

**Conflicting
Information
Reports**
...page 2



**Fistula
First**
...page 4



**What is Quality
Improvement**
...page 9



**Network
Ambassadors**
...page 11



Volume V, Issue 1

FMQAI Access

The Florida ESRD Network

The Basics of Anemia and Iron Management

Anemia is a common complication of ESRD. As the kidneys deteriorate, the ability to produce adequate erythropoietin, a hormone, is impaired, which results in decreased production of new red blood cells and anemia. Red blood cells are important because they carry oxygen throughout the body.

People with anemia will often report feeling weak and tired. They may also complain of shortness of breath, trouble sleeping, poor appetite, sexual problems, dizziness and difficulty exercising. Additionally, when the number of red blood cells decrease, the heart must work harder to pump blood to send more oxygen to the tissues in the body. If the heart is too stressed, it can develop an arrhythmia (a rapid or irregular heartbeat) and/or heart failure. Over time, a serious condition called left ventricular hypertrophy, an enlargement of the heart muscle, may develop that may lead to heart failure, arrhythmias and other serious cardiac complications.

The benefits of controlling anemia in patients with ESRD have demonstrated:

- ✓ Increased survival,
- ✓ Decreased cardiac complications,
- ✓ Improved quality of life,
- ✓ Increased exercise capacity and
- ✓ Decreased hospitalizations.

Adequate iron stores and iron availability are important to control anemia and realize a benefit from epoetin therapy. Correction of iron deficiency in patients receiving epoetin therapy has been shown to:

- ✓ Increase the response to epoetin therapy and
- ✓ Reduce the dose of epoetin required to achieve hemoglobin in target range.

Despite the widespread use of epoetin, anemia continues to be observed in many ESRD patients. Iron deficiency and chronic blood loss associated with the hemodialysis procedure as well as other co-morbid conditions are contributing factors to anemia. ESRD patients should have sufficient iron to maintain Hgb of 11 – 12 g/dl. To achieve and maintain this target Hgb, sufficient iron should be administered to maintain a transferrin saturation (TSAT) of >20%, and a serum ferritin level of >100 ng/ml. To prevent iron deficiency and maintain iron levels >20%, serum ferritin levels >100 ng/ml, many physicians now administer maintenance iron doses

(continued on back page)



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

These are the faxes you get periodically from us indicating that Centers for Medicare and Medicaid Services (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.



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 does not 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, 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.



FISTULA FIRST CHAMPION SURGEONS

MAKE A DIFFERENCE!
*Adopt Fistula First Change
 Concepts and Tools.*
www.fmqai.com/ESRD/FistulaFirst/FFT/

Congratulations!

The Network would like to congratulate the following surgeons who have been nominated by one or more “Champion Facilities” for playing a critical role in their ability to achieve high AVF rates. FMQAI: The Florida ESRD Network thanks you for your outstanding efforts to increase the utilization of AVF for vascular access and improving the quality of care for Florida dialysis patients.

