

## Case Study: Handling the \$5,993 Hemodialysis Treatment

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*Thanks to Medicare and private insurance, citizens and residents in the United States seldom have to worry about going bankrupt when they need renal replacement therapy. This case, however, describes what could have been an exception. When an uninsured, low-income patient with significant assets landed at an outpatient dialysis center, he was charged thousands of dollars per treatment. The nephrology social worker struggled with the dilemma of how best to advise the patient regarding his financial options. His advocacy interventions resulted in the patient receiving a substantially reduced rate. This article discusses this case and the national system of funding dialysis, which consistently puts financial pressure on providers and the uninsured.*

### PSYCHOSOCIAL SUMMARY

Mr. "Bucks" was a single Caucasian male in his late-50s. He lived with and cared for his father who was in his mid-90s. Through a career of modest paying jobs and frugal discretionary spending, Mr. Bucks had managed to save more than \$250,000, which he estimated generated a yearly income of less than \$5,000.

Mr. Bucks recognized the importance of health insurance, and therefore chose COBRA with what he described as a "very good" national plan when he was laid off by his employer. A history of hypertension, atrial fibrillation and mid-stage chronic kidney disease (CKD) convinced Mr. Bucks to put himself under the care of a nephrologist for almost 5 years. During the 18-month period in which he was enrolled in COBRA, his premiums increased from \$450 to \$550 per month, which he willingly paid because of the excellent benefits. For example, he noted that 2 micrograms of oral Hectoral alone without insurance would have cost about \$620. With COBRA, the full monthly copay for this medication as well as multiple others, including Procrit, was only about \$130.

During the COBRA period, Mr. Bucks found another job with a national retailer and considered joining its group health plan to end the running time clock on COBRA. However, the employer had a 6-month probationary period in which new employees could only join a "bridge" medical plan. While the premium was about \$360 a month, the employer instituted a \$1,000 cap on pharmaceuticals during this 6-month period. Mr. Bucks calculated that he would lose thousands of dollars by switching.

Mr. Bucks' COBRA insurance terminated on October 9, 2009, but the next few days for him were an atypical blur. At 3 a.m. on the day after the COBRA insurance terminated, Mr. Bucks was taken by ambulance to the local hospital, unconscious and suffering from a severe upper respiratory infection. He regained consciousness a few days later. The physical stress on his body during this episode tipped him into Stage 5 CKD.

### THE PRESENTING PROBLEM

Similar to most new dialysis patients, Mr. Bucks had various challenges to face. He had been at Stage 3 CKD for some time, and while he had viewed dialysis as an eventuality down the road, he was initially disheartened by how quickly his

respiratory infection and acute hospitalization had taken him there. Having had the benefit of nearly 5 years of nephrology care, he was educated on different treatment modalities and received a fistula in his left arm in the autumn 2005. However, the fistula never worked. Consequently, when it was determined that he would need dialysis emergently, a permacath was placed.

