

Information for the Dialysis Professional

IN OTHER WORDS...

MAKING A BOTTOM-LINE CASE

FOR HEALTH LITERACY

By Helen Osborne, M.Ed., OTR/L, President of Health Literacy Consulting

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Many uninsured and underinsured patients living within 50 miles of Chapel Hill, North Carolina, get their healthcare at the University of North Carolina (UNC) Internal Medicine Clinic. Patients come to this clinic with both urgent medical problems and chronic conditions such as congestive heart failure (CHF) and diabetes. In addition, patients may be struggling with financial or transportation problems and other life stressors, and a number of them also have literacy issues. Despite their health status, life stressors, and literacy level, patients are expected to actively participate in their own treatment and care. To do this, they need to be able to follow self-care instructions, understand risks and benefits, and know what to do when emergencies occur.

When a team at the clinic wanted to make it easier for patients to understand and use important health information, they put together a program based on principles of health literacy to improve communication. At the same time, they realized that putting these principles into practice requires an investment of time and money. So the team also addressed the business side, writing several reports about their efforts, including a recently published study entitled "Labor Characteristics and Program Costs of Successful Diabetes Disease Management Program."

Robb Malone, PharmD, is a clinical pharmacist practitioner, certified diabetes educator, and a coauthor of this study. He recently talked with me about lessons the team learned and offered the following suggestions for healthcare providers who want to improve patient communication and health outcomes while also paying attention to an organization's bottom line.

Health Literacy Principles

The UNC team used several key health-literacy concepts to design an effective program.

Malone and his team start from the beginning each time they meet with new patients, even those who have been diagnosed with chronic conditions for many years. While acknowledging that starting from the beginning can lengthen — not shorten — an initial visit, Malone says that it is important to correct any mistakes or inconsistencies before teaching new information. This way, patients are better prepared to achieve treatment goals and possibly prevent costly emergency care. →

PROJECT MANAGEMENT OPENING

Due to retirement of incumbent in early 2008, we are seeking an Executive Director [ED] for a not-for-profit, government-funded organization.

The ED will provide overall supervision and direction of Network goals and objectives into administrative action. The ED will be responsible for: (1) supervision of staff; (2) preparation of the Network's work plan and budget; (3) coordination of the contract requirements between the Network and the Centers for Medicare & Medicaid Services [CMS]; (4) planning and development of special statewide projects pertinent to the Network goals and interests; (5) providing advice and assistance to the Board of Directors, Medical Review Board and the ESRD Council; (6) providing direct liaison with CMS national and regional offices; and, (7) interfacing and cooperating with state agencies and other renal-related organizations.

Masters Degree in Health Administration or a health-related area preferred but not required. At least five years progressively responsible experience in the health care field is mandatory, including management and supervisory experience.

Submit applications and resume NO LATER THAN MAY 31, 2007 to:

Patricia Philliber
ESRD Network 13
4200 Perimeter Center Drive # 102
Oklahoma City, OK 73112
or
pphilliber@nw13.esrd.net

In initial visits with patients who have diabetes, Malone might ask the following:

- *How long have you known that you have diabetes, and what do you know about diabetes? What does having diabetes mean to you?* Malone finds that patients diagnosed many years ago often have the most trouble with new information. While they might recall what “Dr. Smith” used to say, patients may be unaware of new treatments, goals, and proper self-care.
- *Who else in your family has diabetes?* Beyond the designated healthcare team, patients often get advice from family, friends, and well-intentioned others. This question helps Malone find out what patients already know, believe, and understand.
- *What should your blood sugar be before and after meals? What do these values mean to you? What blood-sugar values scare you or make you nervous and how do you react?* Specific questions like these are a way to gauge patients’ knowledge, self-confidence, and ability to manage self-care tasks. ■

Please plan on attending the ESRD Network 13 Spring Workshop with Helen Osborne, M.Ed., OTR/L, President of Health Literacy Consulting, and author, as we learn what health literacy is, why it is important and have inter-active sessions to practice what was presented.

Dates and locations on page 8.



