelines
...page 6



Volume IV, Issue 1

FMQAI Access

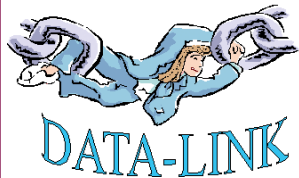
The Florida ESRD Network

BUTTONHOLE TECHNIQUE

Useful Information

- For use with native AV fistulas only
- Used for over 25 years in Europe
- Fewer missed sticks, infiltrations and hematomas
- Scab removal is critical in preventing infection. The following are some scab removal tips:
 - ✓ Moistening scabs make them easier to remove
 - ✓ Tweezers can be used, but should be disinfected prior to scab removal
 - ✓ Use 2 X 2s and soak with saline, an alcohol-based gel or whatever antimicrobial prep you use on the sites and place over sites until moist
 - ✓ Have the patient place an alcohol square over each site before coming to the dialysis unit
- Track formation requires the same angle and depth of entry with every cannulation
- Requires the same cannulator until the track forms
- Changing to blunt needles after the track is formed prevents cutting of the track
- Non-diabetics will form a track in approximately eight days; diabetics in approximately twelve days
- Not everyone is a candidate for buttonhole. The following would be unlikely candidates:
 - ✓ Patients with heavily scarred fistulas
 - ✓ Patients with large amounts of subcutaneous tissue in the upper arm





Conflicting Information Reports – What are they and what do I do with them?

These are the faxes you get periodically from us indicating that CMS has different information on file than what you have reported to us for one or more of your patients. Since we don't know which is right, we are asking you to verify with your internal records, the patient, or whatever means seems appropriate, which of the indicated values is correct. Making corrections on this report will not effect your forms compliance accuracy rate.

Let's take a closer look at the report –

Conflicting Information Report			ATTN: JANET LEA HUTCHINSON	
123 102999 ABC DIALYSIS CENTER			FAX: (813)383-1530	
The Network has received conflicting information regarding the patient(s) listed below from two or more sources. Please CIRCLE the correct value.				
SSN	Name	Element in Question	First Value	Second Value
123456789	SMITH, JULIE	SURNAME	SMITH	SMYTHE
987654321	JONES, SAMMIE	FIRSTNAME	SAMUEL	SAMMIE
012345678	RABBIT, PETER	HIC	012345678T	999888777C3
111222333	PENDRAGON, UTHER	DOD		10/06/1066

For the first record, we don't know if Julie's last name is Smith or Smythe. We need you to confirm by circling the correct spelling of the last name.

Similarly, for the second record, we are unable to tell if Mr. Jones has given you his nickname or if his given name is actually Sammie. Circle whichever is his given name. It is also possible that none of the values on the report are correct. If you have subsequently discovered that his name is actually Sam, please write that in and circle it.

The next record is a little trickier. Mr. Rabbit had a temporary HIC Number at one point, but CMS has a match for him as the third child (hence the "C3") entitled to benefits under the Medicare number of a parent. We need you to check his Medicare card and confirm the correct number. Please keep in mind that CMS may have matched him to the wrong beneficiary so we

ask you not to assume the different number is correct. Again circle the correct number.

Lastly, it seems that someone has reported that poor Mr. Pendragon has died. We need you to let us know if the patient has died and confirm the correct date of death. If the patient has discontinued dialysis and subsequently died, you need to indicate the discontinue date on this report and complete the 2746 (Death Notification) form. Even if you are unable to confirm the death date, we need at least the date the patient discontinued dialysis. Inaccurate responses here could impact on the patient's benefits and your facility's reimbursement. Please pay particular attention to these records.

Once you have circled the correct response for each record, and made any other annotations necessary, simply fax the form back to the

Network office.

FORMS TIPS 2728 Tips

CMS requests that all available lab data be entered on the form, but only the Serum Creatinine is required. Lab Method Used: BCG = bromcresol green and BCP = bromcresol purple. Each lab will probably use one method or the other exclusively. Contact the lab to see which it is and ask them to notify you if they change their method or use different methods for each patient.

