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150 N. Riverside Plaza, Suite 3000, Chicago, IL 60606-1599 • 312.819.1900

Anne M. Cooper
(312) 873-3606
(312) 276-4317 Direct Fax
acooper@polsinelli.com

December 12, 2017

Via Federal Express

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Alpine Dialysis (Proj. No. 17-039)

Dear Ms. Avery:

As you know, Polsinelli is counsel of record on the above-referenced CON permit application and we represent DaVita Inc. and its subsidiary, Total Renal Care, Inc. (collectively, "DaVita"). In this capacity, we are writing in response to the Illinois Health Facilities and Services Review Board's (the "State Board") issuance of an intent to deny DaVita's proposal to establish a small 8-station in-center hemodialysis facility to be located at 3157 South Alpine Road, Rockford, Illinois (the "Proposed Project"). Pursuant to Section 1130.670 of the Board's Procedural Rules, DaVita submits the following supplemental information on the Proposed Project.

1. Disproportionate Access

The Alpine Dialysis patient service area ("PSA") is located on the southeast side of Rockford, which is an economically disadvantaged community. The percentages of PSA residents living below the Federal Poverty Level ("FPL") and 150% of the FPL are twice that of the State. Further, this community has significant African-American and Hispanic populations who are more susceptible to losing kidney function than the general population.

Income and race are important factors when analyzing risk factors for kidney disease and should not be dismissed when determining whether sufficient access to dialysis services exists within a community. Individuals with low socio-economic status frequently lack access to primary care and as such do not receive the same medical attention to predisposing diseases as persons with a higher socio-economic status. In the most recent Winnebago County Health Department IPLAN 2020 report, access to care ranked as the top health issue. A significant barrier to care is lack of health insurance. Within the Alpine Dialysis PSA nearly 15% of

residents lack health insurance (compared to 11% Statewide). Lack of access to health care can also be demonstrated through emergency room use. In 2015, Winnebago County emergency room usage rates ranged between 5 and 8 per 100 residents, double the Statewide usage rates. In 2016, Winnebago County ranked 88 out of 102 counties in Illinois in health outcomes and 98th in quality of life.[1] When looking at these factors, the incidence and prevalence of ESRD is not surprising. Finally, with specific reference to low-income communities, individuals who have not graduated from college or even finished high school often lack the education and income level associated with a higher use rate of home treatment modalities. Further, transplantation is a more onerous process for low-income individuals who lack resources. Therefore, in low income communities, we would expect a higher dependence on in-center hemodialysis services.

While there is a technical maldistribution of dialysis stations in the Alpine Dialysis geographic services area ("GSA") based on raw data, it is important to understand the State Board calculation does not take into account socio-economic status or race in determining whether a maldistribution exists. As noted throughout the Winnebago County Health Department IPLAN 2020 report (excerpts of which along with a link to the full report are included with this submission as Exhibit A), access to health care is a significant issue in Winnebago County. The proposed Alpine Dialysis seeks to address that issue by ensuring access to dialysis services are available to those communities that need it most. Despite the technical finding in the State Board Report, we urge the State Board to look at the bigger picture of health care access in Rockford and recognize the project is serving a low-income area with greater medical needs.

2. Other Area Facilities

While there are currently seven dialysis facilities within the Alpine Dialysis GSA, three of the facilities are either under construction or in their two year ramp up period. Importantly, all of these facilities are operated by DaVita. This is important because there is no incentive to shift patients away from any existing facility as a competitive tactic. Also note that each of these facilities will serve a distinct patient base and the need for these facilities was demonstrated with different chronic kidney disease ("CKD") patients being treated by different nephrologists in Rockford. As shown in the table on the attached Exhibit – B, each of these other facilities is being established based on the CKD patient caseload of different nephrologists who have committed to referring patients to these other facilities. As indicated on the table, each of these facilities is expected to exceed the State Board's 80% utilization standard by the time the

[1] We have included excerpts of the IPLAN 2020 which discussed many aspects of health care access issues in Rockford (See Exhibit – A).

proposed Alpine Dialysis is operational. Finally, each facility has a distinct patient service area. Accordingly, the proposed Alpine Dialysis will not create an unnecessary duplication of services.

3. Internal Health Planning Process

As discussed at the November 14, 2017 State Board meeting, DaVita continually monitors utilization of existing facilities to ensure current and future patients have continued access to dialysis. Once average utilization of a GSA reaches 65% and continued patient growth exists, DaVita begins internal health planning to anticipate future demand. Part of this planning process, involves 5 year growth forecasts. Based upon the historical growth of 2.5% annually (or 13% from September 2012 to September 2017), and the patients of Dr. Ahmed who are being treated for CKD, DaVita projects this proposed facility along with the other DaVita facilities in the area will meet target utilization within two years of operations without a negative effect on any other existing facilities.

It is important to understand that dialysis is unique compared to other regulated health care services. First, once patients are enrolled at a dialysis facility, they visit the facility very frequently for treatment. Specifically, ESRD patients dialyze three times per week or 156 times per year. Many patients rely on family, friends or caregivers and government funded transport services to transport them to and from their dialysis treatments. Transportation issues are directly related to patient non-compliance with the prescribed treatment protocol. To minimize transportation difficulties and other access issues, using proprietary software DaVita locates its facilities as proximately to patients' homes as is supported by population density and disease incidence and prevalence. Based upon the residence of the projected dialysis patients, DaVita concluded a facility on the southeast side of Rockford would address the growing need for dialysis services in that community. While another facility will open soon (owned by DaVita), it is dedicated to another physician's patients in a geographically distinct areas of Rockford and farther than is optimal for the ongoing visits that patients must make for treatments.

Also, when dialysis facilities are heavily utilized it is difficult for new dialysis patients to dialyze at their preferred dialysis facility and on their preferred shift as existing patients are frequently unwilling or unable to change shifts to accommodate another patient. Currently, several Rockford area dialysis patients are either not dialyzing at a preferred facility or on a preferred shift and would like to be adjusted. When this occurs, patients may miss dialysis treatments, resulting in involuntary non-compliance. Skipping one or more dialysis sessions in a month has been associated with a 16% higher risk of hospitalization and 30% increased mortality risk compared to those who did not miss a dialysis session. Establishing a new dialysis facility in

Rockford will allow patients on the Southeast side of Rockford an opportunity to dialyze at a facility closer to their homes and at their preferred times.

Second, this project is put forth based on an extremely well-vetted financial model. We appreciate the State Board's rules but also want to point out that DaVita places facilities to meet demand based on a tried and true financial and operational model. Any potential over projection of patients does not harm payors or patients because the facilities are not reimbursed on a cost basis. Further, the national companies primarily driving the delivery of dialysis have become so efficient that the government reimbursement for dialysis treatments has been reduced over time to reflect such efficiencies. DaVita is confident that this project has the best interests of the patients in mind and also is fiscally prudent from a development perspective. Mary Anderson, the Division Vice-President in the Keystone Region confirmed DaVita has not closed a facility in her region in the 32 years that she has worked for DaVita or its predecessor.

4. Transplantation.

During the November hearing, Dr. Goyal raised questions about transplantation as a modality. DaVita actively assists patients with enrolling eligible patients on transplant lists and its social workers support patients throughout the pre-transplantation process. Under the Medicare ESRD Facility Conditions of Coverage, the standard for patient education and training mandates each patient's plan of care include education and training in aspects of the dialysis experience, dialysis management and transplantation, among other things. See 42 C.F.R. §494.90(d). As shown in the attached materials (Exhibit – C), DaVita educates patients on all modalities, including transplant. DaVita's transplant education program includes not only the benefits of transplant as a modality, but how to obtain a kidney transplant, questions for the transplant team, discussing living donation with friends and family, barriers to transplant, and transitioning from dialysis to transplant. We have also included other materials regarding lack of access to kidney transplantation which are summarized in Exhibit – C.

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Thank you for your time and consideration of DaVita's additional information on Alpine Dialysis. We respectfully request the State Board approve the Proposed Project to improve access to much needed dialysis services on the Southeast side of Rockford.

Sincerely,

Anne M. Cooper

Attachments

Exhibit A

Winnebago County Health Department IPLAN 2020 Report (Sept. 2016) *available at* http://www.wchd.org/images/IPLAN_2020_Winnebago_County_Health_Department_2.1.2017.pdf. (last visited Dec. 11, 2017).

WINNEBAGO COUNTY HEALTH DEPARTMENT
IPLAN 2020

Adopted by Winnebago County Board of Health
September 2016

Winnebago County Health Department
Promoting A Safer and Healthier Community Since 1854

Exhibit A

WELLNESS FOCUSED WINNEBAGO COUNTY

The Winnebago County Health Department is leading a county-wide initiative aimed at creating a common understanding of community needs, gaps, and priorities that will advance the well-being of the Winnebago County community. Wellness Focused Winnebago County will use a Collective Impact approach – common agenda, shared measurement, mutually reinforcing activities, continuous communication, and a strong backbone to drive Winnebago County forward.

WELLNESS FOCUSED
Winnebago County
WCHD

Winnebago County has many organizations focusing on the betterment of the community. Wellness Focused Winnebago County's ambition is to coordinate these efforts to streamline resources to accomplish common goals. The Healthy People 2020 measures were cross referenced with existing Winnebago County initiatives and plans. The instrument will guide the initiative to common goals, measures, and targets set forth by the Centers for Disease Control (CDC), Appendix A. For more on Healthy People 2020 please visit https://www.healthypeople.gov/.

Overall Rank

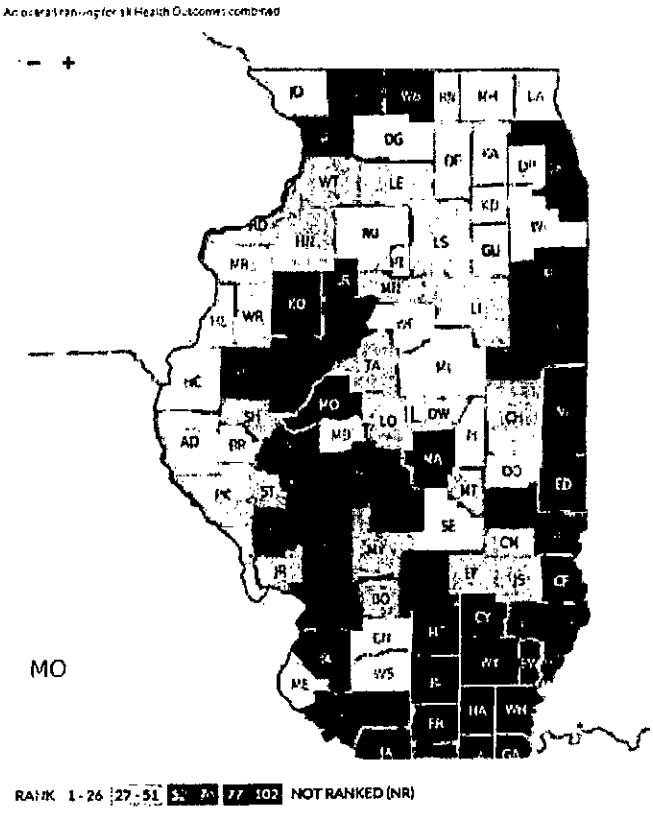


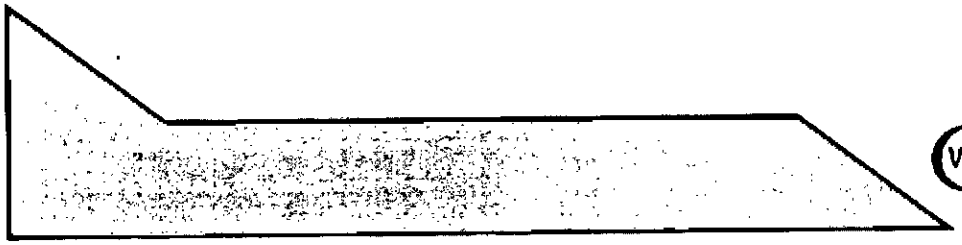
Figure 1

The aim of this initiative is to place in the top third of the County Health Rankings by 2020. Currently (2016), Winnebago County is ranked overall 88th out of 102 counties in Illinois. Wellness Focused Winnebago County believes that with collaboration and a common direction this can be accomplished. For more on the County Health Rankings please visit http://www.countyhealthrankings.org/.