Surgeon	Nominated By
Dr. Mohammed Abdallah	Complete Dialysis Care - North
Dr. Cesar Alegre	FMC Fort Lauderdale
Dr. Christian Allmon	Sacred Heart Pediatric Dialysis
Dr. Sanford Altman	Miami Artificial Kidney Center
Dr. Mark Altschuler	Venture Dialysis Center
Dr. Ron Arison	Universal Kidney Center, Inc.
Dr. Moshe Ashkenazi	Memorial Regional Hospital, University Artificial Kidney Center
Dr. Louis Astra	Gulf Coast Kidney Center –New Port Richey
Dr. Dwayne Badgett	North Melbourne Dialysis
Dr. James Bartek	RAI Punta Gorda
Dr. Robert Blais	Pinnacle Dialysis
Dr. Marcello Borzatta	North Okaloosa Dialysis Center
Dr. Victor Bowers	NRI Tampa, Watson Clinic Kidney Center, Renal Care Center Sebring, Highlands Dialysis Center
Dr. Bert Bowers	Sarasota Physicians Dialysis
Dr. Gordon Burtch	Bonita Springs Dialysis, DaVita Ft. Myers North
Dr. James Burkes	Miami Artificial Kidney Center
Dr. Brian Cameron	Dialysis Services of Central Florida - Sanford
Dr. Santiago Chahwan	ARA Naples Dialysis Center
Dr. Delos Clift	BMA East Orlando, Dialysis Services of Central Florida – Sanford, BMA West Orlando
Dr. Abilio Coello	BMA West Kendall Dialysis
Dr. Michael Cohen	Orlando Southwest Dialysis, Dialysis Services of Central Florida – Sanford, FMC Clermont
Dr. Joseph Coletta	Pinnacle Dialysis
Dr. Paul Steve Collins	St. Petersburg South Dialysis, Seminole Dialysis
Dr. Eugene Constantine	Broward Dialysis, DaVita Plantation
Dr. John C. Dali	North Okaloosa Dialysis, Renal Care Group – Destin, FMC Crestview
Dr. Anthony Deiorio	Ocala Regional Kidney Center
Dr. Utpal Desai	New Smyrna Beach Dialysis
Dr. Douglas Dorsay	Venice Kidney Center, NRI Lakewood, Sarasota Physicians Dialysis
Dr. John Driscoll	VAMC – Bay Pines Healthcare
Dr. Richard Fansler	Seminole Dialysis Center
Dr. T. Patrick Fitzgerald	Sarasota Physicians Dialysis
Dr. James Fogelman	Sarasota Physicians Dialysis
Dr. Mark Friedell	Orlando Southwest Dialysis
Dr. Florin Gadalean	Dialysis Services of Central Florida – Sanford
Dr. Robert Gallinaro	Ocala Regional Kidney Center - Eat
Dr. Charles Garnette	Orlando Southwest Dialysis, Central Florida Kidney Center - Vineland
Dr. Paul Geary	Orlando Southwest Dialysis
Dr. Mark Grove	Weston Dialysis Center
Dr. Steven Halbreich	Sarasota Physicians Dialysis
Dr. Malek Hanano	RAI Lake Wales

Dr. Michael Harrington	New Smyrna Beach, Ormond Beach Dialysis, Palm Coast Dialysis
Dr. Howard Hermans	NRI Lakewood
Dr. Jeffery Hertz	University Artificial Kidney Center
Dr. John Horowitz	Orlando Southwest Dialysis
Dr. Thomas Huber	Pinnacle Dialysis, Ocala Regional Kidney Center – East
Dr. Panagiotis Iakovidis	RAI Lake Wales
Dr. Gary Janko	VAMC - Bay Pines Healthcare
Dr. Mamoon Jarrah	RAI Punta Gorda
Dr. Chaminda Jayanetti	Miami Artificial Kidney Center
Dr. Bernardo Johr	Venture Dialysis
Dr. Humphrey Jones	Center for Kidney Disease at North Shore, Venture Dialysis
Dr. William Julien	Boynton Beach North Dialysis, DaVita Plantation
Dr. Fernando Kafie	Santa Rosa Dialysis, Sacred Heart Pediatric Dialysis, West Florida Dialysis Center
Dr. Steven Kang	Miami Artificial Kidney Center
Dr. Howard Katzman	Center for Kidney Disease at North Shore, BMA West Kendall
Dr. Matthew Klein	Pinnacle Dialysis
Dr. Harold Kulman	NRI Lakewood, Sarasota Physicians Dialysis
Dr. Michael Lane	North Melbourne Dialysis
Dr. Dzuy Le	North Melbourne Dialysis
Dr. Adam Levitt	FMC Clermont
Dr. Michael Lepore	NRI Lakewood, Sarasota Physicians Dialysis
Dr. Bradley Litke	New Smyrna Beach Dialysis
Dr. Mario Martinasevic	FMC Ft. Lauderdale
Dr. Donald Minervini	South Beach Dialysis
Dr. Armaghan Mostafavi	Boynton Beach North Dialysis, Atlantis Dialysis Center
Dr. John Motta	Pinnacle Dialysis
Dr. Donald Netherland	West Florida Dialysis Center
Dr. Eugene Murphy	St. Petersburg Dialysis, St. Petersburg South, Seminole Dialysis Center
Dr. Deepak Nair	Sarasota Physicians Dialysis
Dr. Charles Neustein	Ocala Regional Kidney Center - East
Dr. John Nora	Sarasota Physicians Dialysis
Dr. Russell Novak	Sarasota Physicians Dialysis
Dr. David Nunley	Boynton Beach North Dialysis
Dr. Arthur Palamara	Memorial Regional Hospital
Dr. Hiranya Rajasinghe	ARA Naples Dialysis Center
Dr. Fuad Ramadan	North Melbourne Dialysis, Melbourne Kidney Center, Palm Bay Kidney Center, Harbor City Dialysis
Dr. Jose Ramirez	Gulf Coast Kidney Center – New Port Richey
Dr. Roland Reeves	North Okaloosa Dialysis
Dr. Ronald Reise	Miami Artificial Kidney Center
Dr. Antonio Revilla, Jr.	Universal Kidney Center, Inc.
Dr. Patricia Rosa	Broward Dialysis
Dr. Mark Rosenbloom	North Melbourne Dialysis, Melbourne Kidney Center, Palm Bay Kidney Center, Harbor City Dialysis, DaVita Melbourne Dialysis
Dr. John Royalty	Crystal River Dialysis
Dr. Ignacio Rua	BMA West Kendall
Dr. Russell H. Samson	Venice Kidney Center, NRI Lakewood, Sarasota Physicians Dialysis
Dr. Horacio Schlaen	Memorial Regional Hospital, University Artificial Kidney Center
Dr. Arnold F. Schild	DaVita Miami North Dialysis
Dr. Andrew Schulick	Boynton Beach North Dialysis
Dr. Harry Sendzischew	South Beach Dialysis
Dr. David P. Showalter	Venice Kidney Center, Sarasota Physicians Dialysis
Dr. Steven Silverman	NRI Lakewood, Sarasota Physicians Dialysis
Dr. Bryan L. Smith	Venice Kidney Center