If the patient is informed of transplantation as a treatment option, either by your facility, their nephrologist or another party, and as long as you have documentation in the patients file confirming that before submitting the form to the Network, it is acceptable to answer yes.

continued on page 4

Summary of KDOQI Guidelines “Detection of Access Dysfunction: Monitoring, Surveillance and Diagnostic Testing”

Physical Examination (monitoring): A qualified individual should use physical examination to detect dysfunction in fistula and grafts at least monthly.

◆ Surveillance of Grafts

- Preferred:
 - ✓ Intra-access flow by using one of several methods using sequential measurements with trend analysis
 - ✓ Directly measured or derived static venous pressure by one of several methods
 - ✓ Duplex Ultrasound
- Acceptable:
 - ✓ Physical findings of persistent swelling in the arm, presence of collateral veins, prolonged bleeding after needle withdrawal or altered characteristics of pulse or thrill in a graft
- Unacceptable:
 - ✓ Unstandardized dynamic venous pressures (DVPs) should not be used

◆ Surveillance of Fistulae

- Preferred:
 - ✓ Direct flow measurements
 - ✓ Physical findings of persistent swelling in the arm, presence of collateral veins, prolonged bleeding after needle withdrawal or altered characteristics of pulse or thrill in a graft
 - ✓ Duplex Ultrasound
- Acceptable:
 - ✓ Recirculation using a non-urea-based dilution method
 - ✓ Static pressure, direct or derived

◆ Referral for Diagnosis and Treatment

- Caregivers should not respond to a single isolated abnormal value. With all techniques, prospective trend analysis of the test parameter has greater power to detect dysfunction than isolated values alone.
- Persistent abnormalities in any of the monitoring or surveillance parameters should prompt referral for access imaging.
 - ✓ An access flow rate less than 600 ml/min in grafts and less than 400 - 500 ml/min in fistulae
 - ✓ A venous segment static pressure (mean pressure) ratio greater than 0.5 in grafts and fistulae
 - ✓ An arterial segment static pressure ratio greater than 0.75 in grafts



Conflicting Information Reports ...continued from page 2

Commonly Missed Fields

Length of therapy prior to ESRD: Make sure you indicate how long the patient was receiving EPO (or equivalent), under the care of a nephrologist or kidney dietitian prior to beginning dialysis. If it was less than 6 months and you are using a form that doesn't have a check box for < 6 months, either write in "< 6 months" or indicate that it was less than 6 months in the Remarks section.

Sessions per week and hours per session: For all hemodialysis patients it is necessary to enter "how many times per week" and "hours per session" that have been prescribed for the patient. Please round the number of hours to the nearest whole number, ie for 3.5 hours enter 4 hours.

Common 2728 Errors

- A Initial** – For patients who initially receive a kidney transplant instead of dialysis and for patients entering an outpatient dialysis setting for the first time ever.
- Re-entitlement** – For those patients returning to dialysis after recovering kidney function for more than 12 months or receiving a kidney transplant where the transplant functioned for more than 3 years.
- Supplemental** – For those patients who receive a kidney transplant or are trained for self-care dialysis within the first 3 months after the first outpatient dialysis.
- 9 Country/Area of Origin** – If Hispanic, Latino, Native Hawaiian or Other Pacific Islander, indicate country of origin
- 16 Employment Status** – Indicate status both six months prior to the patient becoming ESRD, and currently.
- 18a, 18b, 18c Prior to ESRD therapy** – If yes, indicate how long.
- 18d What access was used on first outpatient dialysis** – Only applies to vascular access. If peritoneal access do not check Catheter. Leave blank.
- If not AVF** – Indicate Y/N for AVF maturing and Y/N for graft maturing. Both questions must be answered even if Graft was checked as access first used.
- 19 All Fields** – Dates for labs must be before physician signature date in field 50.
- 26 & 27 Has patient been informed of kidney transplant options** – If patient not informed of transplantation, indicate why not.
- 50 & 55 Physician and Patient Signature** – Dates must be on or after the first date at the unit in field 25.
- 51 Recertification** – To be signed by physician who is currently following the patient if the patient had chosen to delay applying for Medicare benefits.

Death Notification Form (CMS-2746-U3) 2746 Tips

Discharged patients are required to be followed for 30 days unless they are transferred to another Medicare provider who is approved for ESRD services. This applies to all patients including those who discontinue dialysis or who transfer to Hospice. Additionally, if the patient dies within that time, Centers for Medicare and Medicaid Services (CMS) requires the last provider of ESRD service to submit an ESRD Death Notification form (CMS-2746) to the Network office.