The Robert Wood Foundation partnered with the University of Wisconsin to establish metrics to rank the U.S. counties. Table 2 lists the categories and indicators selected. Graphs 1 – 4 show trends in areas that were measured consistently for nearly a decade. As of 2016, Figure 1 depicts Winnebago County as the only county in the region to rank in the bottom third for health rankings.

WINNEBAGO COUNTY, IL 2016

Opportunities for Improvement	Winnebago County	Top U.S. Performers	Illinois	Rank (of 102)
HEALTH OUTCOMES				**88**
LENGTH OF LIFE				**71**
Premature death	7,800	5,200	6,300	
QUALITY OF LIFE				**98**
Poor or fair health**	17%	12%	17%	
Poor physical health days**	4.2	2.9	3.8	
Poor mental health days**	3.8	2.8	3.6	
Low birthweight	9%	6%	8%	
Premature age-adjusted mortality	380	270	320	
Child mortality	50	40	50	
Infant mortality	8	5	7	
Frequent physical distress	12%	9%	11%	
Frequent mental distress	11%	9%	11%	
Diabetes prevalence	11%	9%	10%	
HIV prevalence	161	41	324	
HEALTH FACTORS				**94**
HEALTH BEHAVIORS				**79**
Adult smoking**	17%	14%	17%	
Adult obesity	32%	25%	27%	
Food environment index	7	8.3	7.8	
Physical inactivity	25%	20%	22%	
Access to exercise opportunities	89%	91%	89%	
Excessive drinking**	19%	12%	21%	
Alcohol-impaired driving deaths	36%	14%	36%	
Sexually transmitted infections	632	134.1	495.5	
Teen births	44	19	33	
Food insecurity	16%	11%	14%	
Limited access to healthy foods	6%	2%	4%	
Drug overdose deaths	29	8	13	
Drug overdose deaths - modeled	≥40	6.1-8.0	13.1	
Motor vehicle crash deaths	11	9	8	
Insufficient sleep	34%	28%	34%	

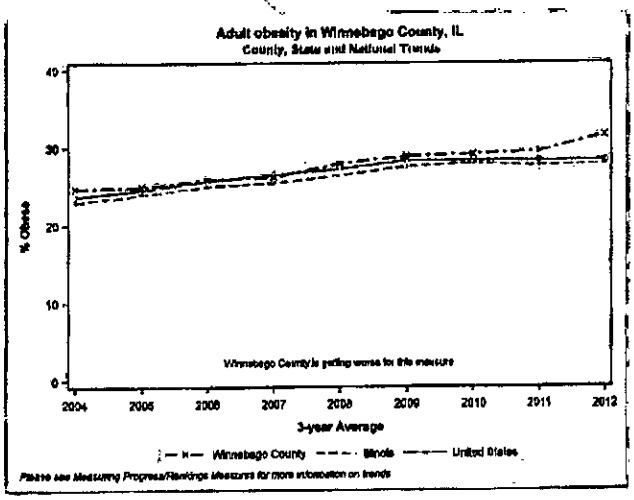


Opportunities for Improvement	Winnebago County	Top U.S. Performers	Illinois	Rank (of 102)
CLINICAL CARE				**31**
Uninsured	13%	11%	15%	
Primary care physicians	1,330:01	1,040:01	1,240:01	
Dentists	1,440:01	1,340:01	1,410:01	
Mental health providers	680:01	370:01	560:01	
Preventable hospital stays	60	38	59	
Diabetic monitoring	86%	90%	86%	
Mammography screening	66%	71%	65%	
Uninsured adults				
Uninsured children				
Health care costs	$9,478			
Other primary care providers	1,266:01	866:01	1,922:01	
SOCIAL & ECONOMIC FACTORS				**10**
High school graduation	72%	93%	83%	
Some college	57%	72%	67%	
Unemployment	8 30%	3.50%	7.10%	
Children in poverty	25%	13%	20%	
Income inequality	4.6	3.7	4.9	
Children in single-parent households	43%	21%	32%	
Social associations	10.3	22.1	9.9	
Violent crime	890	59	430	
Injury deaths	73	51	50	
Median household income	$47,700	$61,700	$57,500	
Children eligible for free lunch	57%	25%	45%	
Residential segregation - black/white	53	23	73	
Residential segregation - non-white/white	44	15	55	
Homicides	7	2	6	
PHYSICAL ENVIRONMENT				**93**
Air pollution - particulate matter	12.3	9.5	12.5	
Drinking water violations	Yes	No		
Severe housing problems	17%	9%	19%	
Driving alone to work	84%	71%	73%	
Long commute - driving alone	22%	15%	40%	

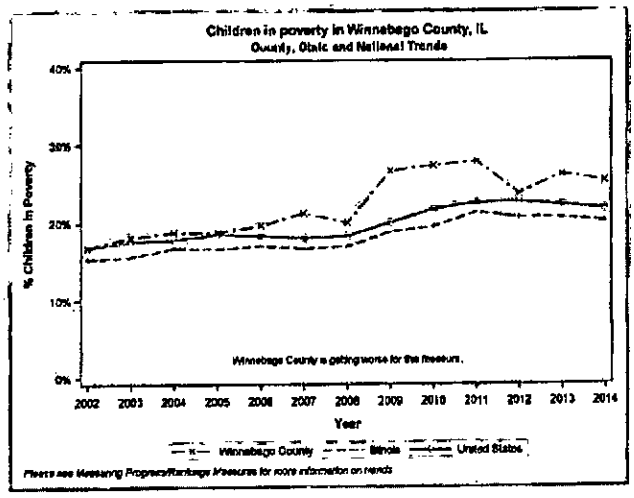
Source: County Health Rankings http://www.countyhealthrankings.org/app/illinois/2016/rankings/winnebago/county/outcomes/overall/snapshot

Table 2

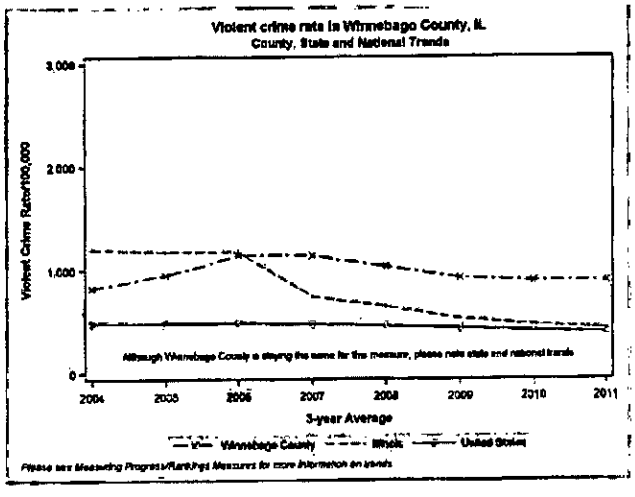
TREND HIGHLIGHTS - WINNEBAGO COUNTY HEALTH RANKINGS



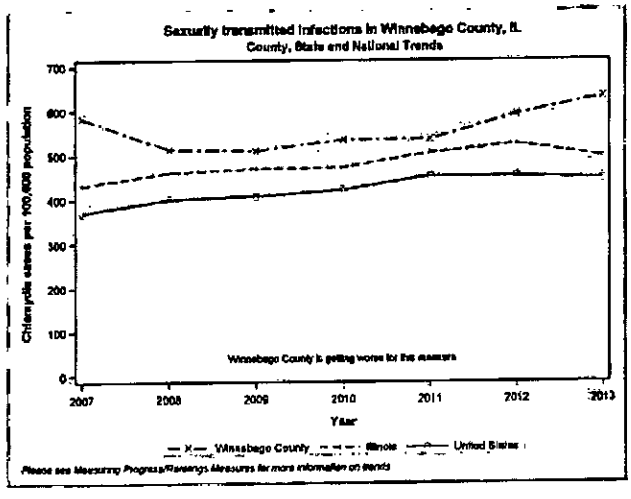
Graph 1



Graph 2



Graph 3



Graph 4

Source: County Health Rankings http://www.countyhealthrankings.org/app/illinois/2016/rankings/winnebago/county/outcomes/overall/snapshot

COMMUNITY HEALTH STATUS ASSESSMENT

The Community Health Status Assessment (CHSA) is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Winnebago County. The information allows stakeholders to identify issues of greatest concern and to make decisions regarding commitment of resources to improve community health and wellness.

Methodology

Information for this study was based largely on the data collected using open data sets available through the U.S. Census Bureau, Illinois Department of Public Health, U.S. Department of Health and Human Services, and the National Center for Health Statistics.

To obtain a clear picture of the community, data was gathered related to the following categories:

- Demographics and Social Economic Status
- Injury, Illness, and Death
- Quality of Life
- Mental Health
- Maternal Child Health
- Environmental Factors

This combined information makes up the Winnebago County Health Department Data Book which is available online at www.wchd.org. A summary of the findings was presented to villages, townships, and cities in Winnebago County during the month of June. The IPLAN Steering Committee arranged for presentations to be delivered at Town Hall and City Council meetings. Community leaders and local residents attending the meeting were asked to complete a prioritization matrix to assist in identifying the health priorities used in IPLAN 2020.

The prioritization matrix was configured using a Lean Six Sigma method. The ultimate objective of this matrix was to create a rating system to identify health concerns of residents and community leaders. The 2015 health priorities were listed first and their relative importance rated in comparison to competing health concerns. An L shaped matrix was used, the scores were calculated and analyzed. This assisted in setting the 3 health priorities for IPLAN 2020:

1- Not as important
2- Equally important
3- More important

THE COMMUNITY DEFINED FOR THIS ASSESSMENT

Figure 4

Winnebago County, IL (pop. 290,666) combines big city assets with a small town lifestyle. Known as the Heart of Illinois, Winnebago County is at the center of a multi-county region along the Rock River midway between Chicago and Iowa, Figure 4. Winnebago County covers approximately 519 square miles. Based on 2010 figures from the U.S. Census Bureau, Figure 5 is a population density map by zip code in Winnebago County. The most densely populated zip code is 61104 located in the City of Rockford east of the Rock River having between 3000.1 and 4500 residents per square mile. The least populated areas having less than 250 residents per square mile include zip codes 61063 (Pecatonica), 61024 (Durand), 61079 (Shirland), 61072 (Rockton), and 61088 (Winnebago). The county is divided into urban, suburban and rural areas, Table 3.

