
2005 Annual Report



End-Stage Renal Disease
(ESRD) –12 Network
Coordinating Council, Inc.
Contract # 500.03.NW12

Providing data management, quality improvement, and grievance mediation services for kidney dialysis and transplant patients in Iowa, Kansas, Missouri, and Nebraska.

Prepared by ESRD Network #12
7505 NW Tiffany Springs Parkway, Suite 230
Kansas City, Missouri 64153

Prepared for Centers for Medicare and Medicaid Services
Baltimore, Maryland
June 30, 2006



NETWORK 12

MISSION

ESRD Network 12 assures and improves ESRD patient care through high-quality data management, quality improvement initiatives, grievance mediation activities, and educational services for the customer in a four-state region.

VISION

ESRD Network 12 is and will continue to be the organization of choice for assuring and improving ESRD patient care through adoption of a quality agenda, designing, and enacting activities and projects to achieve the goals of the quality agenda. Concurrently, Network 12 is the organization of choice for providing comprehensive renal team education within the region.

This report was prepared under contract 500-03-NW12 to the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services (HHS). The content of this publication does not necessarily reflect the views or policies of HHS or CMS, nor does the mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. As the authors, End-Stage Renal Disease (ESRD) –12 Network Coordinating Council, Inc., assumes full responsibility for the accuracy and completeness of this report.

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Preface

Introductory Statement

The Board of Directors and staff of ESRD Network 12 proudly celebrated another year of successfully fulfilling CMS contractual expectations while providing valuable resources and services to the four-state region. The Annual Business meeting and educational sessions welcomed more than 400 renal professionals in January. Through the spring and summer, the Network aggressively restructured the accounting systems and processes in meet the changing business needs of the organization.

The Executive Committee was again afforded the opportunity to move the organization forward through the identification and selection process required to appoint a new Executive Director during late summer and into early fall. During the transition, effective communication between the Acting Director and the Board leadership was instrumental in staff retention and ensuring continuity of business.

Our focus on facility and patient education continued to reach new heights during 2005. While continuing to provide valuable patient newsletters on issues such as treatment options and disaster preparedness, the "Self-Assessment of Vascular Access" resource for staff and patients was created in collaboration with Drs. Gerald Beathard and Scott Trerotola. Additional collaborative efforts in 2005 included the formation of a regional coalition in August. The Quality Improvement Organizations in the four-state region and Network 12 established two task groups: Fistula First and Immunization. Additionally, we supported CMS Special Studies led by fellow Network organizations on End-of-Life Care and Pediatric Quality of Life.

AV Fistula percentage rates continued to improve in our region. In December, the Network continued strong momentum by reaching 40.7% compared to a K/DOQI goal of 40%. Activities supporting the Fistula First Breakthrough Initiative (FFBI) will continue to be a focus of resources in the years ahead. Network staff members are active participants as leads or Network liaisons on various national FFBI task groups.

In 2005, Network 12 far exceeded the VISION recruitment and training goals through regional training efforts. The first major revision to the CMS-2728 Medical Eligibility Form was introduced on June 1. The data staff's proactive education and facility support was instrumental in the success of these programs. Although not directly affected by Hurricanes Katrina or Rita, Network staff offered assistance to the southern Networks in tracking patients displaced during the disaster.

Finally, I thank the Network staff for their commitment to the organization during the 2005 transition. As I conclude my service as the Executive Committee President during 2006, I welcome the leadership of Cory L. Sise, M.D. She will continue to provide the dedication and support necessary to ensure the successful future of the Network and Board membership.

Mary E. Gellens, M.D.
Executive Committee President

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Introduction

Network Description

ESRD Network 12 encompasses the four states of Iowa, Kansas, Missouri, and Nebraska covering approximately 285,604 square miles with a population base of 13 million persons. The geography in the four-state region varies from the bluff terrain bordering the Mississippi River on the eastern borders of Iowa and Missouri to the hardwood forests of the Ozark Mountains. In contrast, gentle, rolling farmland is found in central Iowa and Missouri, while prairies and grasslands predominate in Kansas and Nebraska. The Missouri River, which separates Iowa from Nebraska and parts of Missouri from Kansas, and the Mississippi River, which separates Iowa from Illinois, are the natural waterways of the area.

The climate of the area is typical of the Midwest with hot, humid summers and dry, cold winters. Snowfall is moderate to heavy. Heavy ice and snow accumulation in the winter and flooding in the spring and summer can be obstacles to transportation. Although dormant for more than a century, the New Madrid fault runs through the southeast corner of Missouri. Remarkable storms can disrupt dialysis services; e.g., flooding of water treatment plants producing water shortages, tornadoes demolishing the physical dialysis unit, and loss of electrical power or telephone service.

Population Demographics

The population of the Network area reported in the 1990 census was 11.7 million with an increase to 12.9 million reported in the 2000 census. Estimated and actual counts for the four-state area are as follows:

July 1, 2000	12,920,000
July 1, 2005	13,270,118

Overall population increased 0.6% during the past year. The United States Census Bureau has not yet released the state breakdowns by sex or race for 2005.

Table A

Demographic Characteristics by State July 1, 2004					
	Iowa	Kansas	Missouri	Nebraska	Totals
White	2,804,879	2,440,722	4,932,884	1,611,409	11,789,893
Black	66,987	163,705	668,149	73,468	972,309
American Indian	10,232	26,111	26,175	16,375	78,893
Asian/Pacific Islander	48,228	59,235	80,471	29,211	217,145
Two or More	26,101	44,355	72,104	18,567	161,128
Male	1,454,107	1,358,381	2,810,852	863,628	6,486,968
Female	1,500,344	1,377,121	2,943,766	883,586	6,704,817
State Total	2,954,451	2,735,502	5,754,618	1,747,214	13,191,785

U.S. Census Bureau, Population Division, State Population Estimates. Table ST-EST2002-ASRO
Release Date: May 2005

NOTE: The U.S. Census Bureau has not released the information for 2005.

The sum of the five race groups adds to more than the total population because they are estimates calculated on overall population growth, and rely on previous tables where individuals may have reported more than one race.

Table B

Total Population by State			
	2003	2004	2005
Iowa	2,936,000	2,954,451	2,966,334
Kansas	2,715,000	2,735,502	2,744,687
Missouri	5,672,000	5,754,618	5,800,310
Nebraska	1,729,000	1,747,214	1,758,787
Totals	13,052,000	13,191,785	13,270,118
2005 Total U.S. Population 296,655,404			

U.S. Census Bureau, Population Division, State Population Estimates. Annual Estimates of the Population for the United States, Regions, and Divisions: April 1, 2000 to July 1, 2005 -Release Date: Spring 2006

ESRD Population Demographics

Incidence

Four thousand, ninety-seven (4,097) persons initiated chronic renal replacement therapy including transplantation at a facility located within the Network 12 region during 2005. Adjusted incidence rates per 100,000 persons for the four-state region are as follows:

Iowa	26.16
Kansas	28.34
Missouri	33.46
Nebraska	28.42

It is noted that the adjusted incident rate remained constant in the state of Iowa. There have been decreases in the adjusted incident rates for Kansas and Iowa with an increase in the rate in Missouri. Analysis by sex and race cannot be performed since information is not available from the United States Census Bureau for 2005.

Figure 1

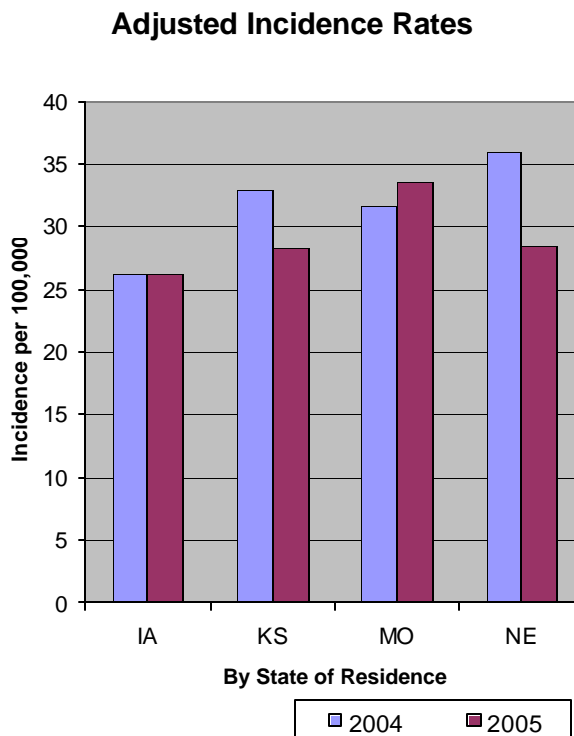
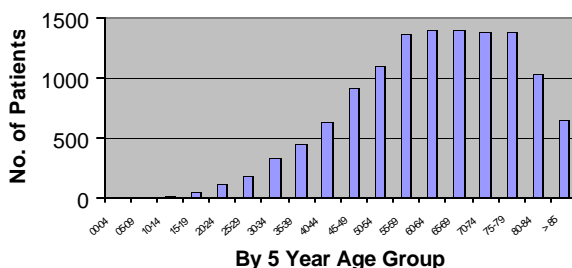


Figure 2

ESRD Dialysis Prevalence

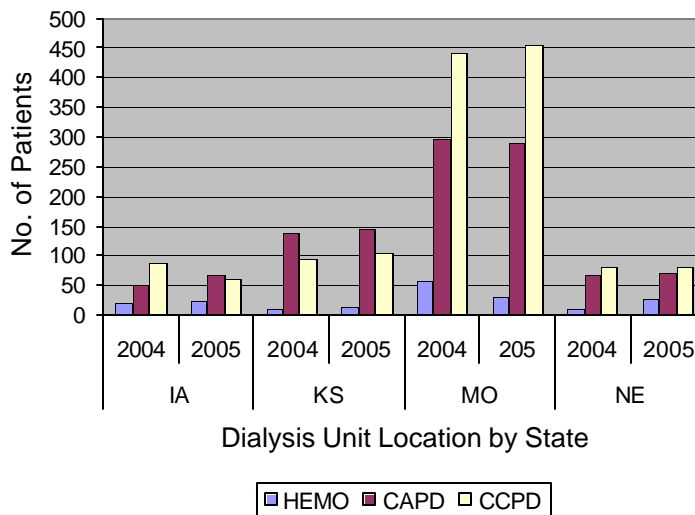


Diabetes has eclipsed all other diseases as the primary cause of renal failure. For 43% of the patients starting renal replacement therapy in 2005 it was identified as the primary cause of kidney failure, the same as 2004. Hypertension was the second-leading primary diagnosis, accounting for 28% of all new patients. Combined these two diseases accounted for 71% of the renal failure leading to initiation of dialysis or transplantation during 2005. Please refer to Table #1 on page 52 for detailed demographics.

As in past years, over half of the newly diagnosed ESRD patients were 65 years of age or older - 54%. Of the dialysis patients prevalent on December 31, 2005, 47% were 65 years of age or older.

Figure 3

Dialysis at Home



Dialysis Prevalence by Modality

At the end of 2005, there were 12,465 patients actively dialyzing at a facility in Network 12. Of the 12,465 persons, 2,172 resided in Iowa, 2,275 in Kansas, 6,143 in Missouri, and 1,391 in Nebraska with 484

patients living in contiguous states while receiving treatment from a Network 12 facility. The heaviest concentration of dialysis patients continues to be around Missouri's major metropolitan areas, St. Louis and Kansas City.

A relatively high percentage of patients being treated at Network 12 dialysis units continue to choose home therapies. State percentages range from 6.57 to 12.66 % with a Network-wide total of 11%. Network-wide, Continuous Cyclic Peritoneal Dialysis (CCPD) is the most common with 704 patients (51.3% of the home population).

Five hundred, seventy-one patients (41.6% of the home population) were receiving Continuous Ambulatory Peritoneal Dialysis and 96 were on home hemodialysis (7% of the home population).

Figure 4

Practice Patterns for Home Therapies by State

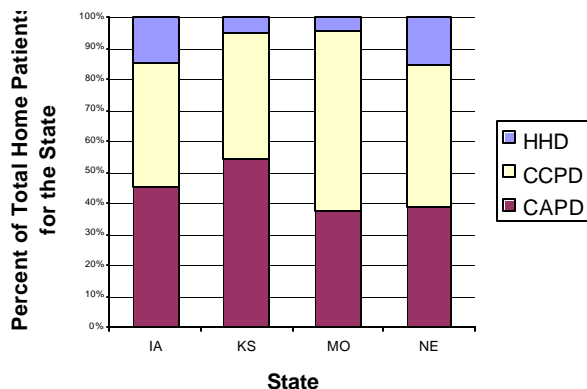


Figure 5

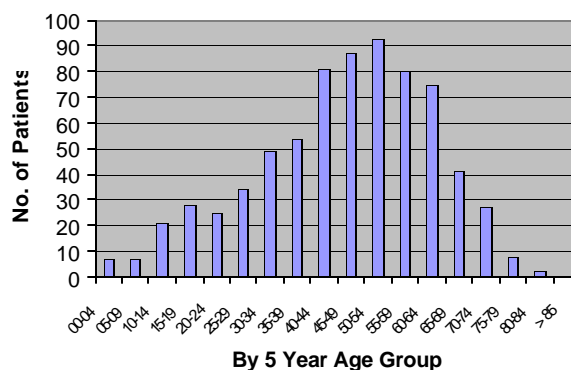
Number and Percent of Patients by Setting and Modality								
	Iowa		Kansas		Missouri		Nebraska	
	Number	Prct of All Dlys	Number	Prct of All Dlys	Number	Prct of All Dlys	Number	Prct of All Dlys
HEMO	22	0.96%	14	0.63%	32	0.49%	28	1.98%
CAPD	68	2.96%	144	6.44%	290	4.50%	69	4.88%
CCPD	60	2.61%	106	4.74%	456	7.07%	82	5.80%
IPD	1	0.04%	0	0.00%	0	0.00%	0	0.00%
In-Center (HD and PD)	2149	93.43%	1971	88.19%	5664	87.92%	1234	87.33%
Totals	2300		2235		6442		1413	

Transplantation

Centers located in the four-state region performed 720 kidney transplants during 2005. Distribution of the recipients is interesting with a relative high occurrence of transplantation in the pediatric population. Proportionally, younger persons are more likely to receive a transplant than older patients (Compare Figures 2 and 6). Racial distribution of transplants also differs from the ESRD population. A disproportionately high number of persons in the categories of Whites, Asian/Pacific Islander, and Other/Multiracial are transplant recipients. Many factors including blood type, antigen typing, concomitant disease, and overall health may account for this inequitable distribution.

Figure 6

Transplant Recipients



As of the end of 2005, area transplant centers reported 816 patients are awaiting transplantation. (Patients may be listed with more than one transplant center located in the four-state region, and the number may represent patients who live and dialyze outside of the area.)

Deaths

Three thousand, twenty-seven patients died during 2005. The age group in which the largest number of persons died was the 75-79 years old range, which is also disproportionate for this age group's population (see Figure 7). As in past years, the leading known causes of death were cardiac related accounting for 41% and infection accounting for 11% (see Figure 8).

Please refer to the Data Tables in Section 6, beginning for specific information on the ESRD population receiving treatment within Network 12.

Figure 7

ESRD Deaths

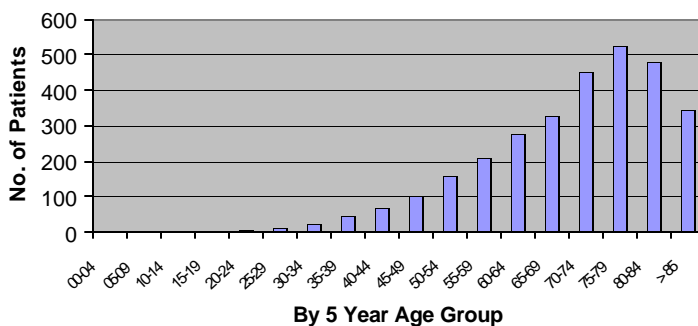
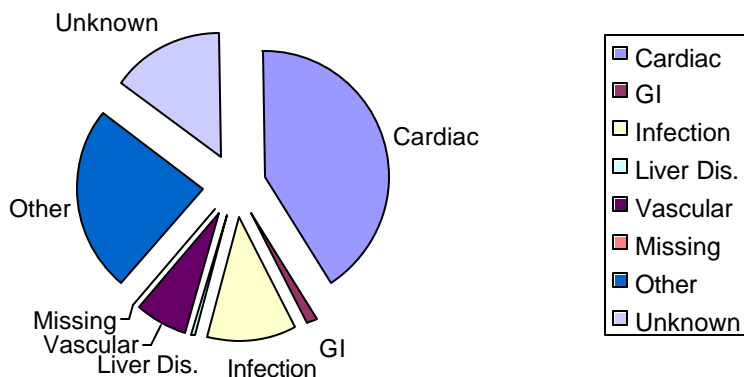


Figure 8

Deaths by Primary Cause



Corporate Description

End-Stage Renal Disease (ESRD)-12 Network Coordinating Council, Inc., is a not-for-profit corporation founded in Missouri on November 7, 1975. Then as now, the primary business is fulfillment of a federal contract as part of the ESRD Program within Medicare. Network 12's leaders and the evolution of the ESRD Program have driven the organization's development.

HISTORY:

The Social Security Amendments of 1972 extended Medicare coverage to individuals who are unable to live without receiving dialysis or a kidney transplant. This unprecedented legislation created the first, and to date, only federal medical insurance program for persons with a specific disease. Individuals could now apply for and if eligible, receive insurance coverage for the majority of costs associated with dialysis, a kidney transplant, hospitalizations, and other medical care even unrelated kidney disease. The federal ESRD program is the only one that allows application for Medicare coverage regardless of age or disability status.

At the time of the legislation, the broad array of professionals and facilities involved in the treatment of such individuals indicated the need for a system to promote effective coordination of services and access to care. The supporters of the legislation believed that the integration of hospitals and other health care facilities into organized networks was the most effective way to assure the delivery of needed ESRD care. Therefore, regulations were published on June 3, 1976, that included provisions for implementing ESRD Networks.

Subsequent federal legislation has continued to mold the ESRD program into the current Network contracts. Network 12 holds the contract to provide service to the dialysis and transplant facilities in the four-state region of Iowa, Kansas, Missouri, and Nebraska. Sections 9335(d) through (h) of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) amended section 1881c(2) of the Social Security Act delineating Network functions as listed below:

- Encourage participation in vocational rehabilitation programs and develop criteria and standards relating to this participation.
- Evaluate the procedures used by facilities and providers in the Network in assessing patients for placement in appropriate treatment modalities.
- Implement a procedure for evaluating and resolving patient grievances.
- Conduct onsite reviews of facilities and providers using standards of care established by the Network Organization to ensure proper medical care, as determined by a Medical Review Board or the Secretary of Health and Human Services.
- Collect, analyze, and validate the data as are necessary to prepare the required annual report to the Secretary and to ensure the maintenance of a national ESRD registry.

- Identify facilities and providers that are consistently not cooperating toward meeting Network goals and assist the facilities and providers in developing plans for correction as well as report to the Centers for Medicare and Medicaid Services (CMS) on those facilities and providers that are not providing appropriate care.
- Submit an annual report to the Secretary by July 1 each year.

From these legislative requirements, CMS developed the Network contracts that are rewritten every three years. The contract has evolved from including utilization review, medical care studies, case review with CMS-defined care statements to embracing clinically-important advances in technology and science, basing projects on nationally-developed clinical practice guidelines, and inclusion of beneficial new paradigms in health care.

NETWORK COORDINATING COUNCIL

Membership in the Network 12 Council is extended to a representative of every ESRD facility located within the four-state region. Delineated in the bylaws, Council representatives have rights and responsibilities similar to shareholders. The Council determines its committee representatives responsible for implementing the corporation's bylaws and overseeing the company's business. The three standing committees of the Council are as follows: the Executive Committee, the Finance Subcommittee (a subcommittee of the Executive Committee), and the Medical Review Board.