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.

Hospice & ESRD

Hospice is a team approach to health care that helps patients at the end of life, either at home or in a facility. Hospice care provides physical, emotional and spiritual comfort for the patient, and education and support for the patient and family. It is possible for dialysis patients to receive hospice care.

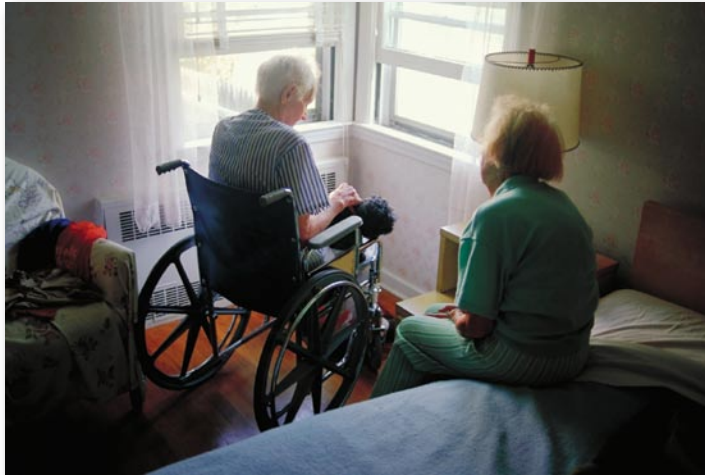
Hospice is paid for through the Medicare Hospice Benefit, Medicaid Hospice Benefit and most private insurers. If a person does not have insurance coverage, hospices will work with the person and his/ her family to ensure needed services are provided. Hospice is available to all persons regardless of age, race or religion.

Underutilization of hospice in the end-stage renal disease (ESRD) population may be fostered by confusion with regard to eligibility and variability of providers to accept ESRD patients. A patient with ESRD may receive Medicare coverage for hospice services. Medicare coverage for both dialysis and hospice services is available under separate benefits for ESRD and hospice. ESRD patients are not required to withdraw from dialysis to be eligible for the Medicare hospice benefit.

ESRD patients who choose to withdraw from dialysis may receive Medicare coverage for services via the hospice benefit. In this situation, ESRD may be considered the terminal diagnosis and all services related to ESRD would be covered under the Medicare hospice benefit.

ESRD patients with a terminal diagnosis other than ESRD who choose to continue dialysis for palliative reasons may receive the Medicare hospice benefit for services related to the terminal diagnosis. Hospice services not related to the terminal diagnosis are not covered under the hospice benefit. Thus, Medicare

coverage for services related to ESRD (including dialysis and non-dialysis renal related services) would continue under the ESRD benefit.



ESRD patients may elect to use the hospice benefit under a diagnosis of ESRD as the terminal diagnosis. In this situation, the hospice provider must be responsible for all dialysis and supplies as part of the care for the terminal diagnosis and palliation. This must be reflected in the plan of care. Under these circumstances, the Medicare hospice benefit would be engaged without the Medicare

ESRD benefit. A diagnosis of ESRD may be used as the terminal diagnosis only when 1) the hospice provider accepts responsibility for dialysis and non-dialysis renal related services or 2) a patient chooses to withdraw from dialysis.

Additional information on the Medicare Hospice Benefit is available by visiting the [Centers for Medicare & Medicaid website](http://www.cms.gov/center/hospice.asp) at <http://www.cms.gov/center/hospice.asp>. This resource has been developed to incorporate all Medicare Fee-for-Service Hospice information in one location. It includes billing and payment information, CMS Manuals and educational resources.

Educational Tools for Dialysis Facility Staff and Hospice Providers:

Did this patient die with hospice? New questions in caring for patients with ESRD (PDF) at <http://www.kidneyeol.org/DavisPPT.pdf>

Hospice in ESRD: To Withdraw or Not to Withdraw (PDF) at <http://www.kidneyeol.org/SchmidtPPT.pdf>

Network 7 would like to thank Network 5 and the Kidney End-of-Life Coalition for developing this wonderful resource!