(continued on page 6)

Dr. Lawrence Sowka	Watson Clinic Kidney Center
Dr. James Sutton	Ormond Beach Dialysis, New Smyrna Beach Dialysis, Palm Coast Dialysis
Dr. Krishna Swaminathan	Ocala Regional Kidney Center - East
Dr. Charles Thompson	FMC Clermont
Dr. Marwan Tabarra	Universal Kidney Center, Inc., Boynton Beach North Dialysis, University AKC, FMC – Boynton Beach, DaVita Plantation, Complete Dialysis Care –North, FMC Ft. Lauderdale
Dr. Frank Toub	New Smyrna Beach Dialysis
Dr. Athanassios Tsoukas	BMA West Kendall Dialysis
Dr. Arhyrios Tzilinis	ARA Naples Dialysis Center
Dr. Stephen Unger	South Beach Dialysis, Greater Miami Dialysis, DaVita Miami North Dialysis, Venture Dialysis
Dr. Joseph Wasselle	North Melbourne Dialysis, Melbourne Kidney Center, Palm Bay Kidney Center, Harbor City Dialysis
Dr. Jon Wesley	FMC Clermont
Dr. John Wideroff	Pinnacle Dialysis
Dr. Alan Wladis	BMA East Orlando, Dialysis Services of Central Florida – Sanford, BMA West Orlando
Dr. David Wulkan	Pinnacle Dialysis
Dr. Jonathan Yunis	Sarasota Physicians Dialysis
Dr. Marek Zalewski	University AKC, FMC Ft. Lauderdale
Dr. Jack Zeltzer	Boynton Beach North Dialysis



FMQAI: The Florida ESRD Network



Presents

2008 PATIENT & FAMILY CONFERENCES

Ft. Myers – March 30, 2008

Panama City – May 18, 2008

Melbourne – April 20, 2008

Miami – June 22, 2008

TOPICS:

Phosphorus Control – Why & How to Take Binders

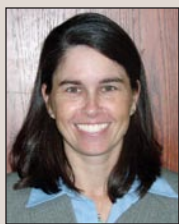
Treatment Options

Decreasing / Dealing with Conflict: Rights & Responsibilities for Patients and Providers

Please watch for more information regarding these locations!

For more information, please call:

800-826-3773 or 813-383-1530, ext 3882



FROM THE PROJECT DIRECTOR

In February of this year, CMS and the Networks celebrated more than 30 years of working together to improve quality care and quality of life for ESRD patients. Many significant events occurred during that time, and with assistance from my colleagues around the country, most of that work was documented in a video timeline. Look for it on www.esrdncc.org/index/2008-cms-esrd-network-annual-meeting. Here are some highlights:

1940s

- ✓ A process called dialysis was first used successfully in the Netherlands in the 1940s.

1960s

- ✓ In 1961, the King County Medical Society in Seattle, WA organized an “Admissions and Polices Committee of the Seattle Artificial Kidney Center at Swedish Hospital” made up of 7 voluntary and anonymous laymen. They were called the Life and Death Committee.
- ✓ President Lyndon B. Johnson signed the Medicare Program into law on July 30, 1965. At the bill-signing ceremony, President Johnson enrolled former President Harry S. Truman as the first Medicare beneficiary and presented him with the first Medicare card.