Cities/Towns
Rockford - Urban
Loves Park - Suburban
Roscoe - Suburban
Rockton -Rural
New Milford - Rural
Cherry Valley - Suburban
Machesney Park - Suburban
Durand - Rural
Pecatonica - Rural
Winnebago - Rural
South Beloit – Rural

Table 3

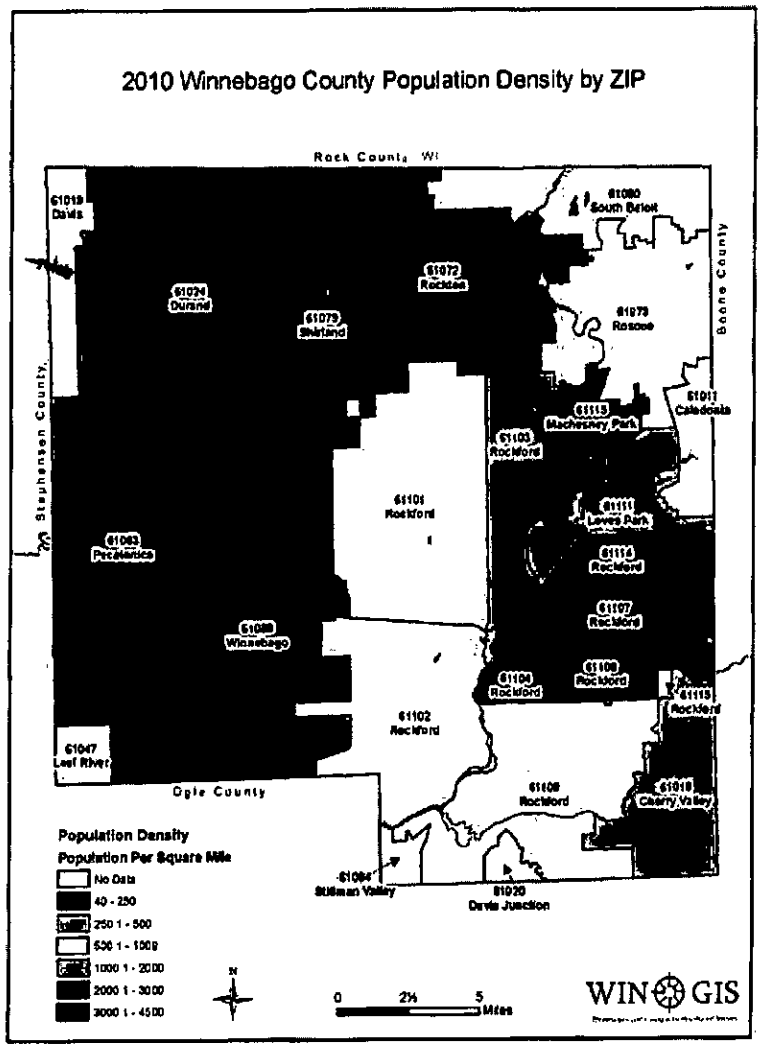


Figure 5

DEMOGRAPHICS AND SOCIAL ECONOMIC STATUS

Population estimates by the U.S. Census Bureau indicate the State of Illinois' population has grown in the past 5 years by 0.40 percent (Table 4). Between 2010 and 2014 there was a decline in population for Winnebago County (Graph 5). The population decreased by 2.30 percent (Table 3) in the past 5 years. The total -2.30 percent is made up of 6,722 former residents. Based on average of 2.55 persons per household (Figure 6), this averages about 1,681 residents, or 659 households leaving Winnebago County each year totaling about 2,636 households leaving in a 5 year period.

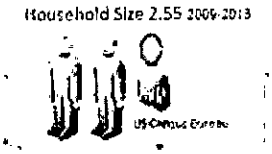
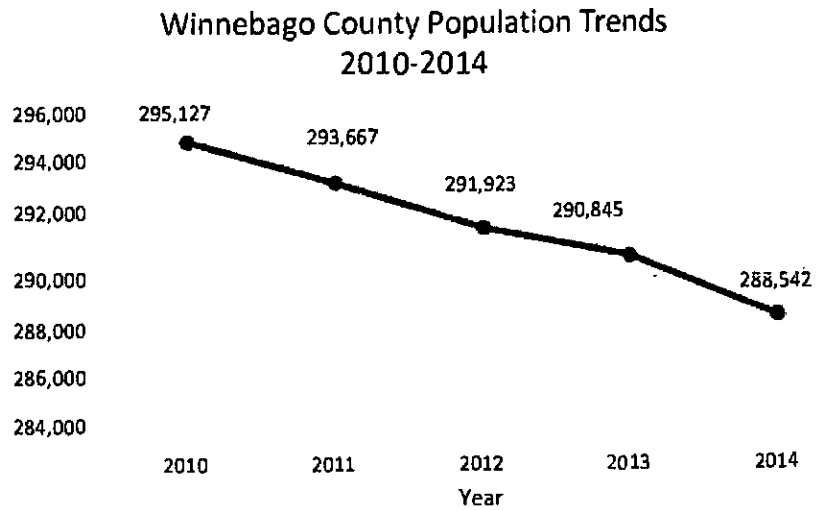


Figure 6

Population % Change - April 1, 2010 to July 1, 2014		
	Winnebago County	Illinois
Population, 2014 estimate	288,542	12,880,580
Population, 2010 (April 1) estimates base	295,127	12,831,587
Percent Change 2010-2014	-2.30%	0.40%

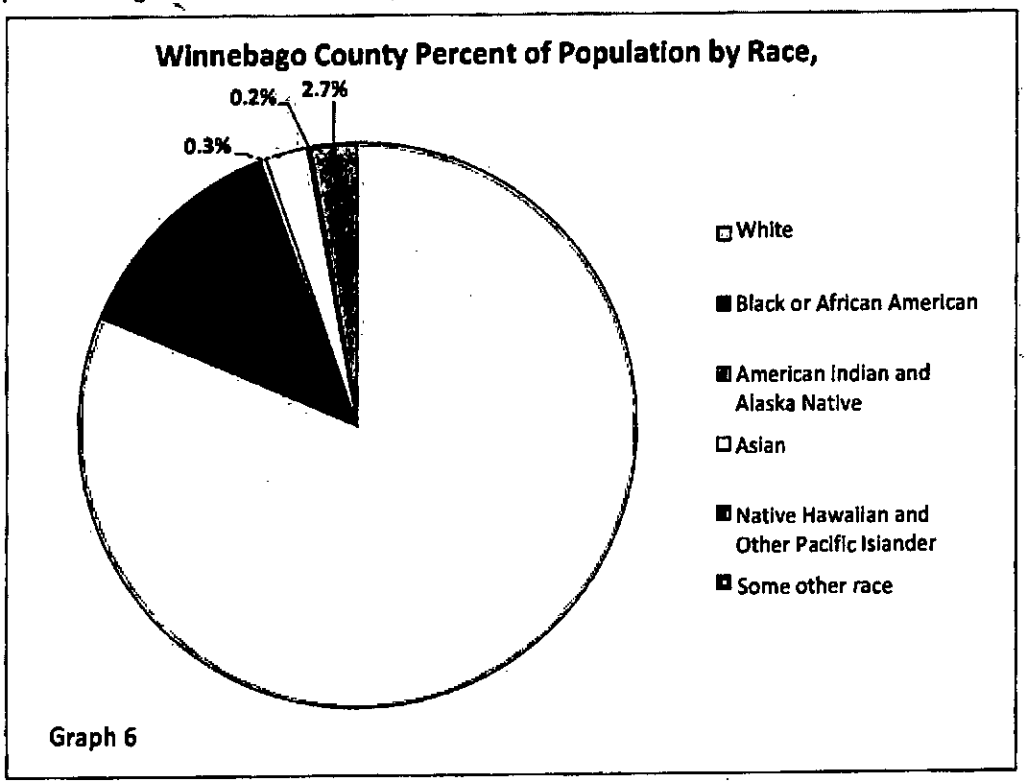
Table 4 Source: U.S. Census Bureau



Graph 5

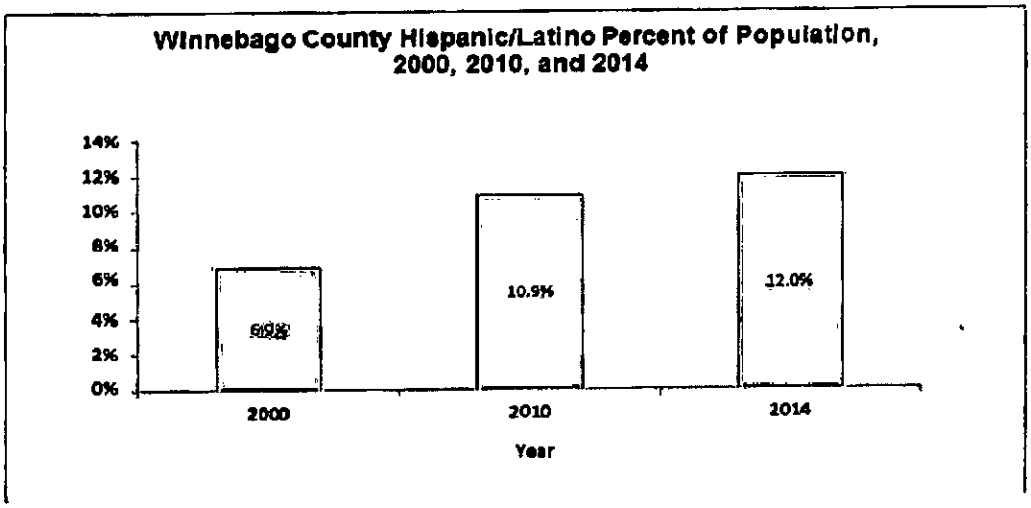
Exhibit A

The distribution of Winnebago County population by race in 2014 is shown in Graph 6. Whites comprised a majority of the population with a distribution of 79.2 percent followed by Black or African American at 12.6 percent. Together these races comprised over 90 percent of the county population.



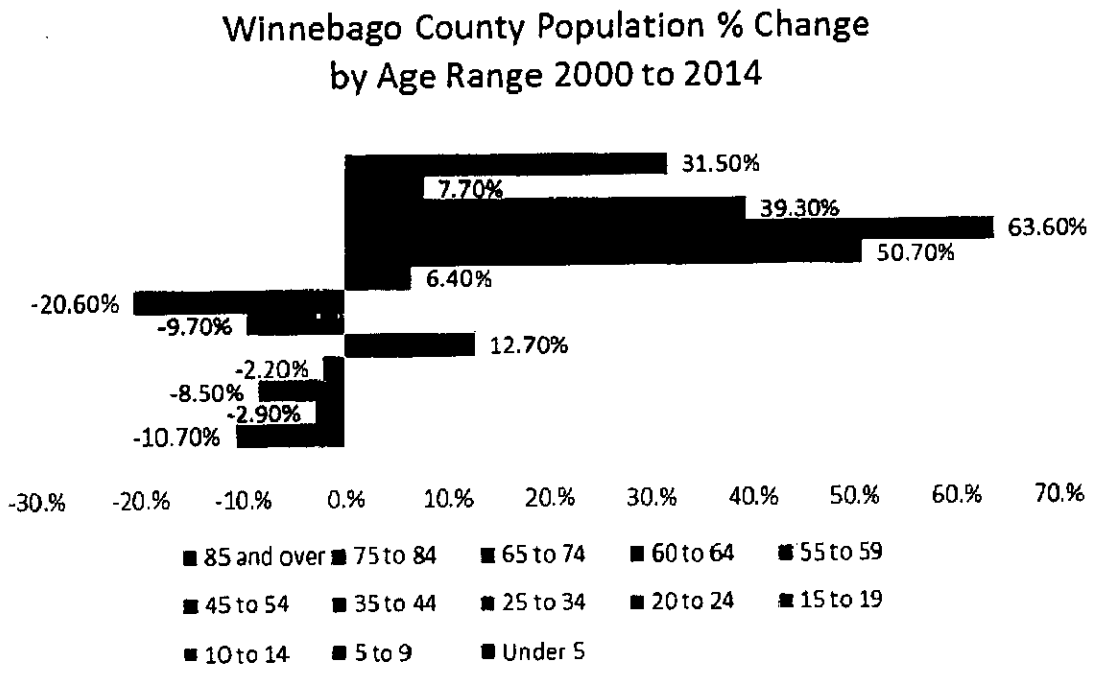
Graph 6

Hispanic/Latino population from 2000 to 2014. The Winnebago County Hispanic/Latino population increased 80.5 percent between 2000 and 2014, Graph 7.



