



ESRD Network #17

ANNUAL REPORT 2010

CENTERS FOR MEDICARE & MEDICAID SERVICES
Contract Number: HHSM-500-2006-NW017C and HHSM-500-2010-NW017C

**“The mission of
Western Pacific Renal Network, LLC
is to facilitate improvement of the quality
of care provided to ESRD patients.”**

January 1, 2010 - December 31, 2010

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I. PREFACE

I am pleased to submit this annual report for the period of January 1, 2010 through December 31, 2010 to the Centers for Medicare & Medicaid Services Office of Clinical Standards and Quality. This report provides both a narrative account and substantiating data to describe the activities and the ESRD patient population of Network #17 for that time period.

During the twelve months covered by this report, ESRD Network #17 performed all functions and completed all activities required by its contract (HHS-500-2010-NW017C). The majority of Network #17 resources were dedicated to Quality Improvement, Patient Services and Data Collection activities.

Quality Improvement projects continue to drive the Network's agenda with numerous resources dedicated to the national Fistula First Breakthrough Initiative. During 2010, Network #17 was consistently in the top three Networks for highest number of prevalent patients utilizing an arterio-venous fistula (AVF) as their primary dialysis access. Additional quality initiatives undertaken in 2010 included decreasing the use of central venous catheters, encouraging the use of buttonhole technique for AVF cannulation, increasing stenosis monitoring, providing information regarding prevention of involuntary discharges, improving immunizations in the ESRD beneficiary population, increasing transplant evaluation in the Pacific Island Territories, and support for facilities as they develop their Quality Assessment and Performance Improvement Projects. Through this calendar year, Network #17 has provided countless hours of technical assistance to the community it serves.

Service to the ESRD Medicare beneficiary population continued to be a major focus of Network #17. The Network staff, in coordination with the Patient Advisory Committee and the Network Boards, continued to provide educational resources, assistance with complaints and grievances, technical assistance and support to both beneficiaries and providers throughout 2010.

Network #17 has actively participated in the phased-in implementation of CROWNWeb during the 2010 calendar year. Network staff has provided educational sessions, technical assistance, encouragement and assistance to its providers through the rollout.

The Board of Directors extends its appreciation to all Network #17 providers who have cooperated in working toward the successful accomplishment of Network goals in 2010. In addition, the time and energy spent by the renal professionals and patients serving on Network boards and committees are gratefully acknowledged.

Richard S. Goldman, MD
Richard S. Goldman, MD, President
ESRD Networks #15 and #17

2010 Annual Report

Western Pacific Renal Network, LLC HHSM-500-2010-017C

II. INTRODUCTION

The ESRD Amendments to the Social Security Act of 1972 contained language for the establishment of a structure of “End-Stage Renal Disease Network Councils” to assist the entity now known as the Centers for Medicare & Medicaid Services (CMS) in the monitoring of the quality of care given to the ESRD patients by providers of dialysis services and transplantation. The Board of Directors of ESRD Network #15/17 established the following goals:

- * To facilitate optimal care to all ESRD patients working in cooperation with facilities’ internal quality improvement programs and through the support of the CMS Health Care Quality Initiative Program (HCQIP): CMS’ definition of quality care under the HCQIP includes access to care, appropriateness of care, desired outcomes of care, and consumer satisfaction;
- * To sustain the Network #17 administrative framework to optimally plan, implement, and evaluate Network responsibilities and goals and to complete all CMS contract requirements;
- * To maintain a patient-specific medical information system based on the data set required by CMS and to meet and/or exceed all data reporting requirements of CMS;
- * To support the CMS goal for the Network program of improving data reporting, reliability and validity between ESRD providers/facilities, Networks and CMS;
- * To promote access to appropriate modalities, including self-care and transplantation;
- * To promote patient knowledge of and involvement in their ESRD care, and to promote patient rehabilitation;
- * To serve as a resource and clearinghouse for information to the renal community including information on patterns, processes, and outcomes of care in order to aid in identifying opportunities for improvement as well as the results of both successful and unsuccessful improvement projects;

- * To assist facilities in developing, implementing, and evaluating intervention strategies to improve patient care and outcomes;
- * To facilitate resolution of patient grievances;
- * To work collaboratively with other organizations to facilitate the improvement of care of ESRD patients;
- * To promote patient-centered care.

These goals are approached in a manner that is patient-centered, safe, effective, efficient, equitable and timely. It is expected that the outcomes will be measurable, using valid, evidence-based measures of performance; developed through broad consensus and that have strong correlation to patient outcomes. The Network will embrace cultural change and process redesign. These goals are communicated annually to the Network providers via the “Annual Update”, which is sent to the facilities each year (Appendix A).

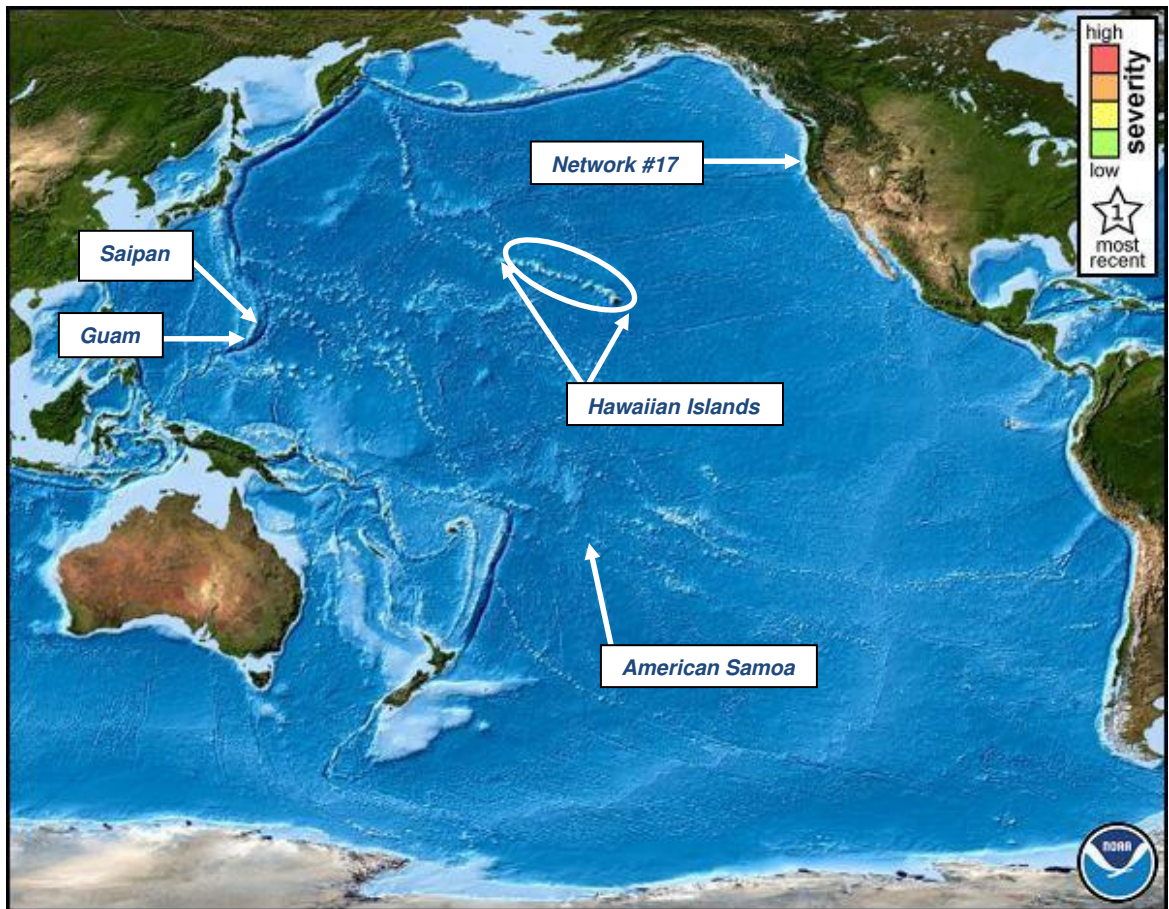
Network #17 pursued these goals through the leadership of knowledgeable individuals serving on the Network #15/17 Board of Directors, the Network #17 Medical Review Board and other Network committees and with the cooperation of the personnel in the ESRD programs throughout the Network #17 geographic region. The Network notified its facilities of the Network goals via direct mail and posts the goals on its website.

A. Network #17 Description

The following description of the Network #17 area provides an overview of the general pattern of the delivery of ESRD care in Network #17. The description of the state, territories and commonwealth that comprise this Network is included in this report to assist in understanding the logistics and complexity of administering an ESRD Network Organization that covers a large geographic area and multiple governmental entities.

Network #17 is composed of the northern portion of the State of California, the State of Hawaii, the Island of Saipan (Commonwealth of the Northern Marianas Islands) and the United States Territories of Guam and American Samoa. The Network spans approximately 8000 square miles which includes crossing the International Date Line to reach Guam and the Saipan and passing south of the Equator to American Samoa. From San Francisco one-way, the distance to: Hawaii is 2397 miles; American Samoa is 4742 miles and south of the equator; Guam is 5803 miles and Saipan 5710 miles respectively.

The map demonstrates the entire geographic area of Network #17. Logistics are not considered a barrier as Hawaii, all United States Territories and the Commonwealth Island facilities were visited by the Network #17 staff twice during the years 2008-2010. Monthly phone conferences are conducted with the Pacific Island facilities as a means of staying aware of potential issues and providing Network and stateside updates and assistance for patient care and/or educational materials to the facilities that are otherwise not available to them.

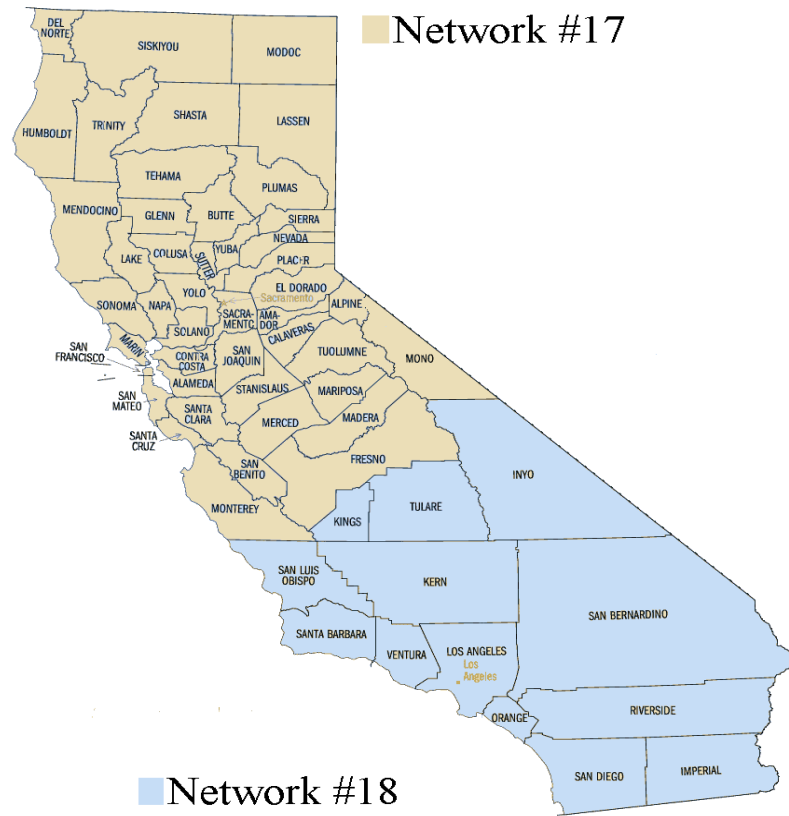


California

California is ranked first in population, 37,253,956, Census 2010, and third in geographic area of the fifty United States. California entered the union in 1850, following the gold rush of 1849. Due to its large population and geography, two ESRD Networks were formed for the State of California. The **Network #17** portion of the state is composed of the 45 most northern counties, starting in Fresno County and ending at the Oregon border, with **Network #18** covering the southern 13 counties. Northern California includes about one-third of the state's population and about 60% of the land area.

The map below shows the defining areas of both **Network #17** and **Network #18** for comparison purposes and geographic boundaries in California. The portion of the Northern California population of Network #17, numbers approximately 10,000 less prevalent or 18,565 ESRD patients. The total population of Network #17, California, Hawaii, and the Pacific Island Territories has increased to 22,016 patients at the end of 2010.

ESRD Network #17



With regard to demographics, California has the largest population in the United States, at an estimated 37,253,956 residents, a 10% increase according to the 2010 Census results. The percentage of Californians by race or ethnicity according to the 2010 Census is as follows: White American at 57.6%; Hispanic or Latino 37.6%; Asian alone 13%; African American 6.2%; Native American or Alaska Indian 1%; Native Hawaiian or Pacific Islander 0.4%. California is viewed as one of the most linguistically diverse areas in the world having at least 100 different languages and dialects spoken throughout the Network.

The culture of California is Western and most clearly has modern roots, but historically, many Hispanic influences. As a border and coastal state, Californian culture has been greatly influenced by several large immigrant populations, especially those from Latin America. California is a true melting pot as well as an international crossroad to the U.S. The gold rush of the 1850s is still seen as a symbol of California's economic style, which tends to generate technology, social, entertainment, and economic fads with booms and related busts.

Hawaii

Hawaii, the fiftieth state, was settled by Polynesians between the years of 300-600 AD. King Kamehameha consolidated the islands under one ruler in 1810. A republic was established in 1894 and Hawaii was annexed into the United States in 1898. In March 1959, Congress passed the Hawaii Admission Act and U.S. President Dwight D. Eisenhower signed it into law. On June 27 of that year, a referendum asked residents of Hawaii to vote on the statehood bill. Hawaii voted 17 to 1 to accept becoming the fiftieth state. After statehood, Hawaii quickly modernized via construction and rapidly growing tourism economy. Later, state programs promoted Hawaiian culture. The Hawaii State Constitutional Convention of 1978 incorporated programs such as the Office of Hawaiian Affairs to promote indigenous language and culture development.

The culture of Hawaii is Polynesian. Hawaii represents the northernmost extension of the vast Polynesian triangle of the south and central Pacific Ocean. While traditional Hawaiian culture remains only as vestiges in modern Hawaiian society, there are reenactments of the ceremonies and traditions throughout the islands. Some of these cultural influences are strong enough to affect the United States at large, including the popularity of luaus and hula.

Hawaii currently ranks 40th in population with an increase of 12.3% (1,360,301 Census 2010) and 47th in land area. The center of the population of Hawaii is located between the two islands of Oahu and Molokai. The population is very diverse, comprised of persons identifying themselves as Native Hawaiian, Asian, Caucasian and Pacific Islanders. According to the 2010 United States Census, Caucasians made up 24.7% of Hawaii's population; African Americans made up 1.6%; American Indians and Alaska Native 0.3%; Asian at 38.6%; Hawaiian and Pacific Islander 10%; Hispanic or Latino 8.9%. The average life expectancy of those born in Hawaii in 2010 dropped slightly to 79.8 years (-.1%), (75.3 years if male, 80.3 years if female), longer than any other state.



American Samoa

American Samoa is located in a group of volcanic islands and coral atolls. American Samoa has been a territory of the United States since April 17, 1900. In 1960 American Samoa ratified its territorial constitution and has since developed a modern, self-governing political system. American Samoans elect a governor, lieutenant governor, and legislature. Since 1981, American Samoa has been represented in the U.S. House of Representatives by a non-voting delegate. The people of *American Samoa are U.S. nationals, not U.S. citizens, but many have become naturalized American citizens.*

American Samoan ESRD patients are Medicare eligible and treatments are reimbursed by CMS accordingly. It is also worthy to note that mail is delivered to the post office only as there are no street addresses. American Samoa dips below the equator and is eleven hours by air from San Francisco with only two flights a week, one to the island on Sunday and one leaving the island on Thursday.

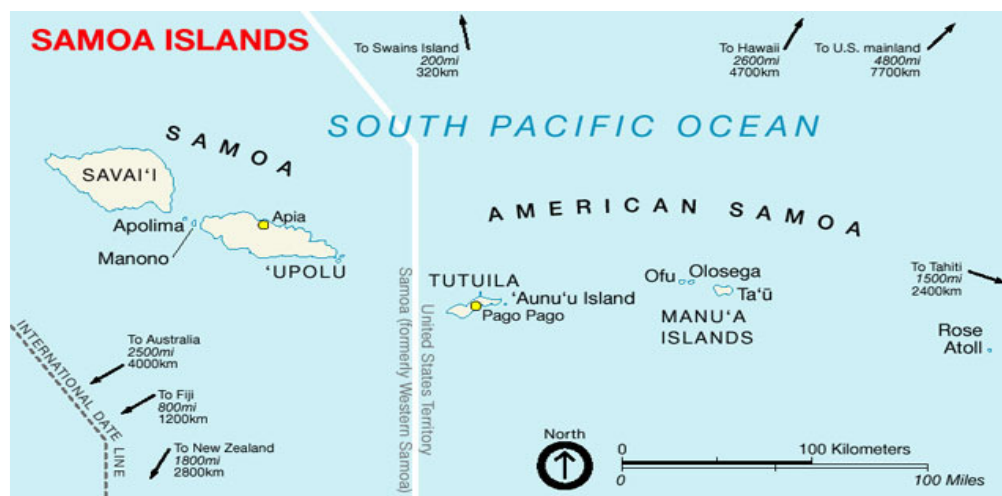
The population of American Samoa stands at approximately 64,000, of whom 95% live on the largest island, Tutuila. The population is diverse with 91.6% of the population being native Samoans, 8% Asian, 1.1% White, 4.2% Mixed, and 0.3% other. The language spoken by 90.6% of the people is Samoan (closely related to Hawaiian and other Polynesian languages), 2.9% English, 2.4% Tongan, with 2.1% of the people being bilingual.

In August of 2009, American Samoa experienced the worst disaster in several decades. An earthquake between the islands of Tonga and Western Samoa measuring 8.3 on the Richter scale, created an enormous Tsunami that struck American Samoa taking thirty four lives and completely wiping out several villages directly in its path. Emergency services from the mainland of the United States and Hawaii were dispatched for aid, food and housing. The dialysis facility located in the hospital was spared any damage and the dialysis patients and all patients hospitalized at the time, were safely evacuated. In a return visit to the island in 2010, evidence of the Tsunami remains as the island continues to recover from the devastating damage left behind.

Economically, the island suffered a severe economic blow, when one of the two major industries of the island was closed. Over 1200 people became unemployed creating further devastation to the island. The remaining major industry also had a significant layoff of employees further increasing the unemployment rate, which in 2005 was already at 29.5% before the 2010 census data was released. The census data for the Pacific Islands has not been disclosed at the time of this report. With the closing of the largest industry in American Samoa, the hospital has now become one of the largest employers of Native American Samoans. Because of geographic location and available land mass, sustainable industry is difficult to find. The government of American Samoa is looking to develop tourism as a major industry to support the island.

In June of 2010, Network #17 representatives made a trip to American Samoa to assist in the process of training and certification testing of the hemodialysis technicians employed at the Lyndon Baines Johnson Tropical Medical Center located in the village of Faga'alu.

Five technicians were required to pass the Patient Care Technician certification exam, as required by CMS, to continue employment in the dialysis facility. At the end of the four-day intense training class, the technicians took the online exam and passed well over the expected standard for certification. Training consisted of classroom instruction onsite, with additional technical assistance on water treatment presented by phone conference from California and slides presentation on-site at the same time. The LBJ Administration, hospital employees and particularly the dialysis facility staff were committed to the project which was highly successful.



