

IN-CENTER HEMODIALYSIS (HD) CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2003

[Before completing please read instructions at the bottom of this page and on pages 4, 5 and 6]

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|---|--|
| PATIENT IDENTIFICATION <div style="background-color: #cccccc; height: 80px; display: flex; align-items: center; justify-content: center; margin-top: 20px;"> Place Patient Data Label Here </div> | MAKE CORRECTIONS TO PATIENT INFORMATION ON LABEL IN THE SPACE BELOW |
| 12. If the above patient information is incorrect make corrections in space above then continue to question 13. Please verify patient's race and answer question 13 below. If patient unknown or was not dialyzed in the unit at any time during OCT 2002 – DEC 2002 return the blank form to the Network. | |
| 13. Patient's Ethnicity (Check appropriate box). <input type="checkbox"/> non-Hispanic <input type="checkbox"/> Hispanic, Mexican American (Chicano) <input type="checkbox"/> Hispanic, Puerto Rican <input type="checkbox"/> Hispanic, Cuban American <input type="checkbox"/> Hispanic, Other <input type="checkbox"/> Unknown | |
| 14. Patient's height (MUST COMPLETE): _____ inches OR _____ centimeters | |
| 15. Did patient have limb amputation(s) prior to Dec. 31, 2002: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 16. Has the patient ever been diagnosed with any type of diabetes? <input type="checkbox"/> Yes (go to 17) <input type="checkbox"/> No (go to 18) <input type="checkbox"/> Unknown (go to 18) | |
| 17. If question 16 was answered YES , was the patient taking medications to control the diabetes during the study period? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , was the patient using insulin during the study period? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Individual Completing Form (Please print): First name: _____ Last name: _____ Title: _____ Phone number: (_____) _____ - _____ Fax number: (_____) _____ - _____ | |

INSTRUCTIONS FOR COMPLETING THE IN-CENTER HEMODIALYSIS CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2003

The label on the top left side of this form contains the following patient identifying information (#'s 1-11). If the information is incorrect make corrections to the right of the label.

- | | |
|---|---|
| 1. LAST and first name. 3. SOCIAL Security Number (SSN). 5. SEX (1=Male; 2=Female; 9=Unknown). 7. PRIMARY cause of renal failure by CMS-2728 code. 9. ESRD Network number. Do not make corrections to this item. | 2. DATE of birth (DOB) as MM/DD/YYYY. 4. HEALTH Insurance Claim Number (HIC), (same as Medicare number). 6. RACE (1=American Indian/Alaska Native; 2=Asian; 3=Black; 4=White; 5=Unknown; 6=Pacific Islander; 7=Mid East Arabian; 8=Indian Subcontinent; 9=Other Multiracial). 8. DATE, as MM/DD/YYYY, that the patient began a regular course of dialysis. 10. Facility's Medicare provider number. 11. The most RECENT date this patient returned to hemodialysis following: transplant failure, an episode of regained kidney function, or switched modality. |
|---|---|
12. Review the patient and facility-specific information contained on the pre-printed label. Please verify the patient's race, item 6 above. If any of the information is incorrect write corrections in the space to the right of the label. If the patient is unknown or if the patient was not dialyzed in the unit at any time during OCT 2002 through DEC 2002, send the blank form back to the ESRD Network office. Provide the name and address of the facility providing services to this patient on December 31, 2002, if known.
 13. Patient's Ethnicity. Please verify the patient's ethnicity with the patient and check appropriate box.
 14. Enter the patient's height in inches or centimeters. HEIGHT MUST BE ENTERED, do not leave this field blank. You may ask the patient his/her height to obtain this information. If the patient had both legs amputated, record pre-amputation height and check YES for item 15.
 15. For the purpose of this study, check NO if this patient has had toe(s), finger(s), or mid-foot (Symes) amputation; but **check YES if this patient has had a below-knee, below-elbow, or more proximal (extensive) amputation prior to Dec. 31, 2002.**
 16. Check either "Yes", or "No", or "Unknown" to indicate if the patient has ever been diagnosed with any type of diabetes. If **YES**, proceed to question 17.
 17. If the answer to question 16 is **YES**, please check either "Yes" or "No" to indicate if the patient was taking medications to control the diabetes during the study period. If the answer to 17 is **YES**, please check either "Yes" or "No" to indicate if the patient was using insulin during the study period. Study period is OCT 2002-DEC 2002.