1970s

- ✓ In the early 1970s, kidney patients were being discussed on Capitol Hill. At least two proposals to fund treatment and rehabilitation of kidney patients were made and vetoed due to the large fiscal impact.
- ✓ On September 25, 1972, Senator Vance Hartke of Indiana submitted a provision to the Social Security Amendments and Welfare Reform package – for renal disease to be considered a disability for the purpose of Medicare hospital and health insurance.
- ✓ President Richard Nixon signed the Medicare ESRD Program into law on October 30, 1972. Proposed costs for the first year of operation were estimated at \$98 million for hospital and health insurance benefits alone.
- ✓ The three-year mortality rates for 1972 – 1974 were 21.4% for home dialysis patients, and 28.6% for in-center patients.
- ✓ The ESRD Medical Information System Facility Report No. 1 reported 763 dialysis facilities and 24,391 for July 1, 1975 – June 30, 1976.
- ✓ The ESRD Network Program began in 1977. Twenty-nine Networks were originally proposed, but a total of 32 Networks were established, with 40,000 dialysis patients and 600 facilities. Florida was identified as Network 19.
- ✓ The Networks’ focus was on self-care dialysis, transplantation and organ procurement, minimum criteria for quality, medical care evaluation, review of requests for new or expanded ESRD services, and a system to augment the information available in the Federal Medical Information System.

1980s

- ✓ The three main tasks for the ESRD Networks were quality assurance, data management and Network administration. This was accomplished via MRB review and analysis of facility internal quality assurance plans and maintenance of the patient-specific medical information system.
- ✓ The Omnibus Budget Reconciliation Act authorized a National End Stage Renal Disease Registry in 1986.
- ✓ In 1987, the 32 Networks consolidated into 18 with 98,432 patients and 1,701 facilities. The state of Florida became Network 7. Funding for the Networks was established at \$0.50 per treatment.

(continued on page 8)

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- ✓ Just before the year 1990, a major event occurred in the renal community -- the Morbidity, Mortality and Prescription of Dialysis Symposium. Renal professionals around the country gathered to discuss high mortality noted among hemodialysis patients in the US, and to consider that inadequate dialysis might explain the high rates.

1990s

- ✓ The shift from quality assurance to quality improvement oversight began with the Institutes of Medicine's report "Medicare: A Strategy for Quality Assurance."
- ✓ By 1992, the number of dialysis patients had risen to 157,354.
- ✓ The Core Indicators Project began with four key indicators to assess and measure ESRD care -- hematocrit, URR, serum albumin and blood pressure.
- ✓ Medical Case Review was discontinued in July 1994.
- ✓ CMS initiated ESRD Health Care Quality Improvement Program using clinical practice guidelines to define processes of care closely associated with patient outcomes.
- ✓ The National Anemia Cooperative Project began in 1994 as a cooperative effort between the dialysis provider community, ESRD Networks and HCFA to promote improvement in the management of anemia through use of modern QI tools and techniques. 100% of participants identified opportunity for improvement.
- ✓ In 1998, a set of ESRD CPMs based on the DOQI Guidelines was developed -- five for hemodialysis adequacy, three for peritoneal dialysis adequacy, four for anemia management and four for vascular access.
- ✓ The Core Indicators Project was merged into the ESRD CPMs Project on March 1, 1999.

2000s

- ✓ All Networks were addressing adequacy of hemodialysis.
- ✓ The Dialysis Facility Compare tool was launched on www.medicare.gov providing information on nine facility characteristics and three quality measures (adequacy, anemia and mortality) on over 3,500 dialysis facilities in the US.
- ✓ Many Networks focused on special projects, including patient safety, communication, disaster preparedness and response, end of life care, transplantation and dialysis in the SNF.
- ✓ HCFA became the Centers for Medicare & Medicaid Services (CMS) in 2003.
- ✓ CMS, ESRD Networks, Institute for Healthcare Improvement, and the kidney community joined together in a partnership in launching the National Vascular Access Improvement Initiative. Later that year, CMS formally expanded its commitment by elevating the initiative into the Agency's first breakthrough initiative, "Fistula First."
- ✓ As of December 31, 2007, the ESRD Networks served 108,759 new ESRD patients, 362,172 prevalent patients, 17,304 transplant recipients, 5,187 dialysis facilities and 247 transplant centers.