Guam

Guam is the largest and southernmost of the Marianas Archipelago. The natives of Guam are Chamorro. The Chamorro, Guam's indigenous people, first populated the island approximately 4,000 years ago. Due to cultural influence from outside forces, important aspects of the original Chamorro culture have been lost over the years. There has been a resurgence in protecting and preserving the culture the last few decades, and many scholars have traveled throughout the Pacific Islands conducting research to determine what Chamorro cultural practices such as dance, language, and canoe building may have been like. Guam's economy depends primarily on tourism, Department of Defense installations, and locally owned businesses. Guam crosses the International Dateline and is approximately 19 hours by air from San Francisco.

The Island of Guam is located in the Western Pacific Ocean and elected not to join the Commonwealth of the Northern Mariana Islands but as an organized, unincorporated Territory of the United States. The people have been United States citizens since 1950. It is one of five U.S. Territories with an established civilian government. Guam is governed by a popularly elected governor and a unicameral 15-member legislature, whose members are known as Senators. Guam elects one non-voting delegate, currently, to the United States House of Representatives. U.S. citizens in Guam vote in a straw poll

for their choice in the U.S. Presidential general election, but since Guam has no votes in the Electoral College, the poll has no real effect. In the 1980s and early 1990s, there was a significant movement in favor of the territory becoming a commonwealth, which would give it a level of self-government similar to the Northern Mariana Islands (Commonwealth of Saipan). However, the federal government rejected the version of a commonwealth that the government of Guam proposed, due to it having clauses incompatible with the Territorial Clause (Art. IV, Sec. 3, cl. 2) of the U.S. Constitution. ESRD patients living in Guam are Medicare eligible and treatments are reimbursed by CMS accordingly. Currently there are four dialysis facilities on the island with an additional facility projected to open in 2011.

Saipan

The Commonwealth of the Northern Mariana Islands (CNMI) (Saipan). Saipan is in the United States Commonwealth of the Northern Mariana Islands (CNMI) (Rota/Luta, Tinian), a chain of 15 tropical islands belonging to the Marianas Archipelago in the Western Pacific Ocean with a total area of 44.55 sq miles. The largest of these islands is Saipan, which has the only two dialysis facilities available. The natives are also referred to as Chamorro. The island group was ruled successively by Spain, Germany, and Japan, and after World War II, the United States under a trusteeship. The population includes Chamorro and other Micronesians as well as a large number of guest workers from Asia.

The CNMI joined the United States as a Commonwealth in November 1986. The United States House of Representatives election in the Northern Mariana Islands took place on November 4, 2008 and was the Northern Mariana Islands' first election of a delegate to the United States House of Representatives. The Commonwealth of the Northern Mariana Islands is the last United States jurisdiction to receive congressional representation in the United States House of Representatives (in the form of a non-voting delegate). The first Commonwealth of the Northern Mariana Islands delegate in Congressional history assumed office in January 2009. ESRD patients living on Saipan are Medicare eligible and treatments are reimbursed by CMS accordingly. Saipan crosses the International Dateline and is approximately 19 hours by air from San Francisco.

The population of Saipan has taken a drastic decline over the past year with the closing of the garment factories which employed several thousand people. It is projected that when the 2010 Census data is released, Saipan will show a loss of approximately 40,000 people. The Network #17 2010 Demographics illustrates the decline.

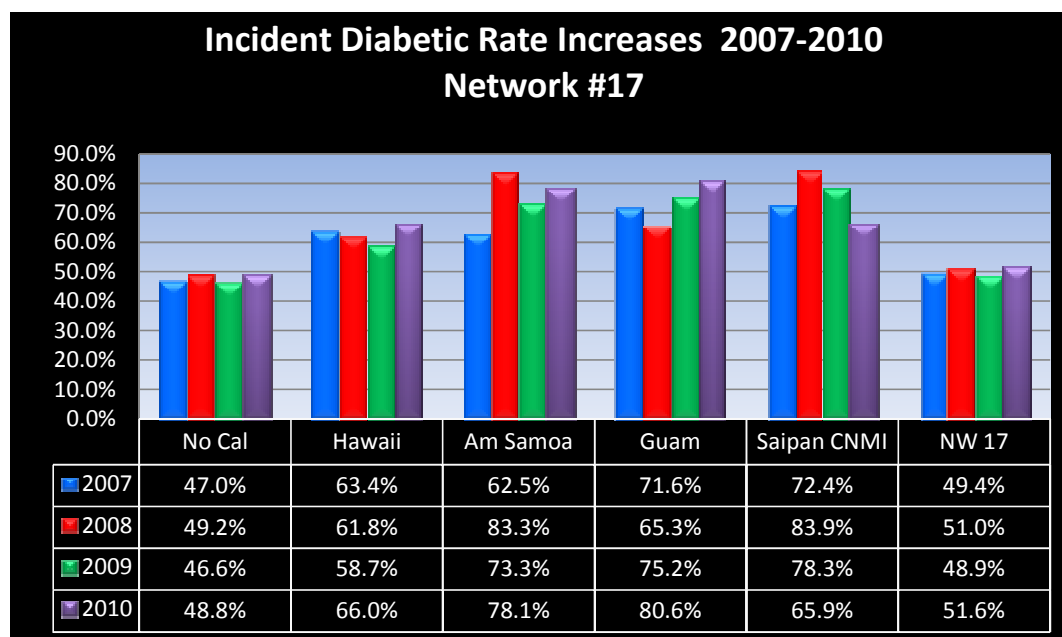
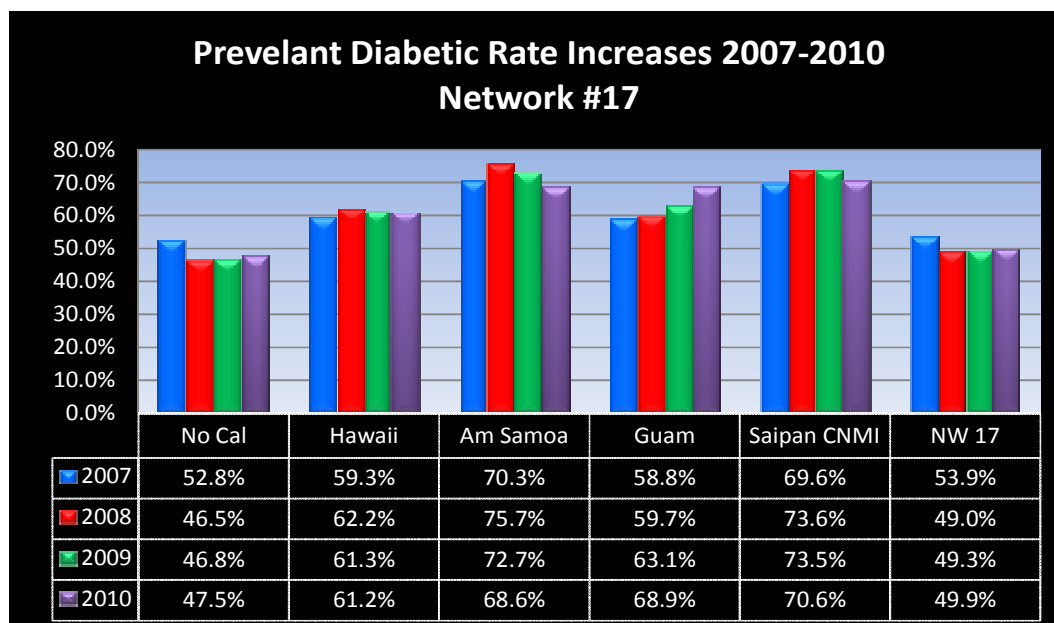


ESRD Prevalence in Network #17

The following information depicted in the graphics below, shows the steady increase of the ESRD patient population in Network #17. With the exception of Saipan and American Samoa, whose general populations decreased due to unemployment, all other US Territories, Hawaii and California increased in general census numbers according to the US 2010 Census official website. With population increases comes the reality of chronic illness rising steadily as well.

Diabetic Rates in Network #17

Diabetes continues to be the primary diagnosis for both the incident and prevalent ESRD population in Network #17. There is also a regional variation of diabetics associated with the cultural composition. The Pacific Islands and Hawaii have demonstrated a much higher percentage of diabetes as depicted in the charts below. The Network recognizes the severity of the problem and is in the early stages of developing a DM II initiative to include programs, educational materials, patient education a possible cookbook and other contributions to the programs that may help reduce the critical raise in Diabetes Mellitus II rates. Fifty percent of the dialysis population enters the ESRD arena with DMII.



Network #17 ESRD Demographics at a Glance

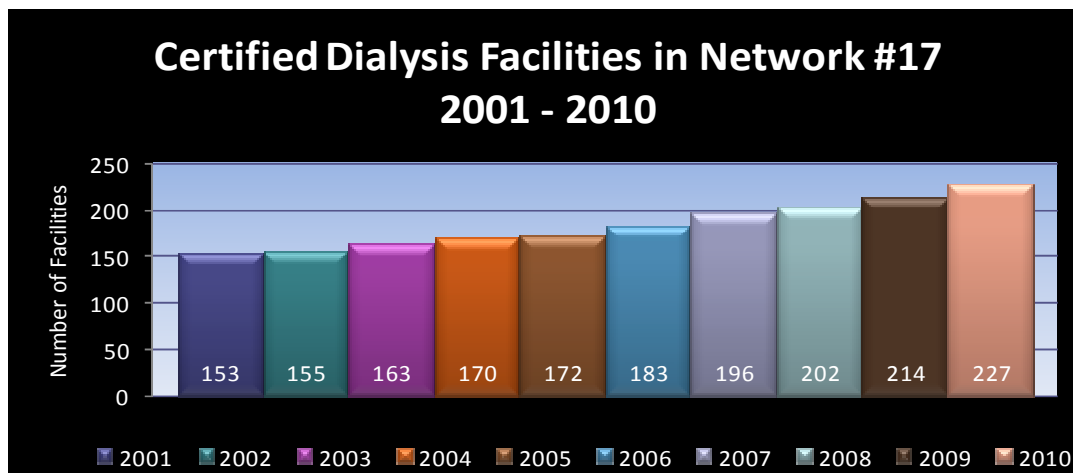
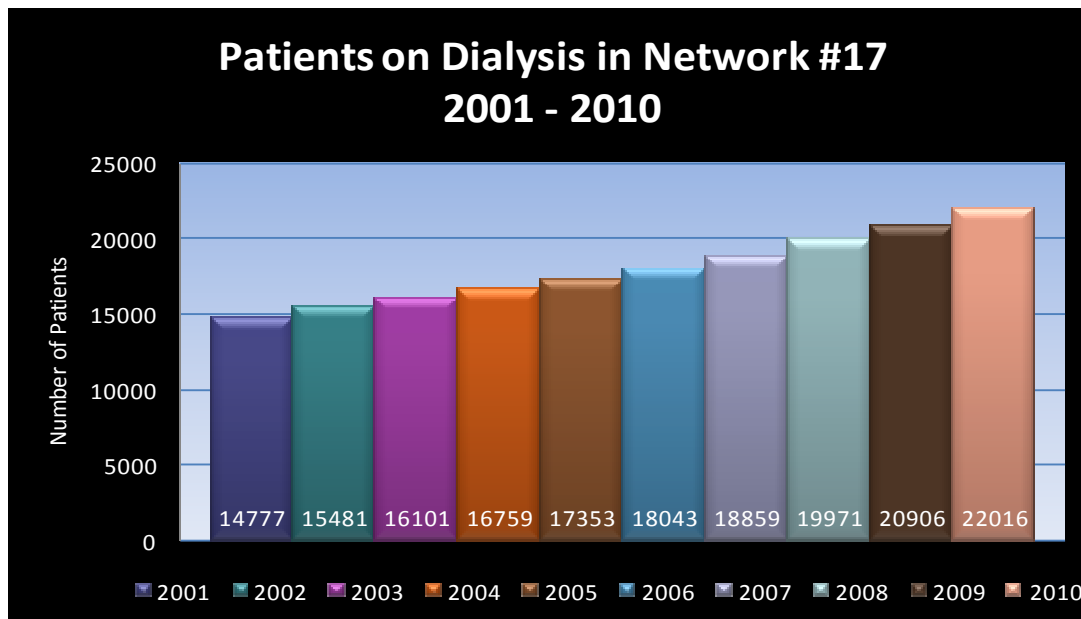
As of December 31, 2010, there were 22,016 patients on chronic dialysis in Network #17 showing an increase of 5.3% from 2009. There were 227 Medicare-certified dialysis facilities and four Veterans Affairs facilities within the Network boundaries.

ESRD Network #17 2010 Demographics							
	Network #17	Northern California	Hawaii	American Samoa	Guam	CNMI (Saipan)	Other
Total Population	15,794,350	14,142,905	1,360,301	64,827	178,000 Est.	48,317 Est.	
Prevalent Dialysis Patients **							
Number of Patients	22016	18565	2769	102	427	153	
Male	12053	10196	1511	45	243	62	
% of patients	54.7%	54.9%	54.6%	44.1%	56.9%	40.5%	
Primary Diabetes	10989	8823	1694	70	294	108	
% of patients	49.9%	47.5%	61.2%	68.6%	70.6%	70.6%	
Hispanic Patients	5130	5039	65	0	23	3	
% of patients	23.3%	27.1%	2.3%	0.0%	5.4%	2.0%	
Asian Patients	4830	3314	1425	4	72	15	
% of patients	21.9%	17.9%	51.5%	3.9%	16.9%	9.8%	
Pacific Island Patients	2228	758	889	97	346	138	
% of patients	10.1%	4.1%	32.1%	95.1%	81.0%	90.2%	
Total In-Center Hemo	19576	16356	2567	102	402	149	
% In-Center Hemo	88.8%	88.1%	92.7%	100.0%	94.1%	88.1%	
Mean Age	61.6	61.6	61.9	56.7	55.6	55.1	
Incident Patients ***							
Number of Patients	5723	4912	579	32	139	41	20
Male	3241	2783	326	17	78	24	13
% of incident patients	56.6%	56.7%	56.3%	53.1%	56.1%	58.5%	65.0%
Primary dx diabetes	2950	2399	382	25	112	27	5
% of incident patients	51.5%	48.8%	66.0%	78.1%	80.6%	65.9%	25.0%
Hispanic Patients	1230	1220	7	0	3	0	0
% of incident patients	21.5%	24.8%	1.2%	0.0%	2.2%	0.0%	0.0%
Asian Patients	1161	813	306	2	26	9	5
% of incident patients	20.3%	16.6%	52.8%	6.3%	18.7%	22.0%	25.0%
Pacific Island Patients	503	162	168	30	166	32	0
% of incident patients	8.8%	3.3%	29.0%	93.8%	79.9%	78.0%	0.0%
Mean Age	62.3	62.6	62.2	56.7	58.3	54.3	55.6
ESRD Facilities							
# of Dialysis Facilities	228	198	23	1	4	2	
# of Transplant Units	7	6	1	0	0	0	
# New Facilities in 2010	12	12	0	0	0	0	
# Pending Certification	5	3	1	0	1	0	
Facilities closed 2010	1	1	0	0	0	0	
# Veterans Health Administration (VHA) Units	4	3	1	0	0	0	

****Prevalent dialysis patients:** Total includes 11 patients not resident in Network #17 at time of onset. All of these patients received initial treatment at Northern California dialysis facilities and are counted in those totals.

*****Incident patients:** Total includes 20 patients not resident in Network #17 at time of onset. Fourteen of these patients initiated therapy with a transplant

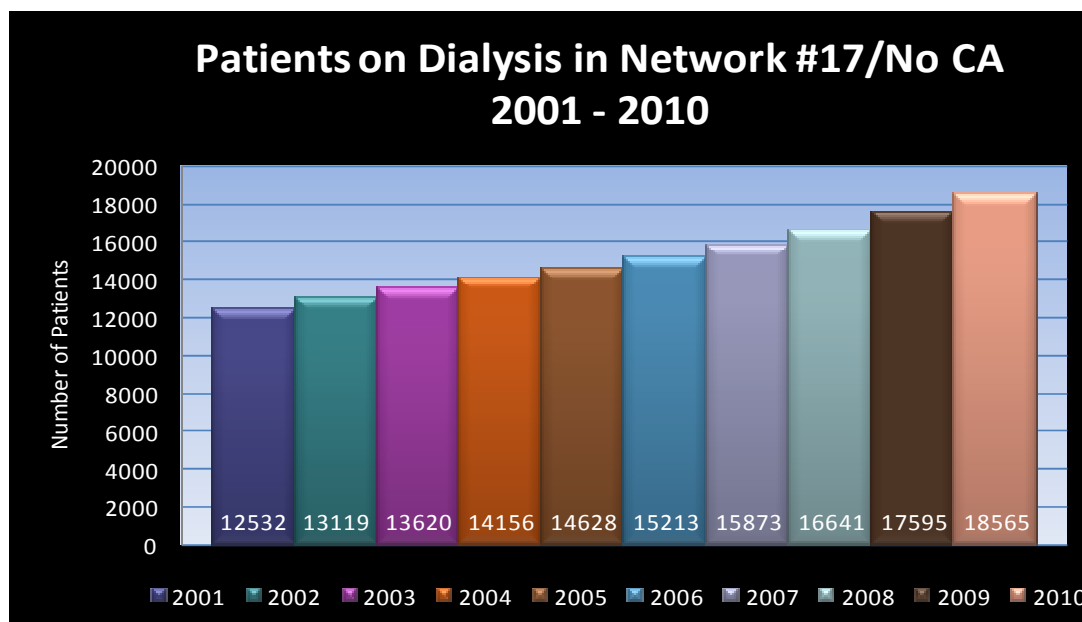
ESRD Network #17 Total Facility and Patient Demographics 2001-2010



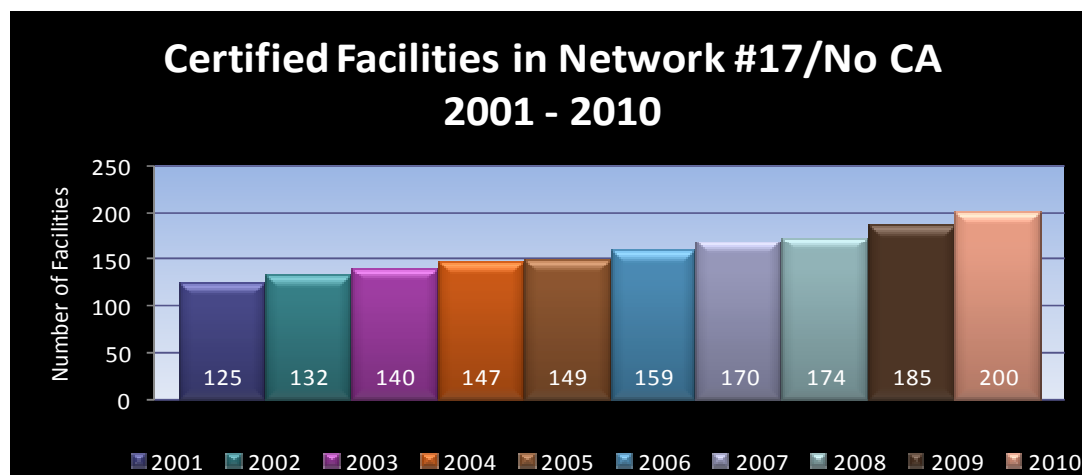
Network #17 Individual Statistics

Network #17 includes the forty five northern most counties of California. Network #17 contains about 60% of the geography but only 35% of the population. Only thirty one counties the Network #17 currently have dialysis facilities as of December 2010.

