

# Quality Performance Measures

**“Assisting the Renal Community  
to Improve the Quality of Patient Care”**

# 2002

**Quality Improvement Activity**

**End stage  
Renal Disease  
Network 13**



# Table of Contents

<b>Table of Contents.....</b>	<b>1</b>
<b>Introduction.....</b>	<b>3</b>
<b>Anemia Management.....</b>	<b>5</b>
<b>Adequacy of Dialysis.....</b>	<b>7</b>
<b>Hemodialysis.....</b>	<b>7</b>
<b>Peritoneal Dialysis.....</b>	<b>9</b>
<b>Vascular Access.....</b>	<b>10</b>
<b>Nutrition.....</b>	<b>12</b>
<b>Infection Control.....</b>	<b>14</b>
<b>Prevention.....</b>	<b>15</b>

This page left blank intentionally.

# Introduction

## Background

As of December 31, 2001, there are 12,225 people in Network 13 who have end stage renal disease (ESRD), of which 91% (11,170) are treated by hemodialysis and 9% (1,055) are treated by peritoneal dialysis. The available National data activities (historically Core Indicators and now Clinical Performance Measures) report on the quality of care being provided to the ESRD beneficiaries and are a commitment to improving ESRD patient care and outcomes. Results provided to date argue strongly that meaningful feedback data reports are an important tool that can be used by the Network 13 facilities in assessing patient care processes and outcomes, as well as helping providers in identifying opportunities for improving their processes of care. However, these National projects report on a percentage of patients and providers within the Network. A truly reflective facility-specific snapshot of the dialysis care provided throughout Network 13 is now available on an annual basis through the annual Quality Performance Measures (QPM) activity.

It appears that there has been widespread distribution and implementation of Clinical Practice Guidelines from the National Kidney Foundation (NKF) - Kidney Disease Outcomes Quality Initiatives (K/DOQI™). The Clinical Practice Guidelines referenced in this report are specific to Hemodialysis Adequacy, Nutrition in Chronic Renal Failure, Peritoneal Dialysis Adequacy, Treatment of Anemia of Chronic Renal Failure, and Vascular Access. Based on these guidelines as well as National data, the ESRD Network 13 Medical Review Board and Board of Directors have approved utilization of the QPM as a map to direct areas in which to focus Network 13 Quality Improvement (QI) activities.

## Objectives

QPM is based on a combination of two separate but complementary activities: outcomes assessment and continuous quality improvement.

- Outcomes of Interest = (1) Anemia management; (2) Delivery of adequate dialysis therapy; (3) Monitoring of vascular access; (4) Management of nutrition; (5) Infection control practices; and (6) Prevention issues such as immunizations and foot care.
- Process Indicators = (1) Early detection of anemia, inadequate dialysis therapy, vascular access complications, inadequate nutrition management, inappropriate infection control practices, and (2) Prevention of influenza, pneumococcal pneumonia, and hepatitis as deemed appropriate, as well as diabetic/neuropathy foot complications (e.g., foot ulcers, amputations).
- The anticipated short- and long-term goal of this activity is to stimulate facility-specific ongoing QI processes specific to listed outcomes.

## Methodology

Two hundred, forty (240) CMS-approved ESRD providers/facilities within Network 13.

- The Network provided project facilities with data abstraction tool.
- Exclusions – Any facility pending Medicare certification at time of data abstraction, as well as units declaring “primarily acute” patient populations and prison units.
- Timeframe: July 2002

## Methodology (Continued)

### Data Analysis:

It should be noted that the data analyzed for QPM reports (summary & facility-specific) was self-reported, facility-specific data. Quality of data issues was clarified via telephone and fax replies to questions regarding data. Each facility's medical director and nurse manager were asked to 'sign off' that the "information provided was current and reflective of performance at their facility". The Network staff, Quality Improvement Committee (QIC) and the Medical Review Board (MRB) reviewed preliminary data analysis and report(s) prior to distribution.

### Data Validation:

Each facility was asked to submit July 2002 facility-specific lab reports for validation purposes. The Network QI staff randomly selected 11% of participating facilities (26) for QPM data validation. The data validation included the review of 100% patient-specific monthly lab reports to verify previously self-reported data. This activity allowed the Network to validate adequacy, anemia, and nutrition sections of the QPM.

## Review and Distribution of State and Facility-Specific Data

The Network annually submits a preliminary report detailing the results of individual facility and statewide (AR, LA, OK) QPM results for review by the Network's MRB prior to distribution to the renal community. Based on their review, the MRB can direct the Network to notify facilities of concerns with facility outcomes, as well as to offer Network assistance in facility quality improvement activities.

## Opportunity to Improve

Each Network 13 dialysis facility receives facility-specific color charts displaying their outcomes and state and Network comparisons. It is expected that facility leadership will review their charts for opportunities to improve. The Network QI staff are available upon request to assist facilities in reviewing their outcomes and in implementing quality improvement activities.

## Acknowledgments

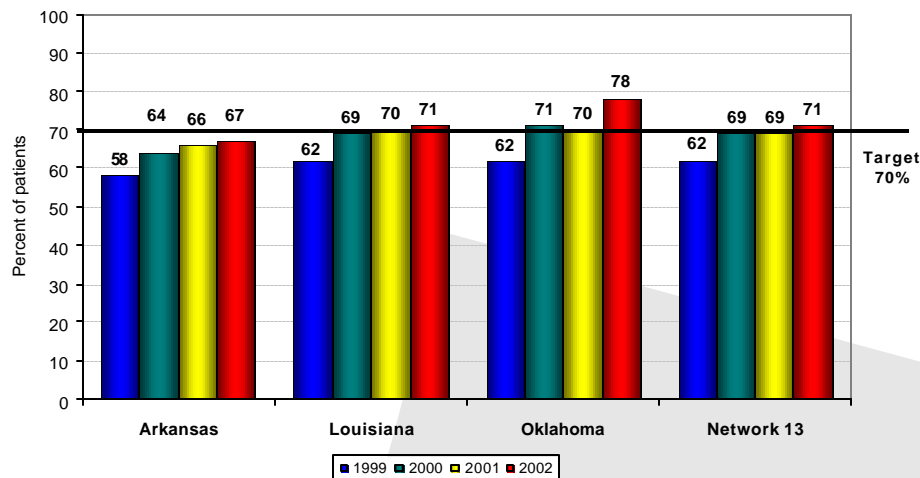
ESRD Network 13 staff and the Medical Review Board commend the Network's dialysis community for their cooperation in collecting and reporting facility data for the 2002 Quality Performance Measures Report. This report, which represents many hours of hard work, is a symbol of your ongoing commitment towards providing dialysis patients with longer, healthier, more active lives.

