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Network Notes

Inside Network Notes:

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Still Room for Improvement: Stenosis Monitoring

Annually, Centers for Medicare and Medicaid Services (CMS) evaluates the clinical performance of the ESRD program by publishing for the public and congress an annual report. This report contains comparative data on clinical measurements selected from K-DOQI guidelines. The Network of New England statistics reflect the professional good efforts of providers in this region. New England has exceeded the national average and benchmark targets set by CMS in adequacy of dialysis, anemia and AV fistula.

One area that all of us need to improve is graft stenosis monitoring. The surveillance of AV grafts for hemodynamically significant stenosis, when combined with corrective action, improves patency and decreases thrombosis. K-DOQI vascular access guideline states;

Physical examination of an access graft should be performed weekly and should include, but not be limited to, inspection and palpation for pulse and thrill at the arterial, mid, and venous sections of the graft (Opinion). The DOQI Work Group recommends an organized monitoring approach with regular assessment of clinical parameters of the arterial venous access and dialysis adequacy. Data from the monitoring tests, clinical assessment, and dialysis adequacy measurement should be collected and maintained for each patient's access and made available to staff. The data should be tabulated and tracked within each dialysis center as part of a Quality Assurance/Continuous Quality Improvement (QA/CQI) program (Opinion). Prospective monitoring of arterial venous grafts for hemodynamically significant stenosis, when combined with correction, improves patency and decreases the incidence of thrombosis (Evidence). Techniques, not mutually exclusive, that can be used to monitor for stenosis in arterial venous grafts include:

A. Intra-access flow (Evidence)
B. Static venous pressures (Evidence)
C. Dynamic venous pressures (Evidence)

Other studies or information that can be useful in detecting arterial venous graft stenosis include:

D. Measurement of access recirculation using urea concentrations (Evidence)
E. Measurement of recirculation using dilution flow techniques (nonurea-based) (Evidence)
F. Unexplained decreases in the measured amount of hemodialysis delivered (URR, KT*N*) (Evidence)
G. Physical findings of persistent swelling of the arm, clotting of the graft, prolonged bleeding after needle withdrawal, or altered characteristics of pulse or thrill in a graft (Evidence/Opinion)
H. Elevated negative arterial pre-pump pressures that prevent increasing to acceptable blood flow (Evidence/Opinion)
I. Doppler ultrasound (Evidence/Opinion).

Persistent abnormalities in any of these parameters should prompt referral for venography (Evidence).

2001 Comparative Data

	Target	National	Network
URR % ≥ 65	80 %	84 %	87 %
KT/V ≥ 1.2	84 %	89 %	91 %
Hemoglobin > 11 gm/dL	70 %	76 %	76 %
Catheter Use > 90 days	10 %	19 %	17 %
AV Fistula Use	40 %	31 %	46 %
AV Graft Monitor Stenosis	100 %	51 %	28 %
S. Albumin ≥ 4.0/3.7 gm/dL	35 %	36 %	32 %

Source: CMS/CPM 2002 Report

Coming Soon To a Computer in Your Neighborhood: VISION and QNet Exchange ESRD Electronic Reporting

Network of New England is in the process of training free standing facilities (national dialysis corporations will train their staff internally) and preparing them to transfer data electronically. Thus far, the Network has trained ten facilities and two facilities have started submitting data electronically. Training can be given at the Network office (in CT) or can be conducted at your facility, if at least two other facilities participate. For more information, please contact Jaya Bhargava or Karen DeGeorge at the Network office.

Centers for Medicare and Medicaid Services (CMS) is moving the ESRD community in the direction of paperless transfer of data. The electronic reporting or E-Reporting of data uses two applications, VISION and QNet Exchange.

VISION allows entry of patient data and creates CMS required forms. The software will assure that only complete and accurate electronic forms are submitted to the Network. VISION is more than a data entry system for CMS forms. It also has integrated facility, personnel, and patient management features for use in ESRD facilities.

Better productivity, efficiency, and accuracy of data are the benefits of VISION application. Most importantly, VISION will improve the process for determining patient eligibility for Medicare benefits, and increase compliance with CMS ESRD form processing.