**Figure 1.** Mr. Bucks' Itemized Bill for His First Outpatient Hemodialysis Treatment

DATE	PROCEDURE	UNITS	DIAG	CHARGE
10/27/09	-Tx High Flux-Cath	1.00		2,125.00
10/27/09	-EPO < 10,000 units	600.00	285.21	960.00
10/27/09	-PTH Intact (Plasma)	1.00	588.81	511.82
10/27/09	-Zemplar 1 Mcg	4.00	588.89	305.60
10/27/09	-Hep C Virus AB	1.00	V15.85	176.86
10/27/09	-Hep B Surface AB	1.00	V15.85	133.21
10/27/09	-Heparin-Pork 1000 Un	25.00	E934.2	132.00
10/27/09	-Hep B Surface AG	1.00	V15.85	127.90
10/27/09	-Hemoglobin, A1C	1.00	250.42	120.29
10/27/09	-UIBC	1.00	280.00	108.28
10/27/09	-HDL Cholesterol	1.00	272.0	101.39
10/27/09	-CHR (Reticulocyte Hg)	1.00	285.21	99.32
10/27/09	-Admin Supply Injection	2.00	E934.2	84.52
10/27/09	-Iron	1.00	280.0	80.23
10/27/09	-Triglycerides	1.00	272.0	71.27
10/27/09	-CBC W/O Differential	1.00	285.21	69.21
10/27/09	-ALT- SGPT	1.00	573.9	65.62
10/27/09	-Alkaline Phosphatase	1.00	588.89	64.00
10/27/09	-Calcium, Total Serum	1.00	588.89	63.83
10/27/09	-Creatinine. Blood	1.00	585.6	63.38
10/27/09	-Albumin,	1.00	263.9	61.40
10/27/09	-Bicarbonate	1.00	276.2	60.60
10/27/09	-Phosphorous, Serum	1.00	588.89	58.81
10/27/09	-Chloride, Blood	1.00	276.2	56.92
10/27/09	-Potassium, Serum	1.00	276.7	56.92
10/27/09	-Sodium, Serum	1.00	276.9	54.15
10/27/09	-Cholesterol, Total	1.00	272.0	53.96
10/27/09	-Admin Supply Injection	1.00	588.89	42.26
10/27/09	-Admin Supply Injection	1.00	V74.1	42.26
10/27/09	-Admin Supply Injection	2.00	285.21	42.26
Total Charges				\$5,993.27

During the psychosocial intake, Mr. Bucks stated that he knew he would not be eligible for state assistance because of his savings. He had budgeted about \$1,000 a treatment, based on what the hospital social worker and nephrologist had told him. He was informed that his Medicare effective date would be January 1 with in-center hemodialysis, or October 1 with home dialysis. The patient decided to pursue in-center hemodialysis. The patient was informed that he lived in a state where the law mandated insurance companies could not discriminate based on pre-existing conditions for certain Medigap plans.

Mr. Bucks' first bill from the dialysis center arrived about 10 days after his first treatment. For three treatments, the total cost was \$14,581.43 (an average of \$4,860.47 per treatment). Because his first treatment contained initial lab work, its cost was \$5,993.27. The charges from this first day are reproduced in Figure 1, which includes the procedure, diagnosis code and costs. Mr. Bucks presented the bill to the clinic manager and social worker with distress, anger and questions about what others were paying for treatment.

### THE ENVIRONMENT

Having worked with dialysis patients for 14 years, I always considered myself fortunate to be able to assist a population that has so many resources available. Much has been written about the sorry state of access to American health care compared with other industrialized democracies. America has 47 million uninsured, a majority of whom work full-time and endure higher costs for poorer outcomes (Park, 2008). Since 1973, the year after Congress established the Medicare End-Stage Renal Disease Program to pay for dialysis, kidney patients in the United States have enjoyed increasing access to care (Egan, 2000). Private biotech companies, such as Amgen, have a long history of generosity with their life-enhancing products for people with limited means. The large dialysis organizations (LDOs) have indigent programs to document uninsured or underinsured patients and then take a partial tax credit against the bad debt. The LDOs also provide millions of dollars of funding through the American Kidney Fund to assist in paying insurance premiums for Medicare, Medigap and COBRA plans for patients with limited means. This is a win-win for the patient and the LDOs, albeit a drain on profits for the insurance industry. For example, in the author's state, a Medigap C plan costs about \$200 per month but often pays more than \$500 per month for the 20% of dialysis services not covered by Medicare.

The ample access to care for dialysis patients is not without a bizarre and somewhat precarious nature of funding. With respect to Medicare payment for dialysis, the U.S. Government Accountability Office has stated:

... payments did not meet costs for small facilities. In addition, composite rate payments, intended to cover the costs of dialysis services associated with a treatment, including nursing, supplies, social services, and certain laboratory tests, were

11 percent less than the costs of providing those services, while payments for separately billed drugs, drugs not included in the composite rate, exceeded the costs of those services by 16 percent (2004).