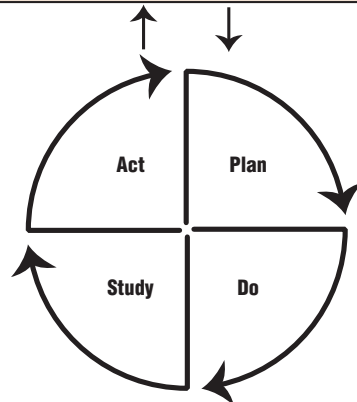
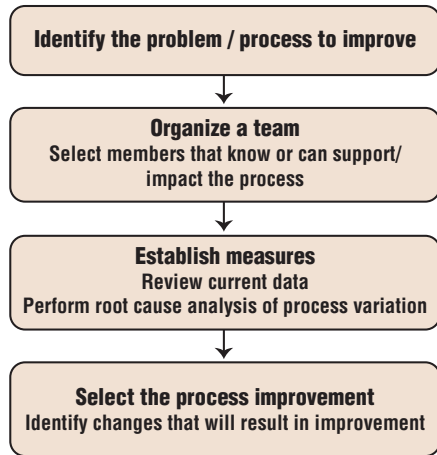
Dialysis and transplant providers are a dedicated community; passionate about the people they serve and committed to continual improvement in the Medicare ESRD Program. Thanks for all that you have done, all that you do, and all that you will do in the future!

Kelly M. Mayo, MS

Network 7 would like to thank the Upper Midwest Fistula First Coalition for sharing the article entitled, "Preparing for the Vascular Access Portion of Your Medicare Survey," which was printed in the December 2007 edition of this newsletter. You may reach the Upper Midwest Fistula First Coalition's website at www.esrdnet11.org.

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.



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.

FMQAI: The Florida ESRD Network bases its 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 our Quality Improvement Toolkit web page at <http://www.fmqai.com/ESRD/QIP/QIP2/> to download the form.



BUILDING STRENGTH TOGETHER - Patient Councils and Support Groups

Beverly Moreland, LCSW

Adjusting to the demands of End Stage Renal Disease (ESRD) poses many challenges for the dialysis patient. There are challenges of adjusting to lifestyle changes, relationship changes with family and friends, problems with body image and struggles with self-esteem. Within these realities, patients do benefit from the support of caring families and caregivers; however, another excellent source of support are patient support groups.

Programs of support provide a way for patients to learn more about their ESRD disease process and an opportunity to share information, feelings and goals with others who share in similar situations.

At FMC North Jacksonville, our Patient Council not only provides excellent support for the members of the group, they have evolved into an advocacy council for the rest of the patients in the clinic. The council members are divided into “shift representatives.” Each member gets to know the patients on their shift and reports in the monthly group meeting any problems that patients encounter. The clinic manager and the clinical social worker chair the Patient Council. Members include eight patients, a family caregiver and a transplant patient. There is a peritoneal representative on call, as needed. The meetings are scheduled monthly and all discussions are documented and shared during the clinic’s monthly interdisciplinary quality assurance meeting.

Support groups provide a safe place to share thoughts and feelings with others who are dealing with similar problems and emotions.⁽¹⁾ There are many benefits to joining a support group or organizing a Patient Council in the dialysis clinic:

1. Patients learn more about ESRD and the treatment choices.
2. Patients feel a sense of caring and understanding.
3. Patients don’t feel alone in dealing with the challenges of dialysis.

(continued on page 10)

BUILDING STRENGTH TOGETHER ...continued from page 9

4. Patients in support groups receive first hand explanations of educational materials and brochures and information about Network 7, NKF, AAKP, etc.
5. Above all, patients find hope and encouragement in managing their ESRD.

We have learned at FMC North Jacksonville that our Patient Council has become a viable part of the clinic.

The other patients benefit from their enthusiasm and advocacy and the members personally benefit from the support of the group. The group members feel strengthened as they receive support and encouragement to cope with their disease and its demands.

⁽¹⁾ From: Self-Help: Concepts and Applications, edited by A. Katz, et. Al, Charles Press 1992.

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.

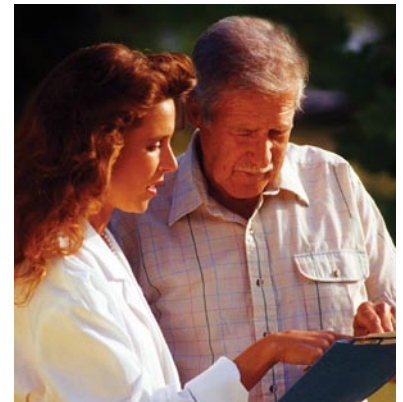
You can compare facility characteristics and quality measures for the facilities you select in your state. This will show you how the facilities you have selected compare with state and national averages.