The dialysis community experienced a great loss with the untimely death of Ms. Susan Knapp, RD, CS, LD. She turned 54 on January 1, 2007 and on January 8, 2007 she passed away. Susan was very active in the nephrology community. She was the lead dietitian for Davita in Tulsa, OK for the Sundance Region. She was on the Medical Review Board for ESRD Network 13. She was well respected and cared for by both her professional colleagues and patients. Her death is a tremendous loss to all she touched and cared for. Our sympathies go to her family during this difficult time.

SPOTLIGHT ON ALBUMIN’S ROLE IN HEALTH

By Joanne Cooke, MS RD CSR

Low albumin affects over 40 % of dialysis patients and is the strongest predictor of death ⁽¹⁾. The CANUSA study showed that CAPD patients had an additional risk of failure of their peritoneal dialysis when their albumin decreased. With each 1 g/L decrease in serum albumin their risk of dialysis failure increased 5%, in addition to an increased risk of death ⁽²⁾.

Albumin plays many important roles in the body. It acts as a “cork” in capillaries to control the flow of fluid into tissues, maintaining oncotic pressure. When albumin is low, fluid seeps from the capillaries into tissue, causing edema. Albumin carries many types of medications as they travel through the bloodstream, so low albumin can cause the effective dose of medication to drop. Albumin also plays an important role in fighting infection, but may be suppressed by inflammatory conditions, resulting in loss of muscle and protein.

Although albumin is the most common protein in the blood, dialysis patients have many complications which can cause it to become too low. Protein is lost at every dialysis treatment and muscle tissue is broken down ⁽³⁾. Replacement of protein after each treatment is the first step in preserving muscle strength and nutrition status. In addition, patients with insulin resistance often have high blood sugar, leading to poor utilization of protein. Janeen Leon’s recent study identified 10 potential barriers to improving albumin level ⁽⁴⁾. The following table spotlights selected strategies to improve albumin. Get actively involved in removing barriers to good health! →



Poor nutritional knowledge	Education on protein sources may include puzzles, articles, label reading, and help in taste testing and/or ordering supplements.
Poor appetite	Patients who rated their appetite for common high protein foods “poor to fair” may benefit from screening of medications that may be suppressing appetite and evaluation for appetite stimulant.
Need help with shopping or cooking	Ask the social worker about home services. Use community, family or church support.
Low fluid intake	Patients who have low fluid gains may benefit from a protein enriched beverage.
Inadequate dialysis dose	Evaluate patients with Kt/V < 1.2. What is the reason for poor dialysis? Attendance, access, and/or dialysis prescription changes?
Depression	Patients suffering from depression benefit from clinical treatment, and have additional nutrition related issues of higher fluid gains, higher serum K+ and reduced immune function.
Difficulty chewing.	Patients who report they “always” or “sometimes” have difficulty chewing may benefit from instruction on modified diet options
Difficulty swallowing	Patients who report they “always” or “sometimes” have difficulty swallowing may benefit from instruction on modified diet and supplement options; medical evaluation; speech therapist evaluation.
Gastrointestinal symptoms	Patients with recurring heartburn or nausea may benefit from instruction on bland diet and medical evaluation.
Acidosis	Patients whose predialysis bicarbonate level is < 22mEq/L may benefit from oral sodium bicarbonate supplement or adjustment of dialysis bicarb level to promote normal albumin ⁽⁵⁾ .

References:

1. Pupim, LB et al, (2004) Uremic Malnutrition is a predictor of death independent of inflammatory status. *Kidney International*; 66 (5): 2054-2060
2. Anonymous, (1996) Adequacy of dialysis and nutrition in CPD: association with clinical outcomes. *CANUSA. Journal of Am Soc Neph.*, 7(2): p. 198-207.
3. Ikizler, T.A., et al. 2002 Hemodialysis stimulates muscle and whole body protein loss and later substrate oxidation. *Am. J Physiol.* 282: E107-E116.
4. Leon J, et al Improving albumin levels among hemodialysis patients: a community based randomized controlled trial. *AJKD Vol 48, July, 2006: pp 28-36*
5. Ballmer, P.E., et al .1995 Chronic metabolic acidosis decreases albumin synthesis and induces negative nitrogen balance in humans. *J. Clin. Invest* 95: 39-45. ■

The two words “information” and “communication are often used interchangeable, but they signify quite different things. Information is giving out; communication is getting through.

---Sydney J. Harris.