PLEASE COMPLETE ITEM 18 ON PAGE 2 OF THIS DATA COLLECTION FORM, ITEMS 19 AND 20 ON PAGE 3, 21 AND 22 ON PAGE 4.

INSTRUCTIONS FOR COMPLETING THESE ITEMS ARE ON PAGES 4, 5 AND 6.

IN-CENTER HEMODIALYSIS (HD) CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2003 (CONTINUED)
18. ANEMIA MANAGEMENT: For each lab question below, enter the lab value obtained from the monthly lab draw for each month: OCT, NOV, DEC 2002. Enter NF/NP if the lab value cannot be located.

| | OCT 2002 | NOV 2002 | DEC 2002 |
|--|--|--|--|
| A. Pre-dialysis laboratory hemoglobin (Hgb) from the monthly lab draw: | _____ . _____ g/dL | _____ . _____ g/dL | _____ . _____ g/dL |
| B.1. Was there a prescription for Epoetin during the seven days immediately before the Hgb in 18A was drawn or a prescription for Darbepoetin (Aranesp™) during the month immediately before the Hgb in 18A was drawn? | Epoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C) Darbepoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C) | Epoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C) Darbepoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C) | Epoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C) Darbepoetin: <input type="checkbox"/> Yes (go to 18B.2) <input type="checkbox"/> No (go to 18C) |
| B.2. What was the PRESCRIBED Epoetin dose in units for each treatment during the 7 days immediately BEFORE the Hgb in 18A was drawn or the PRESCRIBED Darbepoetin dose in micrograms for the MONTH immediately BEFORE the Hgb in 18A was drawn? (See instructions on page 4) | Epoetin: _____ _____ _____ Darbepoetin: _____ mcg/month | Epoetin: _____ _____ _____ Darbepoetin: _____ mcg/month | Epoetin: _____ _____ _____ Darbepoetin: _____ mcg/month |
| B.3. How many times per week was Epoetin prescribed or how many times per month was Darbepoetin prescribed? | Epoetin: _____ x per week Darbepoetin: _____ x per month | Epoetin: _____ x per week Darbepoetin: _____ x per month | Epoetin: _____ x per week Darbepoetin: _____ x per month |
| B.4. What was the prescribed route of administration? (Check all that apply) | Epoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC Darbepoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC | Epoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC Darbepoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC | Epoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC Darbepoetin: <input type="checkbox"/> IV <input type="checkbox"/> SC |
| C. Serum ferritin concentration from the monthly lab draw: | _____ ng/mL | _____ ng/mL | _____ ng/mL |
| D. % transferrin (iron) saturation from the monthly lab draw: | _____ % | _____ % | _____ % |
| E. Was iron prescribed at any time during the month? | <input type="checkbox"/> Yes <input type="checkbox"/> No (go to 19) | <input type="checkbox"/> Yes <input type="checkbox"/> No (go to 19) | <input type="checkbox"/> Yes <input type="checkbox"/> No (go to 19) |
| F. If yes, what was the prescribed route of iron administration? (Check all that apply). | <input type="checkbox"/> IV <input type="checkbox"/> PO | <input type="checkbox"/> IV <input type="checkbox"/> PO | <input type="checkbox"/> IV <input type="checkbox"/> PO |
| G. If the patient was prescribed IV iron, what was the total dose of IV iron administered during the month? | _____ mg/month | _____ mg/month | _____ mg/month |