# Anemia Management

The most commonly used laboratory test to assess anemia management is the hemoglobin (Hgb). Additional tests measure serum ferritin and transferrin saturation (TSat). The National Kidney Foundation (NKF) Kidney Disease Outcomes Quality Initiative (K/DOQI™) Clinical Practice Guidelines for anemia management recommend the following:

1. Target range for hemoglobin for Epoetin therapy.
  - Target range should be Hgb 11 -12 g/dL.
2. Assessment of iron stores among anemic patients or patients prescribed Epoetin therapy.
  - Iron status should be monitored by the percent transferrin saturation (TSat) and the serum ferritin.
  - Target iron level. Chronic renal failure patients should receive sufficient iron to achieve and maintain hemoglobin levels of 11-12 g/dL.
  - Monitoring iron status:
    - a. During the initiation of Epoetin therapy and while increasing the Epoetin dose in order to achieve an increase in hemoglobin, the TSat and the serum ferritin should be checked every month in patients not receiving intravenous iron, and at least once every 3 months in patients receiving intravenous iron, until target hemoglobin is reached.
    - b. Following attainment of the target hemoglobin, TSat and serum ferritin should be determined at least once every three months.

**Percent of Patients Achieving Hgb >= 11  
1999-2002**



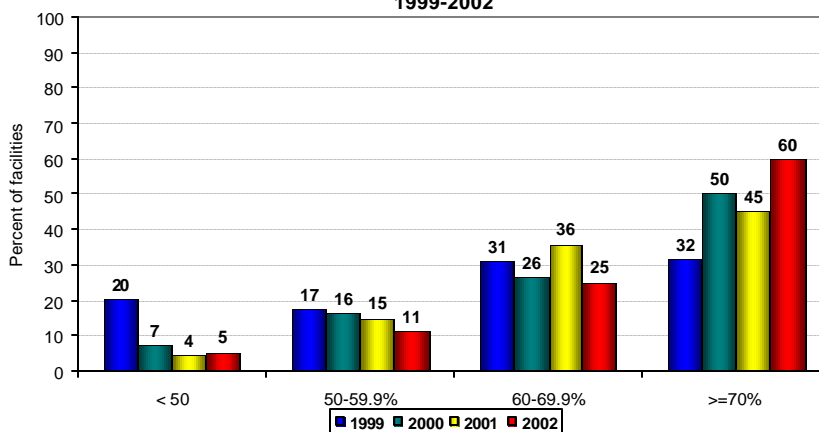
<b>Anemia Management: 2002</b>				
<b>All ESRD Patients</b>	<b>Arkansas</b>	<b>Louisiana</b>	<b>Oklahoma</b>	<b>Network 13</b>
Mean Hemoglobin	11.6	11.7	11.9	11.7
% Facilities with 70% or more of their patients with Hgb >= 11	42	60	81	60
% Facilities reporting an Epoetin protocol	97	99	98	98
% Facilities reporting an Iron protocol	40	91	78	88
% Facilities who have protocol for hyporesponse to Epoetin/Iron therapy	77	72	67	72
% Patients with serum ferritin	90	90	91	90
% Patients with TSat >= 20%	71	76	79	76
<b>Opportunity to Improve</b>				
<p><b>Only 60% of facilities achieved target of 70% of their patient population with Hgb's &gt;= 11g/dL. Additional QI focus is needed to assist patients in achieving Anemia Management target.</b></p>				

# How Does Your Facility Compare?

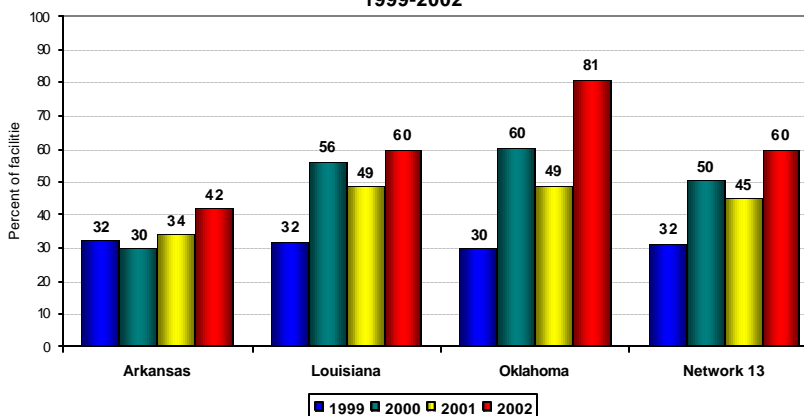
Distribution of Facilities by Percent of Patients with Hemoglobin $\geq$ 11g/dL: 2002								
% of ESRD patients with a Hgb $\geq$ 11	Arkansas		Louisiana		Oklahoma		Network 13	
	# Facilities	% Facilities	# Facilities	% Facilities	# Facilities	% Facilities	# Facilities	% Facilities
0-9.9%	1	1.7	0	0.0	0	0.0	1	0.4
10-19.9%	0	0.0	1	0.8	0	0.0	1	0.4
20-29.9%	0	0.0	1	0.8	0	0.0	1	0.4
30-39.9%	1	1.7	3	2.4	0	0.0	4	1.7
40-49.9%	2	3.3	2	1.6	0	0.0	4	1.7
50-59.9%	10	16.7	12	9.5	4	7.4	26	10.8
60-69.9%	21	35.0	32	25.4	6	11.1	59	24.6
70-79.9%	16	26.7	40	31.7	20	37.0	76	31.7
80-89.9%	6	10.0	30	23.8	17	31.5	53	22.1
90-100%	3	5.0	5	4.0	7	13.0	15	6.3
<b>Total</b>	<b>60</b>	<b>100</b>	<b>126</b>	<b>100</b>	<b>54</b>	<b>100</b>	<b>240</b>	<b>100</b>

These facilities have been identified as having an opportunity for improvement.