QNet Exchange is a secure electronic data submission process that enables and protects transport of data, via the web, in accordance with HIPAA guidelines. It has strict user identification and token-based access features (TecSec CKM® technology) that allows safe transfer of confidential or private information. QNet Exchange is equipped with advanced encryption (scrambling) technology.

The main goals of E-reporting is to reduce system redundancy and refocus emphasis on the intended purpose of reporting - the establishment of ESRD Medicare coverage benefits for eligible patients. Secondary goals are to gather data electronically at its source, use data to update multiple databases, take advantage of newer technology and to utilize a web-based environment.

Recommendations to the Field: End of Life Care

The Robert Wood Johnson Foundation, under one of its nation programs; Promoting Excellence in End of Life Care has produced an ESRD specific tool for utilization in healthcare planning. The tool, entitled "Recommendations to the Field," has been sent to New England Renal Social Workers. Jenny Kitsen, Executive Director of ESRD Network of New England, was a member of the workgroup responsible for the development of the "final piece of the puzzle" in care planning for ESRD patients and families. The booklet is a 65-page document full of useful recommendations for renal health care professions related to end-of-life decisions. Before this tool was conceived there had been few resources designed to help patients and their loved ones navigate the difficult process of death. Information contained in the booklet includes topics such as quality of life, quality of death, life satisfaction tools, DNR models, hospice, palliative care, advance directives and spirituality. We are certain you will find the booklet indispensable once you have read its many practical recommendations. Look for it in your internal mail system.

Nephrology Related and/or Clinical Websites

Please note some excellent professional websites available on the Internet:

www.renalweb.com
Provides you with up to date clinical and product information; has numerous links to other nephrology sites for staff and patients. From this one site you can link to AAKP, the CDC, CMS, NKF, ESRD Networks, NANT, ANNA, etc.

www.fda.gov/medwatch
This is an automated E-mail system that notifies you of medical product safety information or recent medication problems.

www.rxlist.com
Provides downloadable patient and professional information on medications

www.diabetes.org
Has good teaching resources for patients with Diabetes

www.medicare.gov/Dialysis/Home.asp will assist you in locating and evaluating Dialysis clinics by zip code, state or geographic region.

Administrative Simplification Under HIPAA: National Standards for Transactions, Security and Privacy

October 15, 2002

Contact: HHS Press Office
(202) 690-6343

OVERVIEW

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 included a series of "administrative simplification" provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. By ensuring consistency throughout the industry, these national standards will make it easier for health plans, doctors, hospitals and other health care providers to process claims and other transactions electronically. The law also requires the adoption of security and privacy standards in order to protect personal health information. HHS is issuing the following major regulations:

- *Electronic health care transactions (final rule issued);*
- *Health information privacy (final rule issued);*
- *Unique identifier for employers (final rule issued);*
- *Security requirements (proposed rule issued; final rule in development);*
- *Unique identifier for providers (proposed rule issued; final rule in development);*
- *Unique identifier for health plans (proposed rule in development); and*
- *Enforcement procedures (proposed rule in development).*

Although the HIPAA law also called for a unique health identifier for individuals, HHS and Congress have indefinitely postponed any effort to develop such a standard.

Under HIPAA, most health plans, health care clearinghouses and health care providers who engage in certain electronic transactions have two years from the time the final regulation takes effect to implement each set of final standards. More information about the HIPAA standards is available at ***http://aspe.hhs.gov/admnsimp/*** *and* ***http://www.cms.gov/hipaa****.*

BACKGROUND

Today, health plans, hospitals, pharmacies, doctors and other health care entities use a wide array of systems to process and track health care bills and other information. Hospitals and doctor's offices treat patients with many different types of health insurance and must spend time and money ensuring that each claim contains the format, codes and other details required by each insurer. Similarly, health plans spend time and money to ensure their systems can handle transactions from various health care providers and clearinghouses.

Enacted in August 1996, HIPAA included a wide array of provisions designed to make health insurance more affordable and accessible. With support from health plans, hospitals and other health care businesses, Congress included provisions in HIPAA to require HHS to adopt national standards for certain electronic health care transactions, codes, identifiers and security. HIPAA also set a three-year deadline for Congress to enact comprehensive privacy legislation to protect medical records and other personal health information. When Congress did not enact such legislation by August 1999, HIPAA required HHS to issue health privacy regulations.