Members of the Executive Committee, Medical Review Board, Council representatives, and the Network 12 staff are a select group of individuals passionate about the care of persons with chronic kidney disease. This mutual interest is served by working together to fulfill not only the products and services required by the CMS contract, but to implement our corporate mission.

MISSION AND VISION

Guided by the leadership of the Executive Committee, Network 12's ultimate goal is to assure and improve the quality of care renal patients receive at facilities within our four-state region. The organization's Mission and Vision statements are listed below:

Mission

ESRD Network 12 assures and improves ESRD patient care through high-quality data management, quality improvement initiatives, grievance mediation activities, and educational services for its customers in a four-state region.

Vision

ESRD Network 12 is and will continue to be the organization of choice for assuring and improving ESRD patient care through adoption of a quality agenda, designing and enacting activities and projects to achieve the goals of the quality agenda. Concurrently, Network 12 is the organization of choice for providing comprehensive renal team education within the region.

BOARD OF DIRECTORS

The Executive Committee (EC) has the full authority of the Council. The EC leadership consists of the President, President-Elect, Secretary, Treasurer and Immediate Past President. In addition, the Chair of the Medical Review Board is also a member of the Executive Committee. EC members include, nephrologists from each state in the Network 12 region, a facility administrator, a renal social worker, a renal dietitian, a transplant surgeon, and one patient representative. The EC meets quarterly to manage and monitor financial, personnel and other administrative matters.

During 2005, the Executive Committee was involved in the following activities:

- Fiscal oversight of the organization;
- Evaluate the co-employer agreement with Administaff© which manages and administers employee benefits and provides human resources support;
- Planning the educational portion of the Annual Business Meeting and Clinical Care Conference;
- Identified candidates with the assistance of Administaff Services then appointed the new Executive Director.

The Medical Review Board (MRB) is responsible for the coordination of quality improvement activities and other activities as set forth in the CMS contract. The MRB is composed of ESRD professionals and patients including, nephrologists, a registered nurse, a renal social worker, a renal dietitian, a transplant surgeon, a pediatric nephrologist, a facility administrator, a nephrology technician, and four patient representatives. During 2005, these activities included the following:

- Patient grievance reviews;
- Development of all projects designed to improve the quality of health care delivered to ESRD patients; e.g., the Quality Agenda;
- Vocational rehabilitation activities;
- Oversight of the Clinical Performance Measures data collection (part of a national project);
- Review and strategic planning to meet the goals of the Fistula First Breakthrough Initiative.

STANDING COMMITTEES AND RESPONSIBILITIES

The Network utilizes ad hoc committees and subcommittees to direct project specific and business needs of the organization. These small groups review the details of the Network activities and make recommendations to the appropriate board upon review. These committees met on an as-needed basis during 2005. The individual committee activities and responsibilities are as follows:

FINANCE SUBCOMMITTEE

A Subcommittee of the Executive Committee

The Finance Subcommittee is responsible for detailed oversight of the Network operations and finances. These duties include review and development of personnel policies, staffing requirements, job descriptions, salary evaluations, fringe benefits, and oversight of general corporate financial affairs. During 2005, the Finance Subcommittee was involved in the following:

- Continuous monthly oversight of the accounting procedures;
- Cash flow management review;
- Review and replacement of outdated office equipment.

NOMINATING SUBCOMMITTEE

Appointed by the Executive Committee

The Nominating Committee is integral to the Board election process. Nominations are solicited from all listed personnel in the Network 12 facility database. Nominees are contacted and a resume or curriculum vitae is requested. The Nominating Committee, consisting of Executive Committee members, reviews the requested documents of interested nominees and prepares the slate of final candidates. The Nominating Committee members consider geographic composition and professional expertise when selecting the candidates.

GLOMERULAR FILTRATION RATE SUBCOMMITTEE

Appointed by the Medical Review Board

Annually, this committee made up of the Past MRB Chair and one Unit Administrator; assists the Network Quality Improvement (QI) staff by reviewing data to determine whether providers or physicians are misusing Medicare funds by initiating dialysis treatments inappropriately.

FISTULA FIRST SUBCOMMITTEE

Appointed by the Medical Review Board

Formed in the fall of 2003, the Fistula First Subcommittee has guided the Network in designing and evaluating Network 12's Fistula First Project. The Fistula First committee works closely with the Network QI staff to review data, plan interventions, and strategize ways to overcome barriers in order to meet contract goals. In addition to the Network QI staff, this ten-member committee consists of six physicians, two surgeons, and two registered nurses.

QUALITY AGENDA COMMITTEE

Appointed by the Medical Review Board

The Quality Agenda Sub-committee was charged by the EC and MRB with determining the quality improvement needs of Network 12 and developing resource-appropriate interventions to address these issues. Goal setting, brainstorming interventions, and assisting with data analysis are ways in which this committee has been beneficial. In addition to the Network staff, membership includes a physician, registered nurse, patient, social worker, and registered dietitian.

GRIEVANCE COMMITTEE

Appointed by the Medical Review Board

The grievance committee reviews and makes determinations on formal grievances. The MRB Vice-Chair serves as chairman for this committee. The Patient Services Coordinator holds investigative calls with the committee as needed to discuss recommendations, corrective action planning, mediation, and referral activities. Six members of the Medical Review Board, including two patient representatives, serve on this committee.

Executive Committee Membership

December 31, 2005

Mary E. Gellens, M.D., President
Nephrologist
St. Louis University Hospital
St. Louis, Missouri

Stan Langhofer, B.S.N., R.N., C.N.N.
Administrator
Kansas Dialysis Services
Topeka, Kansas

Cory L. Sise, M.D., President-Elect
Nephrologist
Cotton O'Neil Clinic
Topeka, Kansas

Robert Saylor, M.D.
Nephrologist
Springfield Nephrology
Springfield, Missouri

Barbara Kabel, B.S.N., M.B.A., M.S.N.
Treasurer
University of Iowa Hospital & Clinics
Iowa City, Iowa

John L. Smith, M.D., F.A.C.S.
Transplant Surgeon
Via Christi Regional Medical Center
Wichita, Kansas

Thomas Bainbridge, M.D.
Nephrologist
Southeastern. Renal Dialysis
Mount Pleasant, Iowa

Jason Taylor, M.D.
Medical Review Board, Chair
Kansas Nephrology Physicians
Wichita, Kansas

Jacqueline S. Carder, M.A., L.M.N.T., RD
Renal Dietician
Dialysis Center of Lincoln
Lincoln, Nebraska

Lisa VanHoose, M.S.W.
Social Worker
Dialysis Clinic, Inc.
Columbia, Missouri

Robert Dunlay, M.D.
Nephrologist
Creighton University
Omaha, Nebraska

Lisa A. Weber, M.D.
Nephrologist
Kansas Nephrology Physicians, PA
Wichita, Kansas

David Goldner, MD
Nephrologist
Omaha Nephrology, PC
Omaha, Nebraska

John E. Whalen, M.D.
Nephrologist
Tri-State Dialysis
Dubuque, Iowa

Norma. Knowles, M.S.W.
Patient Representative
Dialysis Clinic, Inc
Columbia, Missouri

Katrina M. Dinkel, M.A.
Ex-Officio Member
Executive Director, ESRD Network 12

Theresa M. Lane, R.N., B.S.N., C.N.N.
Registered Nurse
Clinical Trials Office
West Des Moines, Iowa

Medical Review Board Membership

December 31, 2005

Jason Taylor, M.D., Chair
Nephrologist
Kansas Nephrology Physicians
Wichita, Kansas

Martin Jendrisak, M.D., F.A.C.P.
Transplant Surgeon
Washington University
St. Louis, Missouri

Thomas V. Neumann, MD, Vice Chair
Nephrologist
Omaha Nephrology, PC
Omaha, Nebraska

Sheila Kieseey, R.N.
Administrator
Southeastern Renal Dialysis, L.C.
Mount Pleasant, Iowa

Ardyth Boucher
Patient Representative
Mercy Medical Center
Des Moines, Iowa

Patrick Krogman
Patient Representative
Renal Care Group
Wichita, Kansas

Michelle L. Carver, R.N., C.N.N.
Registered Nurse
Dialysis Center of Lincoln
Lincoln, Nebraska

Donovan C. Polack, M.D.
Nephrologist
St. Louis University School of Medicine
St. Louis, Missouri

Robert Dickerson
Patient Representative
Research Medical Center
Kansas City, Missouri

Dennis Ross, M.D., F.A.C.P.
Nephrologist
Renal Care Group, Inc.,
Wichita, Kansas

Douglass T. Domoto, M.D., J.D.
Nephrologist
DaVita, Inc.
St. Louis, Missouri

Michael Schwarz, B.M.E.T., C.H.T.
Renal Technician
Dialysis Center of Lincoln
Lincoln, Nebraska

Mary Sue Donaldson
Patient Representative
Dialysis Center of Lincoln
Lincoln, Nebraska

David Sommerfeld, M.D.
Nephrologist
Springfield Nephrology
Springfield, Missouri

Michael Flanigan, M.D.
Nephrologist
University of Iowa Hospital and Clinics
Iowa City, Iowa

Ellen Wood, M.D.
Pediatric Nephrologist
Cardinal Glennon Children's Hospital
St. Louis, Missouri

Angie Greer, B.A., M.S., M.S.W.
Social Worker
Renal Care Group, Inc.
Joplin, Missouri

Anne L. Voigts, M.D.
Nephrologist
Internists, P.C.
Cedar Rapids, Iowa

Judy Helmer, B.A., M.A., R.D.
Dietitian
East Wichita Dialysis
Wichita, Kansas

Board Subcommittee Membership

December 31, 2005

FINANCE SUBCOMMITTEE	GRIEVANCE COMMITTEE
<p><i>A Subcommittee of the Executive Committee</i></p> <ul style="list-style-type: none"> • Barbara Kabela, RN, MBA, MSN, Finance Chair • Mary E. Gellens, MD, EC Chair • Norma Knowles, Patient Rep • Stan Langhofer, BSN, RN, CNN • Cory Sise, MD, EC Vice Chair • Katrina M. Dinkel, MA, Executive Director 	<p><i>A Subcommittee of the Medical Review Board</i></p> <ul style="list-style-type: none"> • Thomas V. Neumann, MD • Ardyth Boucher, Patient Rep • Robert Dickerson, Patient Rep • Michelle Carver, RN, BSN, CNN • Jason Taylor, MD, MRB Vice Chair • Angie Greer, BA, MS, MSW • Kimberly F. Thompson, RN, BSN, CNN, Network • Katrina M. Dinkel, MA, Executive Director • Sheila Kieseey, RN (Alternate)
NOMINATING SUBCOMMITTEE	GLOMERULAR FILTRATION RATE REVIEW
<p><i>A Subcommittee of the Executive Committee</i></p> <ul style="list-style-type: none"> • Mary E. Gellens, MD, President • Jacqueline Carder, BA, MA, LMNT, RD • Barbara Kabela, RN, MBA, MSN • Theresa Lane, RN, CNN • Jason Taylor, MD • Lisa VanHoose, MSW 	<p><i>A Subcommittee of the Medical Review Board</i></p> <ul style="list-style-type: none"> • Anne L. Voigts, MD MRB Chair • Sheila Kieseey, RN • Sarah Yelton, RN, CNN, Network • Cathy Long, BA, RHIT, Network
QUALITY AGENDA COMMITTEE	FISTULA FIRST COMMITTEE
<p><i>A Subcommittee of the Medical Review Board</i></p> <ul style="list-style-type: none"> • Michael Flanigan, MD • Ardyth Boucher, Patient Rep • Judy Helmer, BA, MEd, CSR • Traci Simpson, RN, BSN (Subject Matter Expert) • Sarah Yelton, RN, CNN, Network • Cathy Long, BA, RHIT, Network 	<p><i>A Subcommittee of the Medical Review Board</i></p> <ul style="list-style-type: none"> • Dennis Ross, MD, FACP • Michelle Carver, RN, BSN, CNN • Douglass T. Domoto, MD, JD • Sue Donaldson, Patient Rep • Michael Flanigan, MD • Donovan Polack, MD • Jason Taylor, MD • Lisa Weber, MD • Sarah Yelton, RN, CNN, Network • Cathy Long, BA, RHIT, Network <p>Subject Matter Experts:</p> <ul style="list-style-type: none"> • Surendra Shenoy, MD, PhD • Andrew Chontos, MD

Network Structure

ESRD Network 12 Staff

December 31, 2005 (with responsibilities)

Katrina M. Dinkel, MA (effective October 14) Executive Director	Financial Management CMS Liaison Renal Community Liaison Daily Operations Personnel Management
Rosalie Littlejohn Office Manager	Office Equipment Management Facility Staff Database Maintenance Correspondence and Communications Office Supplies Management
Sarah Yelton, R.N., C.N.N. Quality Improvement Director	Fistula First Project Quality Improvement Activities USRDS Studies Coordination
Cathy Long, B.A., R.H.I.T. Quality Improvement Specialist	Clinical Performance Measures (CPM) Data Collection
Kimberly Thompson, R.N., B.S.N., C.N.N. Patient Services Coordinator	Patient Grievances and Facility Concerns Patient and Staff Newsletters Facility and Patient Education
Jeff Arnall, M.C.S.E. Information Systems Director	SIMS Database Management Computer System Integrity Management CMS Data Contact Data Request Processing
Glenda Whittle, B.S., C.I.S. Data Analyst	Processing of 2728 and 2746 Forms Forms Compliance Reporting Facility Education on Forms
Marilyn K. Graham Data Analyst	VISION Training and Management Monthly Patient Rosters Annual Survey Facility Education on Rosters

ESRD Network 12 Staff Members and Position Descriptions during 2005

During 2005, ESRD Network 12 employed eight full-time (FTE's) staff members. The stability of our workforce is instrumental to maintaining efficiency and effectiveness to meet the Network contractual responsibilities. The average length of employment with the organization is approximately seven years.

In 2004, Network 12 entered into an agreement with a Professional Employer Organization (PEO), Administaff. The PEO takes responsibility for human resource administration and compliance as well as providing payroll services, as part of their service fees. As part of the

agreement, the Network employees are considered co-employees of both ESRD Network 12 and Administraff.

Administration

Executive Director

Lisa F. Taylor, BSN, Executive Director (through August 17, 2005)

Katrina M. Dinkel, MA, Executive Director (effective October 14, 2005)

The Executive Director (ED) reports to and serves as the primary staff support to the Board of Directors. The ED is responsible for the overall management and coordination of ongoing organizational activities to fulfill the CMS contract requirements and deliverables. In addition to managing all day-to-day business of Network, the ED is charged with financial and personnel activities, while overseeing all departments of the organization. Additionally, the Executive Director serves as the liaison to both the Centers for Medicare & Medicaid Services (CMS) and the renal community while ensuring effective working relationships with Department of Health & Human Services (DHHS), the State Survey Agencies of Iowa, Missouri, Kansas, and Nebraska, facility staff members, and other renal-related organizations involved in the provision, monitoring and improvement of ESRD patient care.

Office Manager

Rosalie Littlejohn

Reporting directly to the Executive Director, the Office Manager is responsible for maintaining the accuracy of facility and staff databases while providing the first-line correspondence and various day-to-day communications with Medicare beneficiaries, family members. Thus he/she is the "voice or face of Network 12" providing the first impression for callers or visitors. Customer service skills for both internal and external customers are vital to this position. The Office Manager is also responsible for maintaining office equipment, evaluating the need for new equipment and scheduling periodic maintenance. Additionally, he/she coordinates the mailing of the Facility-Specific Reports from UM-KECC, updates the new patient roster for the Forum of ESRD Networks and assists in Accounts Receivable and Payable process. In the absence of the Administrative Assistant, the Office Manager supports some of these activities as well.

Administrative Assistant

Vacant from February through December 2005

The Administrative Assistant reports to the Executive Director and provides ongoing administrative support to the ED. Responsibilities for this position include ensuring Board communication and travel arrangements while coordinating special events and educational training arrangements. The Administrative Assistant works with the Executive Director to plan the Annual Business Meeting by coordinating hotel arrangements, contacting and corresponding with speakers while meeting budget constraints. In the absence of the Office Manager, the Administrative Assistant performs many of those duties.

Quality Improvement

Quality Improvement Director

Sarah Yelton, R.N., C.N.N.

The Quality Improvement Director (QID) reports to the Executive Director. The QID is a resource to and the direct supervisor of the Quality Improvement Specialist. The QID is

responsible for coordinating Quality Improvement activities for the four-state area. This includes but is not limited to being a resource to facilities in dealing with clinical questions and Continuing Quality Improvement (CQI), employee management issues, providing technical assistance, difficult management situations, distribution of educational materials, and unit policy enforcement. Additionally, the QID obtains intervention materials, consults with the statistician, reports to the Medical Review Board (MRB), and coordinates the Clinical Performance Measures (CPM) project. The QID coordinates the Internal Quality Plan of the Network. In the absence of the Quality Improvement Specialist and/or Patient Services Coordinator, the QID covers those responsibilities.

Quality Improvement Specialist

Cathy Long, B.A., R.H.I.T.

The Quality Improvement Specialist (QIS) reports directly to the Quality Improvement Director and ultimately to the Executive Director. In the absence of the Quality Improvement Director, the QIS is responsible for the completion of deliverables and maintaining an efficient QI department. The QIS is involved in all aspects of the Network quality initiatives; from the development of the project to writing the final report. The QIS completes the data entry and analysis tasks related to the quality improvement initiatives. In the absence of the Patient Services Coordinator, the QIS assists with these responsibilities.

Patient Services Coordinator

Kimberly Thompson, R.N., B.S.N., C.N.N.

The Patient Services Coordinator (PSC) reports to the Executive Director. The primary responsibility of the PSC is to assist patients and facilities in resolving complaints or grievances. The PSC is responsible for acting as a resource to facilities, including but not limited to, assistance in dealing with clinical questions, technical assistance, and difficult situations. The PSC coordinates patient education/support activities including the development and distribution of educational materials and educational training. The PSC serves as liaison between the State Survey Agencies and other patient-focused organizations/agencies. The Patient Services and Quality Improvement departments work together on various projects and to provide technical assistance as needed.

Information Systems Director

Jeff Arnall, M.C.S.E.

The Information Systems Director (ISD) reports to the Executive Director. The ISD continually assesses and revises data management system output to ensure efficiency, accuracy, Computer System Integrity Management, and adherence to CMS and Network requirements. He/She ensures compliance of all data requirements including SIMS Database Management, facility accuracy & compliance profiles, facility directory information, data storage, security/confidentiality, and CMS-2728, CMS-2746, and CMS-2744 submissions. It is a responsibility of this position to oversee implementation of SIMS/VISION/QualityNet Exchange and related hardware/software updates, facility training and security measures. The Information Systems Director serves as a resource to the Medical Review Board and Quality Improvement staff as needed/requested. The Information Systems Director coordinates the processing of all data requests and is the primary data interface with CMS officials and contractors, Social Security offices and HMOs regarding ESRD Medicare entitlement situations.

Data Analyst

Glenda Whittle, B.S., C.I.S.

The Data Analyst reports to the Information Systems Director. Responsibilities include performing ongoing data entry of the CMS-2728 and CMS-2746, following-up on all new patients, transfers, deaths, transplants, and other patient related events including those submitted through VISION. The data analyst uses data utilities to prepare periodic accuracy and compliance profiles, missing/incomplete forms summaries and other facility feedback reports while preparing notices to facilities with delinquent CMS and Network data forms. He/She analyzes forms compliance and provides facility education regarding the forms as needed. Additionally, the data analyst is charged with maintaining well-organized hard copy files of forms and providing monthly Network Patient Status forms. The data analyst researches and responds to facility inquiries regarding CMS and Network forms/data reporting requirements.