Distribution of Percent of Facilities by Percent of Patients with Hgb  $\geq$  11  
1999-2002



Percent of Facilities Meeting Minimal Anemia Management Target (Hgb  $\geq$  11)  
1999-2002



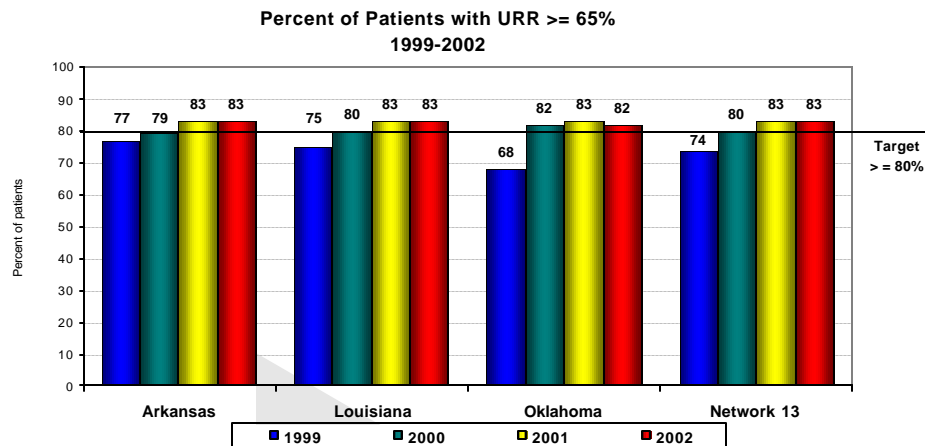


# Adequacy of Dialysis

## Hemodialysis Adequacy

The two common measures to assess hemodialysis adequacy are urea reduction ratio (URR) and Kt/V. The NKF-K/DOQI™ Clinical Practice Guidelines recommend the following:

1. Minimum Delivered Hemodialysis Dose
  - The dialysis care team should deliver a Kt/V of at least 1.2 (single-pool, variable volume) for both adult and pediatric hemodialysis patients. For those using the urea reduction ratio (URR), the delivered dose should be equivalent to a Kt/V of 1.2, i.e., an average URR of 65%; however, URR can vary substantially as a function of fluid removal. **URR has been selected by the Network 13 MRB as the primary measure of HD adequacy for this report and follow-up QI activities.**
2. Monthly Measurement of Delivered Hemodialysis Dose
  - The dialysis care team should routinely measure and monitor the delivered dose of hemodialysis



Adequacy Management: 2002				
Hemodialysis	Arkansas	Louisiana	Oklahoma	Network 13
Mean URR	71.0	70.1	70.1	70.3
# Facilities reporting	60	125	54	239
Mean Kt/V	1.5	1.4	1.5	1.5
# Facilities reporting	46	82	42	170
% Facilities with 80% or more patients having URR >= 65%	65.0	64.8	64.8	64.9
Average time on dialysis (min)	221	228	219	224
# Facilities reporting	60	125	54	239
% Facilities that reporting performing post-BUN collection audits	51.7	49.2	59.3	52.7
% Facilities reporting performing residual renal function (RRF)	46.7	63.5	64.8	59.8
<b>Opportunity to Improve</b>				
<b>35% (84 facilities) need to focus QI activities towards achieving performance target (80% of HD patients achieving URR &gt;= 65%)</b>				

# How Does Your Facility Compare?

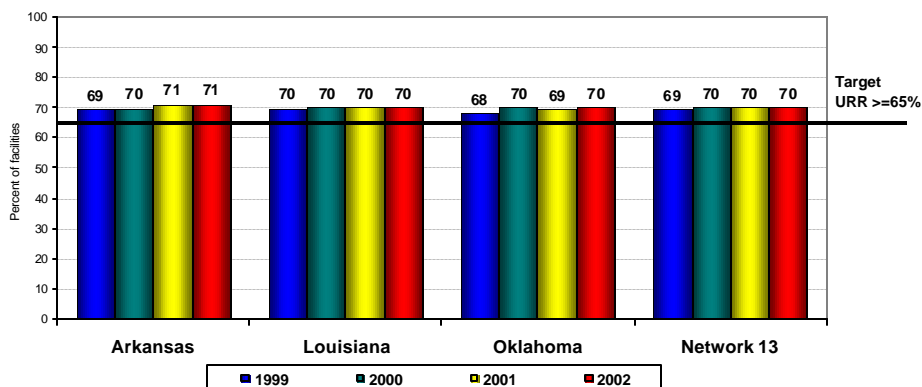
## Distribution of Facilities by Percent of Patients with URR >= 65%: 2002