Security and privacy standards can promote higher quality care by assuring consumers that their personal health information will be protected from inappropriate uses and disclosures.

In addition, uniform national standards will save billions of dollars each year for health care businesses by lowering the costs of developing and maintaining software and reducing the time and expense needed to handle health care transactions.

COVERED ENTITIES

In HIPAA, Congress required health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions electronically (such as eligibility, referral authorizations and claims) to comply with each set of final standards. Other businesses may voluntarily comply with the standards, but the law does not require them to do so.

COMPLIANCE SCHEDULE

In general, the law requires covered entities to come into compliance with each set of standards within two years following adoption, except for small health plans, which have three years to come into compliance. For the electronic transaction rule only, Congress in 2001 enacted legislation allowing a one-year extension for most covered entities provided that they submit a plan for achieving compliance. As a result, covered entities that qualify for the extension will have until Oct. 16, 2003 to meet the electronic transaction standards instead of the original Oct. 16, 2002 deadline. (Small health plans must still meet the Oct. 16, 2003 compliance date and are not eligible for an extension under the new law.) The legislative extension does not affect the compliance dates for the health information privacy rule, which remains April 14, 2003 for most covered entities (and April 14, 2004 for small health plans).

DEVELOPING STANDARDS

Under HIPAA, HHS must adopt recognized industry standards when appropriate. HHS works with industry standard-setting groups to identify and develop consensus standards for specific requirements. For each set of standards, HHS first develops proposed requirements to obtain public feedback. After analyzing public comments, HHS makes appropriate changes before issuing a final set of standards. The law also allows HHS to propose appropriate changes to the HIPAA regulations to ensure that the standards can be implemented effectively and be maintained over time to continue to meet industry needs.

ELECTRONIC TRANSACTION STANDARDS

In August 2000, HHS issued final electronic transaction standards to streamline the

processing of health care claims, reduce the volume of paperwork and provide better service for providers, insurers and patients. The new standards establish standard data content, codes and formats for submitting electronic claims and other administrative health care transactions. By promoting the greater use of electronic transactions and the elimination of inefficient paper forms, these standards are expected to provide a net savings to the health care industry of $29.9 billion over 10 years. All health care providers will be able to use the electronic format to bill for their services, and all health plans will be required to accept these standard electronic claims, referral authorizations and other transactions.

In December 2001, Congress adopted legislation that allows most covered entities to obtain a one-year extension to comply with the standards, from Oct. 16, 2002 to Oct. 16, 2003. To qualify for the extension, the covered entity must submit a plan for achieving compliance by the new deadline. (The legislation did not change the compliance date for small health plans, which remains Oct. 16, 2003.) HHS' Centers for Medicare & Medicaid Services (CMS) has issued a model compliance plan that covered entities may use to obtain an extension. The model plan is available at ***http://www.cms.gov/hipaa***.

PRIVACY STANDARDS

In December 2000, HHS issued a final rule to protect the confidentiality of medical records and other personal health information. The rule limits the use and release of individually identifiable health information; gives patients the right to access their medical records; restricts most disclosure of health information to the minimum needed for the intended purpose; and establishes safeguards and restrictions regarding disclosure of records for certain public responsibilities, such as public health, research and law enforcement. Improper uses or disclosures under the rule are subject to criminal and civil sanctions prescribed in HIPAA.

After considering public comment on the final rule, HHS Secretary Tommy G. Thompson allowed it to take effect as scheduled, with compliance for most covered entities required by April 14, 2003. (Small health plans have an additional year.) In March 2002, HHS proposed specific changes to the privacy rule to ensure that it protects privacy without interfering with access to care or quality of care. After considering public comments, HHS issued a final set of modifications on Aug. 14, 2002. Detailed information about the privacy rule is available at ***http://www.hhs.gov/ocr/hipaa***.

EMPLOYER IDENTIFIER

In May 2002, HHS issued a final rule to standardize the identifying numbers assigned to employers in the health care industry by using the existing Employer Identification Number (EIN), which is assigned and maintained by the Internal Revenue Service.