Data Analyst

Marilyn K. Graham

The Data Analyst reports to the Information Systems Director. He/She continually monitors data to ensure its performance meets internal and external customer requirements. The Data Analyst provides technical support to facilities receiving VISION training. The Data Analyst prepares special data reports for Administration and Quality Improvement staff as needed. It is the responsibility of the Data Analyst to fulfill the Annual Survey (CMS-2744) deliverable. Education for the facility staff on the completion of the patient and staff roster and patient activity report forms is provided as required. In the absence of the Information Systems Director, the Data Analyst assist in the Network system back-up and ensures proper storage.

3

CMS National Goals and Network Activities

Summary

Rewritten every three years in the federal contract, the 2003-2006 contract goals for the ESRD Network program are as follows:

- Improve the quality of health care service and quality of life for ESRD beneficiaries;
- Improve data reliability, validity, and reporting among ESRD providers/facilities, Networks, and CMS (or other appropriate agency);
- Establish and improve partnerships and cooperative activities. These activities may include ESRD Networks, Quality Improvement Organizations (QIOs), State Survey Agencies (SAs), ESRD provider/facilities, Medicare + Choice (M+C) Organizations, ESRD facility owners, professional groups, and patient organizations;
- Support the marketing, deployment, and maintenance of CMS approved software; i.e., CROWN—Consolidated Renal Operations in a Web-enabled Network;
- Evaluate and resolve patient grievance as categorized in the Standard Information Management System (SIMS).

Section 3 addresses how Network 12 actively worked to fulfill these goals during 2005.

CMS Goal #1 Improving the Quality of Health Care Services and Quality of Life for ESRD Beneficiaries

Improving patient care is the overarching goal of all Network 12 activities; accomplishments toward this are grouped into the following three categories and seven subcategories:

- Quality Activities
 - Quality Improvement Projects (QIPs)
 - Quality Agenda
 - Glomerular Filtration Review
- Community Information and Resources
 - Provider community education

- Patient education and outreach
- Resources through the Network 12 website
- Assistance Activities
 - Assistance to facilities and patients related to care issues

Quality Activities: Quality Improvement Projects

Fistula First Breakthrough Initiative



Background

In 2002, CMS asked the Institute for Healthcare Improvement (IHI) to assist in the development and implementation of an ESRD Network-based improvement project on increasing arteriovenous fistula (AVF) rates in the United States. The National Vascular Access Improvement Initiative (NVAII) was officially launched in January 2003. A CMS press release formally introduced the project as the Fistula First Breakthrough Initiative in March 2005. FFBI or “Fistula First” is “a true partnership in the sense that it involves CMS, all ESRD Networks, large dialysis providers (LDO), independent dialysis providers, nephrologists, vascular surgeons, interventional radiologists, nephrologists, patients, and other entities with an interest in nephrology” (www.fistulafirst.org).

“The intent is for CMS, the ESRD Networks and the renal community to reach or surpass the goals set forth in the CMS Clinical Performance Measures project, that is, regional and national AVF rates of 50% or greater for incident patients, and at least 40% for prevalent patients undergoing hemodialysis” (www.fistulafirst.org).

The ESRD Networks, working cooperatively with assistance from the

Figure 9

Fistula First Subcommittee

Medical Review Board Members

Dennis Ross, MD, FACP, Committee Chair
Renal Care Group, Wichita, Kansas

Douglass Domoto, MD, JD
DaVita Dialysis, St. Louis, Missouri

Donovan Polack, MD
Metro Hypertension & Kidney Center
St. Louis, Missouri

Michelle Carver, RN, BSN, CNN
Dialysis Center of Lincoln
Lincoln, Nebraska

Jason Taylor, MD
Renal Care Group, Wichita, Kansas

Sue Donaldson, Patient Representative
Dialysis Center of Lincoln, Lincoln,
Nebraska

Michael Flanigan, MD
University of Iowa Hospital and Clinics
Iowa City, Iowa

Lisa Weber, MD
Kansas Nephrology Physicians, Wichita,
Kansas

Subject Matter Experts

Surendra Shenoy, MD, PhD
Washington University, St. Louis, Missouri

Andrew Chontos, MD
Surgical Consultants of North Platte
North Platte, Nebraska

Institute for Healthcare Improvement (IHI), laid the groundwork for the project nationally. Since this is a multi-year national project, the Medical Review Board (MRB) of Network 12 established a subcommittee to work exclusively on the Fistula First Project in 2003. The membership includes volunteers from the MRB and subject matter experts from the medical community. The committee members are listed in Figure 9.

Principles for Developing a Change Strategy and Goals

Fistula First aims to build on prior work and to take advantage of system-level diagnosis and strategies for improvement. The following list summarizes the key principles that govern the development of change strategies for the project:

- Core strategies that address the fundamental “failure” points in the system and are operational enough to be adopted with manageable levels of external support;
- Focus on “spread” of successful ideas on a Network and national scale;
- Collaboration among Networks, providers and key health professionals;
- Leveraging of resources, including Network QI resources and other relevant sources of expertise and support;
- Minimize burden on dialysis facilities (www.fistulafirst.org).

The purpose of the national groundwork by IHI and the workgroups was to collectively produce tools for the Networks to use in developing and implementing the project within its region. One of the first products developed by the national workgroup was a list of all potential strategies, called a change package, for increasing fistula placement and use. As in 2003, the Medical Review Board NVAII sub-committee reviewed the eleven change strategies. The five that were reaffirmed as top priorities for impacting change in Network 12 during 2005 are listed below:

- Routine continuous quality improvement review of vascular access;
- Training for the cannulation of AVFs;
- Early referral to a surgeon for “AVF only” evaluation and timely placement;
- Full range of appropriate surgical approaches to AVF evaluation and placement;
- Surgeon selection based on best outcomes, willingness, and ability to provide access services.

National Goals

- The United States renal care system as a whole will make significant progress toward attaining clinical performance measures (CPM) and Kidney Disease Outcomes Quality Initiative (K/DOQI) goals for AVF use (50% incidence; 40% prevalence) by the end of the upcoming ESRD Network contract period (July 1, 2003 to June 30, 2006).

- Several Networks will meet or exceed the goal of 50% AVFs for incident patients by the end of the upcoming contractual period. (July 1, 2003 to June 30, 2006).
- Several Networks will meet or exceed the goal of 40% AVFs for prevalent patients by the end of the upcoming contractual period. (July 1, 2003 to June 30, 2006).
- Networks that are currently operating at, or close to, the minimum standard for AVF use will establish stretch goals based on assessment of maximum feasible use of AVFs in their patient populations, and will make significant progress in meeting those stretch goals by the end of the upcoming contractual period. (July 1, 2003 to June 30, 2006).
- All networks will reduce to zero the number of patients with catheters or grafts who have not been appropriately assessed for possible AVF placement.
- As noted on the website www.cms.hhs.gov/quality/esrd/FFFAQs.pdf "CMS would like to see the percentage of patients with fistulas as their access increase to 66% over the next 5 years."

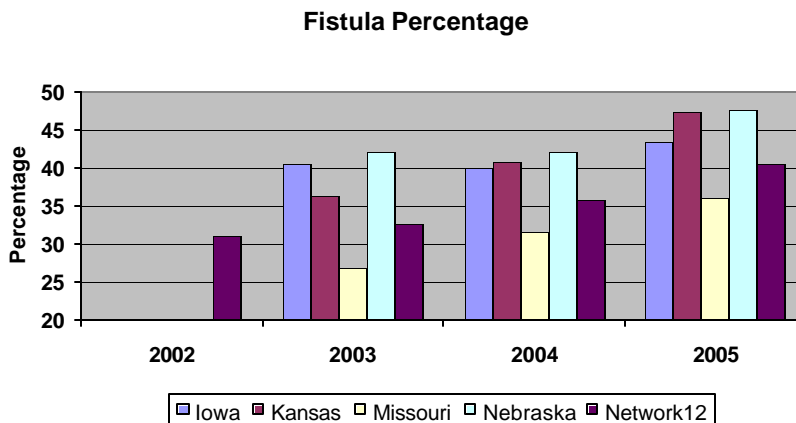
Network 12 Goals

- Network 12 will meet or exceed the CMS goal of 35.1% AVFs for prevalent patients by the end of the upcoming contractual period (July 1, 2003 – June 30, 2006).
- CMS determined that by March 2006, Network 12 must increase the absolute percentage of prevalent patients using AVF by four percent (4%) over the 2002 data from the Centers for Disease Control annual dialysis unit practices survey (31.1%).
- Stretch goal: Network 12 will meet or exceed the K/DOQI goal of 50% AVFs for incident patients by the end of the upcoming contractual period (July 1, 2003 – June 30, 2006).
- Stretch goal: Network 12 will meet or exceed the K/DOQI goal of 40% AVFs for prevalent patients by the end of the upcoming contractual period (July 1, 2003 – June 30, 2006).

Fistula First Breakthrough Initiative: Network Staff Leadership

Network 12 continues to demonstrate exceptional leadership and collaboration through active participation in this initiative. The Patient Services Coordinator served as the Network Liaison for the Beneficiary Education Task Force. The Quality Improvement Director served as Liaison-Elect and will succeed as the Liaison in 2006. This task force reviewed and accepted 30 beneficiary education items from national renal coalition members. Seven of the 30 accepted were publications created by Network 12 staff. These resources will become some of the key tools for educating the beneficiary at Chronic Kidney Disease Stage 5 and prior to entry into the End-Stage dialysis. Medicare currently considers the Fistula First Breakthrough Initiative the "gold standard" of collaborative efforts for change in a system.

Figure 10



Dialysis Facility/State Data

Prior to November 2003, only Network wide vascular access data abstracted from the CDC survey was available. Using the facility-specific data collection tool from all four states, it became possible to determine AVF percentages by state in November 2003. Because Missouri had the lowest AVF percentage at that time (26.71%), the Medical Review Board required monthly aggregate vascular access data from dialysis facilities in that state. Quarterly data was required of facilities located in Iowa (40.46%), Nebraska (41.98%), and Kansas (36.33%), as their AVF percentages were higher.

Beginning in June 2005, monthly aggregate data was required of all facilities in the four-state area. The AVF percentage in Network 12 continued to improve, having already surpassed the CMS mandated goal of 35.1% in November 2004. For the month of November 2005, the state AVF percentages were as follows: Iowa (43.34%) Kansas (47.33%), Missouri (35.98%) and Nebraska (47.43%). For November 2005, the Network AVF percentage was 40.5%.

On a quarterly basis, the following CMS generated reports were forwarded to the Unit Administrator of each dialysis facility: Fistula Use and Placement Rates in Incident Patients, Vascular Accesses used in Prevalent Patients, and Fistula Rate Comparison, Prevalent Patients: Facility, Network, US. These reports were supplemented by additional state specific graphs.

Dialysis Facility Staff: Identification of Best Practices

During 2005, telephone calls were placed to high performing facilities to ascertain the factors that contributed to their success. Calls were placed on a quarterly basis. From the beginning of this project, high performing facilities or those with an AVF percentage greater than 40, tended to have the following three characteristics in common:

- Designated Vascular Access Coordinator;

- Effective Communication with in the facility;
- Emphasis on Patient Education.

Utilization of these three areas, were consistently verbalized by high performing facilities in Network 12. These indicators will be shared with the facilities in the form of a handout at the January 2006 Annual meeting with an overarching goal that more facilities would reach quality goals through these spread techniques.

Intra-Facility Communication

Based on verbal feedback from facility unit administrators, the most significant factor impacting change was the increased communication within the multidisciplinary team. Physician's, who are actively involved to the point of passion, lead the change process in their facility. They clearly convey that AVF is the ethical choice and the best medical choice for patients. All patients should be evaluated for candidacy.

Vascular Access Surgeons

The MRB Fistula First Subcommittee met on February 14, 2005, to discuss the distribution strategy for the "Creating AV Fistulae in All Eligible Hemodialysis Patients". After a lengthy discussion, the MRB recommended that the educational resource, a CD/DVD, targeting vascular access surgeons, be distributed to every surgeon practicing in our four-state area. A letter to announce the distribution was forwarded to MRB members, Medical Directors, and Unit Administrators in July. The letters were used as a tool requesting these individuals to alert their surgeons to look for the CD/DVD in August. This additional communication to renal community leadership was an effort to prepare for the success and effectiveness to the 328 vascular access surgeons.

On September 2, 2005, three hundred twenty-eight "Creating AV Fistulae in All Eligible Hemodialysis Patients " were mailed to practicing vascular access surgeons in the four-state area. Additionally during Fall 2005, billing data from CMS was utilized to create surgeon specific arteriovenous percentage reports. One hundred eighty-one surgeon specific reports were mailed to surgeons in the four state area practice patterns. Included in this mailing was a National Vascular Access Improvement Breakthrough Initiative (Fistula First), National Surgeon Questionnaire requesting information on practice patterns. The questionnaires are to be returned to the Network by January 5, 2006. The responses will be entered into an excel spreadsheet and forwarded to a partnering Network for analysis.

Dialysis Patients

The heart of the renal care treatment team remains the ESRD Medicare beneficiary. An integral piece to accomplishing the goals of the Network is through beneficiary education. Network 12 continues to provide educational materials through newsletters and brochures directly mailed to each dialysis facility. Engaging patients and promoting active involvement with the renal treatment team is considered essential and remains a priority.

“Putting U in Fistula”, one of the patient newsletters created and distributed during 2005, was devoted to vascular access and the Fistula First project. Information provided included: vein mapping, pre and post AVF surgical preparation, venous pressure monitoring, arm exercises, and self-cannulation. In addition, patients were encouraged to participate in a contest. The entry form requested feedback and personal experience about fistulae longevity, cannulation practices, body image issues, and use of topical anesthetics.

Past and current newsletters remain available as a continued resource on the Network website.

Network Contributions to Facility Success

The Network Quality Improvement staff members have worked as facilitators and supporters this year. The main contributions made to the Fistula First project this year were conference calls and providing educational materials for surgeons, nephrologists, nurses, and patients. Network 12 was successful in raising the awareness and bringing the project to the forefront in our region. The renal community is becoming more and more aware of the project through exposure at meetings, renal publications, and corporate initiatives. The champion facilities are taking active roles in their communities.

Progress Relative to Contract and Network’s Goal

The Medical Review Board voted unanimously on April 8, 2005, to allow monthly data collection from facilities in all four states. Previously, only Missouri had been reporting data on a monthly basis due to its low baseline. The Centers for Medicare & Medicaid Services suggested that Network 12 begin collecting monthly data from the four-states in order to facilitate future data comparisons.

Maintaining Momentum: “The I-70 Series”



Missouri has two major league baseball teams: The Kansas City Royals and St. Louis Cardinals. The teams played against each other in the 1985 World Series; commonly referred to as the “I-70 Series.” The Network capitalized on the areas love of baseball to foster competition in a state needing of improvement. All dialysis facilities located in Missouri were “drafted to play” in the game for one of the teams, dependant upon their geographical location.

Interstate 70 was used as the dividing line and facilities were placed on team rosters accordingly. Updates were posted on the Network 12 website.

The facilities enjoyed the contest as a light-hearted approach to a serious quality improvement project. The contest began in 2004 and remained in effect until the winning team was announced on April 30, 2005. The Kansas City Royals were the winners with a geographical score of 40% AVF compared to the St. Louis Cardinals with a regional score of 30.9%. Figures 11 and 12 show the progress and results of the I-70 Series.

Figure 11

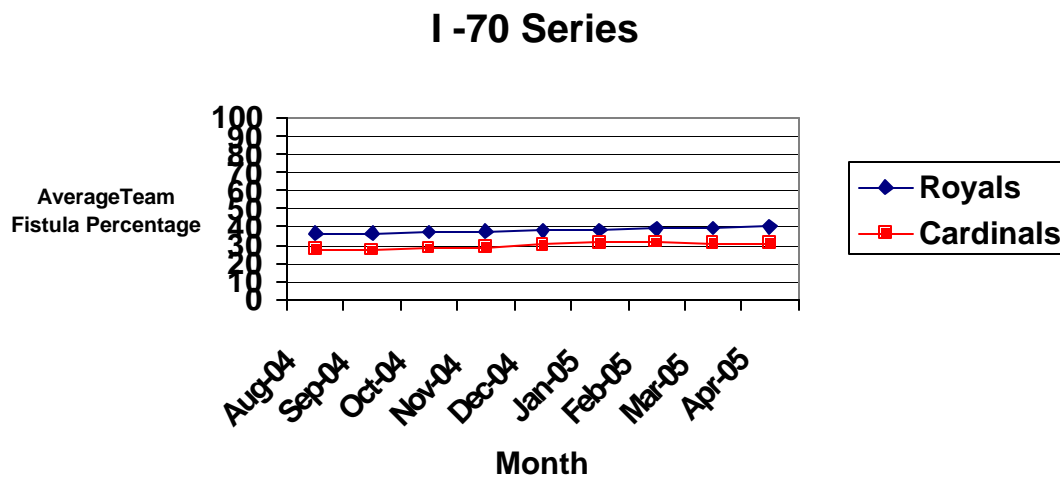


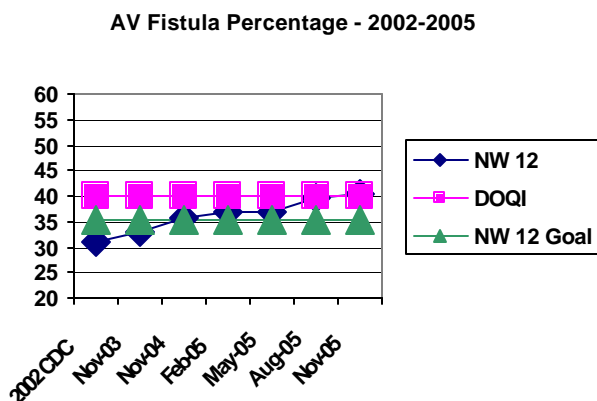
Figure 12

Network 12 Missouri Teams	Grand Slams 50% + fistula	Home Runs 40%-49% fistula	3rd Base 31% -39% fistula	2 nd Base 21% -30% fistula	1st Base 11% - 20% fistula	Still at home plate 0% - 10% fistula
Cardinals Facilities n=67	5	14	17	17	9	5
Royals Facilities n=31	7	6	9	7	2	0

Summary and Findings

Although much work lies ahead in order for Network 12 to reach the stretch goals, the benchmarks that were attained in 2005 have laid the groundwork for the realization of broader improvements in the future. Figure 13 below illustrates the progress that Network 12 has accomplished toward reaching our goals during 2005.

Figure 13



Recommendations

Collaborations and partnerships have become important and will play an even more vital part in future Network activities. The lessons learned during the project this year were shared with other ESRD Networks during conference calls, Quality Improvement Director meetings, and email communications. The State Survey Agency (SA) personnel were provided with a quarterly update on the project during regularly scheduled conference calls. The Network has formed a coalition with all four QIOs for both Fistula First and Immunization to further pursue quality improvement activities.