% of Hemodialysis patients with a URR >= 65%	Arkansas		Louisiana		Oklahoma		Network 13	
	# Facilities	% Facilities	# Facilities	% Facilities	# Facilities	% Facilities	# Facilities	% Facilities
0-9.9%	0	0.0	0	0.0	0	0.0	0	0.0
10-19.9%	0	0.0	0	0.0	0	0.0	0	0.0
20-29.9%	0	0.0	0	0.0	0	0.0	0	0.0
30-39.9%	0	0.0	0	0.0	0	0.0	0	0.0
40-49.9%	2	3.3	0	0.0	0	0.0	2	0.8
50-59.9%	3	5.0	0	0.0	3	5.6	6	2.5
60-69.9%	4	6.7	11	8.8	4	7.4	19	7.9
70-79.9%	12	20.0	33	26.4	12	22.2	57	23.8
80-89.9%	19	31.7	47	37.6	23	42.6	89	37.2
90-100%	20	33.3	34	27.2	12	22.2	66	27.6
<b>Total</b>	<b>60</b>	<b>100</b>	<b>125</b>	<b>100</b>	<b>54</b>	<b>100</b>	<b>239</b>	<b>100</b>

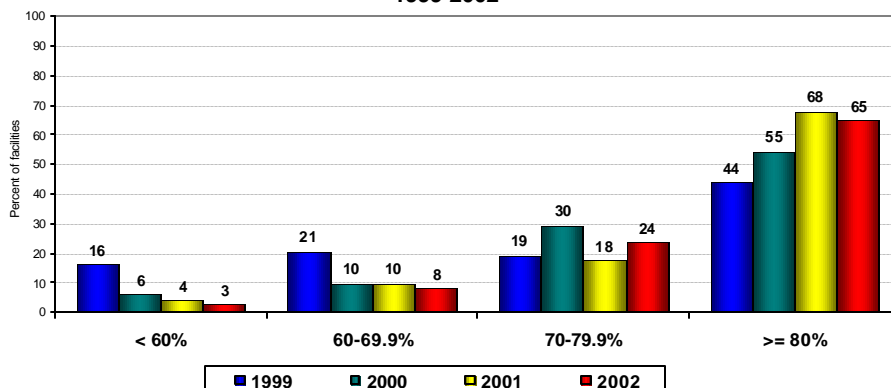
These facilities have been identified as having an opportunity for improvement.

These facilities have been identified as having an opportunity for improvement.

Mean HD Adequacy Measures (URR) 1999-2002



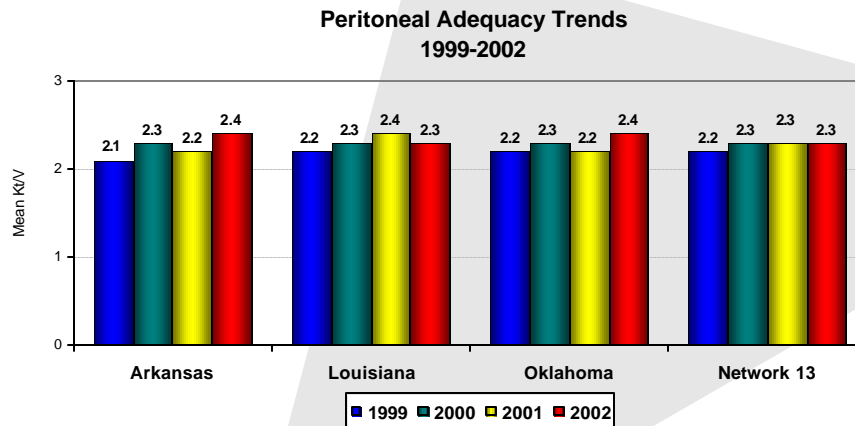
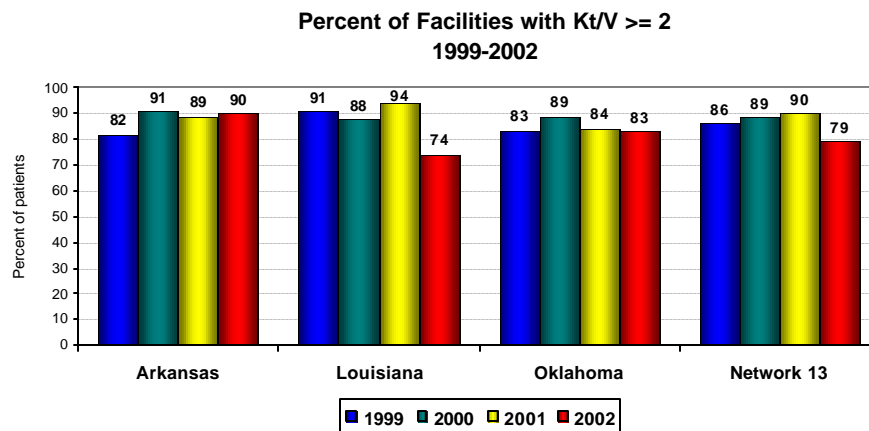
Distribution of Percent of Facilities by Percent of Patients with HD Adequacy (URR) 65% or Higher 1999-2002



# Peritoneal Dialysis Adequacy

The measures of peritoneal dialysis (PD) adequacy are total weekly creatinine clearance (CrCl) normalized to 1.73 m<sup>2</sup> body surface area and total weekly Kt/V. The NKF-K/DOQI™ Clinical Practice Guidelines recommend the following:

1. Weekly Dose of CAPD
  - The delivered PD dose should be a total Kt/Vurea of at least 2.0 per week and a total CrCl of at least 60 L/week/1.73 m<sup>2</sup>.
2. Weekly Dose of CCPD and NIPD
  - CCPD – the delivered PD dose should be a total Kt/Vurea of at least 2.1 and a weekly total CrCl of at least 63 L/1.73 m<sup>2</sup>.
  - NIPD – the delivered PD dose should be a total Kt/Vurea of at least 2.2 and a weekly total CrCl of at least 66 L/1.73 m<sup>2</sup>.
3. Measurement of Total Solute Clearance at Regular Intervals (Peritoneal Dialysis)
  - Both total weekly creatinine clearance normalized to 1.73 m<sup>2</sup> BSA and total weekly Kt/Vurea should be used to measure delivered peritoneal dialysis doses. Consideration should be given to dialysate and urine collections.