Key Differences Between the 2006 KDOQI Anemia Clinical Practice Guidelines & Recommendations and the Previous Guidelines

Topic	KDOQI 2000	KDOQI 2006
Hb Treatment Range	11.0 to 12.0 g/dL	<ul style="list-style-type: none"> At or above 11.0 g/dL Caution when intentionally maintaining Hb>13.0 g/dL
TSAT	20% to 50%	<ul style="list-style-type: none"> Lower boundary of 20% Upper boundary not specified
Ferritin	100 to 800 ng/mL	<ul style="list-style-type: none"> Lower boundary of 100 ng/mL for peritoneal dialysis and 200 ng/mL for hemodialysis Ferritin greater than 500 ng/mL not routinely recommended
Adjuvants	L-carnitine not recommended	<ul style="list-style-type: none"> L-carnitine and vitamin C not routinely recommended Androgens not recommended

Reference – National Kidney Foundation (NKF) 2006 KDOQI clinical practice guidelines and clinical practice recommendations for anemia in chronic kidney disease.



FMQAI: The Florida ESRD Network
Presents



PATIENT & FAMILY CONFERENCES 2007

- * Sarasota – March 25, 2007
- * Jacksonville – April 22, 2007
- * Boca Raton – May 20, 2007

TOPICS:

Self-Care *In and Out* of the Dialysis Clinic
“Are You Prepared?” – A Survival Kit for Disasters
AV Fistula: The Best Choice for Hemodialysis Access

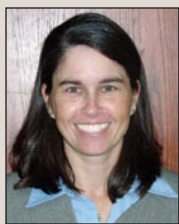
For more information, please call: (800) 826-3773 or (813) 383-1530 ext. 3882

CONGRATULATIONS!!

FMQAI: The Florida ESRD Network is pleased to announce that the following facilities were recently recognized as a “Fistula First Champion Facility” for the Fistula First Breakthrough Initiative. By implementing change concepts and demonstrating leadership in the renal community, these facilities have surpassed the 50% AVF goal for two consecutive months (Aug. & Sept. 2006).

Facility	Prev AVF %
Memorial Regional Hospital Dialysis	62.50%
VAMC – Bay Pines	65.71%
VAMC – Palm Beach Dialysis	57.69%
South Broward Artificial Kidney Center	50.85%
BMA – Orlando	54.29%
BMA – Gainesville	52.05%
Melbourne Kidney Center	62.5%
West Florida Dialysis	62.24%
Jupiter Kidney Center LLC	55.10%
FMC Dialysis Services – Key West	54.55%
NW Broward Artificial Kidney Center	61.19%
Broward Dialysis	54.46%
Florida Kidney Center	52.34%
Renal Care Center – Sebring	61.36%
BMA – Metropolitan Miami	61.54%
Watson Clinic Kidney Center	51.76%
Cape Coral Dialysis	56.25%
West Boca Dialysis Center	69.57%
Greater Miami Dialysis	63.53%
Zephyrhills Dialysis	54.39%
West Kendall Dialysis Center	56.14%
Sarasota Physicians Dialysis Center	50.00%
BMA – East Orlando	53.33%
Artificial Kidney Center Broward West	50.91%
North Palm Beach Dialysis Center	54.17%
Lake Worth Dialysis	50.00%
Complete Dialysis Care	61.98%
Palm Bay Kidney Center	59.41%
Pinnacle Dialysis Inc.	55.05%
AKC of Deerfield Beach	50.85%
Nephrology Center of Crestview	50.00%
Ocala Regional Kidney Center East	50.35%
Ocala Regional Kidney Center West	56.67%
Miami Beach Kidney Center, Inc.	56.00%
RAI Care Centers – Lake Wales	53.85%
New Smyrna Beach Dialysis	58.97%
Nephrology Center of Century	68.97%
RCG – Ft Walton Beach	63.24%
RAI Care Centers – Punta Gorda	56.00%
Pine Island Kidney Center	62.50%