Facility Recognition

As of October 31, 2005, there were one hundred seventeen dialysis facilities located in Network 12 whose mean AVF percentage for November 2004 through October 2005 achieved or exceeded the K/DOQI goal of 40% AVFs. The Network recognizes these facilities at the Annual Meeting and presents certificates of achievement to them. These facilities are recognized below:

Fistula First Gemstone Achievers

Mean AV Fistula Percentage for November 2004 thru October 2005

DIAMOND LEVEL (90-100% AVF PERCENTAGE)

Veterans Administration Medical Center – Iowa City

SAPPHIRE LEVEL (70-79% AVF PERCENTAGE)

Kansas Dialysis Services – Sabetha
 Renal Treatment Centers – Scottsbluff
 Warner Dialysis

EMERALD LEVEL (60-69% AVF PERCENTAGE)

University of Iowa Hospital & Clinics – Washington
 Renal Care Group – Hays
 Newton Dialysis Center
 Atlantic Dialysis
 Covenant Waverly Dialysis Center
 Kansas Dialysis Services - Topeka
 Dialysis Clinic Inc – Bellevue
 Milton & Ethel Warner Dialysis Unit – Spencer

Chadron Community Hospital Dialysis
 Jackson County Public Hospital
 Kansas Dialysis Services – Manhattan
 Ringgold County Hospital Dialysis
 Susan B. Allen Dialysis
 Tri-State Dialysis – Guttenberg
 Veterans Administration Med Ctr – Omaha
 University of Iowa Hospital & Clinics – North Liberty
 Renal Care Group – North Platte

AMETHYST LEVEL (50-59% AVF PERCENTAGE)

<p>Baker Place Dialysis Renal Care Group - Emporia Bio-Medical Applications of Leawood Bio-Medical Applications of Lees Summit Branson LLC Renal Treatment Centers - Winfield Cherry County Hospital Dialysis Unit Creston Dialysis Dialysis Specialists of Topeka, Inc. University of Iowa Hospital & Clinics Mary Greeley Medical Center - Iowa Falls Renal Center of Storm Lake, LLC Renal Treatment Centers – Wichita North Iowa Mercy Dialysis Center – Charles City Kansas Dialysis Services – Lawrence University of Iowa Hospital & Clinics - Muscatine Kansas Dialysis Services – Ottawa Dialysis Clinic, Inc. - Baptist Salem Memorial Hospital Dialysis Clinic, Inc - Louisiana</p>	<p>Penn Valley Dialysis Center Southeastern Renal Dialysis, L.C. – Lee County Blue Springs Dialysis Center Dialysis Clinic, Inc – Saint Joseph Gambro Healthcare – Washington Dialysis Clinic, Inc – Lees Summit Gambro Healthcare – Atchison Gambro Healthcare - Fremont FMC Dialysis Services of Raytown Kidney Dialysis Center of Grand Island, LLC Overland Trails Renal Care Group, LLC North Iowa Mercy Dialysis Center – Algona Northeast Nebraska Dialysis Center Ozarks Dialysis North Pratt Dialysis Center Renal Care Group – Dodge City Renal Care Group – Liberal Renal Treatment Centers – Derby Southeastern Renal Dialysis – Mt. Pleasant York General Dialysis Services</p>
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TOPAZ LEVEL (40-49% AVF PERCENTAGE)

<p>Gambro Healthcare – Council Bluffs Affiliated Hospital Dialysis – Creve Coeur Mercy Medical Center – Clinton Avera – Saint Anthony’s Dialysis Renal Care Group - Arkansas City Pella Regional Health Center RAI Care Center – Omaha (CKC Dialysis) Tri- State Dialysis – Dubuque Box Butte Dialysis Unit Mary Greeley Medical Center – Marshalltown Kidney Disease Center of the Ozarks, LLC Mary Greeley Medical Center – Ames Grand Island Dialysis Dialysis Clinics, Inc – Moberly Cedar Valley Dialysis Center – West Union Dialysis Clinics, Inc – Belton Kansas City Dialysis & Transplant Center Blessing Hospital ESRD Center Gambro Healthcare - Rolla Dialysis Clinic of Lincoln Northwest Gambro Healthcare - Hazelwood Dialysis Clinic, Inc – Jefferson City West Dialysis of Des Moines Gambro Healthcare - Hospital Hill Ozarks Dialysis Services - South Gambro Healthcare – Omaha South Gambro Healthcare – Omaha West Gambro Healthcare – St Peters Jefferson County Dialysis Center</p>	<p>Mayo – Decorah Ottumwa Regional Health Center Renal Care Group – Harrisonville Renal Care Group- Wichita East Dialysis Clinic, Inc – Clinton NE Wichita Dialysis Center Mercy Dialysis Center – Mason City Hutchinson Dialysis, L L C Renal Care Group - Joplin East Renal Care Group - Newton Dialysis Clinics, Inc - West Omaha Gambro Healthcare – Omaha North Ozarks Dialysis Services – Monet Dialysis Clinics, Inc - Omaha Dialysis Center of Lincoln Quad Cities Kidney Center - Bettendorf Quad Cities Kidney Center – Davenport Quad Cities Kidney Center – Davenport Renal Care Group – Branson Renal Care Group – Butler Renal Care Group – Mercy Des Moines, LLC Renal Treatment Centers – Independence Saint Anthonys Regional Center Saint Charles County Dialysis Saline County Dialysis – Junction City Shenandoah Dialysis Trinity Regional Medical Center University of Iowa - Grinnell</p>
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Quality Activities: Quality of Care Initiatives

QUALITY AGENDA

Clinical Performance Measures Project (CPM) Data Collection

The Clinical Performance Measures Project is a national study that collects data from a five percent random sample of adult hemodialysis and peritoneal dialysis patients throughout the United States annually. Criteria are based on the National Kidney Foundation’s Dialysis Outcome Quality Initiative (KDOQI) Clinical Practice Guidelines. In 2005, six hundred eighty three (683) patients were selected by CMS from Network 12 for inclusion in the study. (Note: A 100% sample of Veterans Health Administration dialysis facility patients and 100% of the pediatric in-center hemodialysis patients were also included in the study.)

The comparison in Figure 13 shows that Network 12 performed well in all of the indicators. The Network either surpassed or closely mirrored the national average, with the exception of albumin.

Figure 14

CPM Results - Hemodialysis

Percentage of Patients with:	2005		2004		2003	
	NW12	US	NW12	US	NW12	US
Kt/V _≥ 1.2	93%	91%	90%	91%	91%	89%
Hgb _≥ 11	83%	83%	80%	80%	78%	79%
AVF (Prevalent)	36%	39%	35%	35%	33%	33%
Catheters	29%	27%	28%	27%	30%	27%
Albumin _≥ 4.0/3.7	31%	36%	34%	39%	30%	35%

Network-Specific CPM Goals 2005

Upon receipt of the preliminary CPM results, the MRB and the Network begin to work to formulate the Network Specific Goals for the year. The Network plan and goals are sent to CMS as a deliverable within 60 days of receipt of the preliminary CPM results. The Network specific CPM goals were set and approved by the MRB on January 12, 2005. The CMS Project Officer approved the CPM Plan on January 21, 2005. The table below illustrates the Network 12 goals for 2005.

Figure 15

Quality Indicator	NW12 CPM 2004 (2003 data)	US CPM 2004 (2003 data)	Network 12 Goal for 2005
Adequacy of Hemodialysis			
% Patients with mean sp Kt/V \geq 1.2	90	91	95%
% Patients with mean URR \geq 65%	85	87	95%
Vascular Access			
% Prevalent pts with AVF	35	35	40%
% Incident pts with AVF	31	35	50%
% Patients with AVG & Stenosis monitoring	76	77	100%
% Prevalent patients with catheter	28	27	10%
% Prevalent patients with catheter \geq 90 days	22	19	< US
Anemia Management			
% Patients with Median Hgb \geq 11g/dL	80	80	85%
% Patients with Median Hgb \geq 11 – 12.0 g/dL	43	36	
% Patients with Median Hgb \leq 10g/dL	7	6	
Serum Albumin			
% Patients with Mean serum albumin \geq 4.0/3.7 g/dL (BCG/BCP)	34	39	\geq US
% Patients with Mean serum albumin \geq 3.5/3.2 g/dL (BCG/BCP)	79	81	

New Patient Outreach

Educating the Medicare beneficiary on the resources afforded to them for grievance investigation, mediation, referral and advocacy remains paramount. In 2005, over 4,000 new patient brochures were distributed to all incident patients. This booklet was designed in 2003 and revised in 2005 to provide comprehensive information on who the Network organization is and how we can confidentially assist with concerns and grievances about their dialysis or transplant facility.

The goal is to provide the new beneficiary with information and welcome them to our Network prior to their receipt of the New Patient Orientation Packet (NPOP) provided by the Forum Office. The data department provides the PSC a monthly list of incident patients, whereby the new patient booklet is directly mailed. In addition to including information on the grievance procedure and the technical assistance offered by the Network, brochures from the Centers for Disease Control (CDC) on influenza, hepatitis B and pneumonia are included in each mailing.

Decreasing Patient Provider Conflict

At the direction of the Medical Review Board, preparation for the Decreasing Dialysis Patient Provider Conflict (DPC) training began in October. Feedback from two volunteer pilot groups allowed the Network to fine tune educational materials necessary to effectively meet the needs of the facility staff members in the four state area. In addition to the excellent resources contained in the DPC toolkit distributed nationwide, Network 12 supplemented the continuous quality improvement tools in response to requests from the pilot groups.

One-day seminars in Wichita, KS, St. Louis, MO, Cedar Rapids, IA, Kansas City, MO and Omaha, NE are scheduled for the spring of 2006. The Network 12 Quality Improvement and Patient Services staff members will provide the training and lectures. Continuing education credits will be applied for and a nominal registration fee will be required from participants.

Lab Data Collection

Network 12 is participating with many other ESRD Networks in a lab collection initiative that will provide patient-specific laboratory data for the months of October – December 2005. This lab information will be used for quality improvement initiatives as well as comparative feedback to each facility.

The Independent dialysis facilities will be asked to submit their data via disk. The large dialysis organizations are automatically providing the data through CMS. The data elements include: hemoglobin along with pre and post blood urea nitrogen (BUN). Discussions regarding this initiative took place in November 2005. Data Collection is scheduled to begin in February 2006. ESRD Network 11 will be coordinating the effort on behalf of the Networks.

Bulletin Board Kits for Patient Education

The MRB Quality Agenda subcommittee recognized that patient education is of vital importance and that time constraints, staffing issues, and finances often limit the ability of the unit to provide information to the patients. The committee identified the opportunity to assist the facilities by providing them with ready-made bulletin board kits at no cost to the facility. Each set of bulletin board kits included eight (8) two-sided 8 ½ x 11-inch colorful laminated sheets. Each of the two sides addressed a specific topic pertaining to the dialysis treatment.

An impact survey conducted by the Network office in November 2004 indicated that the use of the bulletin board kits was an effective intervention. During 2005, two new educational bulletin board kits were distributed on the topics of Patient Safety and Renal Rehabilitation.

Immunization Guideline

On April 8, 2005, the Medical Review Board approved a brief statement encouraging dialysis facilities to provide immunizations such as influenza, pneumonia, and hepatitis B for their patients. This guideline supports the CMS Healthy People 2010 initiative. All Medical Directors and Unit Administrators at Network 12 facilities were forwarded a copy of the immunization guideline in May. The letter incorporated The Centers for Disease Control (CDC) suggestions for immunization and also supported accurate tracking of those patients receiving immunizations.

Glomerular Filtration Rate (GFR) Review

The MRB subcommittee conducts the GFR review annually with assistance from the Network Quality Improvement staff. Patient and facility data is reviewed to determine whether providers or physicians are misusing Medicare funds by initiating dialysis treatments early and/or inappropriately. This CMS deliverable is reported by June 30

for the preceding calendar year, 2004. The review conducted in 2005 did not identify any facility or provider care problems related to initiation of dialysis. The review was noted in the July 8, 2005, MRB minutes. The main trigger for review continued to be the facility error of reporting of a serum creatinine value obtained after the first renal replacement therapy treatment. Educational interventions in the form of a letter and fact sheet were provided to all facility Unit Administrators and Medical Directors by the Network data and quality improvement staff following the review to assist facilities to prevent this from occurring in the future.

Standardized Mortality Rate (SMR) Analysis

Using the data from the University of Michigan Kidney Epidemiology Cost Center (UM-KECC) SMR reports, forty-four (44) facilities were compared in 2005. The review consisted of identifying commonalities and differences between facilities with higher than expected SMR and those with lower than expected SMR. On April 8, 2005, the MRB requested additional analysis to determine practice patterns related to social worker and dietitian workload, primary care visits, patient compliance with dialysis prescription, missed dialysis treatments, dialysis adequacy, and state survey findings, if available. As data becomes available, this issue will be investigated further. This data will be compared to the 2005 CPM adequacy data.

Hurricane Assistance

During September, Hurricanes Katrina and Rita hit the Gulf Coast and directly effecting Networks 8 and 13. Network 12 assisted during the disaster in the following activities:

- Tracking patient movement from the affected areas via database interface with Computer Science Corporation (CSC);
- Posting emergency information, such as diet suggestions and contact numbers on the website
- Participating on national and regional disaster aid conference calls;
- Distributing information to the dialysis facilities;
- Fielding telephone calls regarding beneficiary well-being.

Internal Disaster Planning

The lessons learned from the hurricane disasters were used to formulate the backbone of improvements made to the Network 12 internal disaster plan in October 2005. Frequent fire, weather, and other disaster drills are held to assist the staff members in performing efficient evacuation, data protection, and safety measures.

Off-site contingency and relocation plans to ensure business continuity and to meet contractual requirements have been formulated for both short and long-term events. Network 12 is in the process of implementing reciprocal agreements with neighboring ESRD Networks and/or Quality Improvement Organizations. Geographically distant Networks would ensure the dissemination of information from CMS continues to reach the off-site location. In the event of any type of disaster, strategic positioning and planning will allow Network 12 to continue uninterrupted services.

Avian Bird Flu and/or Potential Pandemic

In the fall of 2005, Network 12 began preparing for the possibility of the avian influenza and/or potential pandemic affect on the United States and specifically the

four-state region. Contacts were made with Health Departments in each of the four states and information regarding the vulnerable end stage renal disease population was shared with them via email.

The Executive Director and Quality Improvement Director attended a Strategic Planning Seminar that was held on December 1, 2005 at the University of Missouri in Kansas City. Dr. Rex Archer, the Director of the Kansas City Health Department, and the President of the National Association of County and City Health Officials was the keynote speaker. The seminar reviewed past pandemics, the current situation, and focused on what the future might hold if the avian influenza virus trans-mutates.

Dr. Archer discussed disaster planning and suggested practical strategies that businesses might take as they plan for a worst-case scenario. Network 12 remains committed to explore ways in which we can assist dialysis and transplant facilities should the avian influenza or a pandemic become an unfortunate reality in the near or distant future.

Education Activities: Provider Community Education

Annual Meeting

The 2005 Annual Business Meeting and Clinical Care Conference was held January 13-14 at the Westin Crown Center in Kansas City, Missouri. More than four hundred renal professionals attended the successful educational conference. Concurrent sessions offered on the following topics:

- Six Sigma: The Changing Role of the Practitioner with Breakout by discipline
- Managing Renal Osteodystrophy
- Recognizing the Value of Cultural Differences
- Addressing Sexuality in ESRD Patients
- Fistula First

Gene Fibuch, MD, presented the keynote address, "Have Physicians Given Up Their Role in Quality?" during the Friday luncheon.

The Business Meeting also held on Friday was well attended. The Council reviewed activities for the previous year including financial information and major accomplishments. The Executive Director presented an overview of future goals and activities. The Executive Committee Chair recognized retiring Board members. No new business was brought before the Council and the meeting adjourned.

Proposed Conditions for Coverage

An overview of the proposed Conditions for Coverage was published in the Federal Register on February 4, 2005. The published document included a preamble that extensively discusses how CMS developed the regulations and provided the new structure and goals of the regulations. The regulation text was divided into the four subparts of general provisions, patient safety, patient care, and administration. CMS requested comments both criticizing and in support of each part of the regulations.

The Executive Committee formulated the Network's response to CMS during their April 22 meeting. There was much discussion about the content of the proposed regulations. Members sent their written comments to the Network office for consideration by the Executive Committee and were encouraged to submit their comments as private individuals via mail or the CMS website. Information about the review process was also forwarded to the dialysis facilities during February. The deadline for submission was May 5, 2005. CMS must review all comments and formulate the final regulations within three years of the proposed rule printing or by February 4, 2008.

Open Door Teleconference and Staff Newsletter

The Network produced and distributed one facility staff newsletter during the year. The newsletter printed in July 2005 "Perceived Entitlement...in an Entitlement System" focused on patient rights and responsibilities. Current and previous staff newsletters are available for download at the Network 12 website.

In lieu of additional newsletters, two Open Door Conferences were held. The topics discussed at the teleconference held April 5, 2005 included: current QI projects, disaster planning, immunizations, available resources from the Network, 2728 changes, and CMS updates. Discussed at the October 25, 2005 teleconference were updates of current QI projects, disaster planning, immunizations, resources available, DPC, CMS, and the Annual Business Meeting and Clinical Care Conference scheduled for January 2006.

Distribution of Materials

The Network office has a large variety of materials that it distributes upon request for technical assistance or when needs are identified. Recipients of the materials include Medical Directors, Unit Administrators, Corporate Quality Improvement Personnel, Social Workers, Nephrologists, Head Nurses, Dietitians, Patients and their families.

Figure 16 provides a listing of many of the materials distributed during the past year:

Figure 16

Behavior Contract Examples	Network 12 Guideline on Threats and Harassment
Grievance forms and FAQs	Grievance Booklet for Professionals
Emergency Preparedness for Dialysis	Grievance Booklet for Beneficiaries
Facilities, A Guide...Dialysis	Patient Outreach and Education
Patient Safety Toolkits	Patient Newsletters
FDA Recall Notice—Heparin	Education Certificates
Comparative Graphs with Facility, State and	Patient Safety
Network Fistula Rates	Network Information
"We're Here for You" Network poster	Emergencies Preparedness for Patients
DPC poster	State Survey Agency Information
Conditions for Coverage	Numerous Educational PowerPoint's
Influenza Vaccination Survey and Information	Difficult Patient Behaviors
Bulletin Board Kits	Documentation
Fistula First Project Interventional Materials	Albumin Materials
"Who is the Network" Materials	Fistula First Materials

Education Activities: Patient Education and Outreach

Patient Newsletters

In 2005, Network 12 continued distribution of a quarterly newsletter for patients and family members via facility personnel. "Putting U in Fist-U-la", one of the patient newsletters created and distributed during 2005, was devoted to vascular access and the Fistula First project. Information provided included: vein mapping, pre and post AVF surgical preparation, venous pressure monitoring, arm exercises, and self-cannulation. Additionally, "Evaluating Alternatives" focused on treatment options with and emphasis on the Dialysis Facility Compare (DFC) website. Additionally, information was available on disaster preparedness including a three-day diet.

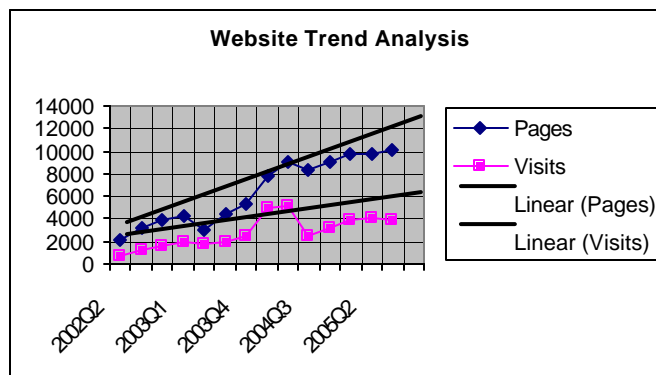
"Navigating the Vascular Seas – A Self-Assessment of Vascular Access" or the "SEAS Booklet" creation began as a collaborative between Scott O. Trerotola, MD, FSIR, FACR, Gerald A. Beathard, MD, PhD, FACP, FASN, and the Network Patient Services and Quality Improvement staff. The publication will be distributed at the 2006 Annual Meeting with a two sided instruction card on fistulas and graphs for patients.

All Network newsletters are available for download at the Network 12 website, www.network12.org.

Education Activities: Resources Through the Network Website

As in 2003 and 2004, Network 12 continued to see an increase in website utilization in 2005. The content at www.network12.org, includes information of interest to patients, professionals, corporations, vendors, CMS, and the general public. During 2005, the website received over 17,471 visits¹ with 37,074 pages² requested. This is a 10% increase in visits and 37% increase in the number of pages being requested compared to last year. (Unfortunately, accurate information for the last quarter was not available due to an error in the web hosting company's software. An average of the first three quarters was used for reporting purposes.)