Businesses that pay wages to employees already have an EIN. Currently, health plans and providers may use different ID numbers for a single employer in their transactions, increasing the time and cost for routine activities such as health plan enrollments and health plan premium payments. Most covered entities must comply with the EIN standard by July 30, 2004. (Small health plans have an additional year to comply.)

ADDITIONAL STANDARDS

Led by CMS, HHS is currently developing other administrative simplification standards. HHS has published proposed regulations for three other major standards - security standards, national identifiers for health care providers and modifications to the original transaction rule - and is now reviewing public comments and preparing final regulations. HHS also is working to develop other proposed standards, including a national health plan identifier and additional electronic transaction standards. In addition, HHS is developing regulations related to enforcement of the adopted standards. The status of key standards required under HIPAA follows:

Security standards. In August 1998, HHS proposed rules for security standards to protect electronic health information systems from improper access or alteration. In preparing final rules for these standards, HHS is considering substantial comments from the public, as well as new laws related to these standards and the privacy regulations. HHS expects to issue final security standards shortly.

National provider identifier. In May 1998, HHS proposed standards to require hospitals, doctors, nursing homes, and other health care providers to obtain a unique identifier when filing electronic claims with public and private insurance programs. Providers would apply for an identifier once and keep it if they relocated or changed specialties. Currently, health care providers are assigned different ID numbers by each different private health plan, hospital, nursing home, and public program such as Medicare and Medicaid. These multiple ID numbers result in slower payments, increased costs and a lack of coordination.

National health plan identifier and other HIPAA regulations. HHS is working to propose standards that would create a unique identifier for health plans, making it easier for health care providers to conduct transactions with different health plans. HHS is also working to develop additional transaction standards for attachments to electronic claims and for a doctor's first report of a workplace injury. In addition, HHS is developing a proposed rule on enforcement of the HIPAA requirements. As with other HIPAA regulations, HHS will first consider public comment on each proposed rule before issuing any final standards.

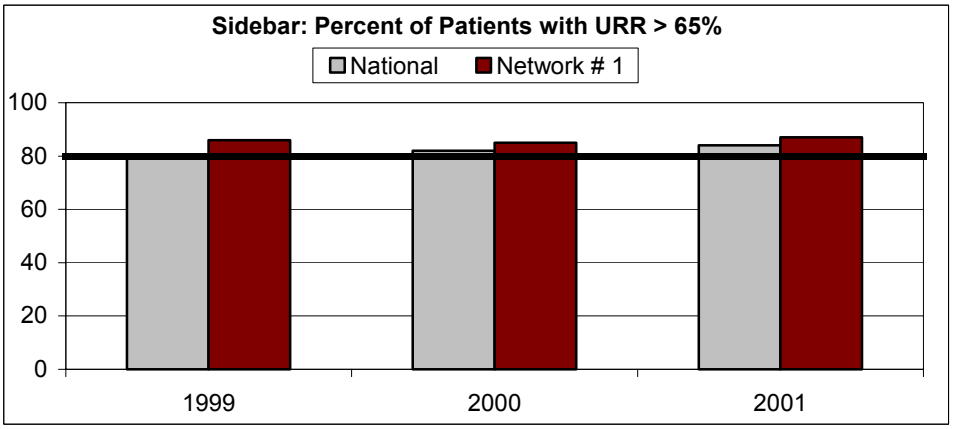
Personal identifier on hold. Although HIPAA included a requirement for a unique personal health care identifier, HHS and Congress have put the development of such a standard on hold indefinitely. In 1998, HHS delayed any work on this standard until after comprehensive privacy protections were in place. Since 1999, Congress has adopted budget language to ensure no such standard is adopted without Congress' approval. HHS has no plans to develop such an identifier.