Facility	Prev AVF %
BMA – Boynton Beach	77.78%
Atlantic Kidney Centers LLC	54.10%
BMA – South Ft Myers	57.14%
South Beach Dialysis	63.10%
Nephrology Center of Milton	53.33%
Crystal River Dialysis Center	52.87%
Santa Rosa Dialysis	59.09%
North Melbourne Dialysis Inc.	62.50%
NRI – Lakewood	60.00%
Miami Artificial Kidney Center LC	50.91%
Universal Kidney Centers Inc.	70.15%
FMC Dialysis Services – Clewiston	60.71%
RCG – Sacred Heart – Adult Dialysis	57.63%
BMA – West Dade	50.82%
FMC Dialysis Services – West Palm Beach	50.00%
Bonita Springs Dialysis	57.69%
North Okaloosa Dialysis Center	54.17%
NRI – Tampa Central	50.00%
FMC Dialysis Services – Alachua	58.97%
FMC Dialysis Services – Ft. Lauderdale	55.84%
St. Petersburg Dialysis	50.00%
Miami North Dialysis	55.17%
Universal Kidney Center of Boynton Beach	71.70%
Miami East Dialysis	55.95%
The Venice Kidney Center	58.00%
Boynton Beach Dialysis Center	54.55%
Ocala Regional Kidney Center North	66.67%
FMC – Dialysis Services – North Boynton Beach	54.55%
Harbor City Dialysis	57.69%
Fort Walton Beach Dialysis	62.96%
Florida Dialysis Institute	56.69%
Universal Kidney Center Of Davie	52.24%
FMC – Royal Palm Beach	62.86%
Renal Care Group – Destin	64.29%
East Ft Lauderdale Dialysis Center LLC	54.29%
Atlantis Dialysis Center	69.00%
Renal Care Group – Navarre	79.17%
Dialysis Care Center of Daytona	52.08%
Miami Childrens Hospital Dialysis Unit	50.00%



FROM THE PROJECT DIRECTOR

FMQAI: The Florida ESRD Network is growing and busier than ever. In addition to serving the Florida renal community through quality improvement, patient and professional education, technical assistance, data management and operation of a grievance mechanism -- Network 7 was awarded three additional contracts that provide a positive impact nationwide. One is related to disaster preparedness and response within the renal community and is based on the good work of our Florida providers. The other two contracts focus on the development of CROWNWeb, which stands for Consolidated Renal Operations in a Web-enabled Network. In the near future, CROWNWeb will serve as a secure, web-based tool for facilities to provide patient data, such as information for the 2728 and 2746.

Kidney Community Emergency Response (KCER) Coalition

In January 2006, the Kidney Community Emergency Response (KCER) Coalition was formed and began development of a national strategic plan for all types of disasters. CMS and FMQAI, through the Network Coordinating Council, has now assumed the administrative support lead for coordination of coalition activities with strong support and participation from the full kidney community, including practitioners, dialysis and transplant facilities, suppliers, beneficiary representatives, local/state/federal agencies, ESRD Networks and other key partners.

On March 1st of this year, KCER held its 2007 Summit, with more than 125 attendees participating in this daylong strategic planning activity. With lessons learned from 2006 disaster events and a tabletop mock disaster drill, the Summit was an overwhelming success. Using information from the Summit, over the next six months, Network 7 and the KCER Coalition will focus on:

- Testing and refining the national response strategy that has been put into place to assist federal, state and local efforts in the event of an emergency and/or disaster.
- Raising public awareness of the critical needs of individuals with kidney failure and the providers that serve them, and the need to plan ahead to ensure that the life saving dialysis services are available and obtainable in the event of an emergency or disaster.
- Promoting and disseminating tools and resources that are available to individuals with kidney failure, dialysis facilities, transplant facilities and key partners in emergency response at the federal, state and local level.
- Planning for a possible flu pandemic, including provisions to provide care under the conditions of scarce resources.

More information about KCER may be found online at www.KCERCoalition.com.

Network IT Support & Quality Infrastructure Support

For the past eight months, Network 7 has been supporting the current data system used by all ESRD Networks across the country – called SIMS – Standard Information Management System. This is the main goal of the Network IT Support contract. While much of this work is not viewed or used directly by ESRD providers, the activities do support Clinical Performance Measures (CPM), lab data collection, annual facility survey, VISION and other business needs.