Figure 17



¹ Visits are requests for web pages from another PC. Multiple requests are still considered one visit, unless they occur after the 30 minute timeout, at which point it is considered a new visit. ² Pages (also known as "page views" or "page impressions") are URLs that would be considered an actual page being requested.

¹ Pages (also known as "page views" or "page impressions") are URLs that would be considered an actual page being requested.

The organization's goal continues to be making all materials and resources distributed by the Network available for easy download from the website. Patient educational newsletters continue to be the most downloaded resources. The table below lists each document, its subject and the number of times it was downloaded (pages requested) during 2005.

Figure 18

Count	Topic
751	Putting U In Fistula
430	Food for Thought
423	Taking the Monster Out
366	Maintaining Your Lifeline
254	Transplant Booklet
199	Blood is Thicker than Dialysate
188	Taking Care of Self
151	Looking at Adequacy
135	A Shot of Information
90	When your Thirst is at its Worst

Continuous Quality Improvement (CQI) Tools

The Network 12 website has been enhanced in 2005 with on-line resource materials to provide facilities with continuous quality improvement (CQI) tools such as run charts to be used to track facility progress toward goal setting and bench marking. Clinical Performance Measures indicators are included (adequacy, anemia management, vascular access, and nutrition) as well as hospitalization and infection (VRE/MRSA).

Assistance Activities: Assistance to Facilities and Patients Related to Care Issues

Outreach to New and Existing Patients and Staff

In October 2002, the Centers for Medicare and Medicaid Services (CMS) began distributing a packet of basic information to every new ESRD patient via their home address. The packet includes a cover letter from the Network 12 Executive Director that contains the following information:

- An introduction to the Network's grievance process
- Instructions on contacting the Network 12 office including our toll-free number maintained for patient use—800-444-9965
- Complaint intake phone numbers for the four state survey agencies

In addition to this packet, facility personnel are required by the Medicare regulations to provide new patients with information on contacting the Network. During 2004, the Network provided all existing facilities an updated poster advertising the Network's toll-free number for display in the patient waiting room or another appropriate area.

Finally, more than 4,000 revised patient education brochures (New Patient Outreach, page 30) were mailed directly to new patients in 2005. The brochure provides information and confidential resources available through the Network office on grievance investigation, mediation, referral and advocacy.

Overview of Activity

During 2005, the Patient Services Coordinator and Quality Improvement staff received calls from patients, family members, facility staff, and others on a variety of issues. As displayed in Figure 19, 118 of the calls received were Facility Concerns. The PSC continued to receive a significant number of calls regarding requests for information addressing abusive, disruptive or otherwise challenging patient behaviors.

Additionally, there were 77 calls from State Survey Agency personnel requesting information related to grievances filed against facilities or questions prior to a site visit in 2005. This number increased more than 200 percent since last year and reflects joint collaboration efforts. Figure 20 lists the type of questions and concerns related to patient care received during 2005.

In response to calls involving challenging patient behaviors, the Network Patient Services Coordinator and the Quality Improvement Director review patient rights and responsibilities posted on Medicare's Dialysis Facility Compare's Website, in addition

Figure 19

Number of Calls by Category, 2005	
Formal Grievance	10
Patient Complaint	41
Patient Inquiry	32
Facility Inquiry/Concerns	118
Other	122

to the ESRD Conditions of Coverage with the caller, in particular, Condition §405.2138, Patient Rights and Responsibilities, paragraph 2 under Standard B states that all patients treated in the facility "are transferred or discharged only for medical reasons or for the patient's welfare or that of other patients, or for

nonpayment of fees (except as prohibited by title XVIII of the Social Security Act), and are given advance notice to ensure orderly transfer or discharge."

Second, the Network staff inquires about the process that the facility has undergone to identify the problem with the patients. The following questions are raised:

- Have there been any care planning meetings? If so, who attended? Was the entire renal team present so that the team is able to be consistent in the message presented to the patient?
- Was the patient encouraged to bring a support person to the meeting?
- Has the patient received a written description of the facility's expectations and the patient's rights?
- What support system does the patient have that might affect the situation?
- Has the Social Worker intervened with community resources, psychosocial interventions, and conducted an updated psychosocial assessment?
- Importantly, does the facility have a policy regarding transfer or termination of patients and is that process being followed?
- If there was a situation that involved violence, were the police contacted and a report filed?
- If there were threats of violence, have appropriate measures been taken to insure the safety and security of other patients and staff members?
- Have staff acted inappropriately and have steps been taken to rectify the behavior?
- Has the facility's legal representation been notified?

If a dismissal is imminent, the Network staff ascertain whether or not the patient has been notified in writing, provided education on fluid overload and increased potassium levels, how long the patient has to locate another unit, and how has the facility helped the patient in transferring. If necessary, Network 12 assists in facilitating a transfer. Unfortunately, an increasing number of patients have been dismissed from different facilities and are relying on hospital emergency rooms to receive care.

Figure 20

Type of Complaints and Questions Related to Patient Care, 2005

Care Practices

- Emergency Preparedness
- Vascular Access
- Cannulation Ability of Staff
- Hepatitis B Requirements
- Unit Cleanliness
- Unit Temperature
- CQI Process

Insurance and Billing Problems

- Transient Costs
- Requests For Replacement Medicare Cards
- Billing questions
- Transplant medication coverage

Other Concerns

- Patient Behavior Contracts
- Inappropriate Staff Behaviors
- Immunizations
- Transient Rights
- Patient Rights
- Transportation
- Respect and Dignity Issues
- Patient Education
- Use of Dialysis Facility Compare
- Staff Professionalism

One of the 2005 Network intervention activities to address this increasing issue included DPC training. For more information on this project, refer to page 30, Decreasing Patient Provider Conflict.

Special Studies Participation

The Evaluation of Quality of Life in Pediatric Dialysis Patients was a collaborative effort between Networks 1, 2, 4, 5, 9/10, 12, 13, 14, 16, members of the Pediatric Nephrology Division of Johns Hopkins Medical Institution (Barbara Fivush, MD, Susan Furth, MD, PhD; Alicia Neu, MD and Arlene Gerson, PhD) and Stuart Goldstein, MD of Baylor College of Medicine/Texas Children's Hospital. The purpose of the study was to:

- To identify which aspects of quality of life (QOL) are impaired and to assess the prevalence of serious QOL impairment in pediatric dialysis patients.
- To assess the impact of dialysis type (HD vs PD) on quality of life.
- To assess the relationship between QOL and measurements of dialysis adequacy in pediatric dialysis patients.
- To quantify the relationship between intermediate outcomes (i.e. level of hemoglobin and albumin) and QOL in pediatric dialysis patients.
- To assess the impact of access type on QOL (physical functioning, school functioning, and psychosocial functioning).

Informational conference calls were held in July 2005 with Network participants to discuss the collaborative. A tentative database of patient participants was forwarded to Network 5 in July. The data collection portion of the study will commence in the spring of 2006.

Office of the Inspector General (OIG) Study

The Office of the Inspector General conducted a study to determine the ways in which ESRD Networks utilized data. Several of the Network staff members participated in the call conducted by the OIG on Friday, October 28. Specifically, the Clinical Performance Measures (CPM), Dialysis Facility Reports (SMR), Survey & Certification Reports, and other Network generated data. During the call, OIG staff requested the Network's feedback on what data we use, how we use the data, why we use it, and the barriers to using existing data.

CMS Goal #2 Improving Data Reporting, Reliability, and Validity between ESRD Facilities, Network 12, and CMS

There are acronyms used in this section are defined as follows:

- SIMS (Standardized Information Management System): The software program the Networks use to track patient demographic and treatment information as submitted by the facilities.
- VISION (Vital Information System to Improve Outcomes in Nephrology): The software program that when installed on a local computer allows facility staff to enter patient information required for the CMS forms and Network tracking.

- QNET (Quality Net Exchange): The software and website through which patient data is securely transmitted from a VISION facility to the Network.
- REMIS (Renal Management Information System): A national database accessible only by Network or appropriate federal personnel that contains minimal patient identifiers and summary information on claims processed by Medicare for the individual.
- CROWN (Consolidated Renal Operations in a Web-enabled Network): The platform and secure wide-area computer network that allows protected exchange of confidential patient information via the Internet between Networks and REMIS. Eventually, CROWN will replace VISION as a web-based software program for entry of forms and events data.
- 2728: The Medical-Evidence Form required by CMS for enrollment in the ESRD Medicare Program.
- 2746: The Death Notice required by CMS and submitted by the dialysis and transplant facilities.
- 2744: Annual Facility Survey that accounts for changes in patient census at a dialysis or transplant facility throughout a calendar year.

Network 12 submitted 4,282 Medical Evidence Reports and 2,914 Death Notices during the past calendar year. The count of Medical Evidence Reports includes duplicate forms submitted for change in modality effecting the eligibility date that occurs within the first 90 days of therapy.

Summary of Activities

VISION Training Goals

Approximately 28 facilities were recruited and trained during the first quarter of 2005; one facility's staff was retrained at the Network office. A budget was submitted and approved to continue support of the VISION program. VISION training's took place in April and were held at New Horizons Computer Training Centers in the following locations:

- Overland Park, KS on April 13;
- St. Louis, MO on April 14;
- Omaha, NE on April 27;
- Des Moines, IA on April 28.

By the end of the second quarter, 49 units were submitting data using VISION, far exceeding the CMS goal for the 2004-2005 contract year. Of the 11 facilities trained in April 2005, 11 were submitting electronically with VISION software.

CMS released the new training deliverables for the contract year 2005-2006, which started July 1, 2005. The new deliverable required the Network train 50 percent of units eligible to use VISION. The definition of eligible units includes all units except those owned by DaVita, Dialysis Clinic, Inc., Fresenius Medical Care and Renal Advantage. The deliverable also required Network 12 to have 25 percent of the eligible units using VISION.

Network 12 met and far exceeded this contract deliverable. In 2005, Network 12 reported 76 percent of eligible facilities were trained and 54 percent operational according to the August 2005 CSC report, "Network 12 VISION Eligible."

New Medical Evidence Report (CMS 2728) Rollout

Use of the new Medical Evidence Report (CMS 2728) form was implemented June 1, 2005. Proactive educational and customer support activities included the following:

- Direct faxes to individuals responsible for the forms alerting them to the changes;
- Distribution of written instructions developed from materials written by Network 14;
- Reminder faxes to the facility personnel;
- Posting of the instructions on the Network website;
- Establishment of an email circle consisting primarily of paper form users that allowed answers to questions posed by facility staff to be easily forwarded to all interested. (Please note, no patient specific information is ever exchanged in this format.)

The content on the 2728 form and the changes made were more dramatic, than those on modified Death Notification (CMS 2846) released in October 2004. Because the Network provided more proactive customer support and instruction than with the 2746 rollout, the Network Data staff spent approximately 20 percent less time and resources on corrections and one-on-one customer support.

Most notably, the facilities demonstrating the fewest problems were those that participated in the email circle. As the Data Analyst identified common errors while processing the forms, an email highlighting the issue was created and forwarded to all of the circle participants. The amount of time spent in proactively education for the facilities showed significant return.

Hurricane Assistance

As previously noted, in the aftermath of Hurricane Katrina, a great deal of time was spent during the third quarter by all Network departments. Network staff not only to support the affected ESRD Networks by data tracking evacuated Medicare Beneficiaries but to utilize the lessons learned from this disaster to improve our internal disaster preparedness processes.

Annual Facility Survey (2744)

The first quarter of the year was dedicated to completion and submission of the annual facility survey. Annual Facility Surveys were mailed during the second half of February. A record number, 125 (46%), balanced when printed: indicating dramatic improved in patient events reporting by the facilities and processing by the Network staff. This year's facility survey was completed on time with minimal disruption to the facilities or Network personnel.

Data Stars

The Network provides facilities with reports on accuracy and timeliness of submitted CMS forms. Distributed semi-annually these compliance reports provide feedback on the facility's data reporting performance. The calculation is a simple percentage of forms received divided by the number of forms completed accurately and the number submitted on time.

We honor our "Data Stars" facilities that met the CMS compliance guidelines with publication of each facility's name in this report and at the Annual Business Meeting.

Figure 21 2005 DATA STARS

Affiliated Hospital Dialysis	Milton & Ethel Warner Dialysis Unit
Affiliated Hospital Dialysis - South	Missouri Delta Medical Center Dialysis Unit
Atlantic Dialysis	North Iowa Mercy Dialysis Center
Avera St Anthony's Hospital ESRD	North Iowa Mercy Dialysis Center
Barnes Jewish Dialysis Center	North Iowa Mercy Dialysis Center
Bio-Medical Applications of Independence	Northeast Nebraska Dialysis Center
Bio-Medical Applications of Leawood	Ottumwa Regional Health Center
Blessing Hospital ESRD Center	Ozarks Dialysis Services
Bluff City Dialysis	Ozarks Dialysis Services - North
Box Butte Dialysis Unit	Ozarks Dialysis Services - Primrose
Cardinal Glennon Children's Hospital	Ozarks Dialysis Services - South
Cedar Valley Dialysis Center	Pella Regional Health Center
Cherry County Hospital Dialysis Unit	Perry Co Dialysis Centers
Chromalloy American Kidney Center	Poplar Bluff Dialysis Center
Covenant - MercyCare, Inc	Potosi Dialysis Centers
Covenant Waverly Dialysis Center	Quad Cities Kidney Center
Covenant - Mercycare	Quad Cities Kidney Center
DCI Onawa	RAI Care Center
Dialysis Center of Beatrice	RAI Care Center - Baker Place
Dialysis Center of Columbus	RAI Care Center - Fremont
Dialysis Center of Lincoln	RCG Mercy Des Moines, LLC
Dialysis Center of Lincoln Northwest	RCG North Platte
Dialysis Center of South Omaha	RCG Wichita East
Dialysis Center of St. Joseph	Renal Care Group
Dialysis Center of West Omaha	Renal Care Group
Dialysis Clinics, Inc.	Renal Care Group
Dialysis Clinics, Inc. - Baptist	Renal Care Group
Dialysis Clinics, Inc.	Renal Care Group
Dialysis Clinics, Inc.	Renal Care Group - Nixa
Dialysis Clinics, Inc.	Renal Center of Storm Lake, LLC
Dialysis Clinics, Inc.	Renal Treatment Centers
Dialysis Clinics, Inc.	Renal Treatment Centers
Dialysis Clinics, Inc.	Renal Treatment Centers
Dialysis Specialists of Topeka, Inc.	Renal Treatment Centers
Dialysis Treatment Center of North County	Renal Treatment Centers
East Wichita Dialysis Center	Renal Treatment Centers
Farmington Dialysis Center	Renex Dialysis Center of St. Louis
FMC Midwest Dialysis	Renex Dialysis Clinic of Bridgeton
Gambro - St Louis West	Renex Dialysis Clinic of Maplewood
Gambro Healthcare	Ringgold County Hospital Dialysis
Gambro Healthcare	Saline County Dialysis
Gambro Healthcare	Saline County Dialysis
Gambro Healthcare - Hospital Hill	Saline County Dialysis
Gambro Healthcare - Northland	Samaritan Dialysis Unit
Gambro Healthcare - Wyandotte West	Samaritan Memorial Hospital
Garden City Dialysis Center	Siouxland Dialysis
Genesis Medical Center	Southeastern Renal Dialysis, LC

Harlan Dialysis	Southeastern Renal Dialysis - Lee County
Hastings Dialysis Center	St Louis Renal Care - Forest Park
Hutchinson Dialysis, LLC	St. Anthony's Hospital
Jackson County Public Hospital	St. John's Mercy Medical Center
Jefferson County Dialysis Center	St. Louis Children's Hospital
Kansas City Dialysis & Transplant Center	Susan B. Allen Dialysis Center
Kansas Dialysis Services	Trinity Regional Hospital
Kansas Dialysis Services	University Hospital - Transplant Unit
Kansas Dialysis Services	University of Iowa Hospital & Clinics
Kansas Dialysis Services	University of Iowa Hospital & Clinics
Kansas Dialysis Services	University of Iowa Hospital & Clinics
Kennett Dialysis Center	University of Iowa Hospital & Clinics
Mary Greeley Medical Center	V. A. Medical Center
McCook Dialysis Center	V. A. Medical Center
Mercy Dialysis Center	V. A. Medical Center - Transplants
Mercy Hospital Transplant Department	V. A. Medical Center - Transplants
Mercy Medical Center	Wayne County Hospital ESRD
Mercy Medical Center - Mercy Plaza	York General Dialysis Services

CMS Goal #3 Establishing and Improving Partnerships and Cooperative Activities among and between Network 12, Quality Improvement Organizations (QIOs), State Survey Agencies (SSAs), and ESRD Facilities

Summary of Activities

Routine collaborative activities during 2005 included the following:

- Informal exchanges of information between Network staff and state surveyors prior to routine, recertification surveys;
- Informal consultations between Network staff and state surveyors in regard to questions arising from grievances or complaint surveys;
- Referral of a grievance to the appropriate Quality Improvement Organization for peer review services;
- Referral of grievances to the appropriate state survey agency when the matter was directly related to the regulations;
- Effective communication to educate ESRD facilities regarding complaint and grievance issues;
- Providing technical assistance as requested by ESRD facilities and the renal community;
- Coalitions promoting Fistula First and Immunization established with the respective Quality Improvement Organizations.

Network 12 held quarterly teleconferences throughout the year inviting representatives from each State Survey Agency (SA) and CMS Region VII office, including the Certification and Survey Division personnel, to attend. Issues discussed included Network QI initiatives and area survey trends. Communication between the

SAs and Network 12 has continued to improve with sharing of Network projects and survey results.

State Survey Agencies

The Network hosted quarterly teleconferences with invitations extended to each of the four State Survey Agencies and CMS Regional Office. Each teleconference provided updated information on current Network activities with specific focus on:

- Grievance Activities;
- Patient Educational Efforts;
- Quality Improvement Initiatives.

Seventy-seven calls occurred between the State Survey Agencies and the Network prior to site visits this year, with seven calls referred by the Network to the State Agencies for immediate threat.

Renal Communities and Professional Organizations

The Network continued to strengthen their relationships within the renal community during 2005. Activities included presenting to member organizations at national or local chapter events. The year began with the Network's QI staff presenting at an ANNA and NKF joint chapter meeting in St. Louis, Missouri.

As the year progressed, the Executive Director continued support and participation on the Early Intervention planning committee with National Kidney Foundation of Kansas and Western Missouri. The educational meeting held in April 2005, targeted primary care physicians for appropriate and timely referral to nephrologists and vascular surgeons in patients with CKD. Additionally, the NKF affiliates and CMS are offered complementary booth space as exhibitors during the Annual Business Meeting and Clinical Care Conference. The Executive Director also represents the Network as an active, non-voting member on the Missouri Kidney Program's Advisory Council.

Please refer to the table below for a comprehensive list of all Network participant activities. (Figure 22)

Strategic Partnership for Change: Coalition Building

In August, Network 12 formed a coalition with the four Quality Improvement Organizations (QIOs) in the region. As mentioned previously in this report, two workgroups were created during this meeting to promote Fistula First and Immunization.

Throughout the fall of 2005, the Network spent time reviewing the Fistula First Breakthrough Initiative, successes to date, and the expectations for the project with the QIO representatives. The Immunization workgroup focused on identifying all available resources through the QIOs and Network. The QIOs forwarded a packet of their materials to each of the dialysis facilities in their respective states.

Monthly conference calls were held for each workgroup to establish the mission, vision and goals of each. Additional coalition activities will be established at the January 2006 face-to-face meeting in Kansas City.