More recently and specifically (Conte & Fabregas, 2009), one LDO stated "it spends about \$289 per treatment but receives about \$250 from Medicare." In the same news article, the vice president of another LDO said, "We need to identify ... certainly, new patients with insurance. That's what allows us to treat all patients. This private subsidy really allows the whole model to work." Because of the disproportionate monetary value of these payments, the LDOs have developed special customer service paths to retain and develop that portion of their business. Additionally, because the Coordination of Benefits Rule relegates almost all patients to Medicare primary 33 months after initiating hemodialysis, companies are under unceasing financial pressure to find new commercial patients (Conte & Fabregas, 2009).

### THE INTERVENTION WITH ANALYSIS

Potential dialysis patients without any insurance arrive at my local hospital infrequently. When it does happen, the social work team at the hospital is prompt to evaluate and usually helps the patient apply for state Medicaid. In these situations, the responsibility for accepting the patient into our clinic falls to the Administrator of Functions (AF). According to the job description, in the context of promoting excellent patient care, an important part of the AF's position is to practice cost-containment strategies, maintain profitability and grow business. When a patient does not have insurance, the AF has the option to reject admission as ultimately the AF is responsible to the Executive Vice President (EVP) for justifying the financial results of their area. Our AF accommodates staff needs and patient wants within the philosophy of a for-profit corporation that embraces austerity. He has a long history of accepting patients without insurance when it appears likely that insurance will be forthcoming.

Speaking with my social work colleague at the hospital, I was surprised when I heard about Mr. Bucks' assets because we both knew he would not qualify for state assistance. I emailed my AF that from a financially risk-averse perspective, he might want to proceed cautiously. For better or worse, I was trying to protect my AF and company from incurring bad debt. Knowing the hospital had a legal obligation to treat the patient, I preferred to let it bear the burden of financial risk until more details emerged. I shared with the AF what I had learned from my hospital colleague. The AF then gave financial approval for the patient to be admitted.

In my psychosocial assessment, I discussed his future insurance effective dates with each modality contingency. I was relieved that Mr. Bucks expected to pay about \$1,000 per treatment in the short term and that he perceived it would not cause him undue financial distress. I informed the AF

that it was my impression that he would pay his \$1,000 bill per treatment on a timely basis. The AF noted that he thought Mr. Bucks' price per treatment would be considerably more since it was based on the "standard rate." My concerns for my company losing money were quickly replaced by dread for Mr. Bucks' financial well-being.

The AF indicated that he was uncertain of the exact amount of the standard rate. I purposely did not pursue asking the standard rate price because in my social worker role I had no desire to deliver nor defend the bad news. I realized that Mr. Bucks would be receiving a bill fairly soon. In my own research on the company's website, I found no standard rate prices. However, I did find that rates were set by a strategic payer committee and could be modified by senior level executives. I also asked my area's Billing Coordinator (BC) if she knew the standard rate price because she is responsible for nearly 1,300 patients. She stated that neither she nor her department had the information. I was perplexed by the lack of transparency of the standard rate. She had, however, two self-pay patients who essentially paid nothing because they were indigent and close to obtaining Medicaid.

Coincidentally, on November 2, I learned that my clinic had received a request for one treatment from a patient in the Caribbean who had expressed a desire to visit. When I asked what this patient would be charged, I was quite surprised to learn that our company had internally published rates that could be shared for visiting patients to our clinics. I obtained the official document of published rates for visitors. The rates were all-inclusive per treatment. Stratified by patient origin and destination, they varied, with the minimum more than \$300 and the maximum less than \$900. The Caribbean patient qualified for the high end but he prospectively called a competing clinic that undercut our rate by 50%. This time, our company chose not to match the rate. I feared this response was a harbinger of the response Mr. Bucks would receive. When Mr. Bucks brought us his first treatment bill of \$5,993 and piercing questions, my composure was tested, as I initially was uncertain of how best to help him.