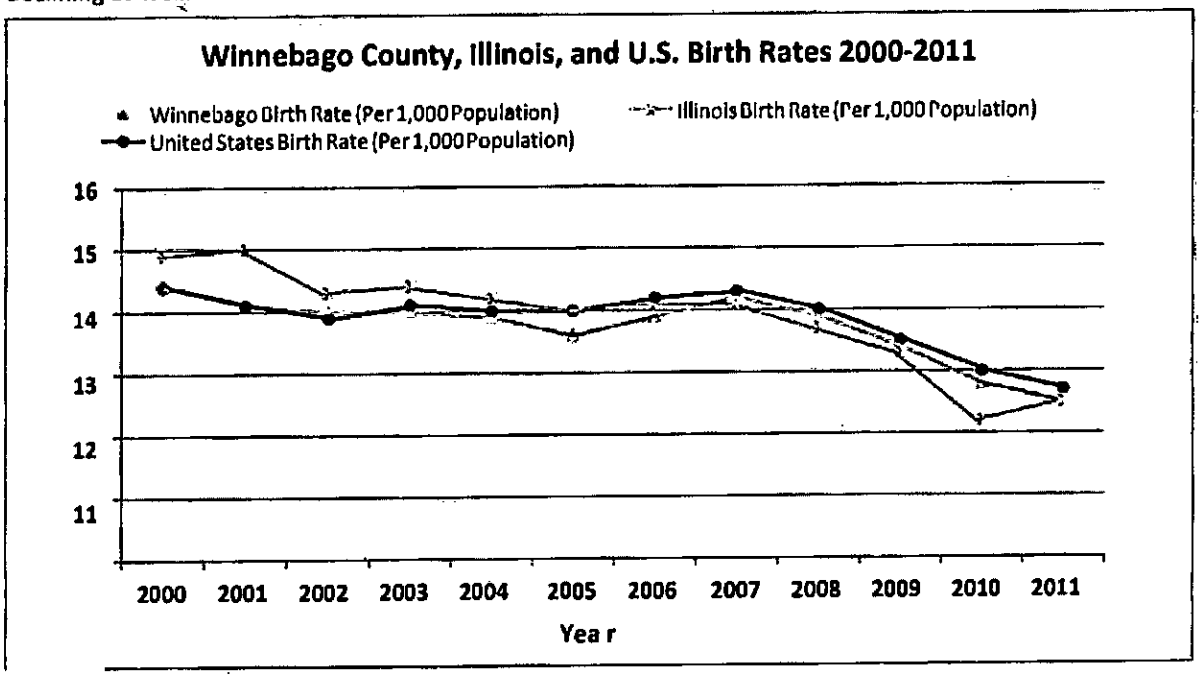
Graph 7

Percent change in population by age is shown in Graph 8. The age categories under the age of 19 have decreased from 2000 to 2014. The group from ages 20 to 24 has increased by 12.7 percent, thus the only group under the age of 44 years old to increase in population. The population groups from 45 years old to 85 and over have all increased with 60 to 64 years old showing the largest growth of 63.6 percent. A significant increase is observed in all the age groups over 45 to 54 years suggesting that compared to younger population in their reproductive years, the percent of older population is increasing in Winnebago County.



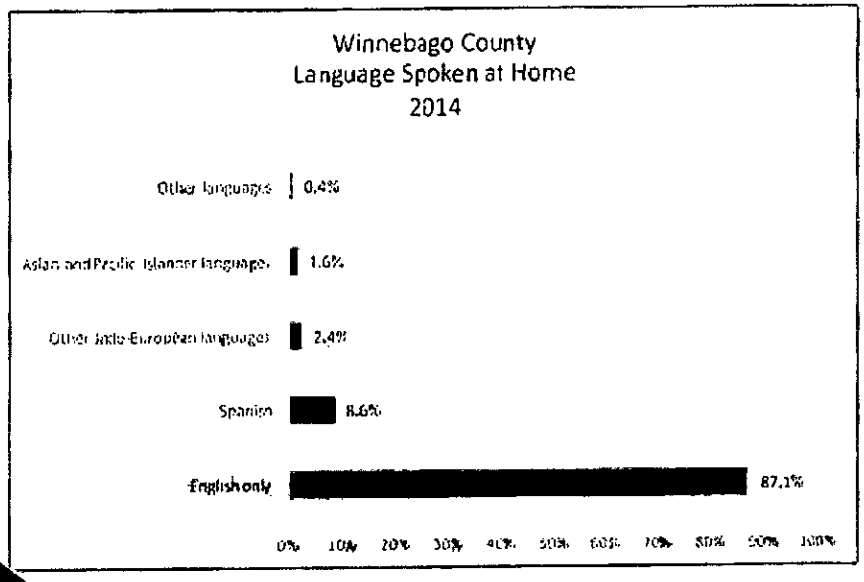
Graph 8

Between 2000 and 2011, the number of births in Winnebago County decreased by 9.0 percent, Graph 9. The decline in births support the previous graph suggesting the younger population in reproductive years is declining as well.

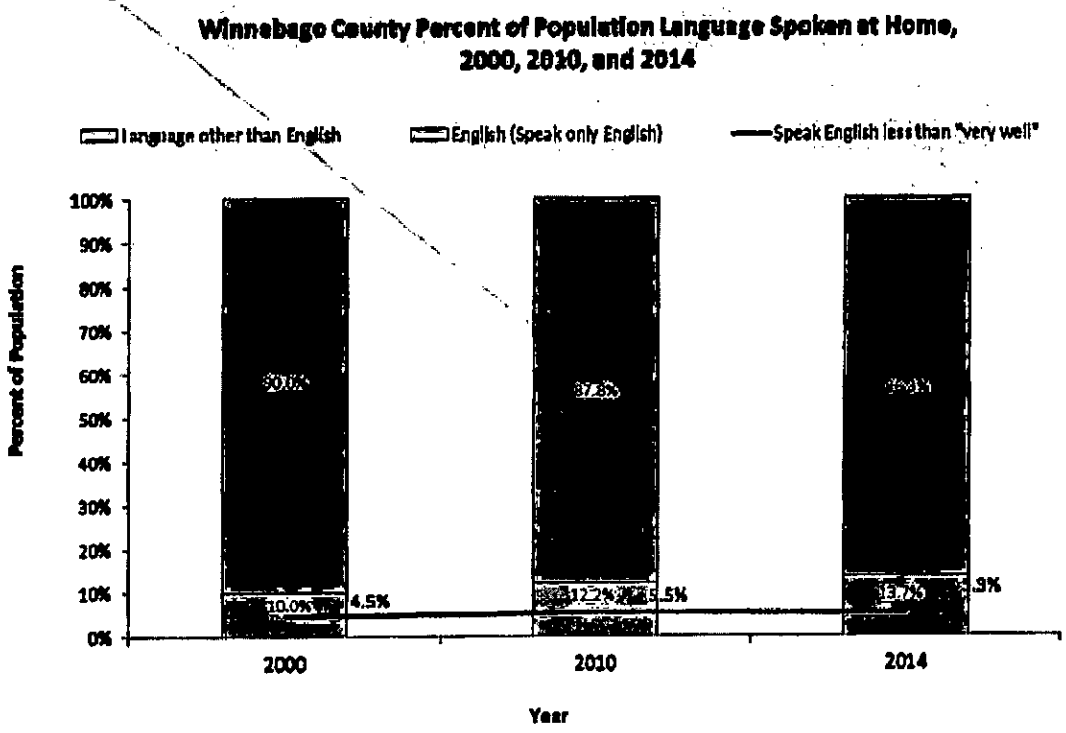


Graph 9

English is the primary language spoken at home with 87.1 percent of Winnebago County residents speaking English. Spanish is the primary language in 8.6 percent of the homes which is lower than the overall Hispanic population of the county at 12 percent. These are followed by other Indo-European languages at 2.4 percent and Asian at 1.6 percent. Other languages comprise 0.4 percent, Graph 10.

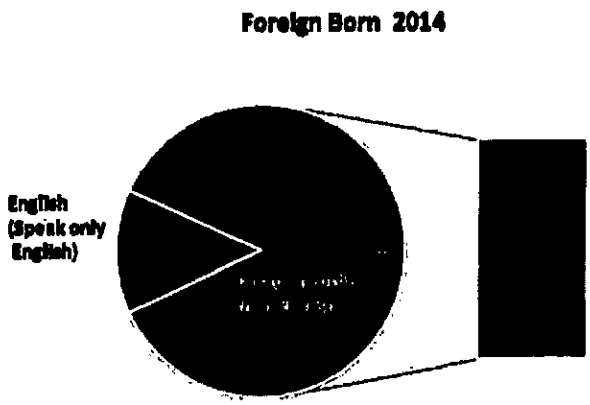


Winnebago County percent of population and language spoken at home during 2000 to 2014 is shown in Graph 11. The percent of population speaking only English has been decreasing, from 90.0 percent in 2000 to 86.3 percent in 2014.



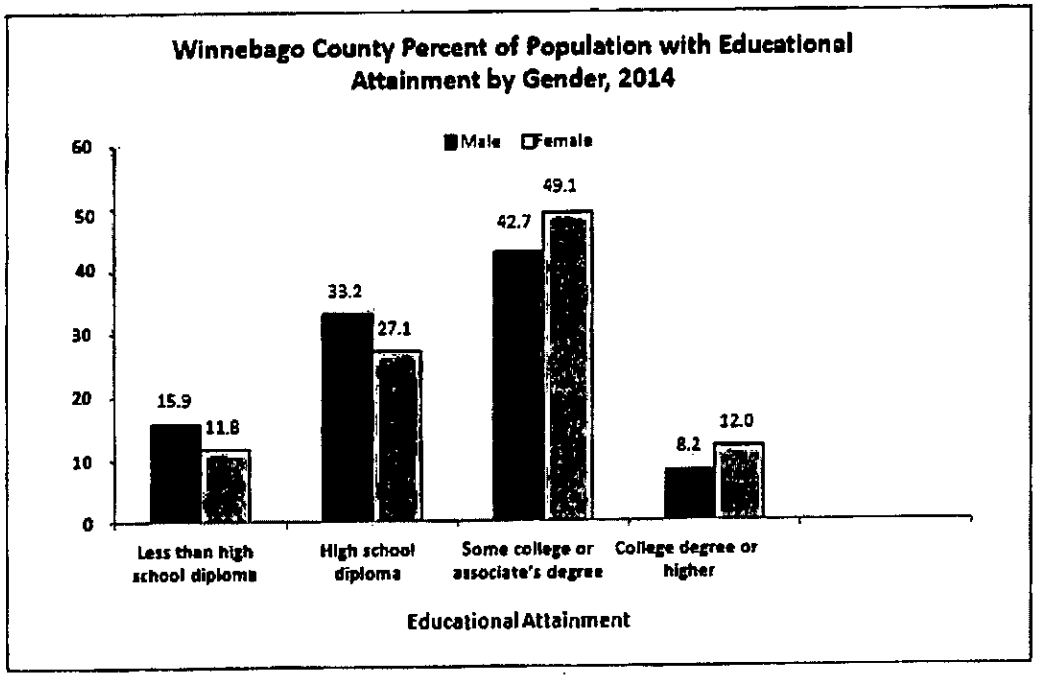
Graph 11

During 2015, among the foreign-born population in Winnebago County, a large majority (86.3 percent) spoke a language other than English. Fifty-two percent of those spoke English but 'not very well', Graph 12.

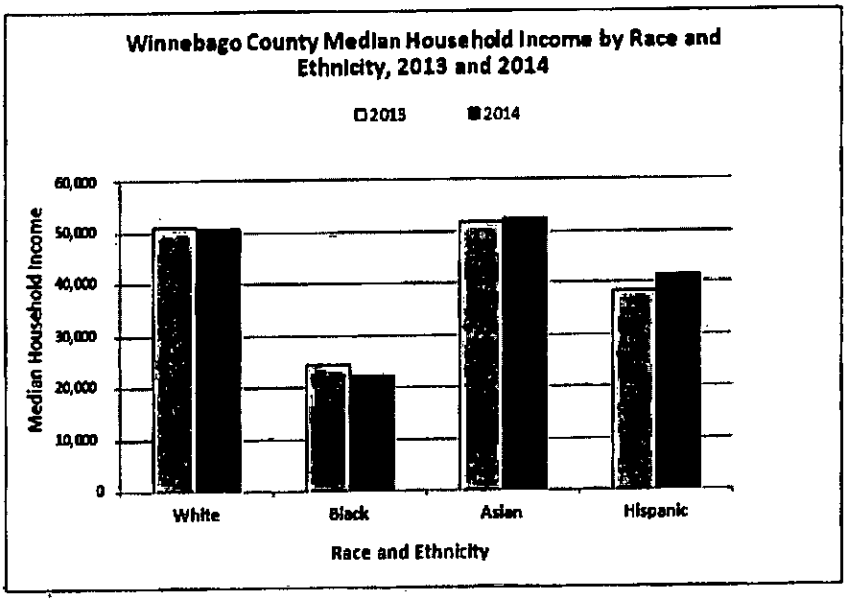


Graph 12

Education attainment by gender suggests 33.2 percent of males in Winnebago County graduated from high school, a higher percentage than females who graduated at 27.1 percent. Almost 7 percent more females seek 'some college or associate's degree' after high school than do males. The female percentage of obtaining a college degree or higher is just over 4 percent higher than males, Graph 14.