Under the Quality Infrastructure contract, Network 7 works with the renal community, CMS and other stakeholders to develop business requirements for the CROWNWeb system. A business requirement or set of business requirements actually defines “what” the electronic system’s capabilities will be. A Kidney Data Dictionary (KDD) is also under

continued on page 9



From the Project Director ...continued from page 8

development and provides detail for all elements that will be included in CROWNWeb, including field name, format or data entry method, definition, permissible data values and other field level requirements. This single, standardized KDD will support quality improvement in the ESRD Program, and initially will contain definitions and representations of necessary data elements for CMS forms 2728, 2746, 820, 821 and other data.

Development of these tools have been created with great input from all aspects of the renal community through use of:

- Data Management Workgroup – (December 2006) developed security requirements, such as user roles and permissions.
- Clinical Performance Measures Workgroup – (February 2007) reviewed clinical data elements and outlined future comparative reporting.
- CRAFT Conference Calls – (Monthly) provide feedback on current Business Requirements and KDD, as well as other issues that impact the data system.
- Alpha Testers – (Daily) use, assess and provide comments on CROWNWeb so that the electronic system can be improved for future use by all providers nationwide.

If you are interested in being an Alpha Tester, participating in CRAFT calls or receiving information about CROWNWeb, please send an email to CRAFT@nw7.esrd.net and we will respond immediately. Ongoing feedback from both dialysis and transplant facilities is key to the development of the CROWNWeb system.

These new opportunities allow Network 7 and the Florida renal community to demonstrate and share its expertise and knowledge across the country. We would like to specially acknowledge several Florida renal professionals for their time and participation in these new contract activities – Sue Rottura (American Renal Associates), Maureen Michael (Central Florida Kidney Centers), Norma Gomez (DaVita), Jeremy Ackley (Bay Pines VA Hospital), Marsha Lisk (Agency for Health Care Administration), Kris Robinson (American Association of Kidney Patients), Jeffrey Sands, MD (Fresenius Medical Care) and Liz Howard (DaVita). As always, thank you to all providers for your support and dedication to improving the quality of care in Florida.

Kelly M. Mayo, MS

FREE CEU OFFERINGS!

Implementation and Use of the DPC 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

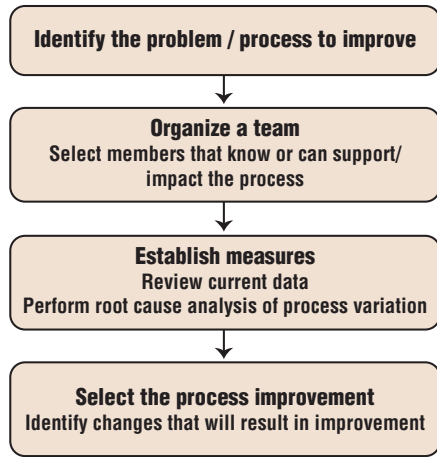
This course examines the need for pure water and the function of a water treatment system necessary to produce hemodialysis quality water. This course can be taken by nurses, technicians, physicians, social workers and administrators that are involved with dialysis patient care. The emphasis will be 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>

What is Quality Improvement?

Quality Improvement is a method of planning and implementing continuous improvements in systems or processes in order to provide quality health care reflected by improved patient outcomes.

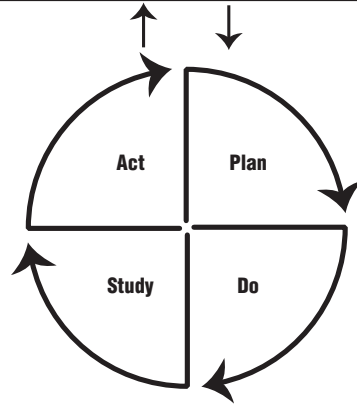


FMQAI: The Florida ESRD Network bases it's improvement process on the Model for Improvement developed by Associates in Process Improvement, and utilized by the Institute for

Healthcare Improvement (IHI). This model has two parts:

- Establishing what is to be studied and how to measure the improvements; and
- Using the PDSA cycle to test changes

Our QI Plan format utilizes the above methodology to document and analyze the overall process improvement initiative. Visit the quality improvement section of the ESRD website (<http://www.fmqai.com/ESRD/>) to download a blank quality improvement plan.



Test Changes:
The Plan-Do-Study-Act cycle is a method of testing change by planning the change, implementing it, observing the results, and acting on what is learned.