I pondered the core question of this case: As a loyal company employee and conscientious clinical social worker who abides by our professional code of ethics, what should I do in a situation where the interests of my company seemed to conflict with the patient? Consulting the *National Association of Social Workers Code of Ethics* (2008) section 3.09, I found "(d) Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the *NASW Code of Ethics*." So I asked myself, was it ethical to allow my patient to pay \$5,993 for a dialysis treatment? He certainly had the money and my company had behaved entirely legally. American citizens go bankrupt from health care expenses on a fairly regular basis. According to Himmelstein, Thorne, Warren and

Woolhandler (2009), "Using a conservative definition, 62.1% of all bankruptcies in 2007 were medical." But I, and my clinic manager, felt troubled that he was being charged close to 10 times what we knew from experience our LDO considered a good commercial rate.

I reread my company's values statement. Ultimately, the word that I had trouble reconciling was "integrity." Had the patient known ahead of time the cost of his treatment in the context of the prevailing rates, I think I would have felt fine. But he came to us with no accurate knowledge of the economics of dialysis, including the intense competition among companies for commercial-sized reimbursement. So while his environment (i.e., our dialysis center) was saving his physical life, the cost was as quickly killing his economic life. My social work training told me, at the very least, I needed to educate the patient about the market for dialysis consumption so that he could make the best choice for himself.

The next day, I met with Mr. Bucks and gave him a quick education as we read my company's value statement verbatim. Proud of this credo, I used it as a platform to increase transparency. I then explained about reimbursement rates, including Medicare, commercial and what I had recently learned about self-pay visitors. After he got past his anger regarding his bill, he volunteered that he really enjoyed the service and staff at the clinic as well as his physician and asked what he could do to get some relief from what he was being charged. I obtained his permission to discuss the specifics of his situation and bill with his nephrologist. Nephrologists obtain medical privileges to practice at outpatient dialysis centers and typically are not employees of the LDOs.

I showed the itemized bill to his nephrologist who, with some encouragement, decided to speak directly with the AF to ask that the charges be brought in line with the commercial rate he and the patient had been expecting. As a referring physician bringing business into the dialysis center, the doctor acknowledged that the dialysis company had a stake in keeping him, as well as his patients, satisfied.

The next business day, the AF called to let us know that he brought the physician's concern to the EVP. The AF apologized but said that no adjustment would be made—that the standard rate could not be adjusted. This answer was not entirely unexpected because of my earlier experience with the Caribbean patient. The AF suggested that the patient talk to the BC to see whether she had any suggestions. The dialysis company's financial assistance programs are quite generous, but they are designed for people with limited income and without substantial savings. From experience, I understood financial relief would not be granted since my patient's liquid assets were so sizable. I asked if we could designate him a visitor for the few months he would be uninsured and implement the internally published visitor rates. The AF said he would check with the EVP. I thanked him. I suggested that the EVP might personally want to gauge the



extent of the physician's displeasure and/or prepare for the revenue-reducing possibility that Mr. Bucks would permanently leave our clinic to another offering a more competitive, market-based price. A few days later, the AF stated that he had spoken with the EVP and that Mr. Bucks' price per treatment had been lowered to \$475, all-inclusive. The physician, Mr. Bucks and I were elated and thankful.

### SELF-REFLECTION AND CONCLUSIONS

The literature contains research studies about social workers' emotional exhaustion and burnout working with kidney patients (Merighi & Ehlebracht, 2005; Merighi, Browne, & Kennan, 2009). The countertransference I experienced in this case from my mutual goals of serving my patient's and employer's best interests equally well created a cognitive dissonance that affected my thoughts and sleep. Peer consultation from a colleague as well as respected nurse managers helped me to navigate through a choice of interventions. Specifically, the ventilation they allowed helped me to keep my interventions with the patient, doctor and AF calm, objective and ultimately successful.

Lest the reader consider my interventions as overly altruistic or sentimental, as a shareholder in my company I acknowledge that my appetite for profit is as sizable as anyone's. It would be hubris to think I could do a better job setting price points than my company's experts. I also, in hindsight, understand the short-term business benefit of charging visitors a transparently lower rate than permanent patients in an opaquely priced market. I am proud of the exceedingly strong ethics and compliance policy my company has. In fact, had Mr. Bucks expressed no concerns about paying the thousands of dollars per treatment, I would have let him. But his vocal dissatisfaction with the bill combined with his lack of knowledge about dialysis market dynamics compelled me to try to help. I felt much better after I educated him knowing that he could exercise his right to self-determination as he saw fit.