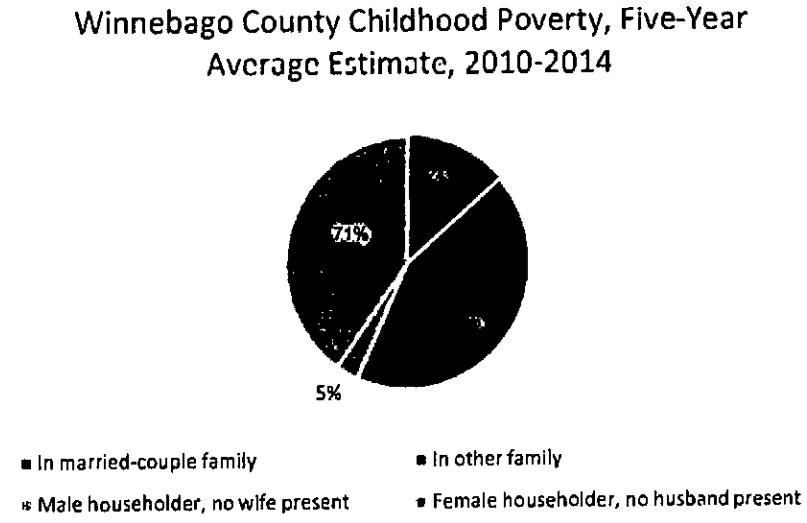
Graph 14



Graph 15

According to the U.S. Census Bureau the median household income has risen by 0.4 percent from 2013 ($46,946) to 2014 ($47,121). The racial disparity in the black community is significant. African Americans make-up nearly 13 percent of the population and are making on average, less than half ($22,129 in 2013) of the average median income in Winnebago County, Graph 15.

Based on a five year average, 2010-2014, of the 70,034 families in the county, 27.3 percent are living at or below poverty levels. Of families living at or below poverty levels, 71 percent have female heads of household, Graph 16.



Graph 16

ASSESSMENT RESULTS

The Community Health Status Assessment prioritization matrix (Appendix D) was completed by 65 community leaders and residents in Winnebago County. These individuals represented 5 rural areas; Rockton, South Beloit, Durand, Pecatonica and Winnebago, 1 suburban area; Roscoe, and 1 urban area; Rockford. The matrices were completed in the months of June and July, 2016. Matrix results were based on point value assigned; 1 – Less Important, 2 – Equally Important, 3 – More Important. Each health issue had 24 possible points (3 max points x 8 comparative health issues), 65 participants totaled 1,560 possible points for each health issue. Points were tallied by health issue and divided by possible points. The percentage of points earned were ranked, and the 3 top health issues were considered when setting final health priorities, Table 5. Violence and Maternal Child Health scored equally. The MAPP model encourages using all four assessments when setting final priorities.

Health Issue	Final Score	Rank
Access to Care	0.700641026	1
Mental Health	0.690384615	2
Violence	0.676923077	3
Maternal Child Health	0.676923077	3
Health Equity	0.663461538	4
Chronic Disease	0.654487179	5
Needs of the Aging Population	0.653846154	6
Adolescent Sexual Health	0.628205128	7
Social Determinants	0.626282051	8

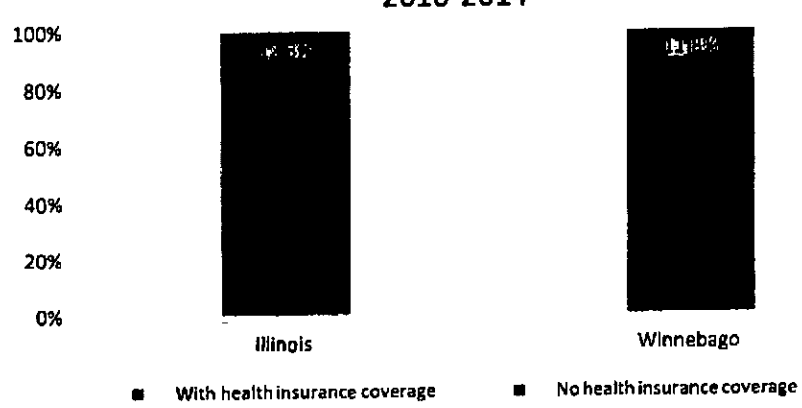
Table 5

CHSA RANK 1 - ACCESS TO CARE

A person's ability to access health services has a profound effect on every aspect of his or her health, yet at the start of the decade, almost 1 in 4 Americans do not have a primary care provider (PCP) or health center where they can receive regular medical services. Approximateiy 1 in 5 Americans (children and adults under age 65) do not have medical insurance. People without medical insurance are more likely to lack a usual source of medical care, such as a PCP, and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions. When they do access health services, they are often burdened with large medical bills and out-of-pocket expenses.

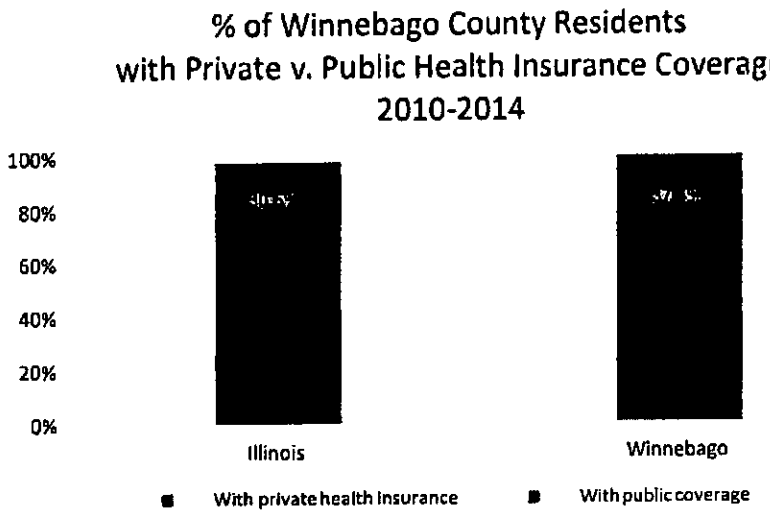
Increasing access to both routine medical care and medical insurance are vital steps in improving the health of all Americans.

While there has been improvement over the last several years due largely to implementation of the Affordable Care Act (ACA) and the expansion of Medicaid, 11.8 percent of residents still do not have health insurance coverage, in comparison this is slightly less than the percentage in the State of Illinois, Graph 17.



Graph 17

The majority, 63.7 percent of Winnebago County residents with health insurance have private health insurance, while 37.4 percent have public insurance. The public insurance percentage is higher than the State of Illinois by 6.9 percent, Graph 18.



Graph 18

According to the Centers for Medicare & Medicaid Services (CMS), Winnebago County is considered a Metro County (1). This requires a ratio of 1.67 Primary Care Providers (PCP) for every 1,000 residents in the county. A primary care provider includes the following Medical Doctors (Family Medicine, General Practice, Pediatrics, Geriatric Medicine, and Internal Medicine), Nurse Practitioners (Family, General, Pediatric), and Physician Assistants (2). Each specialty listed is considered to be equal in the adequacy equation regarding access to primary care (2), Table 6.

Adequacy = 1.67 Primary Care Providers * 288,542 Winnebago County Population 2014 /1000 Residents
Adequacy for Winnebago County (1, 2) = 482 Primary Care Providers (PCPs)

Winnebago County does have adequate access to PCP considering the equation above (505 > 482).

Winnebago County Primary Care Providers as of December 2015	
Specialty	Provider Count
Family Medicine - Medical Doctor	140
General Practice - Medical Doctor	3
Pediatrics - Medical Doctor	41
Geriatric Medicine - Medical Doctor	5
Internal Medicine - Medical Doctor	78
Medical Doctors	267
Clinical Nurse Specialist	8
Family Nurse Practitioner	75
Nurse Practitioner	70
Pediatric Nurse Practitioner	12
Physician Assistant	73
Nurse Practitioner/Physician Assistants	238
Grand Total of PCPs	505

Source: CMS.org

Table 6

Exhibit A

Table 7 breaks down the number of PCPs in each Zip Code. Determination categories used include:

- Not Adequate = Less than 1.67 PCPs per 1,000 residents in the Zip Code
- Adequate = ≤ 5 above 1.67 PCPs per 1,000 residents in the Zip Code
- More than Adequate = > 5 above 1.67 PCPs per 1,000 residents in the Zip Code

According to Table 5, 33 percent of zip codes in Winnebago County do not have adequate access to primary care services.

Winnebago County Primary Care Providers Adequacy by Zip Code						
Location	Zip Code	2010 Population	Actual	CMS Adequate	Difference	Determination
Southeast Rockford	*61109*	28,333	5	17	-12	
Northwest Rockford	*61101*	21,593	4	13	-9	
South Beloit	*61080*	10,599	1	6	-5	
Rockton	*61072*	11,797	3	7	-4	
Machesney Park	*61115*	23,180	10	14	-4	
Durand	*61024*	2,620	1	2	-1	
Pecatonica	*61063*	4,132	2	2	0	Adequate
Shirland	*61079*	188	0	0	0	Adequate
Cherry Valley	*61016*	4,837	4	3	1	Adequate
Winnebago	*61088*	6,020	5	4	1	Adequate
Roscoe	*61073*	20,052	15	12	3	Adequate
Laves Park	*61111*	23,492	31	14	17	
Northeast Rockford	*61114*	15,776	30	9	21	
Southeast Rockford	*61108*	28,550	48	17	31	
Southwest Rockford	*61102*	20,538	47	12	35	
Northwest Rockford	*61103*	24,578	75	15	60	
Southeast Rockford	*61104*	19,269	90	12	78	
Northeast Rockford	*61107*	30,439	132	18	114	

Table 7
Source: CMS.org

CMS recommends a PCP be within 10 miles or 15 minutes driving distance from residents. The map below (Figure 6) displays the location of PCPs in Winnebago County. Each dot may represent more than one PCP. The green buffer defines the 10 mile radius. This map would suggest adequate PCP coverage based on driving distance. However, it does not consider neighboring counties that may use PCP services in Winnebago County and does not consider whether residents have appropriate insurance coverage to use the closest PCP.