The most important thing in communication is to hear what isn't being said.

---Peter F. Drucker

FLUID BALANCE AND THE ISSUE OF DRY WEIGHT

By: Shelly Valadez, RN

Ninety percent (90%) of patients could be normotensive by lowering dry weight. As fluid is removed and an accurate dry weight is achieved blood pressure should begin to decrease. Blood pressure reaches a new steady state within approximately 6 weeks after extra fluid is removed (Mees, 2004). Excess fluid in dialysis patients can increase hospitalizations and increase mortality. It is evident that excess fluid is a major factor in contributing to hypertension, CHF, pulmonary edema, cardiac disease and in sub-optimal outcomes in dialysis patients. With the risk of increased hospitalizations and mortality due to excess fluid, it appears there is a need to focus on dry weights.

Assessment and achieving accurate dry weight equates with better blood pressure management and hopefully an increase in survival rates. Patient understanding and compliance play a role in maintaining an accurate dry weight. The entire patient care team plays a big role in assessing and accurately recording dry weight. However, the ability of the tissue space to hide fluid makes assessment of dry weight difficult and often inaccurate. For a patient weighing approximately 70 kilograms (154 pounds), edema cannot be seen until the patient has an extra 5 liters (5 kilograms or 11 pounds) in the tissue space (Guyton & Hall 2000). This will make proper assessment of dry weight difficult at best. A “crash” of the patient during dialysis treatment has become expected and acceptable side of hemodialysis. Often dry weight is considered to have been “met” when a patient experiences a “crash.” However, this may not be the case and a study in 2004 by Shoji, Tsubakihara, Fujii, and Imai would indicate that the “crash” is actually a symptom of ischemia.

Hypoxemia can be a significant complication of hemodialysis causing intradialytic morbid events such as hypotension, cramping, as well as periods of tissue ischemia. This has been attributed to the release of adenosine. Tissue ischemia causes the release of adenosine, which subsequently blocks the release of nor-epinephrine from the sympathetic nerve terminals and has intrinsic vasodilator properties. Thus, hypotension can perpetuate itself through the release of adenosine and its effects. This further explains why the “crash” may not be an accurate indicator of a dry weight.

Causes of Hypotension May Include:

- Posture
- Low O₂ Saturation
- Medication

- Incorrect ultrafiltration rate
- Hypotonic environment
- Hypoalbuminemia
- Dialysate at body temperature or warmer
- Splanchnic (visceral) vasodilatation secondary to food ingestion
- Severe anemia
- Unstable cardiovascular status
- Septicemia
- Dialyzer reaction, hemolysis and air embolism

Fluid balance is necessary to reduce hospitalization and improve patient outcomes. An inaccurate dry weight will affect **all** outcomes. Yet, despite considerable advances in assessment of dialysis adequacy with respect to solute removal, there is no easy measure for fluid removal. Devices are available but they are costly and not widely used. A comprehensive and ongoing assessment of body fluid and dry weight are necessary for all patients with chronic kidney disease and renal failure in order to reduce hospitalizations and improve outcomes. Ongoing assessments should include the following:

- **Instruct** patients to monitor weight daily and consistently with the same scales and at the same time of day.
- **Evaluate** weight in relation to nutritional status (refer to article in this issue concerning albumin and fluid balance).
- **Monitor** and **document** vital signs. Elderly patients have reduced response to catecholamines, thus their response to fluid overload may be blunted with less rise in heart rate.

Defining Characteristics of Fluid Retention

- Weight gain
- Edema
- Bounding pulses
- Shortness of breath
- Pulmonary congestion (noted on x-ray)
- Crackles
- Rales
- S₃ heart sound (auscultate for a third heart sound)
- Decrease in hemoglobin
- Increase in blood pressure



Keeping an ongoing and open dialog with patients and assessing for an increase and/or decrease in appetite is important. This is necessary to determine nutritional status. As a patient becomes less uremic the appetite will improve, thus an increase in body weight and not fluid weight will likely occur. Urine output will usually decrease over time and will require a decrease in fluid intake and/or



an increase in UF during dialysis in order to maintain fluid balance.