Northern California



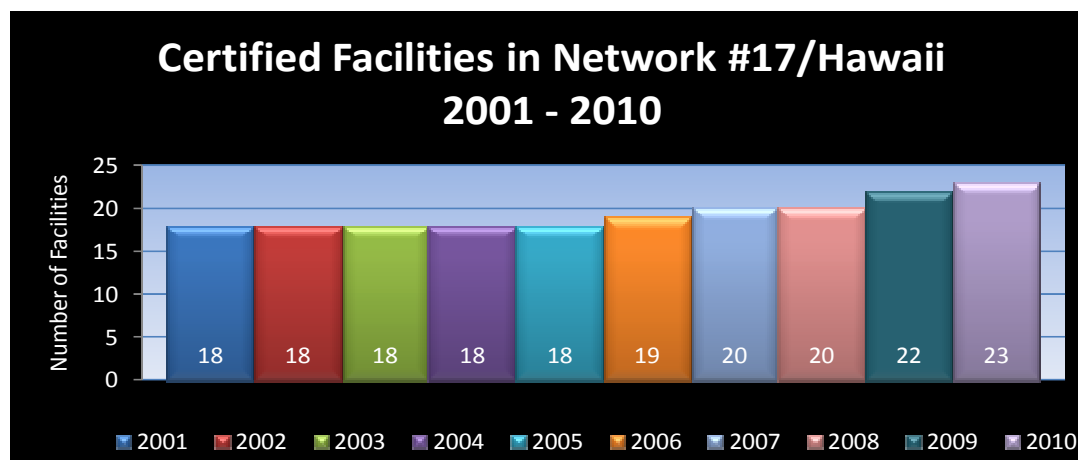
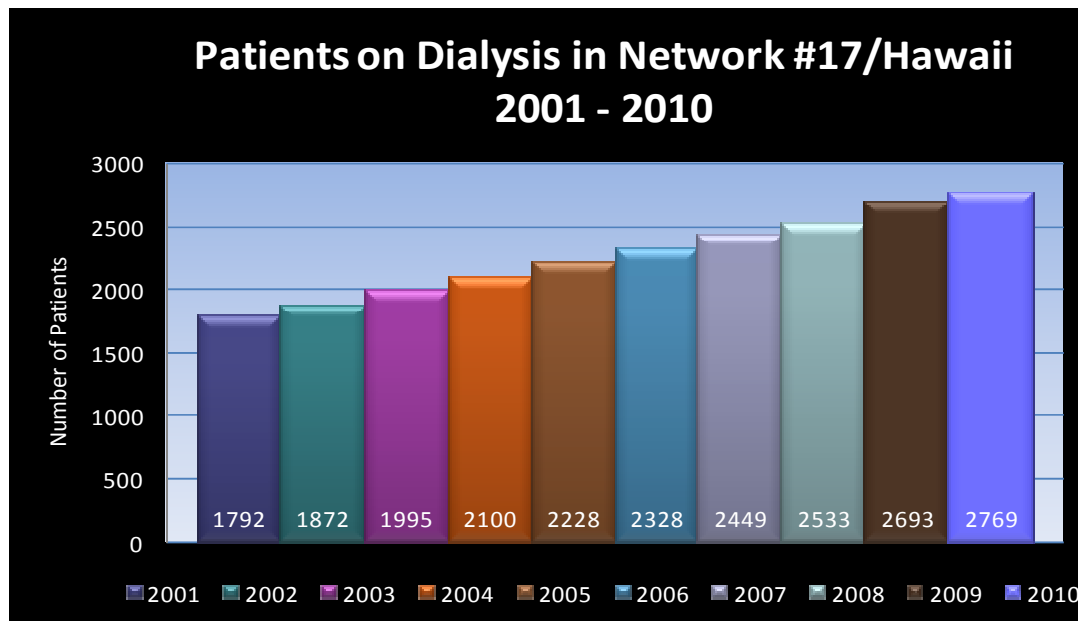
* For 2010 includes 11 patients receiving dialysis treatment in California but resident in contiguous states



Facilities

There were 200 Medicare-certified facilities providing dialysis services in Northern California at the end of 2010 and four Department of Veterans Affairs/Department of Defense dialysis facilities included in the Network totals. Twelve new dialysis facilities opened during 2010. Five facilities were pending certification at the end of 2010.

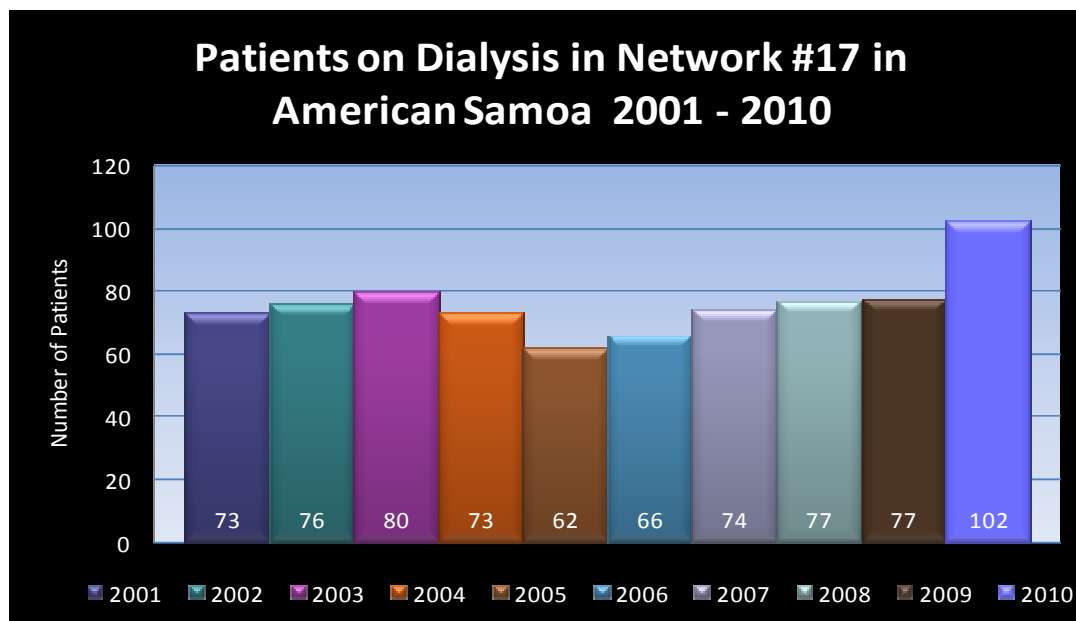
Hawaii



Facilities

There were 22 Medicare certified dialysis facilities in Hawaii at the end of 2010, two pending certifications and one transplant center in Honolulu. There is one Veteran's Administration dialysis facility on the Island of Hawaii which resides on the same campus as the active duty military hospital and is included in the total facility count.

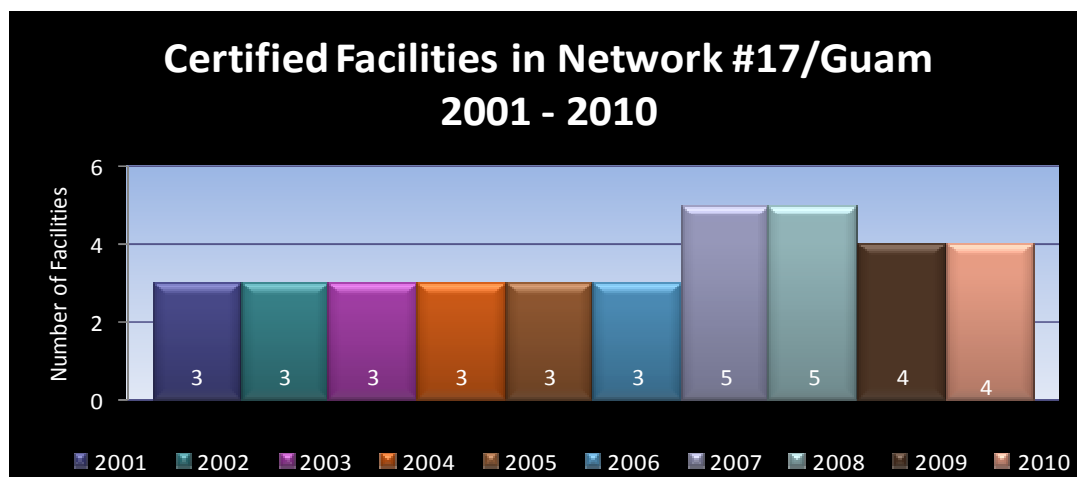
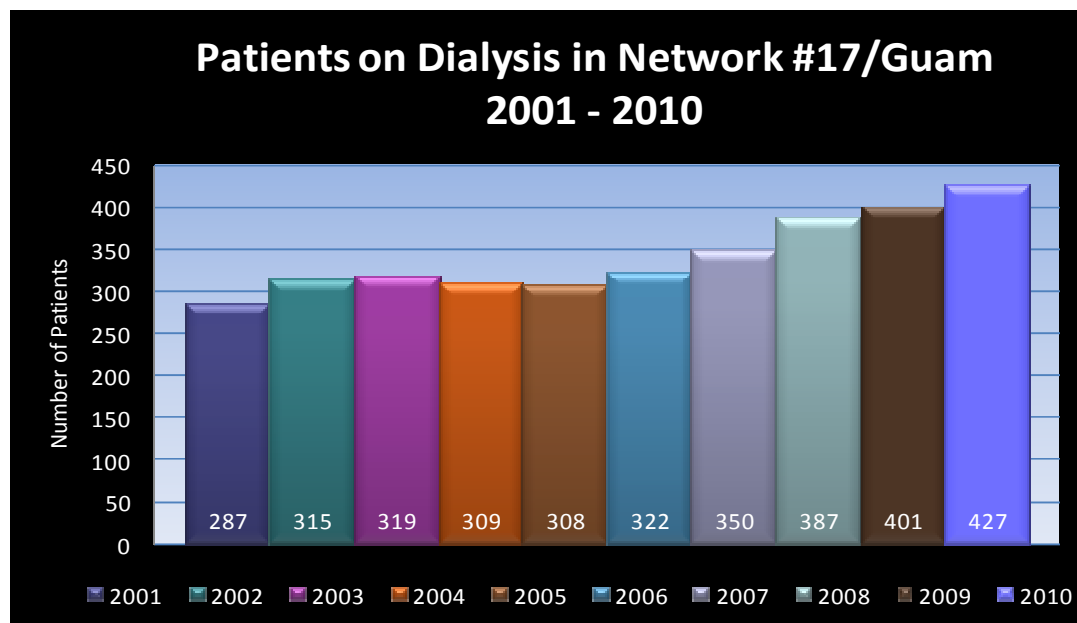
American Samoa



Facilities

American Samoa has one dialysis facility in Pago Pago, offering in-center hemodialysis to 102 patients at the end of 2010. There is no transplant center in American Samoa. At the end of December 2010, an expansion of the LBJ Hospital dialysis facility was underway.

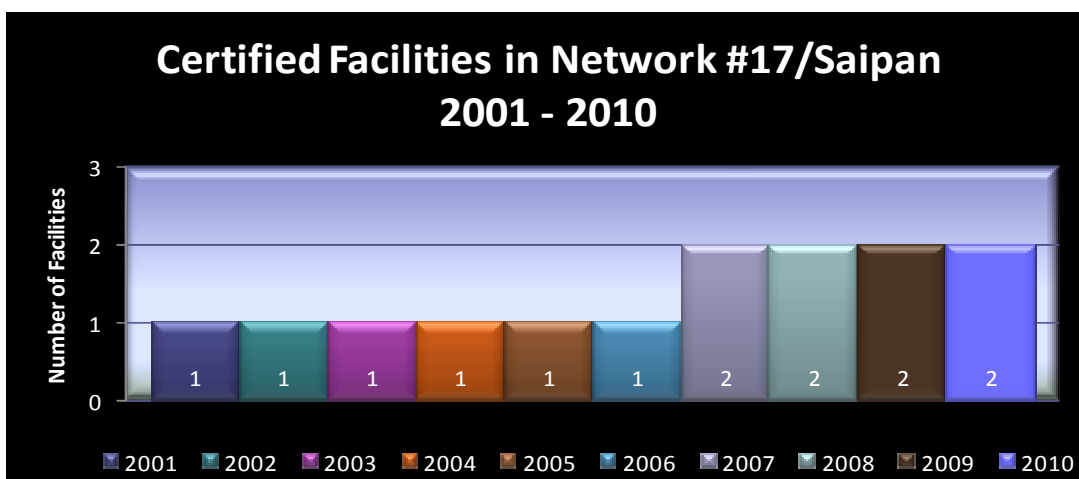
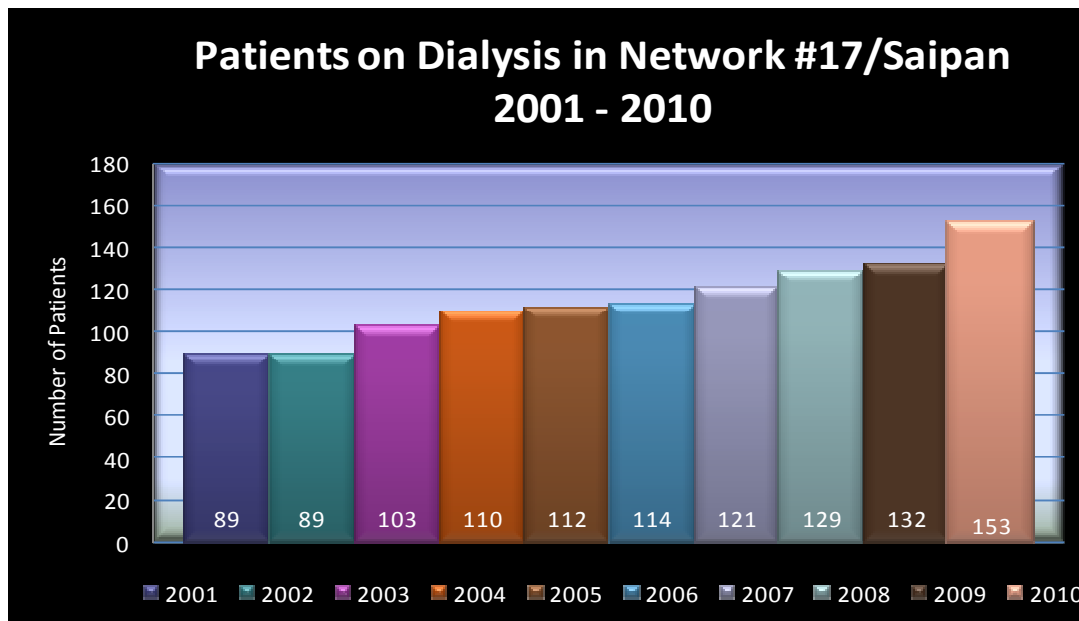
Guam



Facilities

Guam had four Medicare certified facilities providing dialysis as of December 31, 2010 and one facility pending certification. One facility is hospital based with the others freestanding. One of the freestanding facilities also offers peritoneal dialysis. There are no transplant centers located on the island of Guam.

Saipan (Commonwealth of Northern Mariana's Islands) (CNMI)