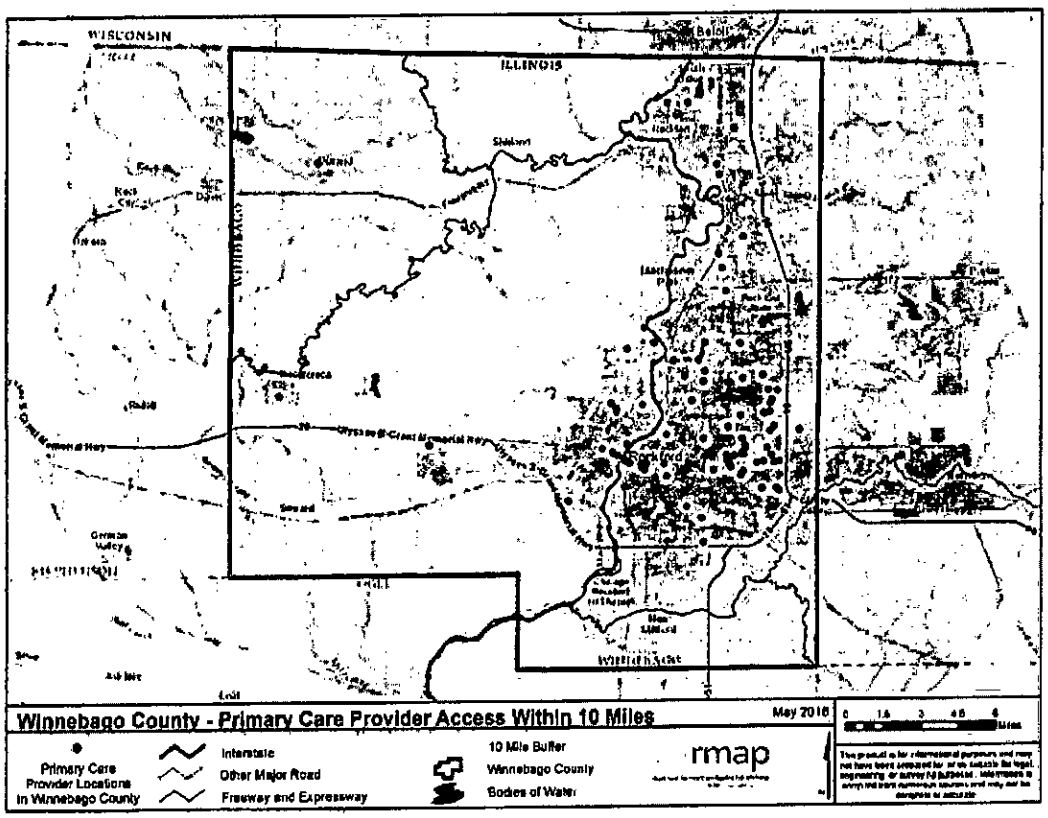
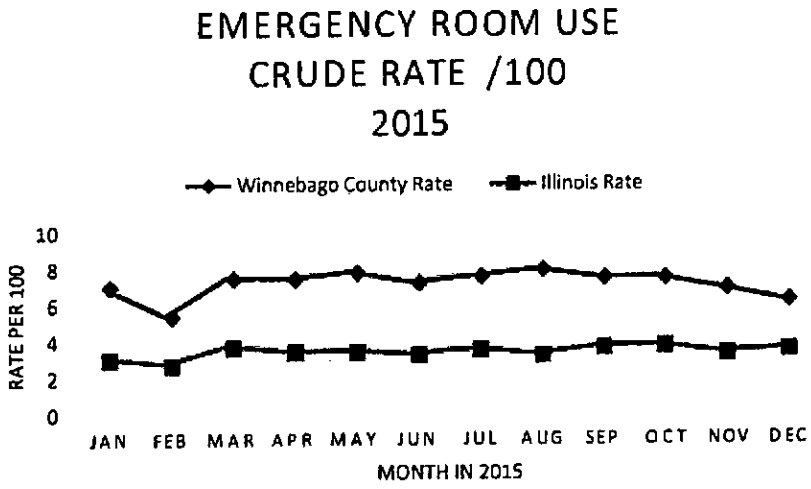


Figure 6

Access to regular primary care is important to the prevention of major health issues and reduces misuse of emergency room services. This is a Healthy People 2020 leading topic. Currently in Winnebago County, 85 percent of residents report having one primary care provider to use for well visits and health issues. This is 1 percent over the nation's target of 84 percent.

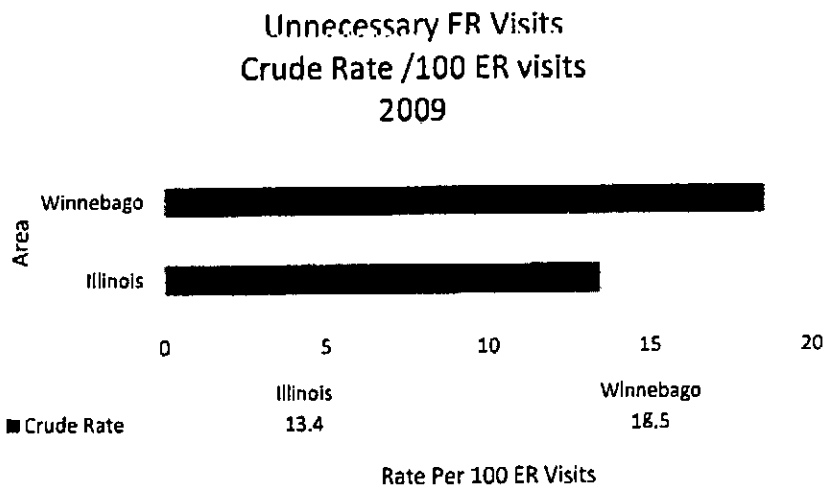
Emergency room use is also an indicator of access to care. In 2015, Winnebago County emergency room usage rates ranged between 5 and 8 per 100 resident, Graph 19. This is twice as high as the state of Illinois average where emergency room visits range between 2 and 4 per 100 residents.



Graph 19

Source: CDC BioSense

Winnebago County has three emergency rooms, one located at each hospital. Of individuals utilizing an emergency room, data from 2009 suggests that 18.5 per 100 visits were unnecessary Graph 20. These visits could have been avoided and treated at an ambulatory clinic. This is significantly higher than the state of Illinois average of 13.4 unnecessary per 100 visits.



Graph 20

Source: iQuery

Exhibit B

Facility	Referring Physician	CKD Patients	Projected Patients	Utilization	Patient Service Area
Forest City Dialysis	Charlene D. Murdakes, M.D.	110	68	94%	• West side of Rockford
Belvidere Dialysis	Mashood Ahmad, M.D.	102	64	89%	• Belvidere • Poplar Grove • Genoa • Kirkland • Caledonia • Cherry Valley • Marengo • Garden Prairie • Capron • Kingston
Machesney Park Dialysis	Michael Robertson, M.D.	119	72	100%	• Machesney Park • Loves Park • Roscoe
Alpine Dialysis	Syed Ahmed, M.D.	69	44	92%	• Southeast side of Rockford

Exhibit C

Information on Kidney Transplantation

DaVita offers many initiatives to improve the lives of patients suffering from chronic kidney disease and end stage renal disease, including efforts to educate patients about transplant and other treatment options and providing ongoing support for patients who are on transplant waiting lists. We have provided examples of the transplant-related support materials that DaVita provides patients in-person and online in Attachments A and B, respectively. As a result of these efforts, DaVita patients are more likely to transplant than the average dialysis patient. For example, in 2014 DaVita saw above industry average transplant rates, with more than 5,000 DaVita patients transplanted.[2]

For a variety of reasons, however, kidney transplantation is not always a viable or preferred option for patients. As discussed briefly below, eligibility factors, waiting list requirements, a lack of donor organs, patient characteristics, and prior transplant organ rejection can cause patients to rely on dialysis for their ongoing treatment.

- Transplant Eligibility – While eligibility criteria vary by hospital and waiting list, there are a variety of factors that can make a patient ineligible for transplant. For example, many transplant centers use a body mass index (BMI) of 30-35 kg/m^2 as a limit for transplant eligibility.[3] In Illinois, of 3,403 reported candidates on the kidney transplant waiting list, 1,515 candidates (**44.5%**) have a BMI > 30.[4] Additional contraindications and grounds for ineligibility include patients who have active malignant cancer. Further, the remission waiting period prior to transplantation can be five years for some cancers. Severe non-compliance with kidney disease treatment or active substance abuse is also contraindications for transplant. Some transplant centers do not accept patients with chronic infections such as Hepatitis B or C and HIV as transplant candidates. Other factors, such as patient financial resources and support, transportation, cognitive impairment, are also considered when transplant centers evaluate patients for transplant

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2 Statistics based on 2014 DaVita internal data on transplant numbers and industry data on transplant volume and pre-dialysis transplant rates. For additional information, see Attachment B at page 13.

3 Kavitha Potluri, M.D. and Susan Hou, M.D., *Obesity in Kidney Transplant Recipients and Candidates*, Am. J. Kidney Dis. 56: 143-156 (2010).

4 Organ Procurement and Transplantation Network, Waitlist: Candidates, BMI By State of Center, Region of Center (Dec. 4, 2017) *available at* https://optn.transplant.hrsa.gov/data/view-data-reports/build-advanced/ (last visited Dec. 5, 2017).

candidacy.[5] Transportation may be particularly challenging for Rockford residents. Because no area hospital performs kidney transplants, patients must travel over 80 miles to access the nearest Illinois transplant hospital. See Attachment A for a list of regional transplant centers.

- Waiting List Requirements – Once patients are preliminarily evaluated and medically and psychosocially approved for transplant, they will only be placed on a waiting list and accrue waiting list time once their estimated glomerular filtration rate or equivalent measure is $\leq$ 20 mL/minute.[6] Once on the list, because many patients have multiple comorbidities, they may require multiple tests and procedures before being deemed medically acceptable for transplantation. While on the waiting list, patients must be medically cleared for transplant at all times, receive routine health maintenance, have periodic cardiovascular testing, maintain a healthy weight, and keep their medical team informed of any health changes or periods of unavailability.

- Lack of Donor Kidneys – This year, 597 kidney transplants have been performed in Illinois and there are currently 3,619 candidates on the state's waiting lists.[7] This illustrates the shortage of donor kidneys in the state. Patients are fortunate when they can receive a living donor transplant from a friend, relative or other generous individual who is compatible with their patient characteristics. Of the 597 transplants performed so far this year, only 199 (**33.3%**) were from living donors. More commonly, patients must wait for a kidney from a deceased donor.[8] According to the National Kidney Foundation, every day 12 people die waiting for a kidney.

- Patient Characteristics – Certain transplant candidates have a longer waiting time on the transplant list due to their personal characteristics and challenges in finding a compatible donor kidney. For example, patients with blood groups O and B wait the longest with a median wait time of approximately five years. Sensitized candidates who have antibodies as a result of a blood transfusion, pregnancy, or prior failed transplant are more likely to have a positive crossmatch to potential kidney donors and therefore also tend to have longer waiting times. Previously transplanted patients wait approximately twice as long

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5 Organ Procurement and Transplantation Network, Educational Guidance on Patient Referral to Kidney Transplantation *available at* https://optn.transplant.hrsa.gov/resources/guidance/educational-guidance-on-patient-referral-to-kidney-transplantation/ (last visited Dec. 6, 2017).

6 UpToDate®, The Kidney Transplant Waiting List in the United States *available at* https://www.uptodate.com/contents/the-kidney-waiting-list-in-the-united-states/print (last visited Dec. 6, 2017).

7 Organ Procurement and Transplantation Network, State Data *available at* https://optn.transplant.hrsa.gov/data/view-data-reports/state-data/# (last visited Dec. 6, 2017).

8 Organ Procurement and Transplantation Network, State Data *available at* https://optn.transplant.hrsa.gov/data/view-data-reports/state-data/# (Last visited Dec. 6, 2017).

as those awaiting a first transplant because of sensitization. Race has also been shown to impact the time a patient spends on the waiting list: waiting time for white candidates is approximately 40 percent less than for all other races.[9] All of these patient characteristics illustrate how patients on the waiting list for a transplant may still require dialysis for many years before a compatible organ becomes available.

- Transplant Rejection – Unfortunately, not all kidney transplants are successful. Within one year, 7% or nearly 3,000 transplanted kidneys will fail, and within three years, 17% or over 6,000 of people will have lost their transplants. At 10 years, only 54% of transplant kidneys are still working.[10] Some of these individuals will have another kidney transplant, while others will rely on continued dialysis for their treatment.

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9 Organ Procurement and Transplantation Network, Educational Guidance on Patient Referral to Kidney Transplantation *available at* https://optn.transplant.hrsa.gov/resources/guidance/educational-guidance-on-patient-referral-to-kidney-transplantation/ (last visited Dec. 6, 2017).

10 Lara E. Tushla, LSW, When a Transplant Fails, National Kidney Foundation *available at* https://www.kidney.org/transplantation/transaction/TC/summer09/TCsm09_TransplantFails (last visited Dec. 6, 2017).

Getting a Kidney Transplant

It's possible to remove a kidney from someone (a kidney donor) and give it to a pati ent like you whose kidneys have stopped working (a kidney recipient). This is known as a kidney transplant surgery.

Getting a donor

- A family member or friend may be able to donate a kidney to you. If not, you may be able to get on a waiting list to get a kidney from a stranger who has agreed to donate one.

Types of Kidney Donors

- **Living Donor:** may be a family member, a spouse, friend, or a stranger who has agreed to donate a kidney to anyone who needs one.
- **Deceased Donor:** a person who has just died and whose loved ones have given permission for the kidneys to be donated.

Getting the transplant

- A transplant team (usually made up of a surgeon, social worker, transplant coordinator, and other medical professionals) will evaluate your health status and lifestyle to determine if you're a good candidate for a kidney transplant. You will need to have medical tests and attend several appointments with the team.
- You may be on the waiting list for a short time or a long time. To get a kidney, you have to be a good match (for example, blood type) for the ones that are available.