Once a dry weight; not always a dry weight. This is key in fluid balance. Each patient is unique and will exhibit an increase or decrease in fluid in different ways. An inaccurate dry weight will skew all outcomes and may not provide an accurate picture of health status. Hypertension is a major forecaster of heart disease and poor outcomes in dialysis patients. Keep in mind that fluid balance and fluid control is a key component to a healthy heart.

- **Do you have a monthly plan to assess dry weights?**
- **Do you know what % of your patients are achieving dry weight?**
- **How do you know the weights are accurate?**

REFERENCES:

Hlebovy, D. (2006) *Hemodialysis special interest group networking session: fluid management: moving and removing fluid during hemodialysis.* *Nephrology Nursing Journal.* 33(4): 441-445.

Mees, E. (2004). *Adequacy of dialysis: An inadequately applied concept.* *Dialysis and Transplantation* 33, 738-748.

Shoji, T., Tsubakihara, Y., Fujii, M & Imai E. (2004) *Hemodialysis-associated hypotension as an independent factor for two-year mortality in hemodialysis patients.* *Kidney International,* 66(3), 1212-1220. ■

STENOSIS **E**VALUATION IS **E**XTRÊMELY IMPORTANT!!

By: Shelly Valadez, RN

Network 13 is contracted with CMS to cover certain Clinical Performance Measures (CPM) every year. The CPM's are divided into tasks. Task 1.c. concerns vascular access monitoring. The Network shall work with the MRB (medical review board) and other partners, as appropriate to determine specific QI projects, as resources permit, which advance the purpose and strategic goals of the ESRD Network Program and are directly aligned with the areas of most need and potential impact for QI within the Network area. Network goal is to achieve 75%, at a minimum, of HD patients with AVG's being monitored for stenosis within our service area by the second quarter of 2007. Facilities who do not appear to have facility-specific protocols for stenosis monitoring will be asked to incorporate stenosis monitoring process to their vascular access management. In addition to monitoring AVG's,

Network is reviewing current submitted vascular access management tools as part of the Fistula First activity.

K/DOQI™ has established recommendation and guidelines for monitoring and surveillance:

- Monitoring, which K/DOQI™ defines as physical examination techniques to detect access dysfunction, has been shown in many studies to be able to identify the majority of patients with AV fistula and AV graft dysfunction.
- Surveillance involves the use of a variety of tests to detect access dysfunction. Intra-access blood flow measurement over time is the best surveillance method available for assessing AV fistula function and detection of dysfunction.
- Other important surveillance for vascular access monitoring include: physical findings of persistent swelling of arm, presence of collateral veins, prolonged bleeding after needle removal or altered pulse or thrill in access.
- Un-standardized dynamic venous pressures (DVPs) should NOT be used.

Two other methods offer significant value for AV fistula/ AV graft surveillance:

- Pre-pump arterial pressure. Pre-pump arterial pressure is measured on almost all dialysis machines, indicating the ease or difficulty with which the blood pump is able to draw blood from the access (inflow). A significant restriction of inflow will cause an excessively negative pre-pump arterial pressure. AV fistula pressures are often the earliest indication of stenosis, so pre-pump arterial pressure is an important tool in assessing an access.
- Access recirculation of measurement. An AV fistula may remain patent but not provide enough blood flow to meet the prescribed blood pump flow rate, resulting in under dialysis. If there is any question about adequacy of blood flow for dialysis, or if there is difficulty dialyzing the patient at the prescribed pump rate, a recirculation study will determine if the AV fistula blood flow is sufficient to meet the prescribed blood pump rate.

Adequate care of the dialysis patient dependent on hemodialysis needs constant attention to maintain vascular access patency. K/DOQI™ states that



People are like stained-glass windows. They sparkle and shine when the sun is out, but when the darkness sets in, their true beauty is revealed only if there is a light from within.
---Elizabeth Kubler-Ross

an ideal access delivers a flow rate adequate for the dialysis prescription, has a long use-life and has a low rate of complications. The A-V fistula comes closest to doing so. The substitution of grafts for AVFs has increased patient care costs in part due to the increased number of procedures needed to maintain patency of grafts compared to AVFs. After evaluating all the available data on vascular access, the Vascular Access Work Group concluded that quality of life and overall outcomes for hemodialysis patients could be improved by achieving two primary goals: (1) increasing the placement of native AVFs and (2) detecting access problems prior to access thrombosis”(K/DOQI™ Clinical Practice Guidelines for Vascular Access, 2000).