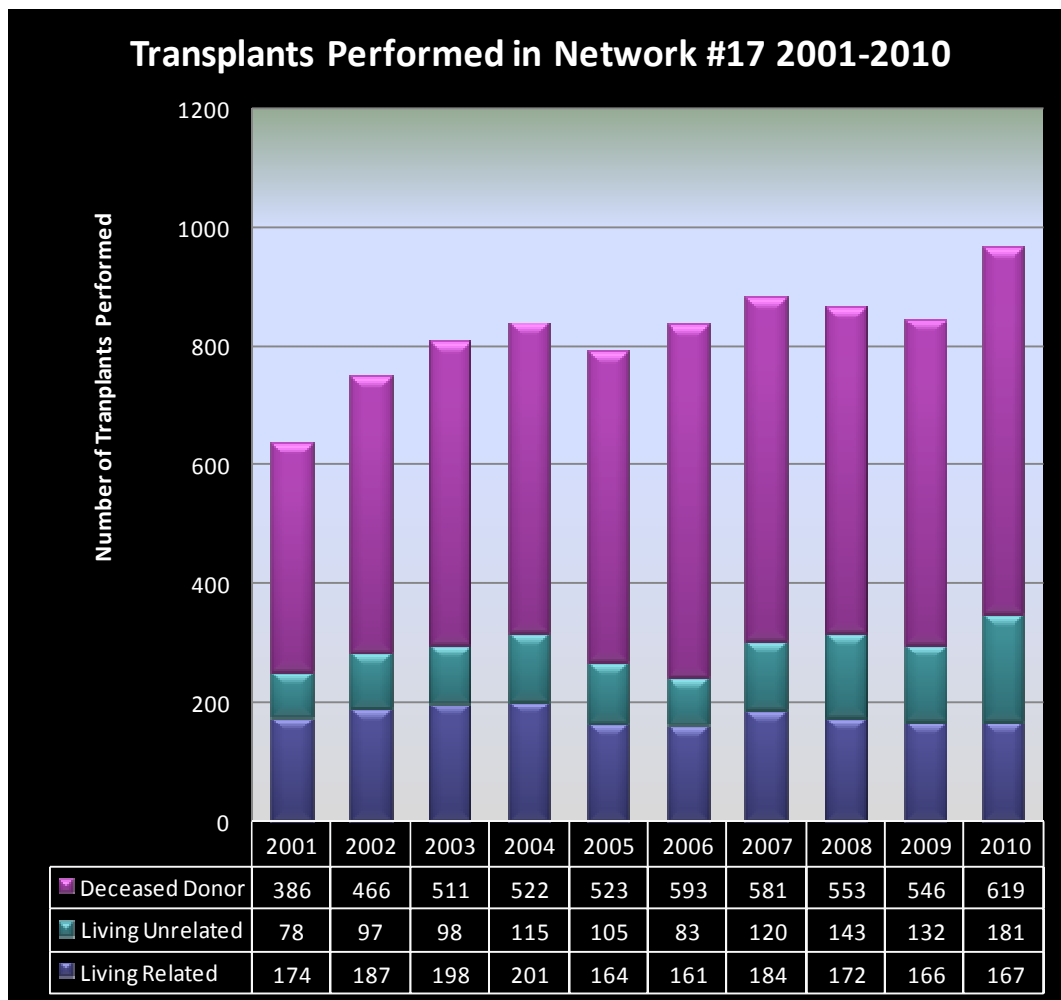
Facilities

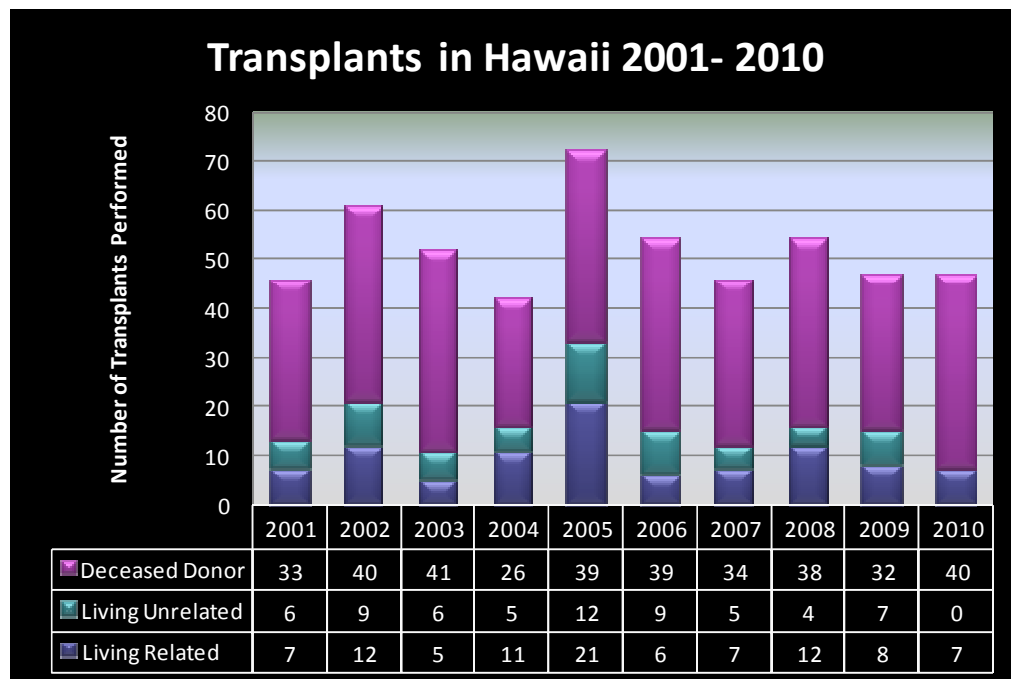
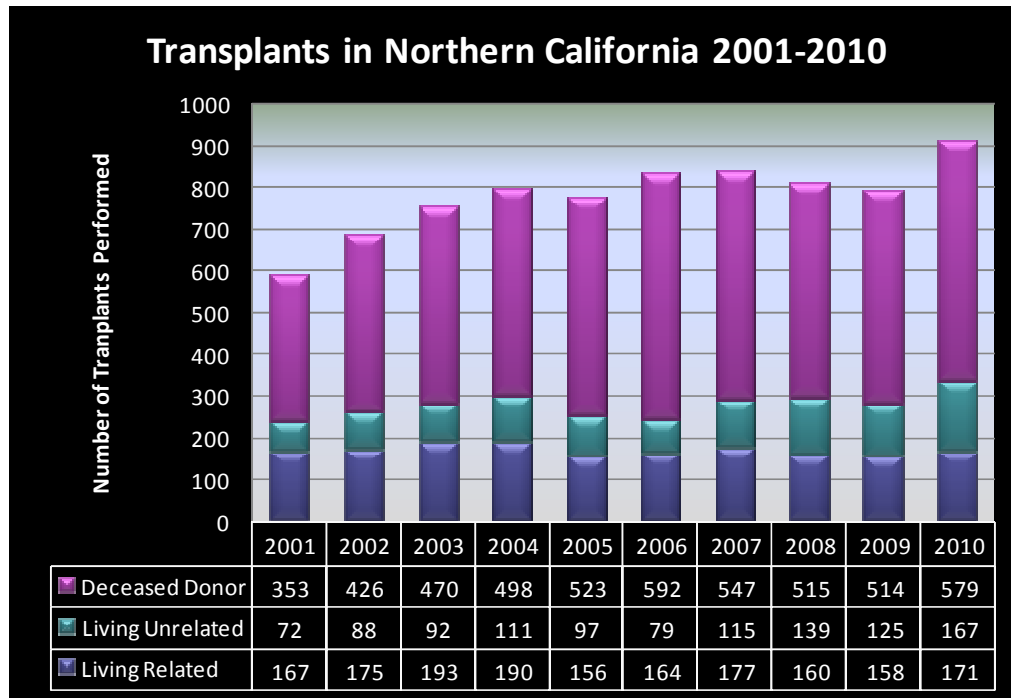
There are two dialysis facilities on the island of Saipan, the capital of CNMI, offering in-center hemodialysis. One also offers CAPD and CCPD. There are no transplant centers in Saipan (CNMI).

Transplants in Network #17

The following table provides an overview of transplant information for Network #17, Northern California, and Hawaii. During 2010, Network #17’s seven transplant centers performed 967 kidney transplants, a increase of 23 procedures from 2009.

In December 2010 there are seven transplant facilities in Network #17; six transplant centers in Northern California, two in San Francisco, two in Sacramento, and two in Palo Alto, one of which specialized in pediatric transplants. Hawaii has one transplant facility.





B. Network Structure

The Western Pacific Renal Network, LLC (also known as ESRD Network #17) service area covers the 45 northern counties of California, the state of Hawaii and the American Territories of Guam, American Samoa and Saipan. As a Limited Liability Corporation with the Intermountain End-Stage Renal Disease Network, Inc. as the sole member, ESRD Network #17 carried out all administrative activities required by its CMS contract as well as those activities required to operate as a California and Colorado non-profit corporation. These activities included, but were not limited to the following:

- Maintained a Board of Directors (BOD) comprised of professionals and at least one patient as specified in the current Network Statement of Work (SOW). The Board of Directors holds ultimate responsibility for the effective functioning of the Network;
- Maintained a Network Council comprised of professionals representing renal dialysis and transplant facilities located in the Network and kept Council members informed on Network activities;
- Maintained a Medical Review Board (MRB) with a membership that includes at least one patient representative, in addition to physicians, nurses, social workers, administrators and renal dieticians engaged in treatment relating to end-stage renal disease. The Network #17 Medical Review Board's activities and programs are directly related to the quality and appropriateness of care;
- Network #17 is also supported by a Patient Advisory Committee (PAC) comprised of patients who represent various regions of the service area to provide input to the Network and its Boards on the concerns and needs of patients;
- Maintained its corporate status as "qualified to do business in other states" in California, Hawaii and the Pacific Island/American Territories. The required corporate reports and forms were submitted to the appropriate state and territorial agencies.

C. Network Staff

The Network Executive Director supervises the Network staff members at both ESRD Network #17 and ESRD Network #15 and is accountable to the Board of Directors for the overall performance and activities of the Network staff. Each employee has a primary area of responsibility. These responsibilities fall within four major areas: Administration, Quality

Improvement, Data Management, and Patient Services. In 2009, the employees were:

- Darlene J. Rodgers, BSN, RN, CNN, CPHQ , Executive Director
Position Summary: Under the general direction of the Intermountain End-Stage Renal Disease Network, Inc. /Western Pacific Renal Network, LLC Board of Directors; administers implements and evaluates the programs and activities of the Western Pacific Renal Network, in accordance with the CMS contract requirements. This individual splits her time between the Network #17 office in California and the Network #15 office in Denver. Colorado.
- Allison Kregness, BSN, RN, CNN, Director of Operations
Position Summary: In cooperation with the Executive Director, as Director of Operations, this individual administers, implements and evaluates the programs and activities of Western Pacific Renal Network, LLC; serves as staff liaison for the Medical Review Board (MRB) and works with the MRB to develop, implement and evaluate Network programs for quality improvement as described by the Statement of Work and CMS's Health Care Quality Improvement Program (HCQIP) in accordance with the CMS contract requirements in the Novato, CA office.
- Noel D. De Ocampo, MSN/ED, RN, Director of Quality Improvement
Position summary: Under the direction of the Director of Operations, develops, implements and evaluates Quality Improvement (QI) activities for dialysis facilities in Network #17's region per contractual agreement with the Centers for Medicare & Medicaid Services (CMS). In October of 2010, the QID resigned from his position.
- Marlene Magaraci, BSN, RN, Quality Improvement Coordinator
Position Summary: Under general supervision of the Director of Quality Improvement, assists the Director of Quality Improvement in the management the Network's quality improvement activities and provide technical support to the Network #17 nephrology community. In November of 2010, Marlene assumed the position and responsibility of Director of Quality Improvement. The QID serves as staff liaison for the Medical Review Board (MRB) and works with the MRB to develop, implement and evaluate Network programs for quality improvement as described by the Statement of Work and CMS's Health Care Quality Improvement Program (HCQIP). Prepares, as directed by the MRB, written recommendations for improvements in the ESRD care of individual patients or groups of patients receiving care within the Network; is responsible for the upkeep of the Network Internal Quality Program (IQP). Works in consult with state survey agencies (SSA) for issues related to ESRD, and partners with Quality Improvement Organizations (QIO) and other ESRD Networks for QI activities.

- Susan Tanner, MA, Director, Information Systems
Position Summary: Under the general supervision of the Director of Operations, this individual assumes responsibility for all day-to-day data collection activities relating to CMS data deliverables; serves as primary Network point of contact for the CROWN (Consolidated Renal Operations in a Web-enabled Network) program, and serves as the liaison between CMS and dialysis facilities for CMS required data activities. This individual also provides data analytical support to Quality Improvement, Patient Services, and Administration. Additionally, this individual acts as the Network contact for the technical needs of the administration of the servers, software, and workstations and serves as primary contact for all VISION/Quality Net Exchange issues between facilities and the Network.
- Connie Lorenz, MSW, Director, Patient Services
Position Summary: Under the general supervision of the Director of Operations, the Director of Patient Services develops, implements, and evaluates all programs relating to ESRD patient services in ESRD Network #17 per contractual agreement with CMS. This individual is responsible for the complaint and grievance process utilizing CMS protocol, as well as for the development of programs and QI activities impacting the quality of life for ESRD patients.
- Karolyn Forbes, Office Manager (Network #15/17)
Position Summary: Under the general supervision of the Executive Director, maintains financial records and financial files for the LLC. This individual prepares financial statements and reports.
- Peter Traub, BS, BA, Community Outreach Coordinator, QI Data Specialist
Position Summary: Under the direction of the Director of Operations, this individual works with the Director of Patient Services and the Director of Quality Improvement, as well as other Network staff as needed to provide educational programs and materials to improve care for ESRD patients. The Community Outreach Coordinator provides education information and training to ESRD professionals, patients and their family members and other members of the renal community including but not limited to disaster preparedness.
- Margaret Gelosi, Administrative Assistant
Position Summary: Under the general supervision of the Director of Operations, assists the management staff as needed and supports other staff members in a variety of tasks including clerical support, maintenance of files, and database support. This individual is responsible for answering incoming telephone calls and opening and distributing mail. This individual maintains office supplies and equipment.

- Laura Ross, Data Specialist
Position Summary: Under the general supervision of the Director of Information Systems, this individual works with the Information Systems team to oversee the flow of data; update and maintain the patient database; promote facility/Network communications; and detail processes pertaining to the transmission of data.

D. Board of Directors

Network #17 and Network #15 are governed by a Board of Directors, which is comprised of representatives from the Network #15/17 area and includes patient representation. The following list shows the Board of Directors membership by state and professional category through 2010:

- | | |
|---------------------------|------------|
| • Nephrologist | Arizona |
| • ESRD Administrator | Arizona |
| • Nephrologist | Colorado |
| • Nephrologist | Colorado |
| • ESRD Nurse | Nevada |
| • Nephrologist | New Mexico |
| • Transplant Nephrologist | New Mexico |
| • ESRD Nurse | Utah |
| • Patient | Utah |
| • ESRD Dietitian | Colorado |
| • Nephrologist | California |
| • Patient | California |
| • Nephrologist | Hawaii |

E. Committees

Medical Review Board (MRB)

The Medical Review Board is a committee whose membership is qualified by education, experience, and position to evaluate the quality and appropriateness of care delivered to ESRD patients. The MRB serves as an advisory panel to the Network Organization on all matters relating to the evaluation of the quality and appropriateness of care. The MRB is responsible for the development and/or revision of all criteria and standards. The MRB committee membership through 2010 included:

- | | |
|----------------------------|---------------------|
| • Nephrology Nurse | Northern California |
| • Patient | Northern California |
| • Nephrology Nurse | Northern California |
| • Nephrology Social Worker | Northern California |

- Renal Dietitian Northern California
- Nephrologist Northern California
- Nephrologist Northern Northern California
- Vascular Surgeon Northern California
- Nephrologist Northern California
- Nephrology Nurse Northern California

At the end of 2010, the Network was in the process of recruitment of MRB members from Hawaii and the Pacific Territories. Securing representation from the Hawaii and the Pacific Territories may prove to be challenging given the distance, time differences (two of the three Pacific Territories are located on the opposite side of the International Date Line) and cost of travel. Participation would be better served by telecommunication as an alternative.

Patient Advisory Committee (PAC)

The Patient Advisory Committee (PAC) is a patient-driven advisory committee to the Network. It was established for the purpose of providing the patient perspective for Network quality improvement interventions. The Director of Operations and Community Outreach Coordinator are the staff liaisons to the PAC. The leadership positions are filled by the members to include a Chairperson, who will represent the PAC at Medical Review Board meetings. All members and officers will be asked to commit to a two-year term. The new Network Community Outreach Coordinator joined the Director of Operations in supporting the PLC's activities and produced the PAC first patient-focused newsletter in November, 2010, "*Windows of Our World*". The newsletter was written by the patients for the patients and evaluations received indicated that the dialysis patient population was very happy with the first edition. See Appendix A.

Tasks assigned to the PAC will include; publishing a bi-annual patient newsletter and an educational project with final MRB approval.

Grievance Committee

This committee is comprised of members of the MRB and is responsible for, in conjunction with the Director of Patient Services and the Director of Operations, the Network grievance resolution process. It is appointed and activated as necessary upon submission of a formal grievance involving clinical or medical matters requiring education, experience, and/or expertise beyond that of Network staff. Care is taken to appoint Medical Review Board members with experience relevant to the grievance, and strict conflict of interest procedures are observed. Any individual who has financial, professional or personal involvement with the beneficiary or provider is excluded from participation on the Grievance Committee. The Grievance Committee consists of, at minimum, a chairperson and two other members. A copy of the Network Grievance Policy is located on the Network website and is attached as Appendix B.

Network Council

The Network Council is composed of members from renal dialysis and transplant providers that are located in Network #17 geographic area. In addition, the patient members of the Board of Directors and Medical Review Board are considered Council members. The Network Council meets the statutory requirements of 1881 (c) of the Social Security Act. The Network Council serves as a liaison between the Network and its provider membership. Every renal facility/provider is represented on the Council. At its September, 1997 meeting, the Board of Directors of ESRD Network #15 redefined Council membership. Instead of each facility appointing a representative, the Council consists of the Medical Director, Administrator and Nurse Manager from each Network facility. All of these individuals are considered Network Council Representatives and receive general mailings. Additionally, each professional category receives mailings relevant to that area of practice. This definition has been applied to the ESRD Network #17 organization.

F. Emergency Preparedness for the Network Organization

The Network maintains a multi-focused approach to internal and external preparedness. Efficient and effective response to emergency and disaster events is optimized by advanced preparation and a clearly-defined process.

Given the increased concern about potential disasters, including an outbreak of the H1N1 Influenza, Network #17 annually reviews the organization disaster preparedness plan. This plan is an extension of the Business Continuity and Contingency Plan (BCCP) required by CMS. The plan speaks directly to the Network function and how it works within the Network office and can be completed in the case of a disaster. The plan also encourages individual employee preparedness for a disaster. The plan is revised as needed.

The Network #17 office personnel have taken measures towards preparation for any given emergency by conducting fire drills, fire extinguisher training, and an earthquake tabletop exercise with evacuation. Each employee has a personalized emergency evacuation backpack and a Neighborhood Emergency Team Training (NERT) manual. The Network Outreach Coordinator is certified in NERT.

The Network was actively involved in the Kidney Community Emergency Response (KCER) Coalition. Network employees dispersed themselves among the various response teams and participated in response team activities throughout the year. The Network Outreach Coordinator is National Co-chair to KCER Patient Response Team.

The Network actively followed-up and offered technical assistance to a Network facility faced with an emergency including a situation that involved a major Tsunami in the Pacific Islands and another involving an earthquake in Northern California. Network #17 also offered technical assistance to facilities and patients that were affected by the massive outbreak of wildfires during the 2010 fire season.

The Network #17 website contains a section on Emergency Preparedness for patients and professionals that are continuously updated. The Network provided emergency information to facilities including how to obtain CMS *Emergency Preparedness* publications for patients as well as providers. All new facilities receive a “Welcome to Western Pacific Renal Network #17 gift box, which includes a hard copy of the CMS *Facility Emergency Preparedness Manual* and *Patients Guide for Emergency Preparedness*.

The Network *Disaster Coalition* has a multidiscipline and diverse membership. An emergency wallet card for dialysis patients was developed and sent to all patients of Network #17 having proved itself as being very successful. Patients presented their cards, identifying themselves as dialysis patients to rescue personnel during a recent emergency, thus proving the value of the project.

 <p>American Red Cross Bay Area Chapter</p> <p>1-877-773-7229 WWW.REDCROSSBAYAREA.ORG</p> <p>EMERGENCY CONTACT CARD EMERGENCY CONTACT CARD</p> <p>Working in Partnership with Western Pacific Renal Network 1-800-232-3773 www.esrdnet17.org</p> 
<p>I AM A DIALYSIS PATIENT</p> <hr/> <p style="text-align: center;">NAME</p> <hr/> <p style="text-align: center;">DIALYSIS CLINIC NAME & PHONE NUMBER</p> <hr/> <p style="text-align: center;">NEPHROLOGIST NAME & PHONE NUMBER</p> <hr/> <p style="text-align: center;">PHARMACY NAME & PHONE NUMBER</p>

EMERGENCY CONTACT		
LOCAL		
Name	Home/Cell	Work
<p><small>If you and your loved ones are separated during a disaster, each person should call the designated contact person to report his/her location and condition. This contact should be out-of-state because it is often easier to call long distance after a disaster.</small></p>		
OUT-OF-STATE		
Name	Home/Cell	Work
<p>EMERGENCY MEETING PLACES</p> <p><small>So you can reunite with your loved ones in case of a disaster, identify your own meeting places and know the evacuation sites.</small></p>		
Near Home (example: across the street, street corner)		
Out of the Neighborhood (example: park, public building)		
Dialysis clinic evacuation site (example: across the street, corner)		
Other evacuation site (example: work or school parking lot)		

The Coalition is currently developing a tool for first responders (EMS) to identify dialysis patients entitled *File of Life* which will attach to the patients refrigerator with important information concerning the patients care plan. Project will be rolled out in mid 2011.

III. CMS END-STAGE RENAL DISEASE NETWORK PROGRAM STRATEGIC GOALS

A. Introduction

Beginning on July1, 2010, ESRD Network #17 entered into a new Statement of Work (SOW) with the Centers for Medicare & Medicaid Services (CMS). The strategic goals described in this report are the goals as stated in the 2006-2010 SOW. In accordance with the legislative mandate for the ESRD Network program, to assist CMS in meeting Agency goals and in keeping with sound medical practice, the strategic goals of the ESRD Network Program (2010-2012) are to:

1. Improve the quality and safety of dialysis related services provided for individuals with ESRD;
2. Improve the independence, quality of life and rehabilitation (to the extent possible) of individuals with ESRD through transplantation, use self-care modalities (e.g., peritoneal dialysis, home hemodialysis), in-center self care, as medically appropriate, through the end of life;
3. Improve patient perception of care and experience of care, and resolve patient's complaints and grievances;
4. Improve collaboration with providers to ensure achievement of the goals through the most efficient and effective means possible, with recognition of the differences among providers (e.g., independent, hospital-based, member of a group, affiliate of an organization, etc.) and the associated possibilities/capabilities;
5. Improve the collection, reliability, timeliness and use of data to measure processes of care and outcomes; maintain Patient Registry; and to support the ESRD Network Program.