Next steps

- Ask your nephrologist (kidney doctor) and social worker about kidney transplant.
- Visit these websites for more information: http://www.davita.com/treatment-options/transplant, www.transplantliving.org, https://www.kidney.org/transplantation
- Talk to the rest of your care team (nurse, dietitian, social worker, PCT) about transplant and ask what you can do to improve your chances of getting on the waiting list and getting a transplant.
- Take your medications, follow your diet, go to your dialysis appointments, and stay on for the prescribed amount of time in order to make yourself as healthy as possible and show your commitment to transplant.

Acknowledgements: Information for this article was made possible through the following references: NKF; NIDDK; United Network of Organ Sharing; USC Kidney Transplant Program; Washington University School of Medicine – St. Louis

SocialWorkers
Helping hands throughout the Village

93% of DaVita patients are satisfied with the quality of care they receive at DaVita.*

Better care. Better quality of life.

Kidney Transplant

:: A treatment, not a cure, for kidney disease.
:: A surgeon transplants one healthy kidney from a living or deceased donor.
:: After a transplant, you will need medication to suppress your immune system.
:: You can get on the kidney transplant list or find a living donor even before you begin dialysis.

Peritoneal Dialysis (PD)

:: This needle-free dialysis treatment uses the inner lining of the abdomen to clean your blood.
:: You can do the flexible, easy treatments at home or at work.
:: Peritoneal dialysis may help preserve your remaining kidney function.

Home Hemodialysis (HHD)

:: You can dialyze on your schedule—up to six times per week.
:: Better blood pressure control, shorter recovery time after treatments and higher energy levels.
:: Enjoy fewer diet restrictions, better fluid control and take fewer medications.

In-Center Hemodialysis

:: Receive your care in one of our clean, friendly dialysis centers.
:: Your treatments will be provided by our certified caregivers.
:: Enjoy the camaraderie of fellow patients.

In-Center Nocturnal Hemodialysis

:: Receive three 6-8 hour dialysis sessions a week at night while you sleep.
:: This slow, gentle treatment can help improve your appetite and energy level.
:: Feel well enough and have a treatment schedule that helps you keep your job.

In-Center Self Care Hemodialysis

:: Administer your own treatments without the need to have a machine in your home.
:: Your personalized DaVita® healthcare team is there to help you when you need assistance.
:: You can choose the tasks you want to perform on your own.

There's more than one kind of dialysis treatment. Which one matches your lifestyle? Go to **DaVita.com/TreatmentEvaluator** to take our short quiz, and remember to share the results with your doctor.

DaVita.

*2017 DaVita patient satisfaction survey

Attachment - 1

Modality Comparison Chart

Not all patients are eligible for each modality. Please talk with your doctor about your options.

Health Benefits	Home		In Center		
	PD	HHD	Nocturnal	Self Care	Hemodialysis
Longer retention of residual renal function. Frequent dialysis more closely matches the work of the natural kidneys, which may help to preserve remaining kidney function.*	●	●			
Preservation of vascular access. Prolong the availability of your veins/arteries by starting with peritoneal dialysis.	●				
Fewer infections requiring hospitalization. Dialysis that is properly done at home generally results in fewer infections.*	●	●			
Shorter recovery time after treatments. More frequent or longer treatments are less stressful on the body.*	●	●	●		
Fewer peaks and valleys. Shorter periods between treatments allow fewer toxins and fluid buildup.	●	●	●		
Treatment by health care professionals. Clinical caregivers provide on-site monitoring.			●	●	●
Improved appetites reported. Patients report improvement in appetite and nutrition along with a more liberal diet.*		●	●		
Improved sleep reported.*	●	●	●		
Improved blood pressure control. Longer, slower and more frequent treatments have reduced some patients need for blood pressure medication(s).*		●	●		
Higher energy levels reported. Patients say they have more energy and feel better all around.*	●	●	●		
Improved outcomes. Patients who become more involved in self care generally have better overall outcomes.*	●	●	●		

Lifestyle Benefits	Home		In Center		
	PD	HHD	Nocturnal	Self Care	Hemodialysis
Convenience and flexibility. Patients who dialyze at home can adjust their therapy schedule as needed to fit their lifestyle.	●	●			
Less restricted diet. Because you're receiving dialysis more frequently your diet may have fewer restrictions.*	●	●			
Independence. Machines can be transported when traveling.	●	●			
Free days. Free up your days by dialyzing at night while you sleep.	●		●		
No supplies to store at home. All needed supplies and equipment stay at the dialysis center.			●	●	●
Minimum weight gain. Minimize your weight gain. Glucose in peritoneal dialysis solution may cause weight gain.		●	●	●	●
No care partner required. Care partners are not required, but some patients may need the assistance of a care partner.	●		●	●	●
Social time with other kidney patients. Other kidney patients can provide friendship and support.			●	●	●
Freedom to travel. With advance planning, DaVita teammates can help arrange for your treatments away from home.	●	●	●	●	●
Needle-free treatments.	●				

TRANSPLANT HOSPITALS

ILLINOIS

Loyola University Health System
2160 s. First Ave.
Maywood, IL 60153
To refer a patient: (708) 327-4897
Fax: (708) 216-6003

Northwestern Memorial Hospital-Klovar Organ Transplant Center Galter Pavilion
675 N. St. Clair St, Suite 17-200
Chicago, IL 60611
Phone: (312) 695-0828 extension 1

Rush University Medical Center
Dept. of Organ Transplant
1725 W. Harrison St, #161
Chicago, IL 60612
Appts. (312) 942-4252

University of Chicago Medical Center
5841 S. Maryland Ave.
Chicago, IL 60637
Phone: 888-824-0200
To refer: (773) 702-4500
Fax: (773) 702-4788

University of Illinois Medical Center of Chicago
Division of Transplantation
840 S. Wood St, Suite 402
Chicago, IL 60612
Appts. (312) 996-6771

OSF St. Francis Medical Center
530 NE Glen Oak Ave
Peoria, IL 61637
Phone: 800-635-1440

WISCONSIN

Froedtert Hospital
9200 W. Wisconsin
Milwaukee, WI 53226
Phone: (414) 955-6920

University of Wisconsin Hospital at Madison
600 Highland Ave
Madison, WI 53792
Phone: (608) 262-6400
To Refer a patient: (608)890-6206
Appts. (608)626-5420
Fax: (608)262-5624
All other inquiries: 608-263-1384

IOWA

Iowa Methodist transplant Center
Methodist Plaza II , suite 506
1215 Pleasant St.
Des Moines, IA 50309
Phone: (515)241-4044
Phone: (888)343-4164

University of Iowa Hospital
Dept of Surgery
1500 JCP
200 Hawkins Dr
Iowa City, IA 52242
Kidney pre-transplant questions (319) 356-4778

MINNESOTA

Mayo Clinic
200 First St SW
Rochester, MN 55905
Phone: 866-249-1648
Appts. (507)284-2111

MISSOURI

Barnes Jewish Hospital
Washington University Transplant Program
4921 Parkview PL
St Louis, MO 63110
Phone: 800-633-9906

St. Louis University Hospital
Abdominal Transplant Program
3635 Vista Ave, 11th floor Desloge Tower
St. Louis, Missouri 63110
Phone: (314)577-8867

Kidney Transplant: What You Need to Know

What do actor George Lopez and NBA champion Alonzo Mourning have in common? Besides being extremely talented in what they do for a living, each of them has received a transplanted kidney. Success stories like these, along with advances in medications, surgery techniques and donor matching, make kidney transplant a viable alternative to dialysis for thousands of people every year. For more information about dialysis patients transitioning to a kidney transplant, go here.

If you're nearing the need for dialysis and would like to explore getting a transplant, start the discussion with your nephrologist. Your doctor will discuss the transplant process with you, which generally starts with being referred to a transplant center for further evaluation. While transplant requirements vary between centers, you'll most likely undergo comprehensive medical tests to determine if you're a viable candidate. If you are, then the search for a donor can begin.

Finding a match

There are two types of organ donors: a living donor and a non-living, or cadaver, donor. Compatibility between a patient and the donor reduces the chances of organ rejection and can contribute to a more successful transplant. Additionally, because medication to help prevent organ rejection is so effective, donors don't always have to be genetically similar to the recipient.

If you don't have a potential living donor, you will be placed on the waiting list for a cadaver organ and will need to register for the national transplant waiting list at United Network of Organ Sharing (UNOS). The wait for a transplant can vary greatly depending on the type of donation you receive, your geographic location and current health.

Know someone who would like to donate a kidney? Visit the National Kidney Registry to start the progress.

Going in for surgery

You'll be scheduled for surgery as soon as an appropriate organ match has been identified. In most cases, your surgeon will leave your kidneys in place and simply place the new, healthy kidney in a different location in your abdomen. You will remain in the hospital for several days after the surgery and be monitored for any complications.

Common transplant concerns

While your age and health conditions prior to the transplant surgery can affect the risk of complications, there are three common post-transplant concerns.

Rejection: Medication will be prescribed to help ensure your body accepts the new kidney.

Functionality: In some cases, the newly transplanted kidney begins working right away, while in others it may require dialysis for a few days before it starts functioning normally.

Organ lifespan: The average life span for a donated kidney is 10 to 15 years. When a transplant fails, a patient may opt for a second transplant or return to dialysis.

Taking care of your new kidney

Maintaining healthy habits and following your doctors' recommendations is vital to help your new kidney function properly so you can have a better quality of life for years to come. Get more details about this alternative to dialysis.

Kidney transplants and patients

- DaVita patients are more likely to transplant than the average dialysis patient. Also in 2014, DaVita saw above industry average transplant rates, with more than 5,000 DaVita patients transplanted. *(Based on 2014 DaVita internal data on transplant numbers and industry data on transplant volume and pre-dialysis transplant rates.)*
- While internal data shows that about 3 percent of our patients transplant every year, more than 7 percent of commercially insured patients transplant compared to about 2.5 percent on Medicare and even fewer on Medicaid.
- Insurance type has tremendous impact on the likelihood of receiving a transplant, primarily because commercial coverage provides access to care most valuable to the patient. An increased likelihood of receiving a transplant with commercial insurance is true across the industry, with commercially-insured patients 2.5 times as likely to transplant than government-insured patients. African Americans are 15 times as likely to transplant with commercial insurance than government insurance. At DaVita, we are passionate about assisting all our patients with the treatment options that are best for them regardless of insurance coverage. *(Source: NCBI)*

Related kidney disease education articles on DaVita.com

- Getting a Kidney Transplant
- Going from Dialysis to Kidney Transplant
- Podcast: Kidney Transplant Advocacy and Innovations
- Your Kidney Transplant Team

Articles in Transplant

Kidney Transplant: What You Need to Know-Updated

Actor George Lopez and NBA champion Alonzo Mourning are extremely talented in what they do for a living. They also each had kidney disease, and in order to help themselves continue down a successful path, they have each received a transplanted kidney. Medical advancements, surgical methods and donor matching make kidney transplant a possible alternative to dialysis.

Learn More »

Going from dialysis to kidney transplant

What's an alternative to dialysis? A kidney transplant. If you're thinking about switching treatments, this may help answer some of your questions about kidney transplantation.

Learn More »

What's it like to donate a kidney?

When a person has end stage renal disease (ESRD)–the last stage of kidney disease–they either need dialysis or a kidney transplant to live. Donating a kidney is a great gift to a person with ESRD. It's also an intensely personal decision that can be a different experience for everyone. Learn what it can be like for a live kidney donor to go through the physical and emotional aspects of a kidney donation.

Learn More »

Going from Dialysis to Kidney Transplant

When should I start the process to get a kidney transplant?

If your kidneys are failing, a kidney transplant may be a treatment option for you. The balance of risks and benefits varies depending on your age and other health problems. If you want a kidney transplant, you must contact a transplant center and ask for a transplant evaluation. It is not automatic. Only a transplant team can tell you that you are definitely eligible (or not eligible) for a transplant.