Putting myself in management's shoes, I now clearly see how providing dialysis services to Mr. Bucks represented an opportunity to earn much-needed resources. Similarly, as the licensed clinical social worker, I was obliged to advocate for the overall well-being of my patient. That our respective functions might at times operate at cross-purposes should not be surprising. As the checks and balances of our successful government can occasionally make democracy a bit messy, so too can the competing goals of all the stakeholders in the dialysis center. The ongoing test then for a nephrology social worker who aspires to be maximally effective is to work in a way that builds all relationships, or at least does not harm them. This challenge may be one of the factors responsible for emotional exhaustion.

I believe that Mr. Bucks might have received a competitive price sooner had management talked with or met him. Like most large companies, the relative insulation leaders have from customers/patients is both an asset and liability. On the positive side, the complex and difficult daily decisions

our corporate leaders need to make to ensure our long-term viability might be harmed if they were overly concerned with the minutiae of patients' daily lives. Yet on the other side, our leaders' decisions often have major implications on the lives of our patients. It can serve the customer and company poorly to have a feedback loop stretched beyond a point where the message is lost towards the top. In a perfect world, those of us at the clinic level bolster the message so that leadership receives patients' feedback intact. But speaking truth to power is not for the faint of heart and it is usually less stressful for line workers on the floor to remain silent.

This case also serves as an important reminder of how differently the health care market functions from other markets of goods and services. Theorists or pundits who express a belief that free-market economics alone can serve patients well fail to realize that ill people are unlike other consumers with the time and flexibility to shop based on published prices. On the contrary, the inability of the sick to shop and the urgency of their need to trust can leave them decidedly disadvantaged or worse, at risk for exploitation.

I find it noteworthy that in the absence of market knowledge, Mr. Bucks would have been willing to pay the \$1,000 per dialysis treatment. While he did have time in the hospital to digest this figure, his attitude demonstrates an appropriate appreciation for the value of dialysis. If the government historically underfunds dialysis, we can understand the potential pressure to seek higher commercial payers and cost shift onto individuals like Mr. Bucks who have the means to pay. Dialysis providers make a reasonable argument that these strategies are not only useful, but in fact, essential if they are to maintain the capital to care for patients and build shareholder value. No doubt, Medicare bundling for dialysis set to begin in 2011 will change the renal care financing landscape considerably. Effects as yet to be determined will ripple through the entire dialysis infrastructure.

Shortly after Mr. Bucks began his course of in-center hemodialysis treatment, he received a visit from the home-training nurse about peritoneal dialysis (PD). His training, combined with a reminder about the potentially accelerated start date of Medicare, caused him to reconsider this modality. While our aforementioned intervention had resulted in Mr. Bucks no longer dreading his hemodialysis bill, he still worried greatly about the cost of his two-week uninsured stay in the hospital. But if he transferred to PD before the first day of the third full month of dialysis, his Medicare would be backdated to the beginning of October (B. Witten, personal communication, November 18, 2009), likely covering the start of his hospitalization. He therefore accurately viewed PD as an 80% solution and is pursuing home training at present. Aside from the medical and psychosocial benefits of home dialysis, an immediate Medicare start date can be highly valuable, as this case illustrates. With its potential to empower, patient education around modalities remains one of the most essential tasks that the nephrology social worker and interdisciplinary team can pursue.

In conclusion, this case serves as another example of how social work can function as an important part of the conscience of a dialysis center. Dialysis social workers actualize their company's core values in tandem with their professional code of ethics. As cost pressures continue to increase in the financing of dialysis, opportunities for nephrology social workers to advocate for their patients will remain, if not increase.