<b>Peritoneal Adequacy Management: 2002</b>				
<b>Peritoneal Dialysis</b>	<b>Arkansas</b>	<b>Louisiana</b>	<b>Oklahoma</b>	<b>Network 13</b>
<b>Mean Kt/V</b>	<b>2.4</b>	<b>2.3</b>	<b>2.4</b>	<b>2.3</b>
<b># Facilities Reporting</b>	<b>10</b>	<b>35</b>	<b>18</b>	<b>63</b>
<b>Mean CrCl</b>	<b>70.4</b>	<b>71.0</b>	<b>66.5</b>	<b>70.1</b>
<b># Facilities Reporting</b>	<b>8</b>	<b>22</b>	<b>12</b>	<b>42</b>

# Vascular Access

The NKF-K/DOQI™ Clinical Practice Guidelines recommend the following:

## 1. Selection of Permanent Vascular Access

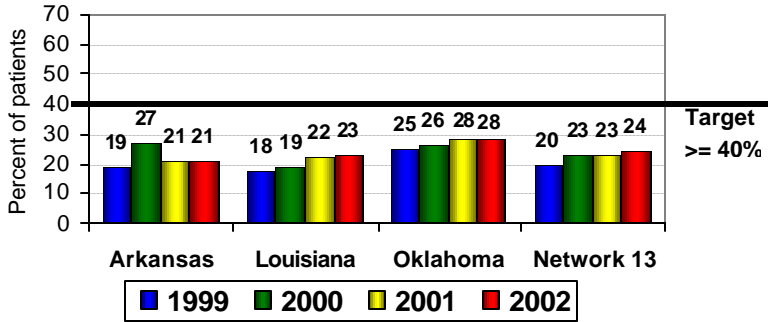
- Maximizing placement of arteriovenous fistulas (AVF). The order of preference for placement of AVF is: 1) wrist (radial-cephalic) primary AVF; 2) elbow (brachial-cephalic) primary AVF.
- If it is not possible to establish either of these AVF's, access may be established using: 1) arteriovenous graft (AVG) of synthetic material, or 2) transposed brachial-basilic vein fistula
- Cuffed-tunneled central venous catheters should be discouraged as a permanent vascular access.

## 2. Monitoring AVG's for Stenosis

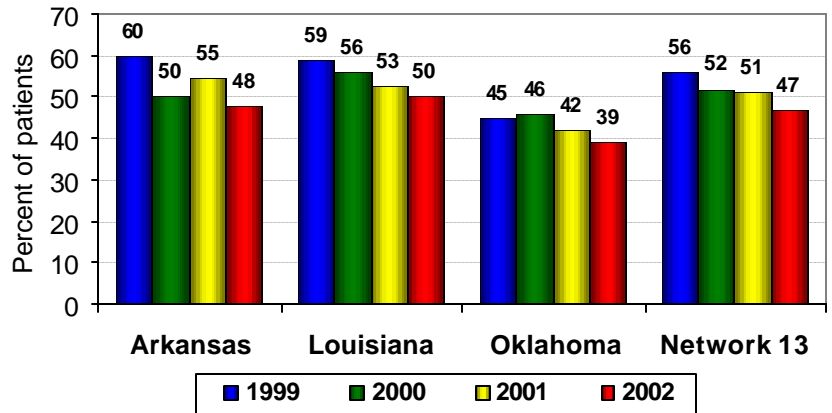
- Physical examination of an access graft should be performed weekly and should include, but not be limited to, inspection and palpation for pulse and thrill at arterial, mid, and venous sections of the graft.
- AVG's should be monitored for hemodynamically significant stenosis. Current CMS performance target is 100% of AVG's are to be monitored for stenosis.
- Techniques, not mutually exclusive, that can be used to monitor for stenosis in AVG's includes: 1) intra-access flow; 2) static venous pressures; 3) dynamic venous pressures; 4) measurement of access recirculation using urea concentrations; 5) measurement of recirculation using dilution techniques; 6) unexplained decreases in measured adequacy; 7) physical findings of persistent swelling of the arm, clotting of the graft, prolonged bleeding after needle withdrawal, or altered pulse/thrill characteristics; and 8) elevated negative arterial pre-pump pressures that prevent increasing to acceptable blood flow.

<b>Vascular Access Management: 2002</b>				
<b>Vascular Access</b>	<b>Arkansas</b>	<b>Louisiana</b>	<b>Oklahoma</b>	<b>Network 13</b>
% Facility reporting access monitoring and maintenance policies in place	75.0	69.4	81.5	73.5
Stenosis*	46.7	50.8	48.1	49.2
Thrombosis	51.7	54.0	59.3	54.6
100% of AVG patients is monitored for stenosis*	85.0	70.6	90.7	78.8
Unexplained decreases in HD adequacy	66.7	61.9	72.2	65.4
Measurement of access recirculation using urea concentrations	16.7	17.5	35.2	21.3
Measurement of recirculation using dilution (non-urea based)	10.0	3.2	11.1	6.7
Elevated negative arterial pre-pump pressures	23.3	27.0	31.5	27.1
Physical findings of persistent swelling of the arm, clotting of the graft, prolonged bleeding after needle withdrawal, or altered pulse characteristics of pulse of thrill in AVG	68.3	61.9	79.6	67.5
Static venous pressure	35.0	29.4	31.5	31.3
Dynamic venous pressure	23.3	36.5	50.0	36.3
Intra-access flow	5.0	7.1	7.4	6.7
% Facilities reporting vascular quality of care standard measurements available	58.3	56.3	75.5	61.1
* <b>Target: 100% of AVG's to be monitored for stenosis. It should be noted that the 2002 Clinical Performance Measures reflected only 43% of AVG's were being monitored for stenosis.</b>				