Figure 22

Organization	Format	Network Participant(s)
CMS FF Core Group Call	Teleconference	QID, PSC
CMS FF Marketing & Communication	Teleconference	ED
CMS/ED/QID/PSC	Teleconference	ED, QID, QIS, PSC
CMS/SA/NW	Teleconference	ED, QID, QIS, PSC
CMS Pandemic Awareness	Teleconference	ED, QID, QIS
Coalition Building	Teleconference	ED, QID, QIS, PSC
CROWN Technical Call	Teleconference	ED, DM, QID, QIS
Data Managers	Teleconference	DM
Disaster Planning	Kansas City area Non-Profits	ED, QID
DPC Pilot Trainings	In-House Training	QID, QIS, PSC
End of Life Special Project with Network of New England	Teleconference	PSC
FF Surgeons Data Project	Teleconference	ED, QID, QIS
FF MRB Committee	Teleconference	QID, QIS
Fresenius Medical Care Collaboration	Teleconference	QID, QIS
LEAN Community	Teleconference	ED, QID, DM, PSC
Missouri Kidney Program	Ad-Hoc Advisory Committee	ED
National Patient Services Coordinators	Teleconference	PSC
National Kidney Foundation	Shirley Melton Awards Banquet	PSC
National Kidney Foundation	Early Intervention & Prevention Committee	ED
OIG Study	Teleconference	ED, QID, QIS, DM
Quality Improvement Directors Call	Teleconference	QID
QIO/NW Coalition FF	Teleconference	QID, QIS
QIO/NW Coalition Immunization	Teleconference	QID, QIS
Security WebEx	Teleconference	All Network Staff
Tom Wolff, Consultant	Teleconference	ED, QID, QIS
KEY	CMS-Centers for Medicare & Medicaid Services DM-Information Systems Director ED-Executive Director FF-Fistula First PSC-Patient Services Coordinator	QID-Quality Improvement Director QIS-Quality Improvement Specialist SA-State Agency

CMS Goal #4: Support the Marketing, Deployment, and Maintenance of CMS-Approved software; i.e., CROWN—Consolidated Renal Operations in a Web-Enabled Network

Summary of Activities

As previously defined, VISION is a software program that allows facilities to enter CMS forms and patient event changes into a Network compatible database. VISION eligibility is exclusive to hospital-based and free-standing, independent facilities. Network 12 continued to demonstrated its leadership in training and implementing VISION during 2005 by exceeding the CMS goal.

VISION Training Activities

Approximately 28 facilities were recruited and trained during the first quarter of 2005; one facility's staff was retrained at the Network office. A budget was submitted and approved to continue support of the VISION program. VISION training's took place in April and were held at New Horizons Computer Training Centers in the following locations:

- Overland Park, KS on April 13;
- St. Louis, MO on April 14;
- Omaha, NE on April 27;
- Des Moines, IA on April 28.

By the end of the second quarter, 49 units were submitting data using VISION, far exceeding the CMS goal for the 2004-2005 contract year. Of the 11 facilities trained in April 2005, 11 were submitting electronically with VISION software.

CMS released the new training deliverables for the contract year 2005-2006, which started July 1, 2005. The new deliverable required the Network train 50 percent of units eligible to use VISION. The definition of eligible units includes all units except those owned by DaVita, Dialysis Clinic, Inc., Fresenius Medical Care and Renal Advantage. The deliverable also required Network 12 to have 25 percent of the eligible units using VISION.

Network 12 met and far exceeded this contract deliverable. In 2005, Network 12 reported 76 percent of eligible facilities were trained and 54 percent operational according to the August 2005 CSC report, "Network 12 VISION Eligible."

CMS Goal #5 Evaluate and Resolve Patient Grievances as Categorized in the Standard Information Management System (SIMS)

Overview of the Grievance Process

The following is a general overview of the Network 12 Grievance Procedure, steps of which are primarily dictated by the CMS contract:

- A written grievance is received at the Network office.
- The Network staff notifies the grievant through certified mail acknowledging receipt of grievance.
- Network staff ascertains what steps the patient has taken previously to resolve the problem and the patient’s goal(s).
- Network staff notifies the ESRD provider or physician’s office of the grievance and request a response to the concern that may include a request for specific records. Notification is sent via certified, return receipt requested mailing.
- Network staff reviews documents and removes all identifiers from information provided by all parties.
- The Grievance Committee reviews the case and either makes a determination regarding patient care, asks for additional information, or refers the case to the Medical Review Board.
- Network staff drafts a response to the grievant, which is sent to the facility or physician for review and comment.
- The grievant is notified of the Grievance Committee’s decision including facility or physician comments and their appeal rights.

A facility visit may be necessary at any time during this process due to the nature of the complaint. Matters serious enough to be an immediate threat to the patient’s or other patients’ health and safety are referred immediately to the appropriate State Survey Agency.

If care problems are found, the Medical Review Board may request an improvement plan from the facility. If the facility is not successful in correcting the identified problem within the time frame of the improvement plan, the MRB with support of the Executive Committee may recommend that CMS sanction the facility. A grievant not satisfied with the Network’s findings in a case, may appeal the decision to CMS Region VII office.

2005 Complaint and Grievance Activity

Thirty patient complaint packets were mailed to concerned individuals with complaints in 2005. Of the 30 packets mailed, twelve grievance forms were received in the Network office. Only one of the 12 forms received was within the scope of the Network and required formal investigation. Three of the remaining eleven were

Figure 23

2005 Grievances Allegations	
Type of Allegation ¹	No.
Treatment Related/Quality of care ²	4

¹ Allegation types are restricted to those available within the Standardized Information Management System software contacts module. Grievances are recorded according to type that best categorizes the complaint of those categories listed.

² Allegations in these cases involved nurse licensure, patient-to-staff ratios, and overall poor care.

referred to other agencies, three were outside the scope of the Network, two were withdrawn by the beneficiary and the remaining three were internally reviewed by the Network staff and Grievance Committee Chair and found without merit.

Figure 24

2005 Grievances Resolutions	
Type of Resolution	No.
Staff education on facility policies and procedures	1
Facility encouraged to uniformly enforce policies and procedures	1
Allegation without merit	1
Referral to State Survey Agency	1

The PSC revised and developed algorithms for each pathway a beneficiary call can navigate through the system. This includes a formal grievance with corrective action requested and subsequent Network oversight. The algorithms will be presented to the Medical Review Board and Executive Committee for acceptance and

distribution to each Medicare approved facility in the summer of 2006.



Sanction Recommendations

No sanctions were recommended or imposed by Network 12 during 2005.

5

Recommendations for Additional Facilities

During 2005, six dialysis units opened, which is a 2.59% growth over the previous year (see figure 19 below). As of December 31, 2005, Network 12 consisted of the following types of facilities:

- 4 Organ Procurement Agencies
- 17 Medicare-certified Transplant Centers (three of which are Veterans Administration facilities)
- 237 Medicare-certified Dialysis Providers (including units offering outpatient, home training, and acute-only services)
- 5 Veterans Administration or Federal Prison System Dialysis Providers

Figure 25 below, tracks a decade of facility growth in the four-state region showing fairly conservative growth through 1995 followed by three years of double-digit expansion.

Figure 25

Dialysis Facility Counts and Growth by Calendar Year		
Year	Facility Count	Average Percent Growth
1995	137	5.38%
1996	159	16.05%
1997	184	15.72%
1998	204	10.87%
1999	205	0.49%
2000	215	4.88%
2001	219	1.86%
2002	226	3.20%
2003	228	0.88%
2004	231	1.31%
2005	237	2.59%

6

Data Tables

2005 Network 12 Incidence Data

Incidence reflects the number of persons who were newly diagnosed as having ESRD during a calendar year. The data show the number of newly diagnosed patients who started renal replacement therapy (dialysis or transplant) in 2005. Patients are not included if they are returning to dialysis following rejection of a kidney transplant or if they are existing ESRD patients transferring from another region into one of the four Network 12 states.

Incidence rates, standardized on the same unit of population, are useful for future population projections, long-range healthcare planning and for comparison among regions. Caution is required in interpreting data where there is a small population base. In such areas, a difference of only a small number of patients can make the rates in different years appear to vary considerably. Incidence rates become more meaningful as the population base increases in size.

2005 Network 12 Prevalence Data

Prevalence reflects the number of people on chronic maintenance dialysis in the Network on December 31, 2005. Patients are reported as to their geographic residence to determine and compare prevalence rates. These data do not include individuals with functioning renal transplants or those patients who are treated in a contiguous state. A prevalence rate will indicate if a certain disease is significantly more commonplace in some areas than in others. It can be applied to future population projections used for long-range health care planning.

Special Note on Data Tabulation

The data tables and charts include only patients who are dialyzing or received a renal transplant at a facility located within the Network's four-state area. Additionally, tabulations are exclusive to those patients for whom the necessary documents have been filed; i.e., Medical Evidence Reports (CMS 2728 forms) or ESRD Death Notifications (CMS 2746). Patient modality or status changes are confirmed with the Annual Facility Survey and Renal Management Information System (REMIS).

ESRD Network 12
Table #1

**Newly Diagnosed Chronic ESRD Patients
(ESRD Incidence)**

Newly diagnosed chronic ESRD patients by state of residence, age, gender, race and primary diagnosis
for calendar year 2005

Age Group	IA	KS	MO	NE	Other	Total
00-04	0	0	1	4	0	5
05-09	0	0	4	1	3	8
10-14	2	5	4	0	3	14
15-19	3	7	11	1	5	27
20-24	6	8	11	3	2	30
25-29	10	10	27	8	2	57
30-34	24	15	45	8	4	96
35-39	10	21	63	10	2	106
40-45	25	36	84	18	2	165
45-49	36	42	122	32	14	246
50-54	46	59	151	46	8	310
55-59	60	85	193	51	12	401
60-64	81	82	207	39	15	424
65-69	94	74	225	55	12	460
70-74	94	98	238	64	16	510
75-79	95	99	241	63	6	504
80-84	111	91	196	49	15	462
>=85	59	46	118	48	1	272
Missing	0	0	0	0	0	0
Total	756	778	1941	500	122	4097
Gender						
Female	332	334	894	215	53	1828
Male	424	444	1047	285	69	2269
Missing	0	0	0	0	0	0
Total	756	778	1941	500	122	4097
Race						
American Indian/Alaska Native	3	5	4	14	1	27
Asian	10	7	12	2	0	31
Black or African	55	142	579	58	22	856
More than one race selected	1	1	4	0	0	6
Native Hawaiian or Other Pacific Islander	1	4	4	0	1	10
White	689	619	1338	426	98	3167
Missing	0	0	0	0	0	0
Total	756	778	1941	500	122	4097
Primary Diagnosis						
Cystic Kidney	18	26	53	16	6	119
Diabetes	323	322	832	213	56	1746
Glomerulonephritis	73	85	139	28	8	333
Hypertension	180	210	607	144	21	1162
Other	124	98	213	77	23	535
Other Urologic	18	14	37	7	2	78
Missing	0	0	0	0	0	0
Unknown	20	23	60	15	6	124
Total	756	778	1941	500	122	4097

Source of information: Network SIMS Database

Date of Preparation: June 2006

Race: The categories are from the CMS-2728 Form.

Diagnosis: Categories are from the CMS-2728. A diagnosis of 'unknown' is ICD-9 code 7999.

This table cannot be compared to the CMS facility survey because the CMS Facility Survey is limited to dialysis patients receiving outpatient services from Medicare approved dialysis facilities.

This table includes 109 patients with transplant therapy as an initial treatment.

This table includes 48 patients receiving treatment at VA facilities.

ESRD Network 12
Table #2

**Living ESRD Dialysis Patients
(ESRD Dialysis Prevalence)**

All active Dialysis Patients by state of residence, age, race, gender and primary diagnosis
as of December 31, 2005.

Age Group	IA	KS	MO	NE	Other	Total
00-04	0	1	1	2	0	4
05-09	0	0	3	2	2	7
10-14	3	5	6	1	2	17
15-19	7	8	28	7	3	53
20-24	15	24	60	11	6	116
25-29	37	39	88	19	10	193
30-34	47	71	169	30	19	336
35-39	52	81	261	43	17	454
40-45	89	116	343	70	24	642
45-49	131	176	459	107	42	915
50-54	146	189	599	112	54	1100
55-59	192	264	692	161	59	1368
60-64	218	273	701	148	56	1396
65-69	253	239	713	155	48	1408
70-74	270	265	642	159	47	1383
75-79	299	237	637	163	48	1384
80-84	253	184	454	124	27	1042
>=85	160	103	287	77	20	647
Missing	0	0	0	0	0	0
Total	2172	2275	6143	1391	484	12465
Gender						
Female	1013	1072	2822	612	182	5701
Male	1159	1203	3321	779	302	6764
Missing	0	0	0	0	0	0
Total	2172	2275	6143	1391	484	12465
Race						
American Indian/Alaska Native	14	33	10	58	5	120
Asian	33	26	37	15	1	112
Black or African	207	574	2501	229	162	3673
More than one race selected	1	2	2	1	0	6
Native Hawaiian or Other Pacific Islander	4	13	12	2	0	31
White	1913	1627	3581	1086	316	8523
Missing	0	0	0	0	0	0
Total	2172	2275	6143	1391	484	12465
Primary Diagnosis						
Cystic Kidney	73	79	164	44	12	372
Diabetes	891	956	2490	622	169	5128
Glomerulonephritis	280	340	650	155	55	1480
Hypertension	505	502	1944	338	138	3427
Other	290	254	567	141	57	1309
Other Urologic	60	56	129	27	6	278
Missing	0	0	0	0	0	0
Unknown	73	88	199	64	47	471
Total	2172	2275	6143	1391	484	12465

Source of information: Network SIMS Database

Date of Preparation: June 2006

Race: The categories are from the CMS-2728 Form.

Diagnosis: Categories are from the CMS-2728. A diagnosis of 'unknown' is ICD-9 code 7999.

This table cannot be compared to the CMS facility survey because the CMS Facility Survey is limited to dialysis patients receiving outpatient services from Medicare approved dialysis facilities.

The numbers may not reflect the true point prevalence due to different definitions for transient patients.

This table includes 114 patients receiving treatment at VA facilities.

Table #3

Dialysis Modality
 Number of living patients by modality by dialysis facility self-care
 settings as of December 31, 2004 and December 31, 2005
Self-Care Settings - Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
160005	0	0	0	0	0	0	0	0	0	0
160016	0	0	0	0	2	1	0	0	2	1
160020#	0	0	0	0	0	0	0	0	0	0
160030	0	0	3	2	0	0	0	0	3	2
160033	0	0	0	0	0	0	0	0	0	0
160044	0	0	0	0	0	0	0	0	0	0
160048	0	0	0	0	0	0	0	0	0	0
16004F	0	0	0	0	0	0	0	0	0	0
160058	18	19	0	2	7	2	0	0	25	23
160064	0	0	0	0	2	0	0	0	2	0
160066^	0	0	0	0	0	0	0	0	0	0
160067	0	0	0	0	1	0	0	0	1	0
160079	0	0	0	0	0	0	0	0	0	0
160080	0	0	0	0	0	0	0	0	0	0
160083	0	0	0	0	0	0	0	0	0	0
160089	0	0	0	0	0	0	0	0	0	0
160112	0	0	0	0	0	0	0	0	0	0
160113	0	0	0	0	0	0	0	0	0	0
161329	0	0	0	0	0	0	0	0	0	0
162500	0	0	8	4	2	3	0	0	10	7
162501	0	0	10	8	15	9	0	0	25	17
162506	0	0	0	0	0	0	0	0	0	0
162507	0	0	0	0	0	0	0	0	0	0
162508	0	0	0	0	0	0	0	0	0	0
162509	0	0	4	6	4	3	0	0	8	9
162511	0	0	0	0	0	0	0	0	0	0
162512	0	0	0	0	0	0	0	0	0	0
162513	0	0	0	0	0	0	0	0	0	0
162514	0	0	0	0	0	0	0	0	0	0
162515	2	3	7	8	14	9	0	0	23	20
162516	0	0	0	0	6	7	0	0	6	7
162517	0	0	0	0	0	0	0	0	0	0
162518	0	0	0	0	1	1	0	0	1	1
162519	0	0	0	0	0	0	0	0	0	0
162520	0	0	0	0	0	0	0	0	0	0
162522	0	0	0	0	0	0	0	0	0	0
162523	0	0	0	0	0	0	0	0	0	0
162524	0	0	0	0	0	0	0	0	0	0
162525	0	0	0	0	0	0	0	0	0	0
162526	0	0	0	0	0	0	0	0	0	0
162527	0	0	0	0	0	0	0	0	0	0
162528	0	0	0	0	0	0	0	0	0	0
162529	0	0	6	9	5	2	0	1	11	12
162530	0	0	0	0	0	0	0	0	0	0
162532	0	0	8	17	16	10	0	0	24	27
162533#	0	0	0	8	0	1	0	0	0	9

Table #3

Dialysis Modality

Number of living patients by modality by dialysis facility self-care settings as of December 31, 2004 and December 31, 2005

Self-Care Settings - Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
163501	0	0	0	0	0	0	0	0	0	0
163502	0	0	0	0	0	0	0	0	0	0
163503	0	0	0	0	0	0	0	0	0	0
163504	0	0	0	0	0	0	0	0	0	0
163505	0	0	0	0	0	0	0	0	0	0
163506	0	0	0	0	0	0	0	0	0	0
163507	0	0	0	0	0	0	0	0	0	0
163508	0	0	0	0	0	0	0	0	0	0
163509	0	0	0	0	0	0	0	0	0	0
163510	0	0	0	0	0	0	0	0	0	0
163513	0	0	0	0	0	0	0	0	0	0
163514	0	0	4	4	12	12	0	0	16	16
IA Total	20	22	50	68	87	60	0	1	157	151
170017	0	0	0	0	0	0	0	0	0	0
170040	4	3	6	4	11	7	0	0	21	14
172501	0	0	3	5	1	1	0	0	4	6
172502	0	0	3	1	4	9	0	0	7	10
172503	0	0	63	56	7	18	0	0	70	74
172504	5	7	32	40	13	20	0	0	50	67
172505	0	0	0	0	0	0	0	0	0	0
172506	0	0	0	0	0	0	0	0	0	0
172507	0	0	0	0	0	0	0	0	0	0
172508	0	2	15	21	29	21	0	0	44	44
172509	0	0	13	13	29	30	0	0	42	43
172510	0	0	0	0	0	0	0	0	0	0
172511	0	0	0	0	0	0	0	0	0	0
172512	0	0	0	0	0	0	0	0	0	0
172514	0	0	0	0	0	0	0	0	0	0
172515	0	0	0	0	0	0	0	0	0	0
172516	0	0	0	0	0	0	0	0	0	0
172517	0	0	0	0	0	0	0	0	0	0
172518	0	0	0	0	0	0	0	0	0	0
172519	0	0	0	0	0	0	0	0	0	0
172520	0	0	0	1	0	0	0	0	0	1
172521	0	0	0	0	0	0	0	0	0	0
172522	0	0	0	0	0	0	0	0	0	0
172523	0	0	0	0	0	0	0	0	0	0
172524	1	0	0	0	0	0	0	0	1	0
172525	0	0	0	0	0	0	0	0	0	0
172526	0	0	0	0	0	0	0	0	0	0
172527	1	0	2	3	0	0	0	0	3	3
172528	0	0	0	0	0	0	0	0	0	0
172529	0	0	0	0	0	0	0	0	0	0
172530	0	0	0	0	0	0	0	0	0	0
172531	0	0	0	0	55	0	0	0	0	0

Table #3

Dialysis Modality

Number of living patients by modality by dialysis facility self-care settings as of December 31, 2004 and December 31, 2005