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.



Network Ambassadors

FMQAI: The Florida ESRD Network (Network 7) would like to recognize and thank the following facility staff members for volunteering to be “Network Ambassadors.”

Ambassador	Facility	Ambassador	Facility
Alishia Head	FMC Clearwater	Jeni Moody	DCI Jax & Southpoint
Anaivis Vazquez	BMA West Dade Dialysis	Jill Swartzel	Home Dialysis of DSCF
Andrea Wendell	ARA W Jacksonville	Joan Hodson	Fort Walton Beach Fresenius
Anyeline (Angie) Wagner	BMA Kendall	Jonathan Viera	Kidney Treatment Center of South Florida
Bethalin Gardose	Orlando Home Training	Judy Brevoort	Davita Guld Breeze
Betsy Perez	Florida Dialysis Institute	Kimberly DeAndrea	DSI Tampa Central
Carol Work	FMC Bonita Springs	Leslie Francois	Davita Ocala Home Division
Cathy Barnett	Davita Lehigh Acres	Linda Millman	Atlantic Kidney Center
Cathy Demmons	Davita Ft Myers South Dialysis	Lucia Rojas	Miami Childrens Hosp Hemodialysis Unit
Christine Muniz	Atlantis Dialysis Center	Marcelo Curi	Arcadia Dialysis
Cynthia Ferracci	Davita dialysis	Marcia Santos	Pompano Beach AKC
Damita Clarke	Renal Care Partners of Coral Gables	Matthew Edmondson	BMA Avon Park
Danielle Bourgeois	Sacred Heart Pediatric Dialysis	Michele Lutz	Crystal River Dialysis
Darlene Willis	Davita Dade City	Michelle Thomas	Shands, JAX
Debbie Shore	West Palm Dialysis RCU	Nance Phillips	Southwest Florida Dialysis Center
Edye Dushek	Davita Fort Myers North	Patricia Cannon	Schwartz Dialysis Center
Eileen Ross	Lakeland Dialysis	Penny Howland	Seminole Dialysis
Elaine Rola	Gulf Coast Kidney Center	Sally Yaralli	Miami Regional Dialysis Center/ ARA
Eileen Schmidt	Bayonet Point Davita	Shayma Salman	Davita Panama City Dialysis
Elsa Weinstein	Fort Lauderdale Artificial Kidney Center	Shirley Holland	ARA-Boca Raton Dialysis
Emma Brown	New Smyrna Beach Dialysis	Stacey Miller	West Tampa Dialysis & Central Tampa
Erin Conner	DSI Lakewood Kidney Center	Susie Repper	Shands Jacksonville Transplant Center
Esther Blanco	North Palm Beach Dialysis	Theresa Doyle	RAI Lakeview Clearwater
Francise Fern	Davita Bonita Springs		
Hank Michael	Kidney Kare, Inc		
Janet Price	DSCF Apopka		
Janisse Watkins	Leesburg Davita		

“Network Ambassadors” function as the facility’s point of contact and communicate with Network staff by means of conference calls, emails, local Network activities and meetings.

Selection criteria for those in this role are staff members who:

- Demonstrate a positive attitude,
- Work independently, and
- Are self-motivated.

This program affords your facility the opportunity to become interactive with Network 7 without time constraints. Let your “Network Ambassador” be a solution to keeping in touch with the ESRD community. If your facility does not already have a “Network Ambassador,” please consider appointing someone by contacting Mary Fenderson at mfenderson@nw7.esrd.net or (813) 865-3332.



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The Basics of Anemia and Iron Management

continued from page 1

(smaller doses weekly or biweekly). Additionally, ESRD patients are unlikely to respond with a further increase in Hgb if the TSAT increases to >50% and/or the serum ferritin level increases to >800 ng/ml.

Network 7's 2007 Lab Data Collection on hemodialysis patients from October – December 2006 reflects 84.2% of Florida patients have a Hgb \geq 11 gm/dl, 81.7% of patients have a TSAT \geq 20%, and 79.9% have a serum ferritin \geq 100 ng and \leq 1000 ng. How does your facility compare with these percentages? Do you have room for additional improvement?

In summary, anemia is a significant risk factor for cardiovascular disease and poor patient outcomes. Diligent follow-up regarding adjustment of epoetin and iron therapy in accordance with physician's orders is critical for the improvement of renal outcomes as well as enhancement of the patient's quality of life.

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.