Has Your Facility Appointed a Patient Coordinator?

Last year the Network Patient Advisory Committee (PAC) recommended that each facility appoint a Patient Coordinator (PC). The individual should be a “patient” who is willing and able to be a bridge between his/her fellow patients at the facility and the Network Patient Advisory Committee. Not every facility may have a patient who is able and willing to fill this role. There are many patients, however, who look for ways to be more involved. The goal of this endeavor is to make more patients actively involved in their care.

If you have not already submitted the name and contact information of one of your facility’s patients, we ask that you reconsider doing so now with the awareness that:

- PCs are to be re-confirmed by the facility each year
- PCs may be given the opportunity to become a member of the Network PAC
- PCs will distribute patient newsletters and other educational materials in their unit or create their own “internal team” by enlisting volunteers from other days / shifts to assist
- PCs who create a “team” are encouraged to hold team meetings
- PCs should encourage fellow patient involvement in local educational seminars and projects
- PCs may be asked to submit articles or suggest topics for publication in the Network Patient Newsletter

Your support of our new initiative will be greatly appreciated. If you have a patient you feel would be willing and able to take on the role, please forward the appropriate contact information (shown below) via fax to (813) 354-1514. We look forward to working with your Patient Coordinator. If you have questions regarding this request, please direct them to the attention of Cindy Woodward at (813) 383-1530 ext. 3882.

Provider Name _____

Provider Number _____

Provider's Phone # _____ Provider's Fax # _____

Patient Coordinator's Name _____

Address _____

Phone # _____

Email Address _____



Dialysis Facility Compare: Your First Source for Information

The Centers for Medicare & Medicaid Services (CMS) has an important tool available for you on the internet at www.medicare.gov. It is called Dialysis Facility Compare. This resource gives you detailed information about Medicare-certified dialysis facilities, and lets you compare facilities in your area. The information helps you with facility characteristics and quality measures.

Dialysis Facility Characteristics include:

- Name, address and telephone number of the facility,
- Date the facility first received Medicare certification,
- Shifts starting at 5:00 pm or later,
- Number of treatment stations, and
- Types of dialysis offered.

Quality Measures include:

- Percent of patients at a facility who receive adequate hemodialysis,
- Percent of patients at a facility treated for anemia, whose anemia was adequately managed, and
- Patient survival information.

Each quality measure is explained in detail. You are told how the information is gathered and calculated.

You can compare facility characteristics and quality measures for the facilities you select in your state. This will show you how the facilities you have selected compare with state and national averages.

Dialysis Facility Compare also has other features, such as a glossary, a list of publications, helpful contacts and related internet resources.

FMQAI: The Florida ESRD Network provides a link to Dialysis Facility Compare at <http://www.fmqai.com/ESRD/FPF/Helpful-Links-Kidney-Organizations/>

While visiting Dialysis Facility Compare, please take a look at your clinic's characteristic information, to be certain that it is correct. If it is not, you may submit corrections to the Network.

The CMS website, www.medicare.gov, also has other excellent tools for dialysis social workers who are assisting with community resource and long term care planning: Nursing Home Compare and Home Health Compare.



FMQAI: The Florida ESRD Network
5201 West Kennedy Boulevard
Suite 900
Tampa, Florida 33609

ACCESS

ACCESS

is written, designed and distributed by FMQAI: The Florida ESRD Network.

This newsletter is published while under contract with the Centers for Medicare and Medicaid Services, Baltimore, Maryland
Contract #
HHSM-500-2006-NW007C

REMINDER:

Please be sure to verify that the Network contact information you have posted for patient use (i.e. the ESRD complaint & grievance process) is the most current information available. CMS regulations require that patients have a means to contact the ESRD Network with their concerns. The most current contact information for Network 7 is:

FMQAI: The Florida ESRD Network
5201 West Kennedy Boulevard, Suite. 900
Tampa, Florida 33609
Telephone (813) 383-1530
Fax (813) 354-1514
For Patients Only (800) 826-3773
www.fmqai.com/ESRD/

If you determine that the information you have posted is not current, please contact Network 7 at (813) 383-1530 ext. 3883.

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 ext. 3882 or
E-mail: cwoodward@nw7.esrd.net