The Health Care Quality Improvement Program (HCQIP) for the ESRD Network Program mission supports achievement of the strategic goals by assuring the Institute of Medicine aims as related to individuals with ESRD by ensuring that care delivery is patient-centered, safe, effective, efficient, equitable, and timely. The CMS strategic goals for Network #17 were met as demonstrated by a passing score during the annual evaluation and site visit in March 2010.

B. Improve the Quality and Safety of Dialysis Related Services Provided for Individuals with ESRD

As defined in the SOW, the mission of the CMS HCQIP is to promote the quality, effectiveness, and efficiency of services to Medicare beneficiaries by strengthening the community of those committed to monitoring and improving care. During 2010, Network #17 defined Quality Improvement Projects (QIPs); and through the work of the Medical Review Board and in partnership with Network renal providers has directed or participated in the following projects:

1. Clinical Performance Measures (CPM) Project-Lab Data Collection (LDC) Project

In 1994, the Centers for Medicare & Medicaid Services initiated the ESRD Health Care Quality Improvement Program (HCQIP) to monitor and evaluate patterns of care and provide feedback to all ESRD providers. HCQIP is based on Continuous Quality Improvement (CQI) concepts. It has been proposed, and fostered by CMS, that the CQI model, utilizing a rapid-cycle methodology, is the best approach for ESRD Networks to take in guiding facilities toward quality care for their patients. In addition, CMS is responsible to the public for managing the financial resources it administers and assuring that an acceptable level of care is provided to ESRD beneficiaries. In order to provide feedback, CMS selected quantifiable clinical indicators, which could be measured easily to determine important aspects of dialysis care. Since the inception of HCQIP in 1994, CMS and the ESRD Networks have been committed to improving ESRD patient care and outcomes by providing data and tools to providers for assessing care and identifying opportunities for improvement.

The CPM Project was designed to assist ESRD caregivers to measure outcomes, assess their care processes, and identify opportunities for improvement. Another purpose of the project was to establish a consistent clinical database. The CPM

Project measured key components of care associated with dialysis, which could be considered data points to use to trigger improvement activities. The clinical data provided information on dialysis adequacy (urea reduction ratio and dialysis prescription), anemia (hemoglobin, use of erythropoietin or darbopoetin and iron administration), mineral metabolism, vascular access, and nutritional status (serum albumin).

In 2009 the CPM Project was to be rolled into CROWNWeb. Due to delays in the full implementation of CROWNWeb, the long-standing Lab Data Collection (LDC) Project was utilized to collect and report the clinical outcomes previously reported by CPM. Due to continued delays in the full implementation of CROWNWeb, the LDC was used again in 2010 to collect and report these data.

The Lab Data Collection (LDC) Project is a method of collecting clinical lab information for these critical areas in order to provide comparative data to ESRD providers and ESRD Networks for use in quality improvement activities. Networks participating in the LDC project collect annual lab data on 100% of hemodialysis (HD) and peritoneal dialysis (PD) patients across the country. The collection includes: Hgb, Tsat, ferritin, URR, Kt/V, albumin, P, and Ca. Kt/V and CrCl are used to determine adequacy of dialysis for PD patients. Following the collection Network #11, the coordinator of the project, produces facility-specific comparative data reports. The reports are distributed by each Network and can be used by dialysis facilities to not only improve clinical outcomes, but also meet part of their quality assessment and performance improvement program (QAPI) requirements stipulated in the 2008 Conditions for Coverage for End-Stage Renal Disease Facilities. Vascular access data are collected on a monthly basis via the Fistula First Dashboard.

Data for the LDC were collected utilizing two methods. Data from the Large Dialysis Organizations (LDOs) were batch submitted to the LDC contractor. For the independent dialysis facilities Network requested facility staff to abstract the required information and return the data to the Network office. Network staff answered numerous questions from facilities regarding the standardized LDC instructions and the data collection forms for this project. Completed and/or edited LDC data were returned to the Network office. Numerous telephone calls were made to the facilities for clarifications and corrections.

Within Network #17, 100% of the eligible dialysis facilities operating in 2009 participated in the data collection for the fourth quarter of 2009 (collected in 2010). Data were collected for the months of October, November and December of 2009 in the spring of 2010. The collected data elements included the following laboratory values for hemodialysis patients: hemoglobin, TSAT (if done), ferritin (if done), pre BUN, Post BUN, albumin, albumin method, calcium, phosphorous, Kt/V for hemodialysis patients. Data elements collected for peritoneal dialysis patients included weekly CrCl, weekly Kt/V urea, anemia and nutrition markers, calcium and phosphorous.

Comparative data reports for this project detailed facility-specific, Network and US outcomes where available. Analyses of these data indicated that all states and the Network as a whole exceed CMS goals in the areas of anemia management, adequacy of hemodialysis and nutrition. Facilities in need of assistance were identified, as well as those facilities that exceeded expectations.

The Network #17 Medical Review Board reviewed the clinical outcome results and formulated a plan of action to address opportunities to improve care within the Network. This information was used to design the 2010 Quality Improvement Work Plan (QIWP) with input and direction from the MRB.

Network #17 facilities received a copy of the clinical outcomes as reported for the 2009 Lab Data Collection in the summer of 2010. At that time the facility representatives were encouraged to review the information that was provided and to develop an improvement plan(s) if appropriate. Follow-up and QI assistance was offered to these facilities by the Network QI staff throughout 2010.

In contract year 2009-2010, and as a follow-up to the 2009 Lab Data Collection project, the Network undertook a project to provide additional support and resource to those facilities who were not meeting clinical outcome goals. Network #17's Statement of Work directs the Network to assist ESRD providers/facilities in the development and implementation of Quality Assessment and Improvement Projects (QAIPs) to improve their patient care processes and outcomes. The Network is tasked with assisting facilities in developing QAIPs when CPM data or other data reports indicate that patient outcomes or processes are not being met.

2. *Network #17 Electronic Lab Collection Project (Elab)*

Network #17's MRB directed the Network to participate in the collection of facility-specific data through the *Electronic Lab Data Collection Project*. This project allows for the collection of limited clinical data to assist in Quality Improvement activities both at the Network and facility level. This data collection involves large dialysis organizations (LDO), small dialysis organizations (SDO) and independent dialysis facilities approved by CMS.

Network #17 participated in the 2010 Lab Data Collection (2009 data). Preliminary results were received in May 2010. These results were used to update the 2010-2011 Quality Improvement Work Plan (QIWP) and Clinical Performance Measure (CPM) projects. The results were shared with participating facilities. Clinical performance measures include, but are not limited to; albumin, Kt/V and URR (dialysis adequacy), Hemoglobin, to name a few.

3. *"Fistula First" Quality Improvement Initiative*

In the ESRD Network SOW issued in June 2003 the Networks moved from methodologically prescribed QIPs with significant CMS oversight to autonomous development of effective facility-based rapid-cycle improvement initiatives. The Institute for Healthcare Improvement (IHI) was contracted to work with CMS,

Networks and dialysis facilities/corporations to develop a collaborative approach to prioritize a quality improvement topics, identify and "package" effective approaches for improvement, assist in the design of an approach that maximizes the "spread" and "adoption" of effective solutions, and "coach" collaborative teams.

All Networks were required to develop and implement a quality improvement project aimed at increasing fistulas within their Networks. This portion of the

Network SOW is performance-based with the target for performance developed by CMS. The target AVF prevalent rate for Network #17, by the end of the calendar year one contract which began on July 1, 2009 and ended on June 30, 2010, was 58.8%. (+1.8%)

For calendar year 2010, the MRB directed Network #17 staff to work towards a goal of 61.0%, a 2.2% percentage point increase from the previous contract year's prevalent AVF rate of 58.8%. The MRB also set the stretch goal at 61.2%. As of December 2010, Network #17 achieved a prevalent AVF rate of 61%.

Network #17 continued to collaborate with Fistula First eligible facilities in increasing the number of patients using AVF as primary access. The following are 2010 Fistula First projects initiated or continued from previous year by Network #17 with assistance from the Fistula First Subcommittee:

Presentation of educational symposia, workshops, and All Networks were required to develop and implement a quality improvement project aimed at increasing fistulas within their Networks. This portion of the Network SOW is performance-based with the target for performance developed by CMS meetings to Nephrologists, Nurses, PCTs, and other ESRD staff members. These were provided in different geographic regions of Network #17, including the Pacific Island Territories, as requested by individual facilities. Focus was given on areas where prevalent AVF rates were lower than the expected average.

- A facility-specific project focusing on facilities with the lowest prevalent AVF rates. Seven facilities were chosen to participate in this project. These facilities were required to submit individual "Action Plans" to improve their prevalent AVF rates, and subsequently, their overall Fistula First programs. Network #17 provided support to these facilities through assistance with writing their "Action Plans", supplying them with tools and resources, and providing feedback. All seven of the facilities on the "Action Plans" increased their fistulas rates to the CMS minimum standards or higher.
- In 2010, three Fistula First Newsletters were produced by Network #17 and sent to all eligible facilities. These newsletters contained useful information that could assist facilities in improving their prevalent AVF rates. These newsletters also listed "Fistula First Champions", facilities with the highest prevalent AVF rates and featured "Best Practice" facilities in Fistula First and Buttonhole Technique.
- Network #17 continued sending the "Fistula First Quarterly Report" to all eligible facilities. These reports contain individual facility AVF, AVG, and Central Venous Catheter rates to assist facilities with their vascular access trending. These reports also come with the "Regional Summary" for comparative purposes. The SIMS-generated vascular access report was sent to all eligible facilities monthly. This report was sent with many Fistula First

related materials that would be useful to staff and patients in each facility's efforts to increase prevalent AVF rates.

- Network #17 developed a separate spreadsheet listing all Fistula First eligible facilities and their vascular access rates. The purpose was to assist in closely monitoring facilities that were performing poorly and track those that may be having difficulty in maintaining prevalent AVF rates in acceptable ranges. This spreadsheet was also useful in assisting the Network trend vascular access rates in certain geographic regions, as well as ownership groups. This information was useful in identifying what areas needed assistance in Fistula First programs.
- Network #17 consistently promoted the importance of a designated Vascular Access Coordinator to facilities by providing tools and literatures about this topic. They are distributed to Network #17 facilities by mail, during workshops, and in conferences where Network #17 staff participated.
- In September 2010, the Network Annual Symposium included a special presentation on "Angio-cath Buttonhole" technique by a nurse from a Canadian hospital. A home training facility in California is utilizing the technique for their home hemo population and the Network felt it very important to present the technique to symposium participants since California currently is the only state using the procedure.
- Dr. Larry Spergel, NW #17 MRB and Fistula First Subcommittee member, presented several one-on-one meeting with surgeons in the Network whose fistula rates had fallen below the CMS standard. All facilities showed increases in their rates after his presentations and are continuously monitored for attribution and maintenance.

Change Concepts #12 & #13 were mailed to Medical Directors, Clinical Managers and designated surgeons/interventional nephrologists. Change Concept #12 encourages hospital systems to detect CKD and promote AV fistula planning and placement. Change Concept #13 supports patient efforts to live the best possible quality of life through self-management. Included in this mailing was the NW15/17 vascular access options brochure in English and Spanish with an emphasis on promoting fistulas

Network #17 partnered with Network #15 to present buttonhole cannulation workshops to four corporate dialysis units in Nevada. Network #17 helped "train the trainers" in Network #15 and shared their cannulation presentation with permission for staff to use it in future cannulation training endeavors. The workshops were presented to 42 facility staff members.

The Fistula First subcommittee, comprised of two vascular surgeons, a Nephrologist, nephrology nurses, regional quality director and facility administrators, was formed
ESRD Network #17

in 2008 to assist in the review of the Network's FF data and to assist in the review of quality action plans received from facilities that have demonstrated difficulty in raising their prevalent AVF rates. This committee also assisted the Network staff with outreach into the community to identify best practices and to examine external factors that are contributing to the successes seen within the Network #17 area. The committee sent those facilities not reaching the minimum goal, action plan templates in 2010 to further assist them in raising their FF rates.

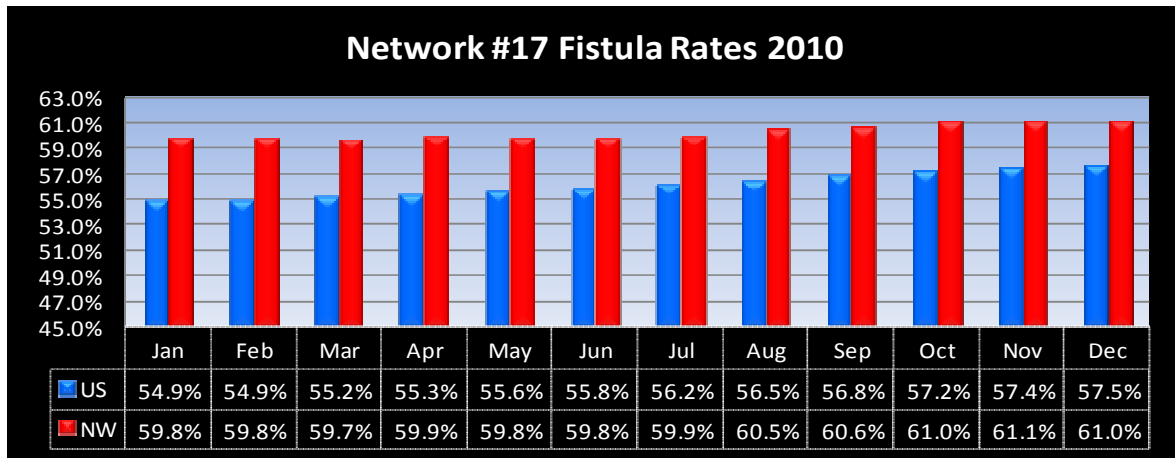
Network #17 continues to utilize the quarterly State Summary Report and facility-specific reports, which were distributed to all FF eligible facilities, LDO and non-LDO, and were well received. The reports were designed to show each facility how their performance compared individually, in the Network and nationally. These reports along with the education provided by the Network were responsible for the 2.0 percentage point increase in prevalent AVF rates during the 2010 calendar year. At the recommendation of the FF subcommittee, the reports were sent individually to the facility Medical Directors, Facility Administrators and Clinical Managers to ensure that all parties received copies of the reports. Several positive calls from Medical Directors were received by Network #17 in response to this action.

The Network #17 Director of Operations presented six Fistula First and Cannulation workshops during the calendar year 2010. Three physician symposiums were held for the Nephrologist and Vascular Surgeons with the leading experts on Fistula First along with the Network #17 MRB Chairperson. The first meeting was conducted at the Annual Network Symposia in September 2010. The meetings were considered very successful and will be utilized again in several other geographic areas in the upcoming year.

A one-day comprehensive training session sponsored by the FFBI was held at the Westin O'Hare Hotel in Chicago, Illinois on November 12, 2010. Facility Directors were asked to share the training opportunity with their surgeons and encourage them to attend. Network #17 was able to recruit a surgeon to attend the meeting and share the results of the meeting with the Network.

The Network website was regularly updated with new Fistula First resources as they became available.

Network #17 continues to partner with numerous entities to promote the Fistula First Initiative. The Network continues to supply facilities and other interested parties with the Fistula First Surgical Video set upon request. The Network website was updated regularly with new Fistula First resources as they became available.



Network #17 has been an active participant with the CMS Fistula First Breakthrough Initiative (FFBI) project during 2010. The Network has two staff members participating in national task groups. Through the collaboration of Surgeons, Interventional Radiologists, LDOs, independent facilities, Networks, payers, patient organizations, RPA, ANNA, NANT, and USRDS, an increase in prevalent AVF rates have been demonstrated throughout the country. Please see Appendix C for documentation related to the Network’s Fistula First project activities.

4. Other Quality Management Activities (QMA)

In addition to those activities described previously in this report, the Network focused on other quality and quality management activities. As directed in the Network SOW, a Quality Improvement Work Plan (QIWP) was drafted and reviewed with the Network MRB at its August 2010 meeting. The plan outlines the Network’s QI focus for the second option year of the current contract cycle and acts as a blueprint for QI activities. The QIWP was submitted to the Network Project Officer as directed and was accepted as submitted with small revisions. This plan was reviewed monthly for additions/revisions and was reviewed with the MRB at each meeting.

QIWP Overview			
1.a. Vascular Access QIP	1.b. CPM Project	1.c. NW-Specific QIP	1.d. Facility-Specific Quality Assessment and Improvement Projects (QAIP)
<ul style="list-style-type: none"> Increasing the NW baseline AVF rate by 2% by March 2010 Facility-specific Vascular Access Quality Improvement 	<ul style="list-style-type: none"> Decreasing CVCs in use >90 days Increasing Vascular Access Stenosis 	<ul style="list-style-type: none"> Provision of “Facility Alert” binder to all Network #17 facilities Increase use 	<ul style="list-style-type: none"> Providing resources for the pacific Island Territories’ (PITs) facilities Increase transplant evaluation for the PITs

<p>Project</p> <ul style="list-style-type: none"> • Increase the use of Buttonhole Technique in Network #17 	<p>Monitoring</p> <ul style="list-style-type: none"> • Improving Dialysis Adequacy • Anemia Management 	<p>of DPC Toolbox</p> <ul style="list-style-type: none"> • 5-Diamond Safety Awards • Immunization Initiative 	<ul style="list-style-type: none"> • Improve clinical outcomes for remote facilities located in the Pacific Territories
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Facility Administrators and Medical Directors received a copy of the annual Dialysis Facility Report (DFR) in August 2010. The University of Michigan Kidney Epidemiology and Cost Center (UMKECC) conducted the statistical analysis for the DFR information with funding from CMS.

Network #17 responded to the CMS request for help to increase ESRD facility staff awareness about immunization adding information to its website about the possibility of a pandemic outbreak. The focus was to increase awareness on the need for each community, employer and family to be prepared to respond, as the Federal and State governments may not be able to assist on an individual level.

Quality Improvement documents and resources related to immunizations were mailed to each facility in August 2010, National Immunization Month along with a laminated poster for each facility.

In conjunction with the National Influenza Vaccination Week (NIVW) of December 2010, Network #17 provided information by sending all facilities resources that can be shared with all patients and staff specifically concerning the Whooping Cough outbreak in California. These materials were sent to inform staff and patients that have not received the vaccine of the importance of immunization.

In light of the many recalls and product updates from CDC, FDA, and many other ESRD related entities, Network #17 developed and provided the “Facility Alert” binders to all facilities. This binder is provided to improve communication of recalls and updates between facilities and the Network. Facilities were instructed to place the binder in a common area and encouraged them to promote its purpose to staff and patients. A “*Facility Alert*” binder is sent to each new facility from the Network as part of the materials sent to prepare for certification.

After the 2008 visit to the islands of American Samoa, Guam, and Saipan, Network #17 established the Pacific Island Territories monthly conference call. This conference call is participated by staff and management from all ESRD providers in the outer pacific islands and provides them the opportunity to exchange information regarding challenges and successes in providing ESRD care within their respective islands. Network #17 serves as support and provides information and resources that may be useful to any concerns that staff and patients have. The conference call has reached the two and a half year mark without missing one call. The positive feedback from the Pacific Island Territories has made this a very successful project and will continue indefinitely.

The Network directed the focus of its facility staffs on Decreasing Patient Provider Conflict (DPC) through direct contact by the Director of Patient Services with facility staff calling to seek assistance with individual problems. The Network professional newsletter provided articles “advertising” the availability of the DPC materials and examples of its potential use within the facility.