Note: All HHS press releases, fact sheets and other press materials are available at http://www.hhs.gov/news

National Quality Improvement Project: Adequacy of Dialysis

Last year all ESRD Networks were required by Centers for Medicare & Medicaid (CMS) to develop a quality improvement project on improving adequacy of hemodialysis at the provider level. Due to the stellar efforts of New England professionals, most providers in this Network have achieved, or exceeded, this level. The Network Medical Review Board (MRB) developed a quality improvement project focused on providers that were in the lowest URR quartile for three consecutive periods to assess what factors contributed to this low URR rate. All 17 selected providers submitted additional patient-specific information on their patients at two different points during a twelve-month period (Q4/2001 & Q2/2002). The plan for improvement would be based on identifying the gap between prescribed versus delivered treatment time and blood flow rate, thereby identifying potential barriers to adequate treatments. Provider-specific comparative feedback reports were given to each provider, along with QI tools to improve management of URR. The CMS benchmark for provider performance is to have a minimum of 80% of patients with a URR $\geq$ 65. The 17 targeted providers did increase the percent of patients with URR $\geq$ 65% (82.8% to 85.3%). Variation in prescribed versus delivered treatment time and blood flow reported at the provider level resulted in little aggregate change between the two data collection points. Physician peer consultation was also provided to some Medical Directors. Provider-specific variation of improvement was noted. The small patient census at some of the providers contributed to lack of statistical significance in the rate of change in URR $\geq$ 65. A second analysis of patients (N = 138) with low URR (< 65) that were common in both reporting periods revealed 72% had improved URR $\geq$ 65 six months later.

The Medical Review Board (MRB) expresses their appreciation to all participating providers for their cooperation and efforts to evaluate their own performance and investigate ways to improve their URR results.



Source: CMS/CPM Annual Report

Primary Outcome Indicator Data Analysis

17 Providers	Q4/2001 Assessments	Q2/2002 Follow-Ups
Total # of Pts. with URR	992	875
Total # of Pts. with $\geq$ 65	821 (82.8%)	746 (85.3%)

Source: Assessment Tool and Assessment Follow-Up

Network (Intervention Providers Removed)	Q4/2001 Assessments	Q2/2002 Follow-Ups
Total # of Providers	108	112
Total # of Pts. with URR	6792	6,993
Total # of Pts. with $\geq$ 65	5,977 (88.0%)	6,179 (88.3%)

Source: Network Indicator Data

Kudos in the Renal Community

Congratulations to the Kidney Transplant Dialysis Association (KT/DA) for winning the 2002 NN & I "Quality of Life Award." We are proud of this very special Boston-based patient organization that has been working tirelessly for almost 40 years to make a difference in the lives of kidney patients.

For more information about this dedicated group, see the January 2003 issue of Nephrology News & Issues, Volume 17, Number 2 or visit the KT/DA website at www.ktda.org.

ESRD Network Reports Available!

2001 Annual Report

2002 Statistical Summary

2003 Facility Directory

Call 203-387-9332 to order copies.

Network Notes

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Patient Safety: Something to Think About

In these days of long working hours, medically complicated dialysis patients, and overworked staff, can you think of safety issues that could become major problems? Here are a few examples:

- Unlabelled syringes left on dialysis machines
- Improper storage of oxygen cylinders
- Chloramine levels not being tested before each patient shift
- Medication vials stored beyond the "timed" or "opened" date
- Overdue preventive maintenance on dialysis equipment
- Infrequent emergency drills for patients and staff
- Spills in patient and staff areas

Do You Have Your Free "BE AWARE, BE SAFE" Poster?

Would you like to have one or get another? Call 203-387-9332 and ask for Roberta to get yours today. The poster is designed by members of the ESRD Network Patient Advisory Committee (the "PAC").

Safety is one of our highest priorities in caring for patients. This poster will help raise awareness among both patients and staff. Get your poster and talk about ways to insure safety at your clinic. The poster is FREE!

We Need Posters for the Network Annual Meeting

While we're still in the midst of winter, it may be hard for you to think about posters for the next Annual Network Meeting scheduled for October 2, 2003. But, we had such high-quality posters from our facilities last year, we want to remind you to think about topics and quality improvement ideas that you can share again this year. The deadline for submitting poster ideas for printing in the initial registration brochures is June 30, 2003.

If you would like to submit an idea for a poster, please contact Connie Hill, RN or Cynthia Lambert, RN at the Network office 203-387-9332 for additional details.