Remember: A patient’s permanent access (AV Fistula or AV Graft) should be monitored for access dysfunction. Physical examination for abnormalities, such as persistent swelling, prolonged bleeding after needle withdrawal or altered characteristics of pulse or thrill in the outflow vein and pre-pump arterial pressure should be done during every treatment and recorded. ■

MEDICARE PRESCRIPTION DRUG BENEFIT ENROLLMENT DEADLINE WILL BE EXTENDED FOR THOSE WHO DID NOT RECEIVE TIMELY INFORMATION ABOUT THEIR CURRENT COVERAGE, CMS SAYS

Medicare beneficiaries who did not receive timely information on about benefit and cost changes for their current Medicare prescription drug plans will have until February 15 to select coverage for 2007. Beneficiaries had until December 31, 2006, to enroll in or change Medicare drug plans, although administration officials had urged beneficiaries to act by December 8, 2006, to avoid problems. Federal officials told private insurers that sponsor Medicare drug plans that they had to send “annual notice-of-change” documentation to beneficiaries by October 31, 2006, informing them of any changes to their plans. Many of the insurance companies did not send the documentation on time. Jeff Nelligan, CMS spokesperson, said the extended deadline applies to beneficiaries who did not receive the documents by November 15, 2006, the start of the open-enrollment period. ■

“I believe that unarmed truth and unconditional love will have the final word in reality.

...Martin Luther King, Jr

DON'T BE PART OF A DATA DISASTER

By Cindy Smith, Data Manager

Here we are with another year gone. Most of you know what that means, 2006 CMS-2744 Annual Facility surveys will soon be winging their way to you. I would encourage you to pay close attention to your ending patient population on your NPARs (National Patient Activity Report, formerly FARs). Remember you can request a patient roster at any time by calling me at 405.948.2240. Any preparations you can make now will make your life (and mine) easier in February. As we move toward all electronic data submission, it is extremely important that our database be accurate.

Also, coming soon will be Annual Forms Compliance. This is your “report card” for timeliness and accuracy of the forms you have submitted to the Network for processing this year. Due to some computer problems at the CMS level, the semi-annual Forms Compliance was not sent for the first half of the year. I will be sending the Annual Compliance for you to check for any errors made in the Network office. You will be given a short period of time to challenge these reports prior to them being reported to CMS.

Field 18 on the 2728 form continues to be a huge problem. Please remember that all of these must be answered. A **yes** response (in a, b or c) must also include a time frame. (**Unknown as the timeframe is unacceptable**). If the time frame is less than 6 months, you may write that in by hand on the form.

All forms that you submit should have “**ALL BLANKS COMPLETED!**”

Reminders:

At **no time** should Protected Health Information (PHI) be transmitted via E-mail. This includes patient’s name, address, telephone number or any other identifier.

All material sent via fax must include a cover sheet. Do **NOT** put individually identifiable or sensitive information on the fax cover sheet. ■

TELL US WHAT YOU'RE DOING!

Are you implementing any QI projects that are having a positive impact on patient outcomes? Let us showcase your successes in our newsletter.

Contact: Shelly Valadez, RN, QI Nurse ESRD Network 13 by phone: 405.948.2250 or by e-mail:

svaladez@nw13.esrd.net ■

ANEMIA CONFERENCE CALLS HELD WITH FACILITIES HAVING SUB-OPTIMAL HGB'S IN 4TH QTR 2005

One of Network 13's CPM's for 2006 was to review those facilities falling below goal (83% of all patients maintaining a Hgb \geq 11). Each facility should have received a memo showing what percentage of the patients were meeting goal in the 4th Qtr of 2005.

Do you know what your facility's percentage was in 2005 and what your percentage is now?

Once the facilities with less than 70% of patients meeting goal was determined, those facilities were contacted by mail and phone to notify them of Network 13's Anemia Workplan. Conference calls and Web-Ex training were scheduled with members of the facility Anemia Team. This was a great opportunity for Cheryl George RN and Shelly Valadez RN, Network 13's new QI nurses, to get to know some of the Nurse Managers and network with these facilities. During the calls, several issues relating to Anemia Management were discussed. Each facility was asked what they thought their biggest barriers were relating to sub-11 Hgb's. See table for those replies.