The Network Patient Services staff collaborated with Network #18 in presenting a group of WebEx seminars for facility Social Workers on the effect use of the DPC Toolkit, during the first six months of 2010. Notification to each facility regarding the Network’s availability to speak to staff and patients regarding the DPC materials is included in the Network “Annual Mailing”.

In order to encourage inclusion of the Patient Care Technicians in the quality improvement process, the Network sponsored a PCT certification exam preceding the Annual Meeting held in September 2010. Approximately 100 dialysis technicians and other dialysis professionals participated in the exam process.

In order to continuously improve the Network’s internal processes and to promote good QI practices within the Network organization, Network #17 has in place a dynamic Internal Quality Improvement (IQI) program. The process utilized at Network #17 is identical to the process used by Network #15 and has been recognized by the Project Officer as a model program.

Network #17 IQI program goals are to:

- Examine, monitor, and improve the performance of the Network in key areas in a systematic, organization-wide manner;
- Create an atmosphere in which staff members seek to improve the processes by which the Network functions;
- Meet or exceed all external and internal customer needs;
- Meet the current contract requirements of CMS.

Network #17 IQI program objectives are to:

- Support and foster continuous quality improvement within the Network in support of the Health Care Quality Improvement Program (HCQIP) and other Statement of Work (SOW) activities;
- Meet contractual requirements as described by CMS in the SOW by developing and implementing a plan to ensure that all aspects of Network #17’s activities run efficiently, comply with the contract, and are consistent with CMS’ goals and objectives for the HCQIP and SOW;

- Ensure the support, understanding, and participation of all beneficiaries, facilities, providers, and other constituencies that are affected by the HCQIP;
- Establish a Network policy that provides ongoing training for Network staff on quality management principles, assessment, and monitoring;
- Maintain an I-QI program that is simple, effective, requires minimal paperwork, and does not overburden Network #17 staff members;
- Maintain Network #17's activities within a permissible range of deviation, with minimum effort;
- Monitor quality of work products by setting and measuring established quality indicators, such as timeliness, accuracy, effectiveness, impact, etc.;
- Ensure the financial integrity of the contract by actively monitoring and staying within the total fixed price (and contract modifications) of the contract;
- Improve the reliability, accuracy, consistency, and timeliness of data processing and data reports;
- Retain and make available reports that allow CMS to monitor the progress of the Network's I-QI; and to
- Develop, implement, and monitor quality improvement or corrective action plans as indicated for each project.

Examples of current IQI focus areas as of the end of 2010 include, but are not limited to:

- Improving the % of facilities reporting Fistula First monthly data to 100%;
- Improve the timeliness and accuracy of manually submitted Fistula First data;
- Improve fax communications with facilities by keeping the fax number list up to date;
- Improve the completeness of contacts entry;
- Improve the effectiveness of communication with DHS contacts;
- Monitor for timely submission of required administrative reports;
- Managing the database;
- Provide timely reporting of renal status of Medicare ESRD beneficiaries.

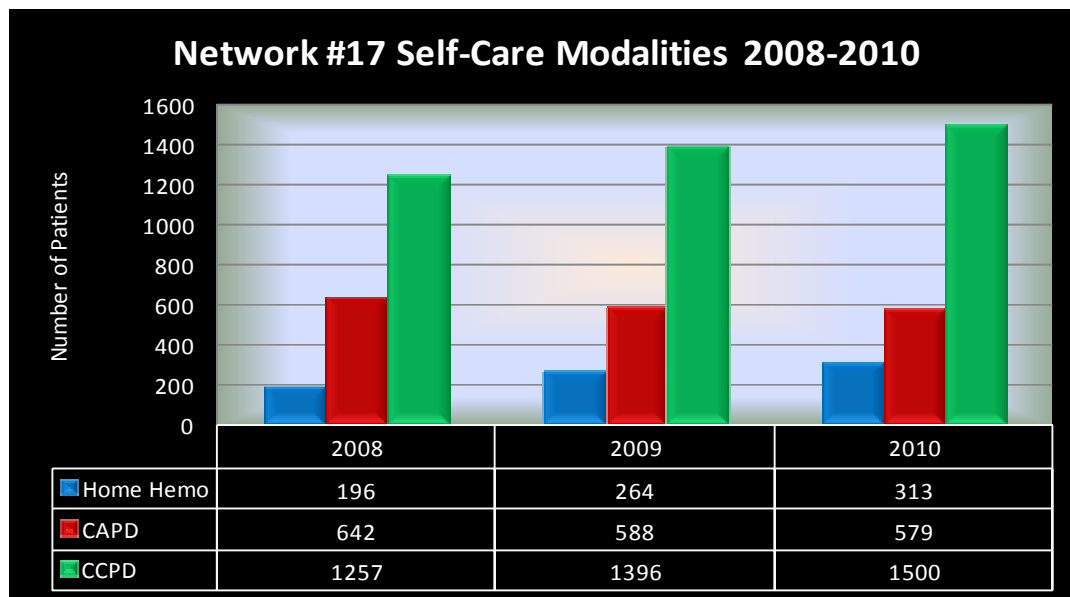
C. Improve the Independence, Quality of Life and Rehabilitation (to the extent possible) of individuals with ESRD through Transplantation, use Self-Care Modalities (e.g., peritoneal dialysis, home hemodialysis), In-Center Self-Care, as medically appropriate, through the End of Life

1. Promotion of Self-Care Dialysis

Network #17 promoted the use of self-care dialysis through educational activities such as distribution of the CMS National New Patient Packet. Information on patient

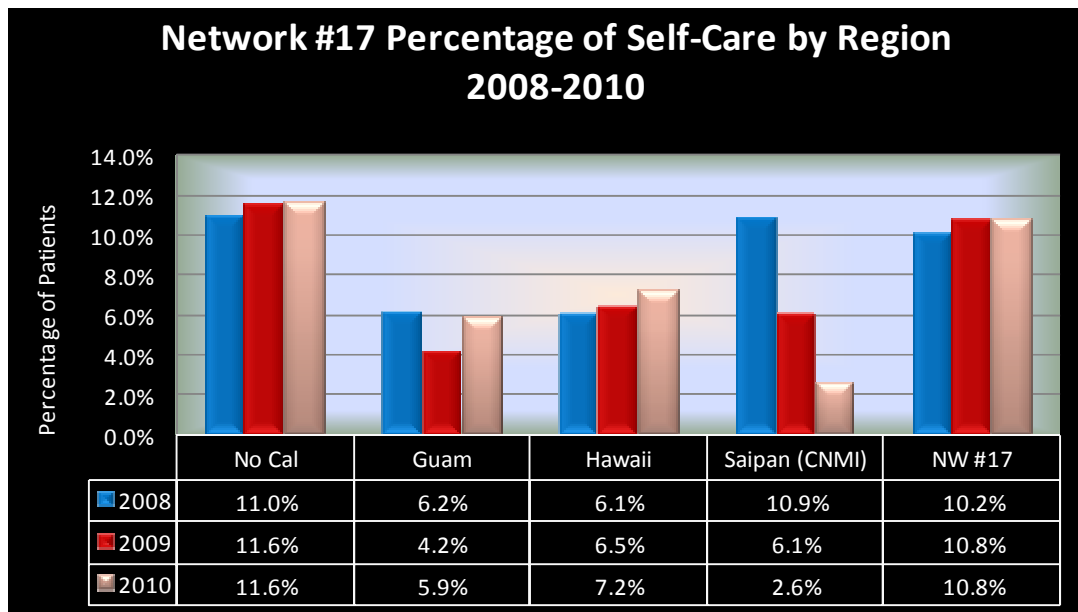
self-care, both as a patient mindset as well as a treatment modality, can be found on the Network #17 website to encourage patient interest and involvement in self-care. The MRB's goal for self-care is to ensure that patients are receiving information concerning self-care dialysis and that they are aided in obtaining this modality if it is their choice and is medically appropriate. In the 2010 calendar year, over 5000 New Patient Packets were distributed from the central distribution point to incident ESRD patients in the Network #17 area.

Network #17 continued to promote self-care modality selection in 2010. There were, however, regional limitations based on the choices offered in the respective regions of the Network. American Samoa's dialysis facility only offers in-center hemodialysis. Guam and Saipan had only one facility each offering peritoneal dialysis respectively. Hawaii and Northern California facilities offered peritoneal and home hemodialysis.



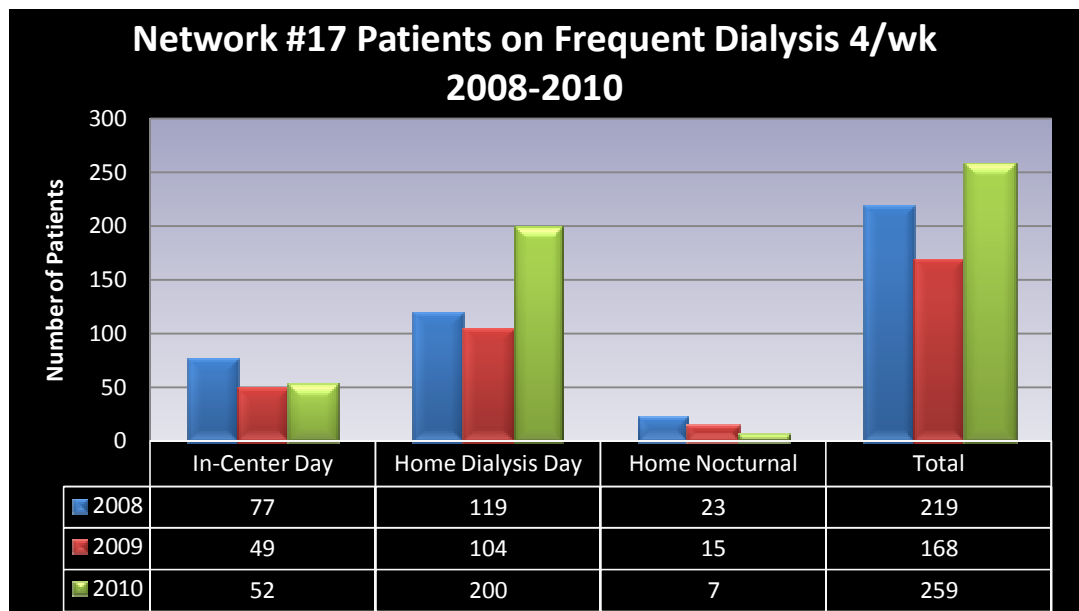
The Conditions for Coverage (CfC) place emphasis on patient education by requiring facilities to inform patients of all possible dialysis treatment modalities and settings, including but not limited to, transplantation, home dialysis modalities (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), and in-facility hemodialysis. Patients are required to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients. Further, the CfC Interpretive Guidelines require documentation in patient records that facility staff provided unbiased education to patients/designees about transplantation and all dialysis treatment options (modalities and settings)

offered for kidney failure, whether or not those options are offered at the current dialysis facility. This includes alternate scheduling options for in-center hemodialysis patients who attend school or are working. Working patients or students should be encouraged to continue doing so and facilities should recommend the most appropriate modality and setting for their dialysis.



Although the number of home hemodialysis patients remained a small percentage of the total self-care population in 2010 the number of patients doing home hemodialysis has continued to increase annually for the last few years.

A related trend is the increase of *frequent hemodialysis*, defined as four or more treatments per week. This modality choice was offered for both in-center and home hemodialysis. Although the percentage of the total dialysis population is small, there has been some increase in the number of patients electing this treatment option during the last three years.



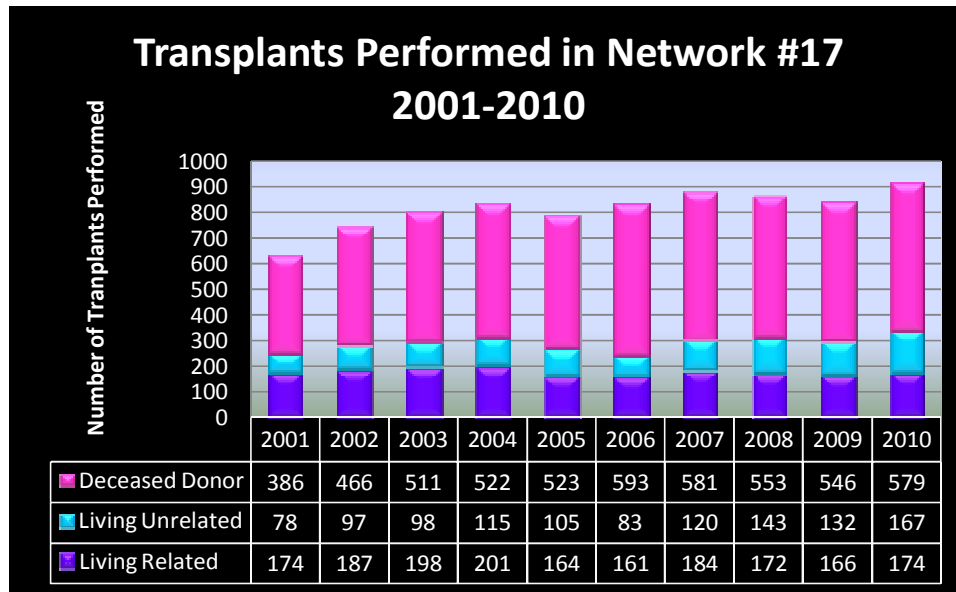
**Nocturnal dialysis is reported only on the CMS-2744.*

2. Encourage the Use of Transplant Modality

Network #17 promotes the use of transplantation as a treatment modality through mailings regarding pertinent technological innovations and modalities information on the Network website.

The MRB has established a Network goal that all patients receive information regarding transplant and be assisted in receiving a transplant if medically appropriate. As in the case with self-care dialysis, the Network has identified important factors affecting patients' choices about transplantation. Cultural factors, age, financial disincentives, co-morbid conditions, and psychosocial factors play significant roles in the patients' decision making regarding modality. The Network continues to work with its providers to encourage transplantation in patients where it is determined that this modality of renal replacement therapy is appropriate.

Currently the Network is developing a program to increase the number of transplant evaluations in the Pacific Island Territories which is extremely limited as logistics identified as the largest barrier. The Network has enlisted the assistance of the MRB members and transplant facilities to develop a strategic plan to explore all the barriers and ways to expand this piece of the patient's care plan. Currently patients from the Pacific Islands can be evaluated in Hawaii, but doing so is cost prohibitive and thus the number of patients' decreases drastically.



3. Rehabilitation/Vocational Rehabilitation (VR)

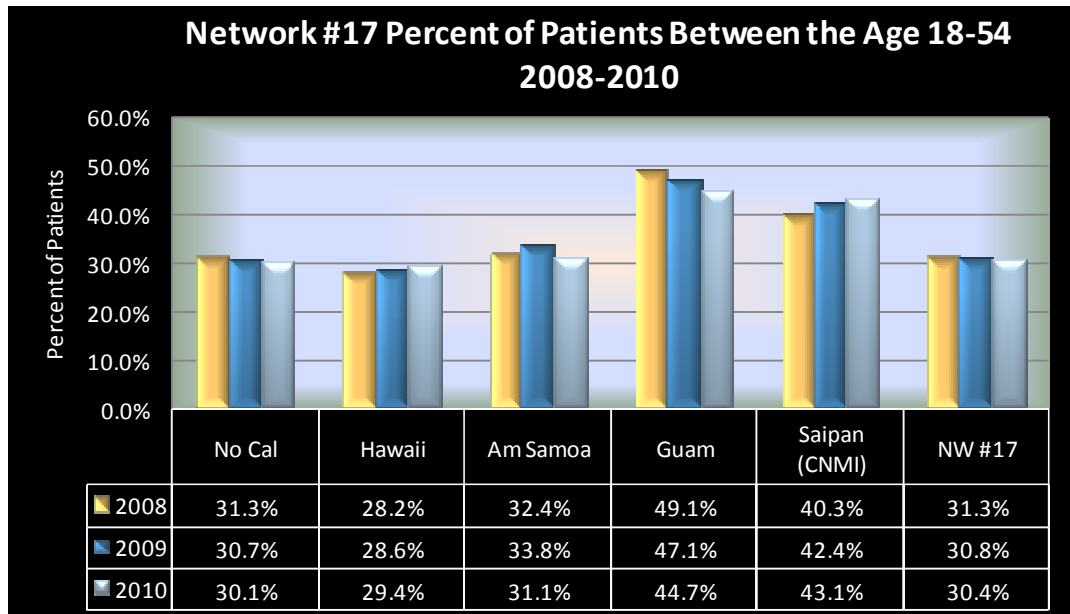
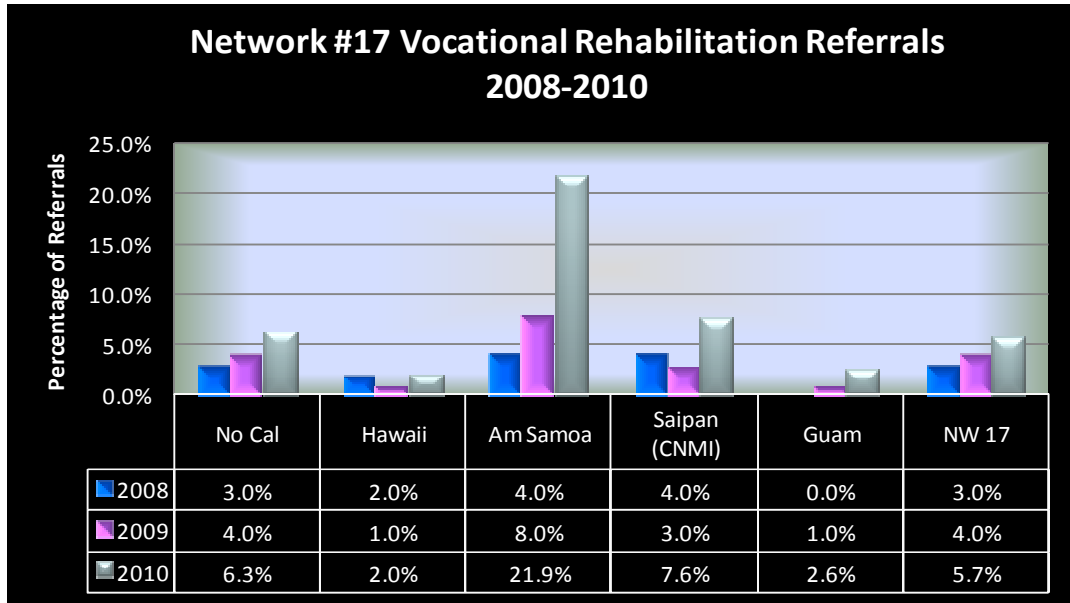
CMS Vocational Rehabilitation Survey

The CMS Vocational Rehabilitation Survey (VR) is completed annually for all dialysis patients between the ages of 18 and 54. Since 2004, it has been part of the CMS Facility Survey. The VR Survey includes patient level data on referrals to vocational rehabilitation services, employment and/or educational status by facility. Facility level data on shifts offered after 5 PM are also included. This has an impact on the ability of the patients to seek and/or maintain employment.

Network #17 has regional variations in the number/percentage of patients between the ages of 18 and 54. The mean age for both incident and prevalent patient populations in the Pacific Islands is five to seven years younger than that of Hawaii and Northern California. Appendix E contains examples of the Vocational Rehabilitation resources provided to the dialysis providers within Network#17.