You can contact one or more transplant centers and start to be evaluated when it seems likely that you will need dialysiswithin two to three years. Most kidney transplants are successful — more than 90% of transplants are still working one year later. Recent studies have found that the odds of good results are somewhat better with a "preemptive" transplant, done before dialysis is needed. Preemptive transplant requires a willing living kidney donor — probably a relative, spouse or friend. In 2016, 38.2% of kidney transplants came from living donors.[1]

If you do not have a living donor, you can ask to be placed on a national waiting list to receive a cadaver kidney from someone who has recently died — usually in an accident. After your evaluation is complete and you are placed on the list, credit for waiting time begins when your glomerular filtration rate (GFR) drops to 20 mL/min or lower. Long waiting times — often years — are common for kidney transplants from cadaver donors.

Can I get on the kidney transplant waiting list before I start dialysis?

Yes, you may want to be evaluated for a transplant before you start dialysis. After your evaluation is done and you get on the waiting list, credit for waiting time starts when your kidney function drops to less than about 20 percent. This is measured by a GFR of 20 mL/min or less. Long waiting times—often years—are very common for kidney transplants from cadaver donors.

Will my kidney doctor automatically put me on a transplant waiting list?

No. Your kidney doctor will not automatically put you on the transplant waiting list. If you want to be evaluated for a transplant, ask your doctor for a referral to a transplant center. Contact your private insurance to help determine which centers are contracted with your plan.

Who pays for transplant costs?

If you want to get a kidney or kidney-pancreas transplant, your employer health plan may cover it (and Medicare would be secondary). If your plan does not cover a transplant, Medicare will pay 100% of the hospital charges, and 80% of Medicare's allowable rate for outpatient care like doctors' fees. Medicare will also pay for a living kidney donor to be evaluated, but your donor may have costs that aren't covered like travel or time off of work. Transplant requires costly anti-rejection drugs, too. If your employer health plans covers drugs, these will be paid for. If not, Medicare covers 80% of these drugs for three years (longer for people who are elderly or disabled).

Ask your dialysis or transplant center to help you figure out what your insurance will pay and how much you will be expected to pay out-of-pocket, or call DaVita Guest Services at 1-800-244-0680.

Can anyone give me a kidney, whenever I want?

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In the past, only a close relative, such as a parent or sibling could give you a kidney. Now more distant relatives, spouses and even friends and neighbors can be donors. If you have a willing living kidney donor, you will both need to be evaluated for general health and to see if your blood type and immune system are matched closely enough with the donor. How close the match needs to be depends on the rules and protocol of each transplant center.

If I have a transplant, will I be able to stop taking pills and seeing doctors?

No. A kidney transplant is a treatment, not a cure, for kidney disease. When you have a transplant, you must take pills to suppress your immune system for the life of the transplant.These pills keep your body from rejecting your new kidney. You will also need to see doctors regularly to monitor your health and your transplanted kidney.

If my transplant fails, can I go back to dialysis?

Yes. You may be able to go back to either hemodialysis or peritoneal dialysis (PD), depending on your medical history.

I am in Stage 4 kidney disease and can't have a transplant. Can I do dialysis for the rest of my life?

The questions, "How long can someone live?" and, "How well can someone live?" are very common when you need to go on dialysis and you're scared. Yes, dialysis is something you can do for the rest of your life. Some people have done dialysis for 30 years or more without getting a transplant. How long you can live on dialysis and how well you can do will depend on a number of things, including:

- How healthy you are, other than kidney disease
- How positive your attitude is (optimists live longer, depression can be treated)
- Whether you receive good quality medical care and dialysis
- How much you learn about dialysis and take an active role in your care.

Nobody lives for 30 years or more on dialysis by accident — it takes a lot of knowledge and effort. Read articles on DaVita.com to learn more about kidney disease and how to stay healthy. You may want to check into joining a kidney patient organization, such as a chapter of the National Kidney Foundation or the American Association of Kidney Patients.

1. Donors Recovered in the U.S. by Donor Type. *Organ Procurement and Transplantation* website.https://optn.transplant.hrsa.gov/data/view-data-reports/national-data/. Based on OPTN data as of May 25, 2017. Accessed May 25, 2017.

Attachment - 2

5 Steps: How Do You Get a Kidney Transplant?

Once your physician determines you are a candidate for transplant, and you've determined you want to pursue it, there are some key steps to keep in mind as you go through the process. Here's a look at the path to receiving a kidney transplant, and how to make it a successful treatment option when you have end stage renal disease (ESRD).

1. Finding an ideal kidney match

There are two types of kidney donors:

- **Living donor:** Elects to donate one of their kidneys and undergo surgery for its removal.
- **Deceased donor:** Allowed usable organs to be donated at their death.

Tests are needed to determine if the donor and recipient are a good match to help increase the chances of a successful transplant. There are three tests: blood type matching, tissue matching and crossmatching.

- **Blood type matching**: Matches your blood type to the potential donor's blood type.
- **Tissue matching**: Measures and defines certain proteins, called antigens, present in the patient and potential donor's blood and tissue proteins.
- **Crossmatching**: Performed by mixing a small amount of the patient's and potential donor's cells.

If you have a potential living donor and the transplant team has determined that person is a good match, they will also undergo a thorough medical evaluation at the transplant center. If things go well, you and your living donor will be scheduled for the transplant surgery.

If you do not have a living donor, you will be placed on the waiting list for a cadaver organ.

2. Getting on the kidney transplant waitlist

If you do not have a living donor, your transplant center will place you on their waiting list for a kidney and you will need to register for the national transplant waiting list at United Network of Organ Sharing (UNOS). Here are some important things to know when you're on the waitlist:

- You will be required to list several phone numbers—home, work, family, friends and neighbors—where you can be reached if a kidney becomes available.
- The average wait time for a kidney transplant is more than three years.
- When you have ESRD, you must undergo dialysis until a kidney is found.
- When a kidney becomes available, the nearest transplant center is notified and it is logged into the UNOS database.
- Once you are called, you only have a few hours to get to the transplant center. Although a call is a good indication, it is not a guarantee of a kidney.
- Transplant surgery often takes place on very short notice.
- Living a healthy lifestyle and following your kidney doctor's (nephrologist's) orders can help you stay on the donor waitlist and be in the best condition possible for surgery.

3. Going through kidney transplant surgery

Different techniques for kidney transplant surgery have been developed over the years. Typically, a large incision is made into the recipient patient's side. Advances in surgical tools and techniques have allowed surgeons to make as small an incision as possible. Your transplant surgeon will discuss the procedure with you, their choice of technique and answer any questions you have.

Attachment - 2

Depending on your condition, your surgeon may opt to remove the damaged kidney(s) or leave them. After the surgery, you will be hospitalized for several days and closely monitored for complications.

Some newly transplanted kidneys begin working right away. Others may start working after a couple of days. If your new kidney isn't working right away you'll receive dialysis until it does. You will remain hospitalized until your doctors are satisfied the new kidney is functioning and you are healthy enough to be released. Your living donor can be discharged from the hospital after a few days.

4. Monitoring your kidney after transplant surgery

Initially, your transplant doctor and nephrologists will require many follow-up visits and tests for a couple of months after the transplant. They want to make sure your new kidney is healthy. Your doctors will also look for signs of complications such as:

- Infection
- Bleeding
- Narrowing of the artery, also called kidney stenosis
- Blood clots: clots in the artery or vein could prevent circulation and cause the kidney to fail
- Kidney rejection
- Weight gain
- High blood pressure
- Cancer: use of immunosuppressant medication may leave you vulnerable to disease

You will remain under the care of your nephrologist for routine visits.

5. Caring for your kidney transplant

When you get a new kidney, it is critical to maintain healthy habits so your new kidney will function properly and give you years of use.

Part of the transplant aftercare is taking required medications. Your doctor will prescribe immunosuppressants, which you will need to take for as long as you have your new kidney. Any pre-existing health conditions you experienced before the transplant will need to be managed as well, especially conditions that contributed to your initial kidney damage such as diabetes or high blood pressure.

By keeping yourself healthy and following your doctors' recommendations, you may set yourself for a successful kidney transplantation. Of course, there are no guarantees.

Know someone who would like to donate a kidney? Visit the National Kidney Registry to start the process.

Want to become an organ donor? Visit OrganDonor.gov to sign up.

Attachment - 2

Addressing 3 Common Barriers to a Kidney Transplant

Posted August 3, 2017 in Clinical Care by Deborah Evans, LCSW.

For most patients with end stage renal disease (ESRD), a kidney transplant can offer the best possible long-term treatment option. Transplanted patients typically have better life expectancy and overall quality of life than ESRD patients who remain on any modality of dialysis.

Pursuing a transplant is a multi-step and often-daunting task, and there are many factors along the way that can derail the process. The following three situations are common barriers to transplantation that we as health care professionals can help patients work through to join the active transplant list.

1. Disinterest in a transplant

While patients may have unmodifiable attributes or conditions (such as poor cardiac status or recent history of cancer) that make them less likely to pursue transplant, there are also psychosocial conditions that can be addressed to increase patients' interest in receiving a transplant.

A recent study indicated the most-frequently identified reasons for lack of interest in a transplant were:

- Advanced age
- Perception of poor health
- Comfort with current modality
- Disinterest in further surgeries

The health care team can address these concerns through in-depth conversations to learn about patients' fears and to provide additional education and/or supportive counseling. Social workers who are trained in cognitive-behavioral and mindfulness techniques, such as Melissa McCool's symptom-targeted intervention (STI), may need to use these tools to address patients' internal narratives on dialysis, disability status and other limiting beliefs. STI could help patients reevaluate the way they are thinking and feeling about themselves and what is possible—leading them to actively combat unhelpful ways of thinking and behaving and to be more open to receiving a kidney transplant.

2. Unemployment

Patients who are employed are more likely to be listed for transplant than those who are not employed. Many barriers to employment (access to transportation, depression and lack of motivation) are similar to reasons patients are not interested in pursuing transplant; conversely, it seems that many of the factors associated with employed patients (improved financial status and sufficient insurance coverage) may also help patients achieve a listed status for transplant.

A DaVita Clinical Research study on currently unemployed ESRD patients indicated the most frequently cited barriers to employment were:

- Lack of energy
- Feeling too ill to work
- Having a disability
- The perception of needing job training to return to employment

Stratification of patients by age revealed that, while lack of energy and feeling too ill were consistently reported as the leading barriers to employment across all age categories, other categories were age-dependent. Disability was more frequently identified as a barrier by older patients, while the need for job training and issues relating to child care and transportation were more frequently identified as barriers by younger patients.

Some aspects of employment, taken in isolation, can help patients be better candidates for transplant; in particular, access to good, comprehensive insurance coverage that covers post-transplant antirejection medications (coverage that won't end after about three years post-transplant, which is the case for many patients on traditional Medicare plans) Employment can also provide a better financial situation, which helps with costs of transplant surgery, follow-up appointments and post-transplant medications.

There are also less-concrete aspects associated with employed patients that make them better candidates for transplant, such asimproved quality of life, decreased incidence of depression and increased motivation. These are equally important to a patient who is trying to navigate the process from referral to listing to receipt of a kidney.

It is important for each member of the health care team to identify the underlying causes to employment and transplant barriers. When patients say they do not have enough energy or feel too ill, what does that really mean? Is it related to poor nutritional status, anemia, insufficient dialysis or uremia? Or could it be from lack of motivation, poor coping or depression? By asking the right questions and offering the right interventions, the health care team can help patients reach their goals, both vocationally and as it relates to transplant.

3. Lack of hope

Having a negative future outlook or dealing with depression can significantly affect dialysis patients' receptivity to a transplant. From the very first contact, we as health care professionals have an opportunity to foster positive expectancy in all of our interactions we have with dialysis patients. When nephrologists meet with patients in the hospital or in their practices, they can convey to the patient that it is possible to lead a normal and fulfilling life that can include employment if the patient chooses to continue working. Surely patients who are not depressed and are hopeful about their present and future will be much better equipped to handle the unique challenges of working on dialysis and/or navigating the transplant process.

Conclusion

There are many barriers, both real and perceived, that can prevent dialysis patients from fully engaging in their lives. These barriers also make pursuit of a kidney transplant daunting and make patients less likely to want to do it. However, there are many ways health care team members and, in particular, social workers can intervene to help our patients overcome these barriers to have the best quality of life possible on dialysis and improve their chances of being able to receive a kidney transplant.

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