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## **CROWNWeb: Transforming How Nephrology Social Workers Access Patient-Centric Data**

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*In February 2009, the Centers for Medicare & Medicaid Services (CMS) launched a web-based data-collection system in an effort to transform the way End-Stage Renal Disease (ESRD) facilities report care provided for their patients. This system, dubbed CROWNWeb, gives Medicare-certified dialysis providers a central database in which clinical and administrative information can be entered. This system is a universal resource that social workers, patient services coordinators (PSCs) and other ESRD Network personnel can use to access near real-time data pertaining to a patient's course of treatment. This key element will also aid CMS and the renal community in their ongoing commitment to improving quality of life for people with chronic kidney disease.*

*This article focuses on the CROWNWeb system's impact as it relates to the duties of social workers and the interdisciplinary team that are outlined by CMS' updated Conditions for Coverage for ESRD Facilities, published April 15, 2008. It analyzes how the system can help the ESRD community as a whole to boost patient care efforts, quality of life and satisfaction with care. In addition, this article delves into how the system is designed to reduce the barriers that social workers and PSCs may face in obtaining key data regarding their patients.*

### **INTRODUCTION**

To gain access to the CROWNWeb system, users must complete what is known as the "QIPS Account Process." This procedure ensures that all Health Insurance Portability and Accountability Act measures are met, and that only authorized personnel can access the patient-sensitive data within the system. See [www.ProjectCROWNWeb.org](http://www.ProjectCROWNWeb.org) for details regarding the QIPS Account Process.

Neither Centers for Medicare & Medicaid Services (CMS) nor the End-Stage Renal Disease (ESRD) Networks specify which facility personnel should enter data into the CROWNWeb system. Each facility is responsible for selecting personnel who have a high-level understanding of the information needed to properly submit data to CMS and the ESRD Networks. This article focuses on tasks that may be required of social workers in the renal community. It is each facility's right and responsibility to appoint responsible staff for these tasks on an individual basis.

### **CROWNWEB OVERVIEW**

CROWNWeb is mandated under Section 494.180(h) of CMS' updated Conditions for Coverage for ESRD Facilities (CfCs), which require all Medicare-certified dialysis facilities to submit data electronically—a move away from previous CMS paper-based data-collection methods (Centers for Medicare & Medicaid Services, 2008).

CROWNWeb is CMS' first step in leveraging the benefits of health information technology for the ESRD population, and will aid the agency in receiving more complete and higher-quality data about dialysis patients (CMS, personal communication, June 23, 2009). The system, which allows authorized users to securely submit patient-based data to CMS from virtually anywhere at any time,<sup>1</sup> provides a means of expediting how patient information is reported,

thus assisting with some of the requirements placed on social workers and interdisciplinary teams (IDTs) by the updated CfCs. These requirements include being informed of patients' current statuses, including:

- Awareness of admission status.
- Assurance that CMS-2728 Medical Evidence forms are completed correctly.
- Awareness of modality, educational level and vocational rehabilitation status.

### **BOOSTING PATIENT CARE EFFORTS**

Social workers are recognized advocates for patients at many dialysis units (Browne, 2009). With the CROWNWeb system, social workers are able to continue campaigning for patients' rights and quality of care. They can also demonstrate that the requirement of measuring patients' psychosocial status (mandated by the updated CfCs) has been met because CROWNWeb allows one to enter the number of patients in each facility who completed the KDQOL-36 survey, a validated health-related quality-of-life analysis specifically created to assess the physical and mental functioning of individuals with kidney disease (Browne, 2009).

### **REDUCING BARRIERS**

CROWNWeb is designed to help reduce the barriers social workers and IDTs may encounter when dealing with patient data procurement. The day-to-day obstacles that are abridged by CROWNWeb include a user's ability to instantly access a CMS-2728 form that was completed at a previous facility and obtain details regarding changes in a patient's treatment modality. Additionally, it provides facilities the ability to work with their respective ESRD Networks to determine if a transfer patient is in a "gap"

<sup>1</sup> With the exception of scheduled downtime for maintenance.