IN-CENTER HEMODIALYSIS (HD) CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2003 (CONTINUED)

19. SERUM ALBUMIN: Enter the serum albumin obtained from the monthly lab draw for each month: OCT, NOV and DEC 2002. Enter NF/NP if the lab value cannot be located. Check the method used (BCG/bromcresol green or BCP/bromcresol purple) by the lab to determine serum albumin. If lab method unknown, please call lab to find out.

| | OCT 2002 | NOV 2002 | DEC 2002 |
|---|---|---|---|
| A. Serum albumin from the monthly lab draw: | _____ . _____ g/dL | _____ . _____ g/dL | _____ . _____ g/dL |
| B. Check lab method used: BCG = bromcresol green; BCP = bromcresol purple | <input type="checkbox"/> BCG <input type="checkbox"/> BCP | <input type="checkbox"/> BCG <input type="checkbox"/> BCP | <input type="checkbox"/> BCG <input type="checkbox"/> BCP |

20. ADEQUACY: Enter the information requested below for the dialysis session when the monthly labs were drawn and used to measure adequacy for each month: OCT, NOV, DEC 2002.

| | OCT 2002 | NOV 2002 | DEC 2002 |
|--|---|---|---|
| A. How many times per week was this patient prescribed to receive dialysis? | _____ times per week | _____ times per week | _____ times per week |
| B. Recorded URR from the monthly lab draw: | _____ . _____ % | _____ . _____ % | _____ . _____ % |
| C. Recorded Kt/V from the monthly lab draw: | _____ . _____ | _____ . _____ | _____ . _____ |
| D. Method used to calculate Kt/V: (If unknown, please ask Medical Director) | <input type="checkbox"/> UKM <input type="checkbox"/> Daugirdas II <input type="checkbox"/> Equilibrated <input type="checkbox"/> Derived from URR (no pt.weights) <input type="checkbox"/> Other/Unknown _____ | <input type="checkbox"/> UKM <input type="checkbox"/> Daugirdas II <input type="checkbox"/> Equilibrated <input type="checkbox"/> Derived from URR (no pt.weights) <input type="checkbox"/> Other/Unknown _____ | <input type="checkbox"/> UKM <input type="checkbox"/> Daugirdas II <input type="checkbox"/> Equilibrated <input type="checkbox"/> Derived from URR (no pt.weights) <input type="checkbox"/> Other/Unknown _____ |
| E. Was residual renal function used to calculate Kt/V on this patient? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| F. Pre-dialysis BUN value from the monthly lab draw: | _____ mg/dL | _____ mg/dL | _____ mg/dL |
| G. Post-dialysis BUN value from the monthly lab draw: (both the pre & post dialysis BUN must be drawn on the same day) | _____ mg/dL | _____ mg/dL | _____ mg/dL |
| H. Pre- & Post-dialysis weight at session when BUNs above drawn: (Circle either lbs or kgs) | Pre: _____ lbs/kgs Post: _____ lbs/kgs | Pre: _____ lbs/kgs Post: _____ lbs/kgs | Pre: _____ lbs/kgs Post: _____ lbs/kgs |
| I. Actual DELIVERED time on dialysis at session when BUNs above drawn: | _____ hrs _____ min | _____ hrs _____ min | _____ hrs _____ min |
| J. Delivered blood pump flow rate @ 60 minutes after start of dialysis session when BUNs above drawn: | _____ mL/min | _____ mL/min | _____ mL/min |
| K. Code for dialyzer used for dialysis session when BUNs above drawn: (see chart) | _____ | _____ | _____ |