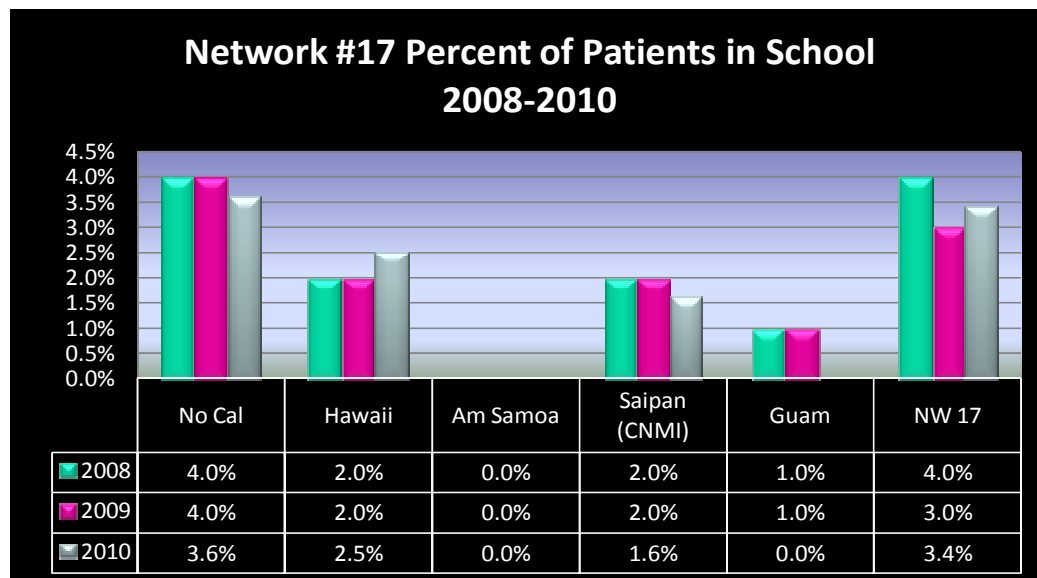
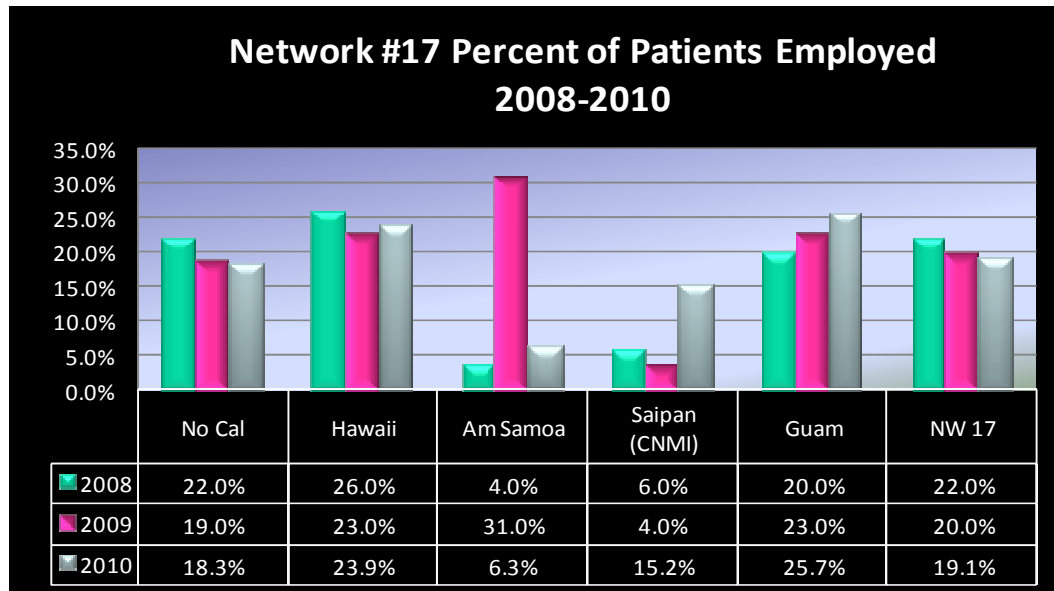
4. Referral to Vocational Rehabilitation

The CMS Vocational Rehabilitation Survey defined referral as action by the patient, not merely receipt of materials from facility staff. The percentage of referrals has remained consistent for the period 2009-2010 at 4-6% with the exception of American Samoa which showed a great increase due to the number of new patients and high unemployment rates that were incurred on 2010.



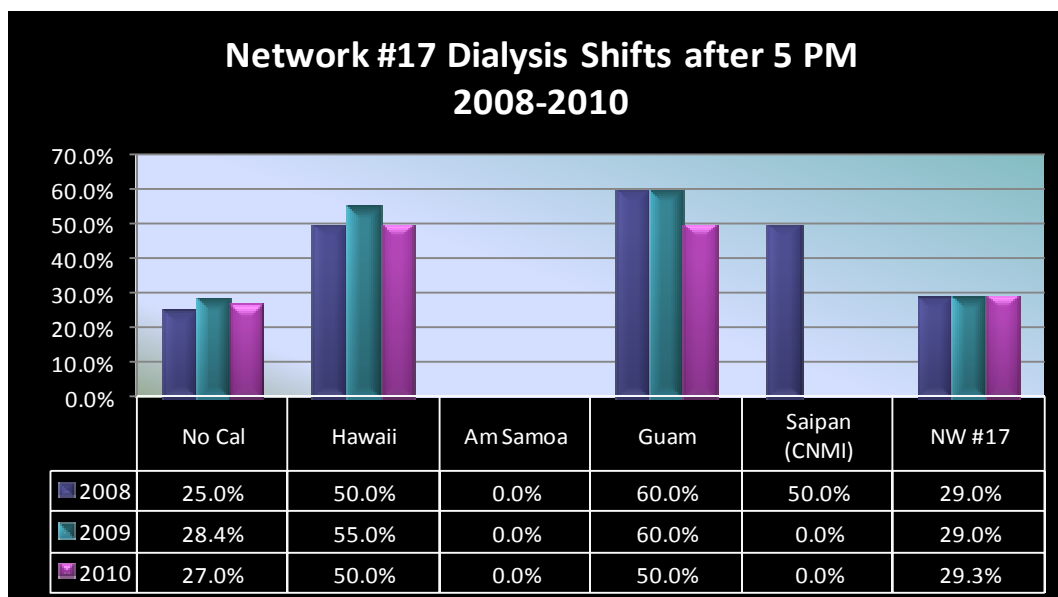
5. Working/In School

The numbers/percentages of patients employed and/or in school has remained consistent at around 20% from 2008-2010. Hawaii continues to have the highest percentage of employed patients with the Pacific Islands being the lowest.



6. Shifts after 5 PM

Network #17 had 89% of its dialysis population on in-center hemodialysis at the end of 2010. Choice of this modality, instead of the self-care modalities, continues to increase the significance of facilities offering shifts after 5 PM. From 2008-2010, less than one-third of facilities in Network #17 offered this service.



Network #17 encouraged patient and facility participation in vocational rehabilitation in a variety of ways:

- Transmitted via email and fax multiple Vocational Rehabilitation resources to facility social workers throughout 2010;
- Provided an ongoing single-number source of information for VR counselors to obtain information about dialysis and transplantation in general or about specific facility resources;
- Provided links to VR services on its website, including Life Options Rehabilitation Advisory Council (LORAC) and the 27th Institute on Rehab Issues “Effective Strategies for Improving Employment Outcomes for People with Chronic Kidney Disease”;
- An article appeared in the spring Network #17 facility newsletter encouraging vocational rehabilitation.

Please see Appendix E for Network #17 Vocational Rehabilitation data for 2010.

7. *Other Patient-Related Activities*

During 2010, Network #17 provided numerous resources to the patients in its geographic area. The Network uses various mechanisms to share this information including U.S. mail, bulk mailings to the facility for distribution to patients and via the Network website. Below is a sample of information, which was made available for patients in 2010:

- Information, including the Network brochure, “Who We Are” and the Facility Poster (including a Spanish version) describing the Network’s functions;
- Information related to complaints and grievances including the Protocol for Evaluation of Patient Complaints and Grievances, Patient Grievance Protocol Sheet, Network #17 Statement of Patient Rights & Responsibilities (Appendix F) and contact information for State Survey Agencies and the CMS Regional Office;
- Educational materials on vascular access, advance health care directives, home dialysis options, kidney transplant, web-based education, emergency preparedness, Medicare coverage, and employment / finances;
- Resources provided by CKD/ESRD community organizations including the NKF, AAKP and RSN;
- Dialysis Facility Compare (DFC) instruction and tips (Appendix G);
- Information related to the Network #17 Patient Leadership Committee;
- Network patient newsletter, *Kidney Connection* (Appendix D);
- Contact information of all renal related patient support and education groups.

In order to continuously improve the Network’s internal processes and to promote good QI practices within the Network organization, Network #15 has in place a dynamic Internal Quality Improvement (IQI) program. Examples of current I-QI focus areas as of the end of 2010 include, but are not limited to:

- Improving the % of facilities reporting Fistula First monthly data;
- Improving the timeliness and accuracy of manually submitted Fistula First data;
- Improving Community Education and Resource Activities, by integrating patient feedback into the Network plan for providing community education and resource materials to patients;
- Evaluating the satisfaction and effectiveness of using an online process;
- Improving the effectiveness of facility-profiling and trend analysis for complaints and grievances/Improving data collection and increasing oversight to deter involuntary discharges;
- Improving communication with the DOH;
- Monitoring for timely submission of required administrative reports;
- Database management;

- Timeliness of reporting renal status of Medicare ESRD beneficiaries;
- Refining missing UNOS transplant registration and follow-up form tracking procedure.

D. Improve patient perception of care and experience of care, and resolve patient's complaints and grievances

1. Complaints and Grievances

Network #17's "Protocol for the Evaluation of Patient Complaints and Grievances" and a summary document that included a Spanish version, was sent out to all facilities in January 2010. It was used to guide Network #17 actions taken on patient complaints and grievances (Appendix B). Some contacts with Network #17 required information from another agency or government entity for problem resolution, such as a new patient calling to inquire when his or her Medicare benefits would be approved. When a call necessitated referral to another source, Network #17 staff made every attempt possible to make accurate and expedient referrals to link the caller to the proper resource.

When dealing with issues that were under its quality of care purview, Network #17 encouraged patients and facilities to work together toward reconciling differences and coming to an acceptable solution about matters called to the Network's attention. Network #17 maintains a file of submitted complaints and Network staff members are always alert for trends in concerns or complaints as to issue and/or location. Network #17 involvement in the grievance process, even at the "informal grievance" (complaint) level, includes (but is not limited to) discussions of the care disputes, interfacing with providers, and, when appropriate, referral to various agencies or other sources of information.

During 2010 several discussions on IVD/DPC were made to facility administrators, head nurses, social workers, and physicians, concentrating on options for dealing with challenging patients in order to prevent/delay patient discharge. Options included implementing a behavior contract immediately following inappropriate behavior and shortened treatment time, dialysis by slot were some of the topics presented. The Network PSC presented several educational and technical assistance programs concerning federal regulations governing patient discharge to facilities and Social Work groups.

During 2010, Network #17 Quality Improvement and Patient Services staff members worked collaboratively with specific Network #17 facilities to improve care in those facilities, based upon patient complaints and concerns. Efforts were made to foster quality improvement activities in not only staff competency and patient safety, but also respect, dignity, and sensitivity issues stemming from previous patient complaints and/or State Survey Agency facility survey results. The Network #17 staff reviewed all involuntary discharges that occurred in facilities. Collaboration

with the SSA increased on behalf of patient complaints and quality of care issues.

As reported using the CMS authorized Standard Information Management System (SIMS) aggregate contact information for Network #17, during the time period of January 1, 2010 through December 31, 2010 there were 730 total contacts. An attachment (Appendix H) to this Annual Report summarizes the contacts entered into SIMS during the time period of January 1, 2010 through December 31, 2010, profiling all data using the 18 standard SIMS categories of Areas of Concern (e.g., Treatment Related/Quality of Care, Staff Related, Patient Transfer/Discharge, Abusive, Disruptive, Non-Compliant). Network #17 did not process any formal grievances in the 2010 calendar year as timely interventions to both facilities and patients proved to be very affective.

The Network staff continues to provide a patient-centered problem resolution process at the entry level of a complaint, thus potentially decreasing the number of concerns that escalate into formal grievances.

E. Improve collaboration with providers to ensure achievement of the goals through the most efficient and effective means possible, with recognition of the differences among providers (e.g., independent, hospital-based, member of a group, affiliate of an organization, etc.) and the associated possibilities/capabilities

1. ESRD Facilities/Providers

Developing and maintaining cooperative and constructive relationships with the facilities included in Network #17, is the MRB's approach to its responsibilities for continuous quality improvement. The Network's philosophy is to meet CMS mandates by implementing programs that provide both the Network and facilities with useful information about the ESRD care being delivered, programs that are least burdensome and most easily carried out within the existing practices of facilities, and those that maintain and improve, where possible, the quality of patient care.

Network #17 provided educational resources for dialysis providers offering the tools and techniques for quality improvement, as well as mentoring for individual QI projects and a focus on Internal Quality Improvement (IQI). This service was provided in various venues within Network #17. Some examples of activities conducted with Network facilities and providers in 2010 were:

- Provision of educational material concerning continuing quality improvement including the National CPM Project, USRDS and KECC-generated, facility-specific reports such as Standardized Mortality Rates, Standardized Transplantation Rates, Standardized Hospitalization Rates, as

well as additional quality improvement materials as directed by the MRB or BOD.

- Educating dialysis providers on the tools and techniques of Continuous Quality Improvement and Internal Quality Improvement;
- Broadcast fax and efax to all facilities in Network #17 to alert them of pressing issues, upcoming projects, and relevant CKD/ESRD community events provided by NKF, Renal Support Network, AAKP to name a few. All ESRD facilities were provided the “Facility Alert” binder where they can place important information sent by fax or email from Network #17;
- Network #17 staff members have worked collaboratively with specific facilities to improve care in those facilities, based on patient complaints or concerns or State Survey Agency reports. There were efforts to foster quality improvement in staff competency/conduct and patient safety issues, providing the facilities with specific suggestions and provision of material, as needed;
- Network goals and objectives are distributed annually. They were included in the first Network professional newsletter that was sent to all facilities in the first quarter of 2010 and in the annual Administrative Mailing;
- Vocational Rehabilitation data is requested from facilities annually. All Network #17 dialysis facilities were sent the survey in April 2010. Additionally, the Director of Patient Services provided VR resources to facilities throughout the year. Numerous VR resources were made available on the Network’s website;
- Network #17 staff provided “Network Updates” in the form of face-to-face meetings or conference calls to facilities upon request;
- Information sent out as a clearinghouse function came primarily from federal sources (regulations, federal register issues, FDA, CDC, OSHA) to which many facilities have limited access;
- The Network provided instructions regarding the use of the Dialysis Facility Compare website to each of its facilities. These directions helped patients and facility staff know how to access the site and the types of information available on it. These posters and accompanying instructions included easy-to-read directions and screen shots to assist patients in navigating to and through Dialysis Facility Compare (Appendix I);
- The Network worked with providers on data compliance issues in an effort to ensure an accurate patient database. Besides individual facility contact for questions and education, the Network data staff presented a WebEx focused on data accuracy and forms compliance. This presentation was recorded and placed on the Network website for easy access for facility personnel who were not able to attend the original presentation and for the Network providers in Guam, Samoa and Saipan;

- Dissemination of clearinghouse information was accomplished in the following ways:
 - Information that needed immediate dissemination to facilities was mailed directly to the appropriate facility personnel through issuance of a Network administrative newsletter.
 - Small news items that did not demand immediate dissemination were saved up and sent at one time in order to conserve resources.
 - The timing of the newsletter depended upon the occurrence of events. Items that were deemed to be of high priority were faxed to the appropriate people.

2. *ESRD Networks*

Network #17 is an active member of the Forum of ESRD Networks. Network #17 participates in Forum activities and contributes to Forum projects. The Network Executive Director is an ad-hoc member of the Forum Board of Directors and the Network #15/17 Board of Directors President is the Immediate Past President of the Forum BOD. Network #17 staff members value the relationships that have been forged with other Networks' staff members and utilize these relationships as valuable resources in Network activities. Network #17 staff participated in conference calls and meetings with staff members from other Networks and freely share resources developed by the Network with others. Through its on-going relationship with the Forum of ESRD Networks, Network #17 was able to participate in or take advantage of the 2010 Forum activities which included, but were not limited to:

- Forum members serve as representatives to the community on the Kidney Care Quality Alliance (KCQA), National Quality Forum (NQF), United States Renal Data System (USRDS) External Advisory Committee, NKDEP Coordinating Council, United Network for Organ Sharing (UNOS/OPTN), and American Association of Kidney Patients (AAKP);
- The Forum supported a conference call to solicit input from Network staff regarding the USRDS Annual Data Report and the USRDS website. This feedback was submitted to USRDS by External Advisory Committee representative;
- The Forum participated in the comment and voting for the National Voluntary Consensus Standards for End Stage Renal Disease Care;
- The Forum Coordinator compiled information submitted by the Networks on the annual Network Evaluations. This information was shared with the Networks via the Executive Director Advisory Council (EDAC) Chair;
- The Medical Advisory Council (MAC) piloted a medication reconciliation questionnaire to assess need for resources on this topic (fall 2009);
- The Forum provided support for the workgroup that developed the CPM QI Committee re-development proposal;

- Forum leadership communicated with CMS regarding the Phase III ESRD CPMs;
- Developed and distributed the first issue of *Forum Matters*, which is shared with the Networks and renal community partners following each Board meeting;
- Reviewed attribution methods and drafted an attribution white paper, which was shared with CMS and other renal community partners;
- Developed Forum evaluation metrics;
- The MAC completed development of four toolkits to assist facilities in meeting requirements of the Conditions for Coverage. The Network ED participated on a subcommittee to develop these resource materials;
- Outreach to QIOs and National CMS Survey and Certification;
- Convened Strategic Partners to identify best strategies to meet the Forum mission and serve the Networks;
- Forum President conducted outreach to Networks via attendance at several Network Board or MRB meetings.

On an ongoing basis, Network #17 staff members provide consultation, technical assistance, or give actual Network #17 work products to members of other Networks who have contacted Network #17 seeking help with an issue.

The Executive Director interacted on a regular basis with other Network Executive Directors. This interaction allows for new ideas and sharing of successes.

The Director of Patient Services, the Director of Information Systems and the Director of Quality Improvement have worked collaboratively with their counterparts in other Networks.

3. *State and Regional Office Survey Agencies*

Northern California and the Pacific Territories located within Network #17, relate to their respective health departments and to their one Regional Office IX in San

Francisco, CA. In addition, CMS Regional Office X in Seattle provides program oversight for the Network #17 program.

Network #17 has a cooperative relationship with the state survey agencies within its geographic region. The ESRD technical expertise of the Network is always available to these agencies. Network #17 routinely participates in the quarterly San Francisco Regional Office State Agency and Network conference calls (ROSAN) to discuss areas of concern for that CMS component.

Internal Quality Improvement (IQI) efforts by Network #17 continued to focus on improving communication between the Network and the various Departments of

Health with which the Network interacts. The Network QI staff has presented Network updates and Fistula First information to Department of Health representatives during 2010. These updates were provided during conference calls, WebEx sessions, mailings and/or face-to-face presentations.