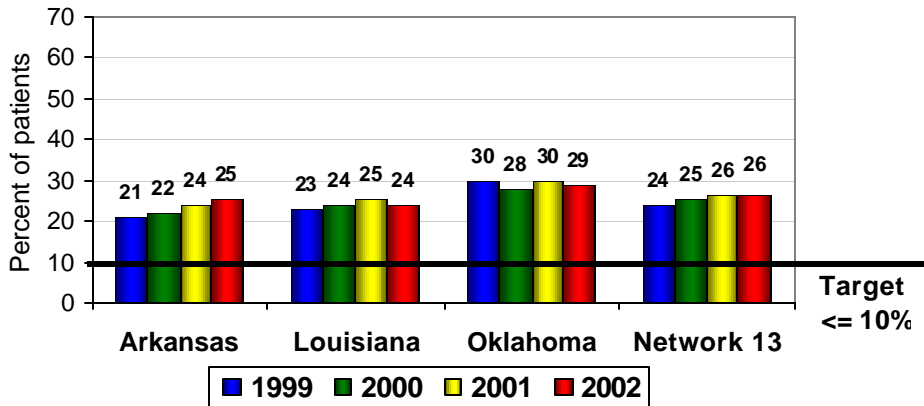
### Fistula Access by Percent of HD Patients 1999-2002



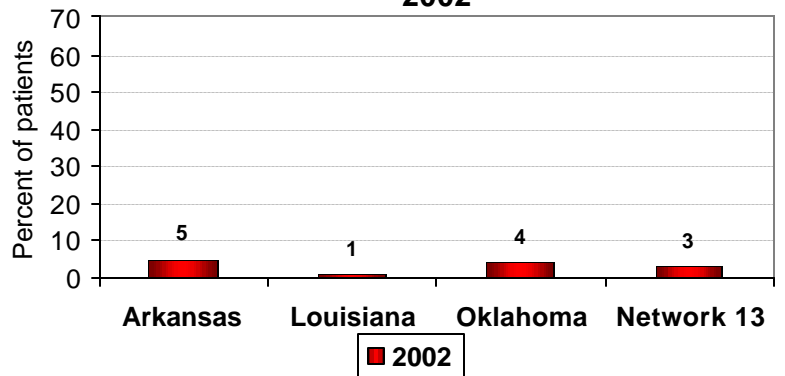
### Graft Access by Percent of HD Patients 1999-2002



### Catheter Access by Percent of HD Patients 1999-2002



### Port Access by Percent of HD Patients 2002

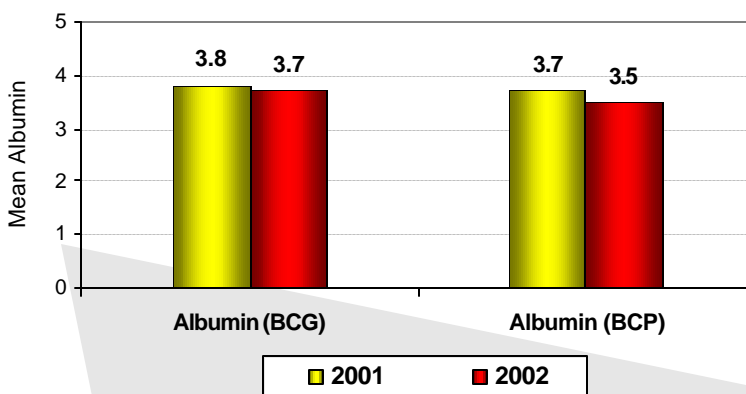


# Nutrition

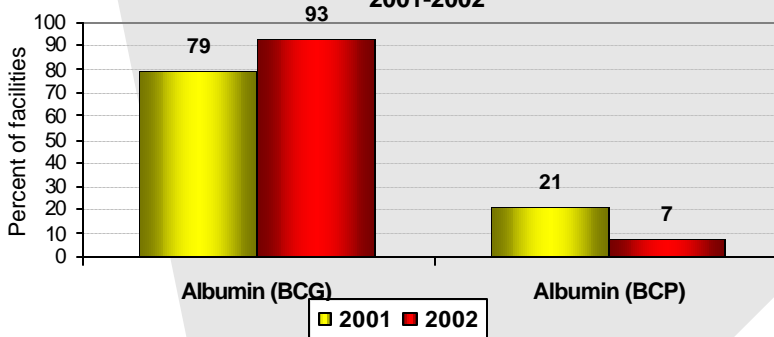
Two laboratory methods exist for determining serum albumin levels; bromocresol green (BCG) and bromocresol purple (BCP). The majority of Network 13 facilities report utilizing BCG to calculate serum albumin levels. The testing methods produce different results with BCP providing systematically lower results. The NKF-K/DOQI™ Clinical Practice Guidelines for nutrition recommend the following:

1. Serum albumin is a valid and clinically useful measure of protein-energy nutritional status in maintenance dialysis patients.
  - A predialysis or stabilized serum albumin equal to or greater than the lower limit of the normal range is the outcome goal. (BCG = 4.0 g/dl and BCP = 3.7 g/dl)