| IN-CENTER HEMODIALYSIS (HD) CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2002 (CONTINUED) |
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| 18B.4: Check the appropriate box to indicate the prescribed route of administration for Epoetin or for Darbepoetin (intravenous [IV] or subcutaneous [SC]). If the patient was prescribed Epoetin or Darbepoetin IV and SC during the month, please check both boxes. |
| 18C: Enter the patient's serum ferritin concentration from the monthly lab draw (or first time during the month if not done with the monthly lab draw) for each month OCT, NOV, DEC 2002. If a serum ferritin concentration test was not found or not performed during the month, enter NF/NP. |
| 18D: Enter the patient's % transferrin (iron) saturation from the monthly lab draw (or first time during the month if not done with the monthly lab draw) for each month OCT, NOV, DEC 2002. If a % transferrin (iron) saturation test was not found or not performed during the month, enter NF/NP. |
| 18E: Check either "Yes" or "No" to indicate if iron was prescribed at any time during the months of OCT, NOV, and DEC 2002. If there was no prescription for iron go to question 19. |
| 18F: If the answer to 18E is "Yes," please check the appropriate box to indicate the route of iron administration (intravenous [IV] or by mouth [PO]) for OCT, NOV, and DEC 2002. If the patient received iron by mouth and IV during the month please check both boxes. |
| 18G: If the patient was prescribed IV iron, add together all doses that were given during the month and enter the TOTAL dose of IV iron (in mg) administered per month during OCT, NOV and DEC 2002. |
| 19A: Enter the patient's serum albumin from the monthly lab draw (or first time during the month if not done with the monthly lab draw) for each month OCT, NOV, DEC 2002. If a serum albumin was not found or not performed during the month, enter NF/NP. |
| 19B: Check the method used by the laboratory to determine the serum albumin value (bromocresol green or bromocresol purple). If you do not know what method the laboratory used, call the lab to find out this information. |
| 20A: Enter the number of times per week the patient was prescribed to receive dialysis in OCT, NOV, and DEC 2002. If the prescription varied during a month, enter the prescription in effect the week the monthly labs were drawn. |
| 20B: Enter the patient's URR recorded on the lab sheet from the monthly lab draw for each month OCT, NOV, DEC 2002. If not found or not performed during a month, enter NF/NP. |
| 20C: Enter the patient's Kt/V recorded on the lab sheet from the monthly lab draw for each month OCT, NOV, DEC 2002. If not found or not performed during a month, enter NF/NP. |
| 20D: Check the box to indicate the method used to calculate the Kt/V in 20C. If you do not know what method was used, please ask the unit's Medical Director. Please check the "Other/Unknown" box if you do not use any of the methods listed or you cannot ascertain the method. If using another method and you know what it is, please write the method in the space provided. |
| 20E: Check the appropriate box to indicate whether residual renal function was used to calculate Kt/V. If you do not know, please ask the unit's Medical Director. |
| 20F & G: Enter the patient's pre- and post-dialysis BUNs from the monthly lab draw (or the BUNs used to measure adequacy for the month, if there was a blood drawing error when the monthly labs were drawn). Enter NF/NP if not found or not performed during the month. |
| 20H: Enter the patient's pre- and post-dialysis weight at the dialysis session when the pre- and post-dialysis BUNs in question 20F&G were drawn. Circle either lbs or kgs as appropriate. |
| 20I: Enter the patient's total treatment time (actual delivered time) on dialysis during the session when the BUNs in question 20F&G were drawn for months OCT, NOV, DEC 2002. Do not enter the prescribed time on dialysis. |
| 20J: Enter the delivered blood pump flow rate in mL/minutes at 60 minutes after the start of the dialysis session when the BUNs in question 20F&G were drawn for months OCT, NOV, DEC 2002. Do not enter the prescribed blood pump flow rate or the highest achieved blood pump flow rate. |