Self-Care Settings - Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
172532	0	0	0	0	0	0	0	0	0	0
172533	0	0	0	0	0	0	0	0	0	0
172534	0	0	0	0	0	0	0	0	0	0
172535	0	0	0	0	0	0	0	0	0	0
172536	0	0	0	0	0	0	0	0	0	0
172537	0	0	0	0	0	0	0	0	0	0
172538	0	0	0	0	0	0	0	0	0	0
172539	0	0	0	0	0	0	0	0	0	0
172540	0	0	0	0	0	0	0	0	0	0
172541	0	0	0	0	0	0	0	0	0	0
172542	0	0	0	0	0	0	0	0	0	0
172543	0	2	0	0	0	0	0	0	0	2
KS Total	11	14	137	144	94	106	0	0	242	264
260020	0	0	0	0	0	0	0	0	0	0
260027	0	0	0	0	0	0	0	0	0	0
260031^	0	0	0	0	0	0	0	0	0	0
260040	0	0	0	0	0	0	0	0	0	0
26004F	0	0	3	2	9	6	0	0	12	8
26008F	0	0	2	2	0	0	0	0	2	2
26009F	0	0	0	0	4	4	0	0	4	4
260100	0	0	0	0	0	0	0	0	0	0
260113	0	0	1	5	3	4	0	0	4	9
260137	0	0	1	3	0	2	0	0	1	5
260141	0	0	1	0	0	0	0	0	1	0
260172	0	0	0	0	0	0	0	0	0	0
260179	0	0	0	0	0	0	0	0	0	0
260180	0	0	0	0	0	0	0	0	0	0
262501	1	1	10	7	30	26	0	0	41	34
262502	0	0	0	0	0	0	0	0	0	0
262503	0	0	1	1	0	0	0	0	1	1
262504	0	0	3	6	29	29	0	0	32	35
262505	0	0	0	0	0	0	0	0	0	0
262506	6	6	32	30	15	24	0	0	53	60
262507	0	1	3	2	5	5	0	0	8	8
262508	1	1	23	17	22	24	0	0	46	42
262509	0	0	0	0	0	0	0	0	0	0
262511	0	0	0	0	0	0	0	0	0	0
262513	0	0	0	0	0	0	0	0	0	0
262514	3	2	16	20	16	10	0	0	35	32
262515	0	0	0	0	0	0	0	0	0	0
262516	0	0	0	0	0	0	0	0	0	0
262517	10	9	2	1	13	11	0	0	25	21
262520	0	0	0	0	0	0	0	0	0	0
262521	1	0	2	3	6	8	0	0	9	11
262522	0	0	0	0	56	0	0	0	0	0

Table #3

Dialysis Modality

Number of living patients by modality by dialysis facility self-care
settings as of December 31, 2004 and December 31, 2005

Self-Care Settings - Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
262523	0	0	0	0	0	1	0	0	0	1
262524	0	0	0	0	0	0	0	0	0	0
262526	0	0	0	0	0	0	0	0	0	0
262527	0	0	0	1	0	0	0	0	0	1
262528	1	3	0	2	5	4	0	0	6	9
262530	0	0	0	0	0	0	0	0	0	0
262531	0	0	0	0	0	0	0	0	0	0
262534	0	1	0	0	0	0	0	0	0	1
262535	0	0	0	0	0	0	0	0	0	0
262536	0	0	2	2	7	6	0	0	9	8
262537	0	0	0	0	0	0	0	0	0	0
262538	0	0	0	0	0	0	0	0	0	0
262539	0	0	0	0	0	0	0	0	0	0
262540	0	0	3	2	4	4	0	0	7	6
262541	0	0	1	8	24	24	0	0	25	32
262542	0	0	0	0	0	0	0	0	0	0
262543	0	0	3	4	10	12	0	0	13	16
262544	0	0	0	2	1	1	0	0	1	3
262547	0	0	24	26	30	25	0	0	54	51
262548	0	0	0	0	0	0	0	0	0	0
262549	1	2	2	2	32	23	0	0	35	27
262550	0	0	0	0	0	0	0	0	0	0
262551	0	0	0	0	0	0	0	0	0	0
262552	0	0	0	0	0	0	0	0	0	0
262553	0	0	0	0	0	0	0	0	0	0
262554	0	0	0	1	2	3	0	0	2	4
262555	0	0	0	0	0	0	0	0	0	0
262556	0	0	0	0	0	0	0	0	0	0
262557	0	0	0	0	0	0	0	0	0	0
262559	0	0	0	0	0	0	0	0	0	0
262560	1	1	2	2	1	2	0	0	4	5
262561	0	0	3	6	9	10	0	0	12	16
262562	0	0	4	4	11	10	0	0	15	14
262563	2	1	0	1	1	0	0	0	3	2
262564	0	0	18	9	19	30	0	0	37	39
262565	5	3	45	43	10	16	0	0	60	62
262567	0	0	1	0	0	3	0	0	1	3
262568	0	0	0	0	0	0	0	0	0	0
262569	0	0	0	1	0	0	0	0	0	1
262570	0	0	0	0	0	0	0	0	0	0
262572	0	0	3	3	6	7	0	0	9	10
262573	0	0	0	0	0	0	0	0	0	0
262574	0	0	1	0	0	0	0	0	1	0
262575	0	0	0	0	0	0	0	0	0	0
262576	0	0	8	7	9	14	0	0	17	21
262577	0	0	0	0	0	0	0	0	0	0

Table #3

Dialysis Modality

Number of living patients by modality by dialysis facility self-care
settings as of December 31, 2004 and December 31, 2005

Self-Care Settings - Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
262578	0	0	0	0	0	0	0	0	0	0
262579	0	0	0	0	0	1	0	0	0	1
262580	0	0	1	2	2	3	0	0	3	5
262581	0	0	0	0	0	0	0	0	0	0
262582	0	0	0	0	0	0	0	0	0	0
262583	0	0	0	0	0	0	0	0	0	0
262584	0	0	0	1	0	0	0	0	0	1
262585	0	0	5	3	40	41	0	0	45	44
262586	24	0	3	0	4	0	0	0	31	0
262587	0	0	1	0	0	0	0	0	1	0
262588	0	0	0	0	0	0	0	0	0	0
262589	0	0	0	0	0	0	0	0	0	0
262590	0	0	0	0	0	0	0	0	0	0
262591	0	0	9	6	1	12	0	0	10	18
262592	0	0	0	0	0	0	0	0	0	0
262593	0	0	0	2	2	1	0	0	2	3
262594	0	0	4	4	12	8	0	0	16	12
262595	0	0	0	0	0	0	0	0	0	0
262596	0	0	0	0	0	0	0	0	0	0
262597	0	0	2	1	6	5	0	0	8	6
262598	0	0	0	0	0	0	0	0	0	0
262599	0	0	0	0	0	0	0	0	0	0
262600	0	0	0	0	1	0	0	0	1	0
262601	0	0	4	1	0	1	0	0	4	2
262602	0	0	0	0	0	0	0	0	0	0
262603	0	0	3	0	3	5	0	0	6	5
262604	0	0	1	1	0	0	0	0	1	1
262605	0	0	0	1	0	0	0	0	0	1
262606	0	0	3	3	10	14	0	0	13	17
262607	0	0	0	0	0	0	0	0	0	0
262609#	0	0	0	0	0	0	0	0	0	0
262610#	0	0	0	0	0	0	0	0	0	0
262611#	0	0	0	0	0	0	0	0	0	0
263300	0	0	1	0	1	0	0	0	2	0
263301	0	0	0	0	10	7	0	0	10	7
263302	1	1	0	0	9	5	0	0	10	6
263503	0	0	0	0	0	0	0	0	0	0
263506	0	0	40	40	8	5	0	0	48	45
263508	0	0	1	0	0	0	0	0	1	0
263510	0	0	0	0	0	0	0	0	0	0
MO Total	57	32	298	290	442	456	0	0	797	778
280020	0	0	0	0	0	0	0	0	0	0
280039	0	0	0	0	0	0	0	0	0	0
28006F	0	0	0	0	0	0	0	0	0	0
280088^	0	0	0	0	58	0	0	0	0	0

Table #3

Dialysis Modality

Number of living patients by modality by dialysis facility self-care
settings as of December 31, 2004 and December 31, 2005

Self-Care Settings - Home

Provider	HEMO		CAPD		CCPD		IPD		TOTAL	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
280118	0	0	0	0	0	0	0	0	0	0
280125	0	0	0	2	0	0	0	0	0	2
281325	0	0	0	0	0	0	0	0	0	0
281329	0	0	0	0	0	0	0	0	0	0
281341	0	0	0	0	0	0	0	0	0	0
281344	0	0	0	0	0	0	0	0	0	0
282500	6	20	16	14	17	14	0	0	39	48
282501	0	1	9	11	17	14	0	0	26	26
282502	0	0	0	0	0	0	0	0	0	0
282503	1	1	8	8	8	8	0	0	17	17
282504	0	0	1	0	15	13	0	0	16	13
282505^	0	0	0	0	0	0	0	0	0	0
282506	0	0	0	0	0	0	0	0	0	0
282507	0	0	0	0	0	0	0	0	0	0
282508	0	0	0	0	0	0	0	0	0	0
282509	0	1	0	0	0	0	0	0	0	1
282510	1	0	0	0	0	0	0	0	1	0
282511	0	0	0	0	0	0	0	0	0	0
282512	0	0	0	0	0	0	0	0	0	0
282513	0	0	0	0	0	0	0	0	0	0
282514	0	0	0	0	0	0	0	0	0	0
282515	0	0	3	4	8	11	0	0	11	15
282516	0	0	11	15	3	2	0	0	14	17
282517	0	0	0	0	0	0	0	0	0	0
282518	0	0	0	0	0	0	0	0	0	0
282519	0	0	2	3	7	13	0	0	9	16
282520	2	5	16	10	4	6	0	0	22	21
282521	0	0	0	0	0	0	0	0	0	0
282522	0	0	1	0	0	0	0	0	1	0
282523	0	0	0	2	1	1	0	0	1	3
282524	0	0	0	0	0	0	0	0	0	0
282525	0	0	0	0	0	0	0	0	0	0
NE Total	10	28	67	69	80	82	0	0	157	179
NETWORK Total	98	96	552	571	703	704	0	1	1353	1372

Source of Information: Facility Survey (CMS 2744) and Network SIMS Database

Date of Preparation: June 2006

This table includes 16 Veterans Affairs Facility patients for 2004 and 12 Veterans Affairs Facility patients for 2005.

Provider not operational in 2004

^ Provider not operational in 2005

Table #4

Dialysis Modality

Number of living patients by modality by dialysis facility
in-center as of December 31, 2004 and December 31, 2005

In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME & IN-CENTER*	
	2004	2005	2004	2005	2004	2005	2004	2005
160005	20	27	0	0	20	27	20	27
160016	64	70	0	0	64	70	66	71
160020#	0	13	0	0	0	13	0	13
160030	29	40	0	0	29	40	32	42
160033	111	107	0	0	111	107	111	107
160044	25	25	0	0	25	25	25	25
160048	17	16	0	0	17	16	17	16
16004F	5	4	0	0	5	4	5	4
160058	58	37	0	0	58	37	83	60
160064	61	64	0	0	61	64	63	64
160066^	0	0	0	0	0	0	0	0
160067	46	46	0	0	46	46	47	46
160079	7	9	0	0	7	9	7	9
160080	60	59	0	0	60	59	60	59
160083	0	0	0	0	0	0	0	0
160089	64	67	0	0	64	67	64	67
160112	26	23	0	0	26	23	26	23
160113	15	10	0	0	15	10	15	10
161329	13	15	0	0	13	15	13	15
162500	127	118	0	0	127	118	137	125
162501	119	57	0	0	119	57	144	74
162506	43	55	0	0	43	55	43	55
162507	31	36	0	0	31	36	31	36
162508	11	11	0	0	11	11	11	11
162509	28	35	0	0	28	35	36	44
162511	23	20	0	0	23	20	23	20
162512	53	61	0	0	53	61	53	61
162513	47	52	0	0	47	52	47	52
162514	17	15	0	0	17	15	17	15
162515	106	99	0	0	106	99	129	119
162516	111	101	0	0	111	101	117	108
162517	25	30	0	0	25	30	25	30
162518	42	39	0	0	42	39	43	40
162519	11	8	0	0	11	8	11	8
162520	13	13	0	0	13	13	13	13
162522	16	17	0	0	16	17	16	17
162523	8	17	0	0	8	17	8	17
162524	22	15	0	0	22	15	22	15
162525	38	45	0	0	38	45	38	45
162526	25	25	0	0	25	25	25	25
162527	42	47	0	0	42	47	42	47
162528	20	18	0	0	20	18	20	18
162529	28	52	0	0	28	52	39	64
162530	10	13	0	0	10	13	10	13
162532	92	96	0	0	92	96	116	123

Table #4

Dialysis Modality
 Number of living patients by modality by dialysis facility
 in-center as of December 31, 2004 and December 31, 2005
In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME & IN-CENTER*	
	2004	2005	2004	2005	2004	2005	2004	2005
162533#	0	53	0	0	0	53	0	62
163501	41	45	0	0	41	45	41	45
163502	20	19	0	0	20	19	20	19
163503	13	15	0	0	13	15	13	15
163504	29	31	0	0	29	31	29	31
163505	27	28	0	0	27	28	27	28
163506	18	19	0	0	18	19	18	19
163507	13	10	0	0	13	10	13	10
163508	10	12	0	0	10	12	10	12
163509	19	22	0	0	19	22	19	22
163510	11	12	0	0	11	12	11	12
163513	15	15	0	0	15	15	15	15
163514	120	141	1	0	121	141	137	157
IA Total	2065	2149	1	0	2066	2149	2223	2300
170017	26	21	0	0	26	21	26	21
170040	98	97	0	0	98	97	119	111
172501	64	74	0	0	64	74	68	80
172502	81	77	0	0	81	77	88	87
172503	87	92	0	0	87	92	157	166
172504	88	81	0	0	88	81	138	148
172505	20	24	0	0	20	24	20	24
172506	35	36	0	0	35	36	35	36
172507	39	39	0	0	39	39	39	39
172508	135	154	0	0	135	154	179	198
172509	40	43	0	0	40	43	82	86
172510	24	23	0	0	24	23	24	23
172511	38	42	0	0	38	42	38	42
172512	26	24	0	0	26	24	26	24
172514	42	43	0	0	42	43	42	43
172515	24	32	0	0	24	32	24	32
172516	16	17	0	0	16	17	16	17
172517	32	40	0	0	32	40	32	40
172518	27	35	0	0	27	35	27	35
172519	88	94	0	0	88	94	88	94
172520	68	79	0	0	68	79	68	80
172521	54	51	0	0	54	51	54	51
172522	38	29	0	0	38	29	38	29
172523	66	91	0	0	66	91	66	91
172524	51	47	0	0	51	47	52	47
172525	15	14	0	0	15	14	15	14
172526	32	34	0	0	32	34	32	34
172527	42	43	0	0	42	43	45	46
172528	30	27	0	0	30	27	30	27
172529	18	17	0	0	18	17	18	17

Table #4

Dialysis Modality
 Number of living patients by modality by dialysis facility
 in-center as of December 31, 2004 and December 31, 2005
In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME & IN-CENTER*	
	2004	2005	2004	2005	2004	2005	2004	2005
172530	20	23	0	0	20	23	20	23
172531	26	24	0	0	26	24	26	24
172532	29	31	0	0	29	31	29	31
172533	70	70	0	0	70	70	70	70
172534	15	19	0	0	15	19	15	19
172535	30	27	0	0	30	27	30	27
172536	55	52	0	0	55	52	55	52
172537	24	22	0	0	24	22	24	22
172538	13	12	0	0	13	12	13	12
172539	0	0			0	0	0	0
172540	33	43	0	0	33	43	33	43
172541	34	38	0	0	34	38	34	38
172542	38	39	0	0	38	39	38	39
172543	30	51	0	0	30	51	30	53
KS Total	1861	1971	0	0	1861	1971	2103	2235
260020	1	0		0	1	0	1	0
260027	40	46	0	0	40	46	40	46
260031^	0	0		0	0	0	0	0
260040	32	35	0	0	32	35	32	35
26004F	21	30	0	0	21	30	33	38
26008F	120	114			120	114	122	116
26009F	27	27	0	0	27	27	31	31
260100	25	24	0	0	25	24	25	24
260113	91	97	0	0	91	97	95	106
260137	20	33	0	0	20	33	21	38
260141	2	0	0	0	2	0	3	0
260172	15	14	0	0	15	14	15	14
260179	1	0			1	0	1	0
260180	0	0			0	0	0	0
262501	89	97	0	0	89	97	130	131
262502	167	170	0	0	167	170	167	170
262503	103	101	0	0	103	101	104	102
262504	66	59	0	0	66	59	98	94
262505	37	36	0	0	37	36	37	36
262506	112	85	2	0	114	85	167	145
262507	34	48	0	0	34	48	42	56
262508	113	119	1	0	114	119	160	161
262509	73	76	0	0	73	76	73	76
262511	53	53	0	0	53	53	53	53
262513	30	32	0	0	30	32	30	32
262514	48	51	0	0	48	51	83	83
262515	56	66	0	0	56	66	56	66
262516	32	31	0	0	32	31	32	31
262517	96	111	0	0	96	111	121	132

Table #4

Dialysis Modality
 Number of living patients by modality by dialysis facility
 in-center as of December 31, 2004 and December 31, 2005
In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME & IN-CENTER*	
	2004	2005	2004	2005	2004	2005	2004	2005
262520	44	36	0	0	44	36	44	36
262521	53	47	0	0	53	47	62	58
262522	19	18	0	0	19	18	19	18
262523	19	22	0	0	19	22	19	23
262524	21	26	0	0	21	26	21	26
262526	18	20	0	0	18	20	18	20
262527	112	114	0	0	112	114	112	115
262528	60	61	0	0	60	61	66	70
262530	42	47	0	0	42	47	42	47
262531	47	58	0	0	47	58	47	58
262534	39	28	0	0	39	28	39	29
262535	95	81	0	0	95	81	95	81
262536	42	55	0	0	42	55	51	63
262537	129	130	0	0	129	130	129	130
262538	49	57	0	0	49	57	49	57
262539	101	103	0	0	101	103	101	103
262540	33	30	0	0	33	30	40	36
262541	58	60	0	0	58	60	83	92
262542	46	51	0	0	46	51	46	51
262543	80	72	0	0	80	72	93	88
262544	107	116	0	0	107	116	108	119
262547	115	91	0	0	115	91	169	142
262548	38	31	0	0	38	31	38	31
262549	125	125	0	0	125	125	160	152
262550	47	43	0	0	47	43	47	43
262551	65	67	0	0	65	67	65	67
262552	32	36	0	0	32	36	32	36
262553	57	49	0	0	57	49	57	49
262554	55	63	0	0	55	63	57	67
262555	38	37	0	0	38	37	38	37
262556	67	78	0	0	67	78	67	78
262557	20	16	0	0	20	16	20	16
262559	31	28	0	0	31	28	31	28
262560	54	56	0	0	54	56	58	61
262561	53	57	0	0	53	57	65	73
262562	47	52	0	0	47	52	62	66
262563	65	65	0	0	65	65	68	67
262564	130	122	3	0	133	122	170	161
262565	161	153	0	0	161	153	221	215
262567	27	25	0	0	27	25	28	28
262568	35	35	0	0	35	35	35	35
262569	49	53	0	0	49	53	49	54
262570	25	29	0	0	25	29	25	29
262572	60	55	0	0	60	55	69	65
262573	31	35	0	0	31	35	31	35

Table #4

Dialysis Modality

Number of living patients by modality by dialysis facility
in-center as of December 31, 2004 and December 31, 2005