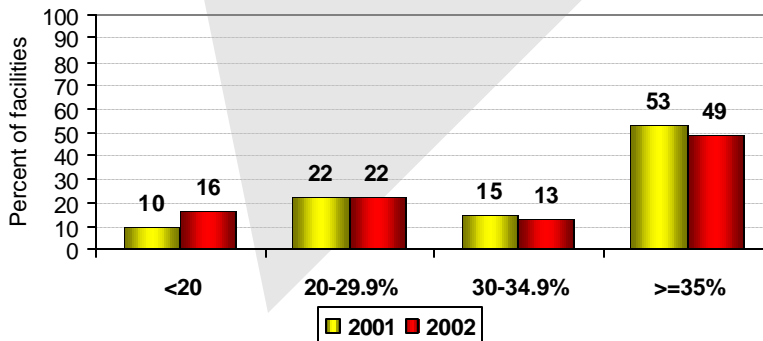
## Nutrition Management 2001-2002



## Reported Methodology for Albumin Testing (BCG/BCP) 2001-2002



## Distribution of Percent of Facilities by Percent of Patients with Albumin $\geq$ (4.0/3.7) 2001-2002



Nutrition: 2002				
Albumin Management	Arkansas	Louisiana	Oklahoma	Network 13
% Patients with mean albumin $\geq$ 4.0 (BCG)	32.3	37.9	30.9	35.1
% Patients with mean albumin $\geq$ 3.7 (BCP)	23.1	49.1	46.7	41.4
% Facilities with 35% of patients with mean Albumin $\geq$ 4.0 (BCG)	36.8	59.3	30.4	47.8
# Facilities reported	57	123	46	226
% Facilities with 35% of patients with mean Albumin $\geq$ 3.7 (BCP)	50.0	75.0	62.5	62.5
# Facilities reporting	4	4	8	16

## How Does Your Facility Compare?

Distribution of Facilities by Percent of Patients with Albumin (BCG) $\geq$ 4.0: 2002								
% of ESRD Patients with a Albumin $\geq$ 4.0 (BCG)	Arkansas		Louisiana		Oklahoma		Network 13	
	# Facilities	% Facilities	# Facilities	% Facilities	# Facilities	% Facilities	# Facilities	% Facilities
0-9.9%	3	5.3	2	1.6	0	0.0	5	2.2
10-19.9%	7	12.3	11	8.9	10	21.7	28	12.4
20-29.9%	16	28.1	25	20.3	13	28.3	54	23.9
30-34.9%	10	17.5	12	9.8	9	19.6	31	13.7
35-39.9%	4	7.0	12	9.8	4	8.7	20	8.8
40-49.9%	9	15.8	34	27.6	7	15.2	50	22.1
50-59.9%	6	10.5	18	14.6	2	4.3	26	11.5
60-69.9%	1	1.8	6	4.9	0	0.0	7	3.1
70-79.9%	1	1.8	3	2.4	0	0.0	4	1.8
80-89.9%	0	0.0	0	0.0	1	2.2	1	0.4
90-100%	0	0.0	0	0.0	0	0.0	0	0.0
Total	57	100	123	100	46	100	226	100

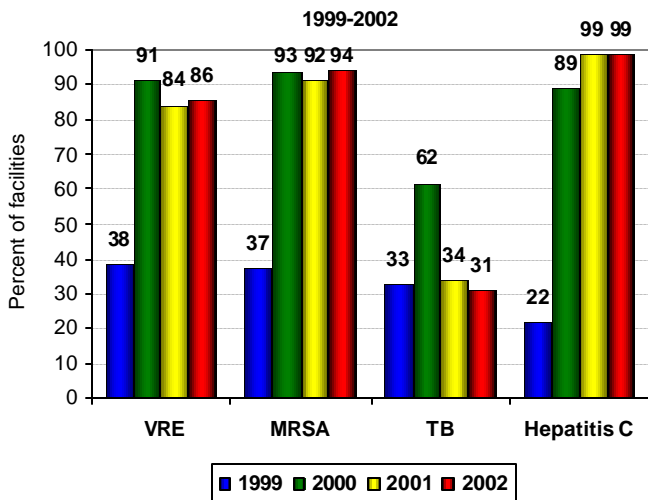
Distribution of Facilities by Percent of Patients with Albumin (BCP) $\geq$ 3.7: 2002								
% of ESRD Patients with a Albumin $\geq$ 3.7 (BCP)	Arkansas		Louisiana		Oklahoma		Network 13	
	# Facilities	% Facilities	# Facilities	% Facilities	# Facilities	% Facilities	# Facilities	% Facilities
0-9.9%	1	25.0	0	0.0	1	12.5	2	12.5
10-19.9%	1	25.0	1	25.0	1	12.5	3	18.8
20-29.9%	0	0.0	0	0.0	0	0.0	0	0.0
30-34.9%	0	0.0	0	0.0	1	12.5	1	6.3
35-39.9%	1	25.0	0	0.0	0	0.0	1	6.3
40-49.9%	1	25.0	0	0.0	0	0.0	1	6.3
50-59.9%	0	0.0	1	25.0	1	12.5	2	12.5
60-69.9%	0	0.0	1	25.0	3	37.5	4	25.0
70-79.9%	0	0.0	1	25.0	1	12.5	2	12.5
80-89.9%	0	0.0	0	0.0	0	0.0	0	0.0
90-100%	0	0.0	0	0.0	0	0.0	0	0.0
Total	4	100	4	100	8	100	16	100

These facilities have been identified as having an opportunity for improvement.