Other issues discussed were frequency of team meetings, lab draws, and timeliness of review. Facilities were supplied with professional and patient educational materials if requested. Quality Improvement Plan (QIP) samples were provided, as well as Anemia Barrier Worksheets (available at <http://www.network13.org/resources.asp>). These facilities will be required to maintain a monthly QIP until meeting Network goals, and will then be reviewed at a later date to assure continuity of care. →

FREE CEU OFFERINGS!!

PRESENTED BY KATHRYN SPIEGEL RN, PhD, CCRN WITH WATSON LABORATORIES, INC., ANEMIA AND IRON MANAGEMENT: SUCCESSFULLY MANAGING PATIENT OUTLIERS. February 6, 2007 at 2:30 PM and February 8, 2007 at 9:30 AM. 15 CEU's awarded by ANNA.

See insert in this newsletter for details

Transplant

United Network for Organ Sharing (UNOS) provides transplantation and donation information - see Web page <http://www.unos.org/>

Each day about 74 people receive an organ transplant. However, seventeen people die each day waiting for transplants that can't take place because of the shortage of donated organs. ■

Table: Barriers Cited in Anemia Conference Calls

CORPORATE/MANAGEMENT	
Anemia Manager time off floor	2
Response time for lab review/dose changes	2
Availability of Medications (run out of epo)	2
No support system (corporate/med reps)	2
TOTAL	8
ANEMIA TEAM/PHYSICIAN	
EMP Policy	3
Protocol (No protocol or frequent changes)	9
No Anemia Manager or system of review	2
Not addressing Barriers	1
Iron Issues (high ferritin/protocols)	4
No support system (physician)	1
Switch from Epo to Aranesp	2
TOTAL	22
STAFF EDUCATION	
Lab Draws/dialyzer clearance/staff education	2
Anemia Manager inexperience	2
TOTAL	4
PATIENT	
Transportation/insurance	1
GI Bleeds	2
Hospitalizations	4
Cancer Patients	1
New Patients	4
Infections	2
Elevated PTH	1
Patient Non-compliance/No Shows	3
TOTAL	18

DID YOU KNOW???

Did you know that many deodorant/antiperspirant manufacturers are putting warnings on their products that state, "consult your doctor before using this product if you have kidney disease" because of the aluminum content? This has been an "on and off" again issue for years. It is note worthy and food for thought for many dialysis patients.

Did you know that Network 13 is your resource? If you need patient education materials, if you have questions or concerns we are here to help. The world of ESRD is a busy place and Network 13 wants to partner with you to provide the best care possible to the patients.

Did you know that ESRD Network 13 now has patient workshops for patients and families/caregivers? Patient/family workshops are held in the evening the night prior to the professional workshops. Encourage all patients and families to take advantage of this great opportunity. **As professionals, you can help patients help themselves by encouraging each of them and their families/caregivers to attend this educational opportunity.** ■

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SAVE THE DATES

SPRING 2007 WORKSHOP LOCATIONS AND DATES

OKLAHOMA - TUESDAY, APRIL 3, 2007

MARRIOTT HOTEL

1902 E 71ST ST

TULSA , OK 74136

PHONE NUMBER: 918.493.7000

LOUISIANA - THURSDAY, MAY 17, 2007

SHERATON BATON ROUGE CONVENTION CENTER

102 FRANCE STREET

BATON ROUGE, LA 70802

PHONE NUMBER: 225.242.2600

ARKANSAS - THURSDAY, MAY 31, 2007

EMBASSY SUITES

11301 FINANCIAL CENTRE PARKWAY

LITTLE ROCK, AR 72211

PHONE NUMBER: 501.312.9000

BE SURE AND ATTEND THE ESRD NETWORK 13 WORKSHOP AND HEAR AND PRACTICE HEALTH LITERACY.

News You Can Use

NEEDS YOU!

The Professional Newsletter is published quarterly by the staff of ESRD Network 13. The next edition is scheduled for Spring/April 2007. If you are interested in contributing to this newsletter, please call us at **405.948.2250**, fax us at **405.942.6884** or send any articles, materials and/or ideas to:

News You Can Use

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Change Service Requested