In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME & IN-CENTER*	
	2004	2005	2004	2005	2004	2005	2004	2005
262574	45	54	0	0	45	54	46	54
262575	34	32	0	0	34	32	34	32
262576	86	78	0	0	86	78	103	99
262577	43	40	0	0	43	40	43	40
262578	24	25	0	0	24	25	24	25
262579	37	30	0	0	37	30	37	31
262580	29	30	0	0	29	30	32	35
262581	21	20	0	0	21	20	21	20
262582	12	13	0	0	12	13	12	13
262583	69	76	0	0	69	76	69	76
262584	35	42	0	0	35	42	35	43
262585	0	0	0	0	0	0	45	44
262586	2	0	0	0	2	0	33	0
262587	48	45	0	0	48	45	49	45
262588	31	31	0	0	31	31	31	31
262589	37	44	0	0	37	44	37	44
262590	17	14	0	0	17	14	17	14
262591	23	25	0	0	23	25	33	43
262592	25	30	0	0	25	30	25	30
262593	96	92	0	0	96	92	98	95
262594	35	39	0	0	35	39	51	51
262595	24	23	0	0	24	23	24	23
262596	26	20	0	0	26	20	26	20
262597	56	55	0	0	56	55	64	61
262598	28	31	0	0	28	31	28	31
262599	27	32	0	0	27	32	27	32
262600	26	25	0	0	26	25	27	25
262601	0	0	0	0	0	0	4	2
262602	18	23	0	0	18	23	18	23
262603	51	64	0	0	51	64	57	69
262604	26	33	0	0	26	33	27	34
262605	24	38	0	0	24	38	24	39
262606	65	75	0	0	65	75	78	92
262607	23	37	0	0	23	37	23	37
262609#	0	46	0	0	0	46	0	46
262610#	0	23	0	0	0	23	0	23
262611#	0	31	0	0	0	31	0	31
263300	10	10	0	0	10	10	12	10
263301	8	6	0	0	8	6	18	13
263302	15	12	1	0	16	12	26	18
263503	25	32	0	0	25	32	25	32
263506	5	0	2	0	7	0	55	45
263508	50	69	0	0	50	69	51	69
263510	39	31	0	0	39	31	39	31

Table #4

Dialysis Modality
 Number of living patients by modality by dialysis facility
 in-center as of December 31, 2004 and December 31, 2005
In-Center

Provider	HEMO		PD		TOTAL		TOTAL OF HOME & IN-CENTER*	
	2004	2005	2004	2005	2004	2005	2004	2005
MO Total	5440	5664	9	0	5449	5664	6246	6442
280020	0	0			0	0	0	0
280039	18	19	0	0	18	19	18	19
28006F	33	41	0	0	33	41	33	41
280088^	0	0		0	0	0	0	0
280118	22	19	0	0	22	19	22	19
280125	34	40	0	0	34	40	34	42
281325	1	0	0	0	1	0	1	0
281329	9	11	0	0	9	11	9	11
281341	9	4	0	0	9	4	9	4
281344	7	5	0	0	7	5	7	5
282500	107	105	0	0	107	105	146	153
282501	34	33	1	0	35	33	61	59
282502	47	44	0	0	47	44	47	44
282503	49	49	0	1	49	50	66	67
282504	117	125	0	0	117	125	133	138
282505^	1	0		0	1	0	1	0
282506	43	45	0	0	43	45	43	45
282507	41	48	0	0	41	48	41	48
282508	18	18	0	0	18	18	18	18
282509	35	35	0	0	35	35	35	36
282510	44	45	0	0	44	45	45	45
282511	43	38	0	0	43	38	43	38
282512	20	28	0	0	20	28	20	28
282513	54	52	0	0	54	52	54	52
282514	34	35	0	0	34	35	34	35
282515	51	53	0	0	51	53	62	68
282516	33	27	0	0	33	27	47	44
282517	24	24	0	0	24	24	24	24
282518	18	19	0	0	18	19	18	19
282519	33	30	0	0	33	30	42	46
282520	65	69	0	0	65	69	87	90
282521	50	58	0	0	50	58	50	58
282522	24	26	0	0	24	26	25	26
282523	31	41	0	0	31	41	32	44
282524	13	30	0	0	13	30	13	30
282525	15	17	0	0	15	17	15	17
NE Total	1177	1233	1	1	1178	1234	1335	1413
NETWORK Total	10543	11017	11	1	10554	11018	11907	12390

Table #4

<p style="text-align: center;">Dialysis Modality Number of living patients by modality by dialysis facility in-center as of December 31, 2004 and December 31, 2005 <i>In-Center</i></p>
--

Source of Information: Facility Survey (CMS 2744) and Network SIMS Database

*Total from Table #3 plus total from Table #4 (for last column of report year)

Date of Preparation: June 2006

This table includes 86 Veterans Affairs Facility patients for 2004 and 102 Veterans Affairs Facility patients for 2005.

Provider not operational in 2004

^ Provider not operational in 2005

Renal Transplants by Transplant Center

Number of transplants performed by transplant center calendar year 2004
and calendar year 2005

Transplant Center	TOTAL TRANSPLANTS PERFORMED		PATIENTS WAITING FOR TRANSPLANT *	
	2004	2005	2004	2005
16004F	11	20	0	58
160058	60	66	0	0
160082	27	26	0	37
160083	21	15	0	0
IA Total	119	127		
170040	68	69	0	0
170122	29	30	31	52
KS Total	97	99		
260014	153	122	0	0
260020	0	0		0
260027	62	63	106	110
26004F	0	0	0	0
26009F	0	0	0	0
260105	47	86	345	295
260138	43	51	96	63
260141	30	27	0	0
263300	0	5	0	4
263301	4	14	8	3
263302	13	16	0	10
MO Total	352	384		
280013	117	110	182	184
NE Total	117	110		
NETWORK TOTAL:	685	720		

Source of information: Network SIMS Database/CMS-2744

Date of Preparation: June 2006

* These numbers are not added to State or Network totals because some patients may be placed on more than one waiting list. The numbers are only accurate for each center.

Provider not operational in 2004

^ Provider not operational in 2005

ESRD Network 12
Table #6

Renal Transplant Recipients

Renal transplant recipients by transplant type, age, race, gender and primary diagnosis
for calendar year 2005

Age Group	CADAVERIC	LIVING RELATED	LIVING UNRELATED	Total
00-04	1	4	2	7
05-09	3	2	2	7
10-14	12	5	4	21
15-19	12	13	3	28
20-24	11	5	9	25
25-29	18	10	6	34
30-34	29	11	9	49
35-39	33	11	10	54
40-45	44	17	20	81
45-49	56	17	14	87
50-54	62	15	16	93
55-59	58	13	9	80
60-64	60	10	5	75
65-69	35	3	3	41
70-74	21	4	2	27
75-79	5	2	1	8
80-84	1	1	0	2
>=85	0	0	0	0
Missing	0	0	0	0
Total	461	143	115	719
Gender				
Female	172	52	50	274
Male	289	91	65	445
Missing	0	0	0	0
Total	461	143	115	719
Race				
American Indian/Alaska Native	2	1	1	4
Asian	11	1	2	14
Black or African	105	15	8	128
More than one race selected	0	0	0	0
Native Hawaiian or Other Pacific Islander	2	1	2	5
White	341	125	102	568
Missing	0	0	0	2
Total	461	143	115	719
Primary Diagnosis				
Cystic Kidney	43	17	19	79
Diabetes	131	29	24	184
Glomerulonephritis	112	38	19	169
Hypertension	72	16	14	102
Other	71	28	32	131
Other Urologic	9	7	4	20
Missing	0	0	0	0
Unknown	23	8	3	34
Total	461	143	115	719

Source of information: Network SIMS Database

Date of Preparation: June 2006

Race: The categories are from the CMS-2728 Form.

Diagnosis: Categories are from the CMS-2728. A diagnosis of 'unknown' is ICD-9 code 7999.

This table includes 20 patients receiving treatment at VA facilities.

Dialysis Deaths

Deaths of dialysis patients by state of residence, age, race, gender, primary diagnosis and cause of death for calendar year 2005

Age Group	IA	KS	MO	NE	Other	Total
00-04	0	0	0	0	0	0
05-09	0	0	0	0	0	0
10-14	0	0	0	0	1	1
15-19	0	0	0	0	0	0
20-24	3	0	2	0	1	6
25-29	1	1	9	1	0	12
30-34	1	6	10	5	3	25
35-39	3	6	29	4	6	48
40-45	12	13	31	8	5	69
45-49	13	21	60	7	4	105
50-54	26	27	83	13	7	156
55-59	33	44	109	16	8	210
60-64	33	49	147	32	13	274
65-69	59	63	156	35	12	325
70-74	76	80	217	56	20	449
75-79	99	96	244	69	15	523
80-84	117	78	224	49	13	481
>=85	77	39	161	54	12	343
Missing	0	0	0	0	0	0
Total	553	523	1482	349	120	3027
Gender						
Female	229	233	691	136	56	1345
Male	324	290	791	213	64	1682
Missing	0	0	0	0	0	0
Total	553	523	1482	349	120	3027
Race						
American Indian/Alaska Native	7	9	18	11	0	45
Asian	3	8	10	2	1	24
Black or African	31	91	413	40	29	604
More than one race selected	0	0	1	0	0	1
Native Hawaiian or Other Pacific Islander	0	0	2	0	0	2
White	512	415	1038	296	90	2351
Missing	0	0	0	0	0	0
Total	553	523	1482	349	120	3027
Primary Diagnosis						
Cystic Kidney	7	10	18	5	4	44
Diabetes	234	246	652	155	40	1327
Glomerulonephritis	43	42	101	17	9	212
Hypertension	146	141	455	99	34	875
Other	89	57	158	38	18	360
Other Urologic	20	9	32	10	1	72
Missing	0	0	0	0	0	0
Unknown	14	18	66	25	14	137
Total	553	523	1482	349	120	3027
Primary Cause of Death						
Cardiac	216	224	586	171	45	1242
Gastro-Intestinal	9	8	18	4	3	42
Infection	74	51	168	36	16	345
Liver Disease	5	1	5	7	0	18
Vascular	28	48	103	12	11	202
Missing	0	0	0	0	0	0
Other	163	130	331	78	29	731
Unknown	58	61	271	41	16	447
Total	553	523	1482	349	120	3027

Source of information: Network SIMS Database

Date of Preparation: June 2006

Race: The categories are from the CMS-2728 Form.

Diagnosis: Categories are from the CMS-2728. A diagnosis of 'unknown' is ICD-9 code 7999.

This table cannot be compared to the CMS facility survey because the CMS Facility Survey is limited to those deaths reported by only Medicare-approved facilities.

This table includes 27 patients receiving treatment at VA facilities.

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
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NETWORK 12

IOWA

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
160005	2	0	1	0	N
160016	14	0	4	1	N
160020	3	0	0	0	N
160030	11	0	3	1	N
160033	36	3	10	1	Y
160044	5	0	4	0	N
160048	1	0	0	0	N
16004F	1	0	1	0	N
160058	21	0	0	0	N
160064	15	1	7	1	N
160067	12	0	3	0	N
160079	2	0	0	0	Y
160080	8	0	2	0	N
160082	0	0	0	0	N
160083	0	0	0	0	Y
160089	14	0	9	0	N
160112	2	0	0	0	N
160113	1	0	0	0	N
161329	1	0	0	0	N
162500	22	2	5	0	Y
162501	25	2	12	0	Y
162506	12	0	6	1	N
162507	16	0	0	0	N

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

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NETWORK 12

IOWA

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
162508	1	0	0	0	N
162509	8	0	3	1	N
162511	1	0	0	0	N
162512	14	0	2	0	N
162513	14	0	0	0	N
162514	3	0	1	0	Y
162515	44	3	8	3	Y
162516	20	0	9	0	N
162517	7	0	2	0	N
162518	9	0	4	0	N
162519	0	0	0	0	N
162520	1	0	0	0	N
162522	3	0	2	0	N
162523	3	0	1	0	N
162524	2	0	0	0	N
162525	7	7	1	0	N
162526	5	0	3	1	N
162527	9	0	2	0	N
162528	4	0	1	0	N
162529	19	0	0	0	N
162530	4	0	0	0	N
162532	44	0	0	0	N
162533	22	0	6	1	N

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

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NETWORK 12

IOWA

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
163501	13	0	4	0	N
163502	2	0	1	0	N
163503	2	0	0	0	N
163504	6	0	0	0	N
163505	7	0	0	0	N
163506	2	1	2	0	N
163507	1	0	0	0	N
163508	3	0	2	0	N
163509	7	0	0	0	N
163510	1	0	0	0	N
163513	4	0	2	0	N
163514	30	0	23	0	N
State Total	546	19	146	11	

KANSAS

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
170017	3	0	3	0	N
170040	55	0	6	2	N

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

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NETWORK 12

KANSAS

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
170122	0	0	0	0	N
172501	21	1	16	0	N
172502	19	0	0	0	N
172503	66	0	26	1	N
172504	67	2	25	3	Y
172505	8	0	4	0	N
172506	9	0	1	0	N
172507	8	0	2	0	N
172508	63	0	10	2	N
172509	32	3	32	2	N
172510	7	0	1	0	N
172511	12	0	5	1	N
172512	10	0	0	0	N
172514	14	0	0	0	N
172515	12	0	0	0	N
172516	2	0	0	0	N
172517	14	0	4	0	N
172518	8	0	3	0	N
172519	40	0	4	1	N
172520	21	0	5	1	N
172521	14	0	0	0	N
172522	10	0	6	0	N
172523	24	0	6	0	N

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

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NETWORK 12

KANSAS

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
172524	12	0	3	0	N
172525	4	0	0	0	N
172526	5	0	1	0	N
172527	18	1	0	0	N
172528	6	0	2	0	N
172529	5	0	2	0	N
172530	2	0	0	0	N
172531	7	0	2	0	N
172532	5	0	2	0	N
172533	12	1	3	1	N
172534	2	0	0	0	N
172535	11	0	1	0	N
172536	13	0	3	0	N
172537	5	0	0	0	N
172538	1	0	1	0	N
172539	0	0	0	0	N
172540	8	1	5	0	N
172541	8	0	3	0	N
172542	9	1	3	2	N
172543	21	1	7	2	N
State Total	693	11	197	18	

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

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NETWORK 12

MISSOURI

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
260014	0	0	0	0	N
260020	0	0	0	0	N
260027	17	0	0	0	N
260040	9	0	1	1	N
26004F	9	0	2	1	N
26008F	47	0	0	0	N
26009F	8	0	0	0	N
260100	3	1	0	0	N
260105	0	0	0	0	N
260113	37	0	5	0	Y
260137	13	0	4	0	N
260138	0	0	0	0	N
260141	0	0	0	0	N
260172	4	0	0	0	N
260179	0	0	0	0	N
260180	0	0	0	0	N
262501	52	0	4	1	N
262502	70	0	22	2	N
262503	60	0	7	1	N
262504	34	0	0	0	N
262505	10	0	3	0	N
262506	59	0	11	2	Y
262507	26	0	1	1	N

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

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NETWORK 12

MISSOURI

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
262508	45	2	32	0	N
262509	27	0	0	0	N
262511	9	0	3	0	N
262513	10	1	4	0	N
262514	23	0	0	0	N
262515	21	0	7	0	N
262516	7	0	3	0	N
262517	43	2	26	0	Y
262520	11	0	2	0	N
262521	13	1	7	1	N
262522	5	0	3	0	N
262523	3	0	0	0	N
262524	7	0	0	0	N
262526	4	0	0	0	N
262527	39	0	4	0	N
262528	30	0	13	2	N
262530	10	1	6	0	N
262531	25	0	1	0	N
262534	9	0	1	0	N
262535	29	0	0	0	N
262536	14	0	4	0	N
262537	43	3	13	1	Y
262538	22	0	8	1	Y

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
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NETWORK 12

MISSOURI

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
262539	41	0	10	2	N
262540	9	0	0	0	N
262541	29	0	13	0	N
262542	10	0	5	0	N
262543	26	0	10	2	N
262544	22	2	7	1	N
262547	47	0	0	0	N
262548	9	0	0	0	N
262549	89	2	20	3	Y
262550	16	1	1	0	N
262551	29	1	0	0	N
262552	10	0	0	0	N
262553	12	0	8	0	N
262554	9	0	1	0	N
262555	14	0	2	0	N
262556	19	0	5	2	N
262557	5	0	1	0	N
262559	5	0	0	0	N
262560	25	0	3	0	N
262561	24	1	9	2	N
262562	17	0	5	0	N
262563	22	0	2	1	N
262564	80	2	22	1	N

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

6/15/2006

NETWORK 12

MISSOURI

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
262565	115	2	48	8	N
262567	10	0	5	0	N
262568	4	0	1	0	N
262569	11	0	3	0	N
262570	9	0	0	0	N
262572	19	1	10	0	N
262573	7	0	7	0	N
262574	14	2	6	0	N
262575	10	0	4	0	N
262576	32	0	4	1	Y
262577	8	0	2	1	N
262578	4	0	0	0	N
262579	15	0	1	1	N
262580	4	0	1	0	N
262581	6	0	2	0	N
262582	1	0	1	0	Y
262583	17	0	15	2	N
262584	7	0	0	0	N
262585	11	0	7	1	N
262586	0	0	0	0	N
262587	9	0	0	1	N
262588	8	0	0	0	N
262589	15	1	5	0	N

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

6/15/2006

NETWORK 12

MISSOURI

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
262590	2	0	0	0	N
262591	9	1	5	0	N
262592	5	0	1	1	N
262593	28	4	13	1	N
262594	9	0	3	0	N
262595	8	0	1	2	N
262596	5	0	0	0	N
262597	22	2	5	1	N
262598	18	0	0	0	N
262599	5	0	3	0	N
262600	6	0	0	0	N
262601	1	0	0	0	N
262602	4	0	0	0	N
262603	28	0	3	2	N
262604	5	1	1	0	N
262605	7	0	2	0	N
262606	25	0	6	1	N
262607	16	0	3	0	N
262609	22	0	2	1	N
262610	3	0	0	0	N
262611	6	0	2	0	N
263300	2	0	0	2	N
263301	4	1	4	0	N

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

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NETWORK 12

MISSOURI

DURING THE SURVEY PERIOD

FACILITIES REPORTING	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
263302	8	0	2	4	N
263503	8	0	0	0	N
263506	19	1	12	1	N
263508	24	2	3	0	N
263510	5	0	2	0	N
State Total	2,116	38	516	59	

NEBRASKA

DURING THE SURVEY PERIOD

FACILITIES REPORTING	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
280013	0	0	0	0	N
280020	0	0	0	0	N
280039	2	0	0	0	N
28006F	10	0	3	0	N
280118	1	0	0	0	N
280125	9	0	4	1	N
281325	0	0	0	0	N
281329	0	0	0	0	N
281341	1	0	0	0	N

**ANNUAL REPORT TABLE 8
VOCATIONAL REHABILITATION
BEGINNING THROUGH END OF SURVEY PERIOD 2005**

6/15/2006

NETWORK 12

NEBRASKA

FACILITIES REPORTING	DURING THE SURVEY PERIOD				
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME	SHIFT AFTER 5 PM
281344	1	1	0	1	N
282500	39	0	19	0	Y
282501	13	0	0	0	N
282502	16	0	7	0	N
282503	19	0	0	0	Y
282504	60	1	21	2	Y
282506	6	1	5	0	N
282507	15	0	5	0	N
282508	4	0	0	0	N
282509	7	1	3	0	Y
282510	9	0	4	1	Y
282511	13	0	1	0	N
282512	6	0	3	0	N
282513	15	0	2	0	Y
282514	9	0	0	1	N
282515	16	0	0	0	N
282516	12	0	9	0	N
282517	6	0	3	1	N
282518	5	0	1	0	N
282519	9	0	1	0	N
282520	43	3	15	1	N
282521	33	0	3	6	N
282522	10	0	0	0	N

**ANNUAL REPORT TABLE 8
 VOCATIONAL REHABILITATION
 BEGINNING THROUGH END OF SURVEY PERIOD 2005**

6/15/2006

NETWORK 12

NEBRASKA

FACILITIES REPORTING	DURING THE SURVEY PERIOD					SHIFT AFTER 5 PM
	AGED 18 THROUGH 54 (as of Dec. 31)	PATIENTS RECEIVING SERVICES FROM VOC REHAB	PATIENTS EMPLOYED FULL-TIME OR PART-TIME	PATIENTS ATTENDING SCHOOL FULL-TIME		
282523	7	0	0	0	0	N
282524	10	0	4	1	1	N
282525	9	1	1	0	0	N
State Total	415	8	114	15	15	
Network Total	3,770	76	973	103	103	
Grand Total	3,770	76	973	103	103	