| IN-CENTER HEMODIALYSIS (HD) CLINICAL PERFORMANCE MEASURES DATA COLLECTION FORM 2003 (CONTINUED) |
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| 20K: Using the enclosed Dialyzer Code Chart, enter the code for the dialyzer used at the dialysis session when the pre- and post-dialysis BUNs in question 20F&G were drawn for OCT, NOV, DEC 2002. If the dialyzer used is not listed on the chart, enter the code for "other" (9999). |
| 21A: Check the appropriate space to indicate type of vascular access used on last hemodialysis session on or between OCT 1, 2002 and DEC 31, 2002 at the patient's primary in-center facility. Exclude dialysis sessions performed at temporary facilities because of holiday travel or hospitalizations. ("Port Access" is considered a vascular access device which consists of a valve and cannula that is subcutaneously implanted and is accessed by dialysis needles). |
| 21B.1 and 21B.2: Complete 21B.1 and 21B.2 only if vascular access checked in question 21A was a catheter or port access . |
| 21B.1: If the vascular access marked for question 21A was a catheter or port access, indicate in the appropriate space the reason for the catheter or port access . |
| 21B.2: If the vascular access marked for question 21A was a catheter or port access, indicate in the appropriate space if one or more catheters or port accesses had been used continuously in this patient for the past 90 days or longer between OCT 1, 2002 and DEC 31, 2002. |
| 21C.1 and 21C.2: Complete 21C.1-21C.2 only if vascular access checked in 21A was an AV fistula, synthetic graft or bovine graft . |
| <p>21C.1: If the vascular access in 21A was an AV fistula, synthetic graft or bovine graft, indicate if routine surveillance for the presence of stenosis between Oct 1, 2002 and Dec 31, 2002 was done. Routine surveillance is the sequential measurement of access flow OR of venous pressure.</p> <ul style="list-style-type: none"> • Indicate "YES" for this question if you measure access flow OR venous pressure using any of the following: <ul style="list-style-type: none"> Techniques and frequencies used to measure access flow include: <ol style="list-style-type: none"> a. one of the dilution methods in which the needles are reversed and recirculation is deliberately induced on a regular basis, OR b. conventional Color-Flow Doppler at a minimum of once every three months. Techniques and frequencies used to measure venous pressure include: <ol style="list-style-type: none"> a. dynamic venous pressure measured at every hemodialysis session; uses low blood pump flow rates usually set at 200 mL/min., OR b. static venous pressure measured at a minimum of once every two weeks; performed at zero blood pump flow. • Indicate "NO" for this question if you only conduct (or note) the following clinical assessments: <ol style="list-style-type: none"> a. Prolonged bleeding after needle withdrawal. b. Altered characteristics of thrill or bruit. c. Adequacy measurements using Kt/V or URR. d. Recirculation methods. |
| 21C.2: If question 21C.1 is yes, check all surveillance methods utilized based on the definitions and intervals given above in 21C.1. If other techniques and/or corresponding intervals were used check "other" and write in the technique and corresponding intervals. |
| 22: Check the appropriate space to indicate if the patient FIRST started hemodialysis during January 1, 2002-August 31, 2002 (see date #8 on page 1). These patients would have begun a regular maintenance course of hemodialysis during January 1, 2002-August 31, 2002. DO NOT include patients who have changed modality, had a newly failed transplant, or returned after an episode of regained kidney function, and were placed on maintenance hemodialysis during the time frame January 1, 2002-August 31, 2002. If "Yes", answer questions 22A-B. If "No", questions 22A-B should be left blank and the form has been completed. |
| 22A: Check the appropriate space to indicate type of vascular access in use upon Initiation of a maintenance course of hemodialysis (see date #8 on page 1) during the time frame January 1, 2002-August 31, 2002. Exclude patients who have received intermittent dialysis treatments for volume overload or congestive heart failure. ("Port Access" is considered a vascular access device which consists of a valve and cannula that is subcutaneously implanted and is accessed by dialysis needles). |
| 22B: Check the appropriate space to indicate type of vascular access, for the patient identified in 22A, in use 90 days after the patient first started hemodialysis. ("Port Access" is considered a vascular access device which consists of a valve and cannula that is subcutaneously implanted and is accessed by dialysis needles). |