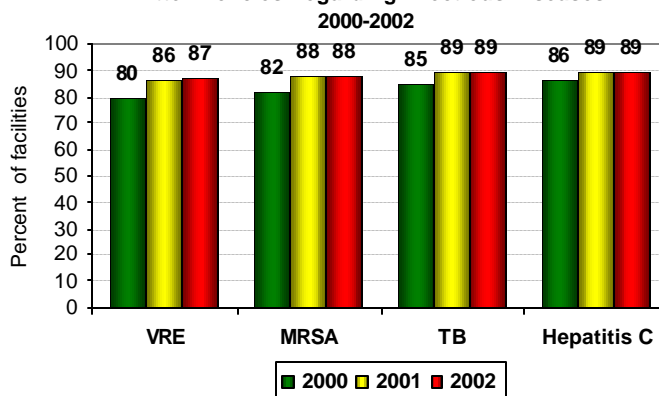
# Infection Control

Infection Control: 2002				
Infection Control	Arkansas	Louisiana	Oklahoma	Network 13
<b>Vancomycin Resistant Enterococcus (VRE)</b>				
% Facilities have written policies	85.0	88.1	85.2	86.7
% Facilities accept patients	88.3	88.9	77.8	86.3
# Facilities reporting	60	126	54	240
<b>Of those facilities who accept patients with VRE</b>				
% Facilities have dedicated machine	67.9	64.3	47.6	61.8
% Facilities have single room	42.3	12.5	7.1	18.9
# Facilities reporting	53	112	42	207
<b>Methicillin-Resistant Staphylococcus Aureus (MRSA)</b>				
% Facilities have written policies	86.7	89.7	85.2	87.9
% Facilities accept patients	96.7	95.2	88.9	94.2
# Facilities reporting	60	126	54	240
<b>Of those facilities who accept patients with MRSA</b>				
% Facilities have dedicated machine	55.2	57.5	39.6	53.1
% Facilities have single room	29.3	8.3	83.0	13.7
# Facilities reporting	58	120	48	226
<b>Tuberculosis (TB)</b>				
% Facilities have written policies	76.7	93.7	92.6	89.2
% Facilities accept patients	65.0	18.4	24.1	31.4
# Facilities reporting	60	125	54	239
<b>Of those facilities who accept patients with TB</b>				
% Facilities have dedicated machine	66.7	56.5	38.5	58.7
% Facilities have single room	56.4	43.5	38.5	49.3
# Facilities reporting	39	23	13	237
<b>Hepatitis C</b>				
% Facilities have written policies	91.7	86.5	90.7	88.8
% Facilities accept patients	100.0	99.2	96.3	98.8
# Facilities reporting	60	126	54	240
<b>Of those facilities who accept patients with Hepatitis C</b>				
% Facilities have dedicated machine	23.3	11.2	13.5	4.8
% Facilities have single room	5.0	0.8	1.9	2.1
# Facilities reporting	60	125	52	75
<b>Fever</b>				
% Facilities have standard protocol for treating fevers (temp > 100F) that develop during dialysis	95.0	92.1	90.7	92.5

Percent of Facilities Accepting Patients with Identified Infectious Diseases 1999-2002



Written Policies Regarding Infectious Diseases 2000-2002



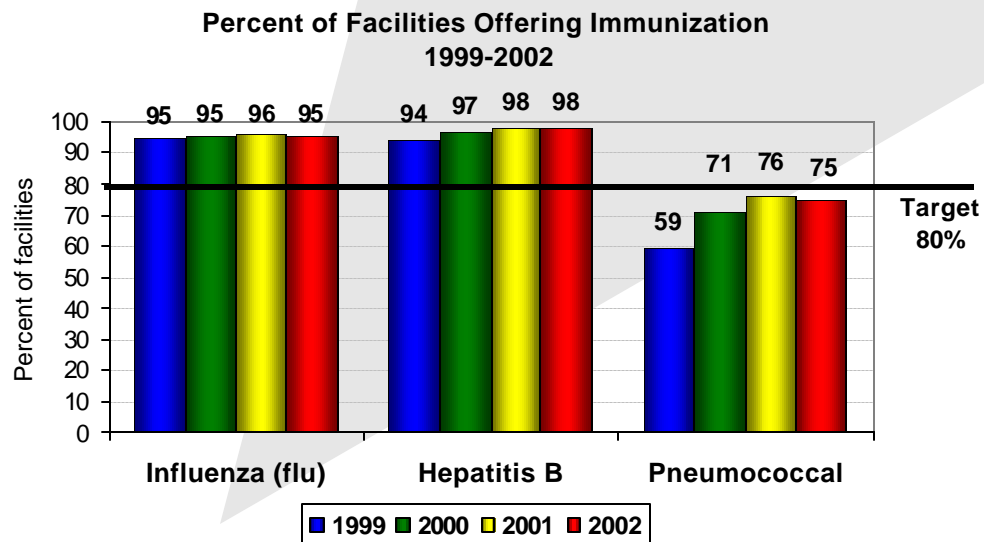


# Prevention

Healthy People 2010 (CMS) goals include the ESRD patient population specific to areas of immunization and the American Diabetes Association recommends at least one complete foot examination a year. If the patient has complications, the frequency is greater depending on the problem. Newly released guidelines encourage foot care exams every six months for patients with diabetes and peripheral neuropathy with loss of protective sensation (LOPS) due to diabetes. (American Diabetes Association publication, 10/30/2001) Financial coverage of prevention items listed exists within the Medicare system and is available for Medicare ESRD beneficiaries.

1. Maximize prevention of diseases where possible through immunizing at least 80% of patient population specific to:
  - Influenza
  - Pneumococcal pneumonia
  - Hepatitis
2. Prevent and/or reduce the rate of foot ulcers, lower extremity amputations, and hospitalization for foot complications secondary to diabetes or peripheral neuropathy.

Prevention: 2002				
Prevention	Arkansas	Louisiana	Oklahoma	Network 13
<b>Foot Exams</b>				
% Facilities perform routine foot exams	58.3	34.9	16.7	36.7
# Facilities reporting	60	126	54	240
% facilities utilizing risk classifications for patient education and follow-up	20.0	34.1	33.3	28.4
<b>Foot exams performed on</b>				
% All patients	28.6	29.5	33.3	29.5
% Diabetic patients only	71.4	70.5	66.7	70.5
<b>Kind of exams</b>				
% Comprehensive	11.4	18.2	33.3	17.0
% Limited	17.1	15.9	11.1	15.9
% Visual	71.4	65.9	56.6	67.0
<b>Immunization</b>				
% Facilities offer Influenza (flu) vaccine	93.3	95.2	96.3	95.0
% Facilities offer Hepatitis B immunization	93.3	98.4	100.0	97.5
% Facilities offer Pneumococcal immunization	68.3	73.6	85.2	74.9



This page left blank intentionally.





**ESRD NETWORK 13**

6600 North Meridian Avenue, Suite 155  
Oklahoma City, OK 73116-1411

(405) 843-8688  
[www.network13.org](http://www.network13.org)

Developed under CMS Contract #500-00-NW13