Network #17 is working toward the continuation of a cooperative relationship with the government agencies that work with renal providers. These include the Survey and Certification Branch staff of the Regional Offices that cover Network #17 area as well as the individual state health department surveyors. Cooperative activities in 2010 with the Network Departments of Health included reciprocal information sharing and joint problem solving:

- Network staff referred a number of patient/family/other concerns that involved survey and certification issues to State Survey Agencies and received requests of information from the State Survey Agencies;
- Several Network staff members collaborated with various State Survey Agency personnel regarding facility quality improvement issues following facility surveys;
- The Network maintains a current list of contacts for each of the Departments of Health within Network #17.

3. *Quality Improvement Organizations (QIOs)*

There are two Quality Improvement Organizations (QIOs) that cover the area contained within Network #17. The Network has reached out to both of these organizations. The Network continues to reach out to the QIOs, which includes a focus on Chronic Kidney Disease (CKD). The Network is collaborating with the Hawaii QIO to develop a strategic plan to reduce the number of Diabetes II patients in the Hawaii and the Pacific Island. The 2011 Annual Report will outline the process and measurement for success.

5. *The Renal Community*

Network #17 recognizes the importance of developing and maintaining cooperative relationships within the renal community. Network #17 has made a determined effort to coordinate its activities with other renal-related organizations and has participated in a variety of joint activities.

Network #17 has fostered a cooperative relationship with the following renal organizations that are active in its Network area:

- Northern California NKF Affiliate (San Francisco and Sacramento offices);
- Hawaii NKF Affiliate;
- CNSW Chapters - Northern California and Hawaii;

- ANNA Chapters in Northern California and Hawaii;
- American Association of Kidney Patients;
- Quality Improvement Organizations (QIO)
- Renal Support Network;

Below is a summary of specific Network #17 community outreach activities:

- Information and referral to facility staff (telephone, e-mail or written inquiries);
- Information and referral to patients/families/advocates (telephone, e-mail, or written inquiries);
- Information and referral to members of other renal organizations (telephone, email, or written inquiries);
- Network #17 continues to participate in the ESRD Networks' Clearinghouse New Patient Packet project, updating information as necessary. Under the direction of the Network Coordinating Center (NCC), a central mailing center sends this standardized packet to all new patients for whom a 2728 has been received in the previous month. This project began in September 2000. During 2010, nearly 5,000 new patient packets were mailed to incident patients within Network #17. Network #17 updated its cover letter in 2010 as directed by CMS;
- The Network #17 *Statement of Patient Rights and Responsibilities* has been available in both English and Spanish and posted on the Network website;
- Network #17 maintains a toll-free phone number for use by patients (1-800-232-3773). This number is included in the letter accompanying the Patient Orientation Package sent out by the Network's Clearinghouse Office, as well as on Network materials designed for patients. The toll-free number is listed on all Network distributed materials and the revised NW poster that was distributed to all facilities for posting in their lobbies in both English and Spanish during 2010.
- Patient Resources section of the Network's website, as well as on all patient-related materials sent by Network #17;
- Network #17 maintains an updated list of all patient support and education groups. A copy is posted on the Network website as well as the website of the NKF of Northern California;
- Disaster preparedness remains a focus for Network #17 and the Network has made available numerous resources related to disaster preparedness to its facilities via mail and on its website.

5. Coalitions/Special Projects

Network #17 has been an active participant in the Kidney Community Emergency Response (KCER) Coalition. Through the work with this coalition, the Network has

added a number of resources for both facilities and patients to the Disaster Preparedness section of its website. As directed by CMS, the Network staff requested two emergency contacts and two ways to reach those contacts for each facility within the Network. This information is contained within the Network's Emergency Preparedness Plan and updated annually. Four Network staff members and one Patient Advisory Committee member are involved in workgroups within this coalition. Activities have included national meetings, routine workgroup conference calls and in turn the sharing of KCER information with the Network #17 community.

The Strategic Partnership for Change is an initiative put forth by CMS to all Networks to support strategic partnerships and coalitions among the renal community through national and local training and on-going consultative support.

Four Disaster Coalition steering committee (SC) meetings were conducted in 2010 with the NW Outreach Coordinator as an advisor. The OC has recruited a broad spectrum of members (18) including a dialysis patient for the coalition which includes the CMS Emergency Response team, the Red Cross, Salvation Army, Facilities Administrators, facility staff, facility regional directors, and other interested parties. The Emergency Coalition has been highly successful and recognized by the Red Cross as an outstanding performer. The OC received special recognition on behalf of the NW by the American Red Cross National Director in 2010 for outstanding contributions.

Other outreach activities:

- The Network responded to requests for data from entities outside Network #17. All Network staff, but usually the Director of Information Systems, Executive Director, Director of Patient Services or Director of Quality Improvement responded to a wide variety of agencies, individuals, and groups. Network #17 may collaborate with other agencies to furnish the requested information;
- Network #17 staff participated on various list-services, and respond, as appropriate, with information that other participants are requesting;
- The Network attends the California Dialysis Council (CDC) meetings quarterly.

7. *Professional Educational Program Attendance/Networking*

Ongoing education and networking is a vital element to Network #17 staff. Through the course of the Network staff's work, the Network staff has been asked to present or host a number of educational presentations throughout 2009. In addition,

Network staff has attended all of the requisite CMS meetings and conference calls. Network staff has also participated in discipline-specific meetings and conference calls.

8. Newsletters

Written and/or electronic media are effective methods of disseminating information to both the professional and patient members of Network #17. Network #17 Patient Advisory Committee (PAC) published and distributed their first patient newsletter throughout 2010 entitled, *Windows of Our World*. The newsletter serves to update patients and health care providers on all Network activities and professional bodies as well as provide information on the Network roles and responsibilities as charged by CMS. The following is a sample of topics covered in the 2010 newsletters:

Window of Our World

- An Introduction to Network #17
- Overview of Network Activities
- Patient Stories
- Contact Information for Concerns or Questions
- Patient Advisory Committee-an introduction
- Role of the ESRD Network
- Immunization
- Infection Control
- Dietary
- Emergency Preparedness
- Patient Leadership Committee information
- Fistula First Focus articles

Please see Appendix D for a copy of the 2010 Network #17 patient newsletter.

9. Website

The Network #17 website, www.esrdnet17.org, has been updated regularly to keep information current and to increase the amount of material available for both Network #17 patients and Network #17 professionals. Additional resources addressing quality improvement, data requirements, data compliance information, emergency preparedness, DFC, and immunization were placed on the website and continuously updated in 2010. Please see Appendix J for screen shots of the Network #17 website.

10. Facility Directory

Network #17 maintains a current Facility Directory and roster of renal professionals by category (physicians, administrators, nurses, dietitians, social workers) for use

within the office. Traveling patients, renal vendors, and other interested individuals requesting information are provided with a directory of facilities by city and state as requested. Directories are created as needed to include the name, address, telephone number, type of facility and services provided for any facility in the area about which the individual is inquiring. Individuals are also referred to the Dialysis Facility Compare.

F. Improve the Collection, Reliability, Timeliness and Use of Data to Measure Processes of Care and Outcomes; Maintain Patient Registry; and to Support the ESRD Network Program.

1. Description of the Network Data System

The Network data system included a server and workstations leased from CMS with the capacity to complete the required contractual obligations. All CMS equipment and peripherals are registered in the REMEDY software. Only CMS approved software is loaded on the workstations. The CMS server connects to the SIMS Central Repository and to the Internet through the CMS maintained firewall.

Security and training

All staff received training on the Quality Net Exchange (Qnet) Security Policy Handbook. New staff members completed training and were tested when hired. No staff member was allowed access to the CMS Network without successfully passing the required testing. The Network updated the Business Continuity and Contingency Plan (BCCP) for disaster preparedness in October 2010. The Network maintains an offsite safety deposit box for weekly storage of backup tapes and copies of key CMS programs such as SIMS and VISION.

Full server backup tapes were completed twice weekly and stored offsite in a three-week rotation. Staff continued to monitor backups and completed all required maintenance of the server on a daily, weekly and monthly schedule. The SIMS tables were backed up nightly to the Central Repository. The results of this backup were checked daily.

Receipt of Forms

The Network received and validated the following into SIMS: CMS-2728, CMS-2746, monthly Patient Activity Reports (PARs), quarterly census validations and CMS-2744. Facility Roster and personnel updates were also updated, as were the facility disaster coordinator names. Incomplete forms were returned to the facility for correction.

ESRD NETWORK #17 CMS FORMS SUBMISSION		
FORMS	01/01/2009-12/31/2009	01/01/2010-12/31/2010
CMS 2728	5861	6041
CMS 2746	3501	3540
CMS 2744*	223	235

* processed March 2010, 2011

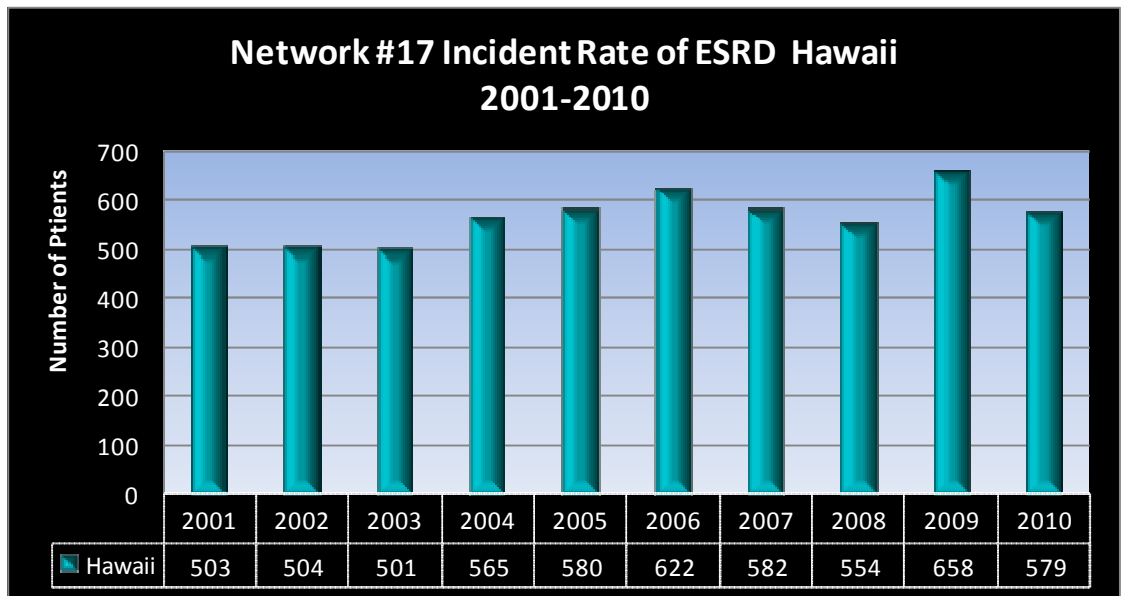
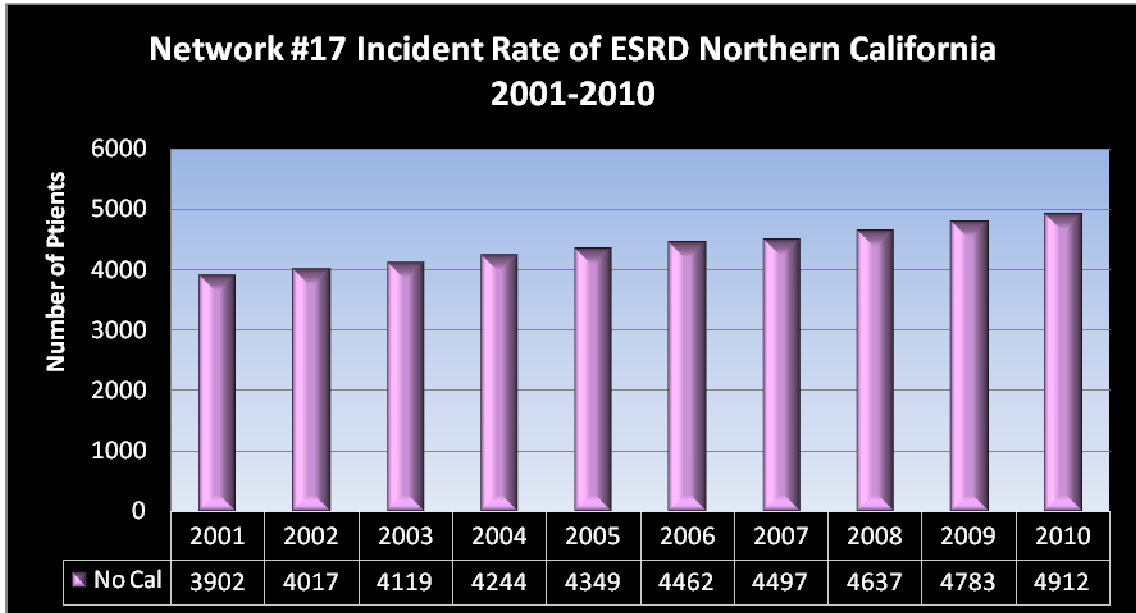
In addition to CMS forms, Network #17 reviewed and resolved notifications, accretions, REMIS alerts and UNOS registration and follow up form requests in a timely manner.

Updates were made to the facility directory table in SIMS and monthly review of Dialysis Facility Compare (DFC) facility lists were completed within requested timeframes. An update to personnel lists was performed in November 2009 in preparation for the CMS Facility Survey. New facility packets for data reporting including supplies of CMS-2728, CMS-2746 and Patient Activity Report (PAR) forms were sent to 13 new facilities during calendar year 2010.

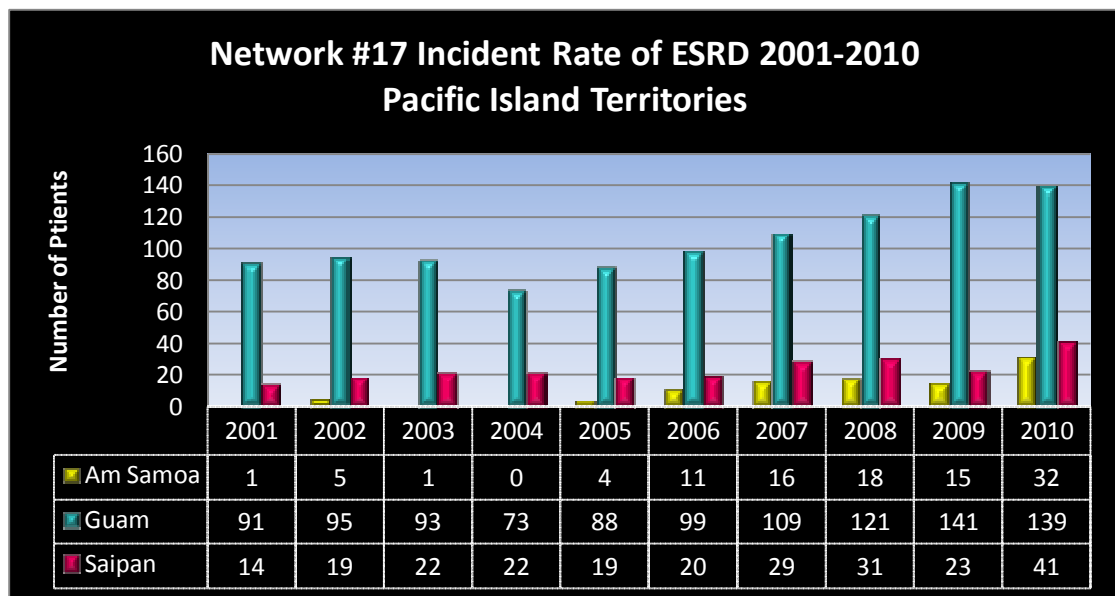
A series of 'quick tip' sheets were prepared and mailed to all facilities. These sheets gave a brief overview of frequently encountered problems in accurate completion of the CMS forms. These 'tip sheets' are also included in all new facility data mailings.

Responses to Medicare + Choice organizations were met within the Network's Internal Quality Improvement goal of 5 business days. The Network responded to queries on 364 beneficiaries in 2010.

The following table illustrates the increase in the number of new patients by year in Network #17. In addition to the new patient forms, 2728s are submitted for patients who have been off dialysis for over a year and then return to dialysis (recovered function/restarted), for patients who start on in-center dialysis and then switch to a PD modality in the first three months of treatment (supplemental training form), and for patients who must go back to dialysis more than three years post transplant. These patients are not reflected in the following table.



Note: Some American Samoa patients initiate treatment in Honolulu and are counted in Hawaii.



Note: Some American Samoa patients initiate treatment in Honolulu and are counted in Hawaii.

2. Report Capability

The SIMS system generated most of the required reports for 2010. These included Annual Report tables, compliance reports, and 2744 Facility Survey reports as well as routine missing forms reports, facility roster updates and facility census reports. Network #17 made use of the SIMS, HMO utility, to respond to queries from Medicare + Choice Organizations.

3. Special Data Requests

The Network responded to 14 requests for zip code counts for specific regions during 2010. Other requests were met by referring callers to the Network #17 website for Annual Report Table data.

4. Data Validation and Improvement Efforts

VISION Validation

As required by CMS, the Network validated a 3% random sample (#5) of CMS-2728 forms submitted from VISION and all required signatures and data were in place. During 2010, Network #17 had one VISION facilities in California.

Forms Submission Compliance

Network #17 notified facilities of CMS forms compliance results in July 2010 and

for calendar year 2010, in January 2010. The Network maintained an average forms compliance rate of 92.5% for 2010. Facility staff turnover was a major factor in the error rate, particularly for accuracy of the CMS-2728 form.

CROWNWeb

Network staff attended all CMS CRAFT calls during 2010. Network #17 data staff also attended data discrepancy calls (biweekly), user group calls, business analyst calls and other CROWNWeb related calls as scheduled.

Network data staff participated in ongoing CROWNWeb Phase 2 testing during 2010. This testing began in mid-2009 and included ten facilities, five independent and five Batch Submitting Organizations (BSOs).

In October, 2010, the Network recruited additional volunteer facilities to participate in CROWNWeb Phase 3 testing. The Network recruited ten independent facilities and ten BSO facilities for this test cycle. Nine of the ten Phase 2 facilities agreed to continue. Eighteen facilities were from northern California, two (1 independent and 1 BSO) from Hawaii and one each from CNMI and Guam.

In December, 2010, CMS announced postponement of CROWNWeb Phase 3 testing until early 2011. During this period, two additional facilities, both BSO, were added to the list of Network #17 testers.

Emphasis was placed on the clean-up utilities developed by the CMS contractor for earlier rounds of testing. Additionally, the CMS CROWNWeb contractor distributed files containing non-matching data elements from BSOs. These were distributed weekly, then monthly to allow reconciliation of identifiers between SIMS and the BSO systems.

IV. SANCTION RECOMMENDATIONS

During 2010, Network #17 did not identify any providers as consistently failing to cooperate with Network goals and objectives.

No sanctions against facilities or providers were recommended. The Network continued to monitor forms submission, QA/QI participation, and other outcomes as described in Sections IIIA and IIIB.

V. RECOMMENDATIONS FOR ADDITIONAL FACILITIES

Network #17 shared aggregate data (planning data) with state governments and regional offices encompassed by its territory:

Region IX (San Francisco)

Network #17 made no specific recommendations for additional or alternative services.

VI. DATA TABLES

The data tables included in the following section are those specified in Attachment J-10 of the CMS/ESRD Network Organization Scope of Work. The data utilized in these tables come from Network #17's SIMS database.

All Tables and Charts refer to Network #17 specific data as of December 31, 2010.