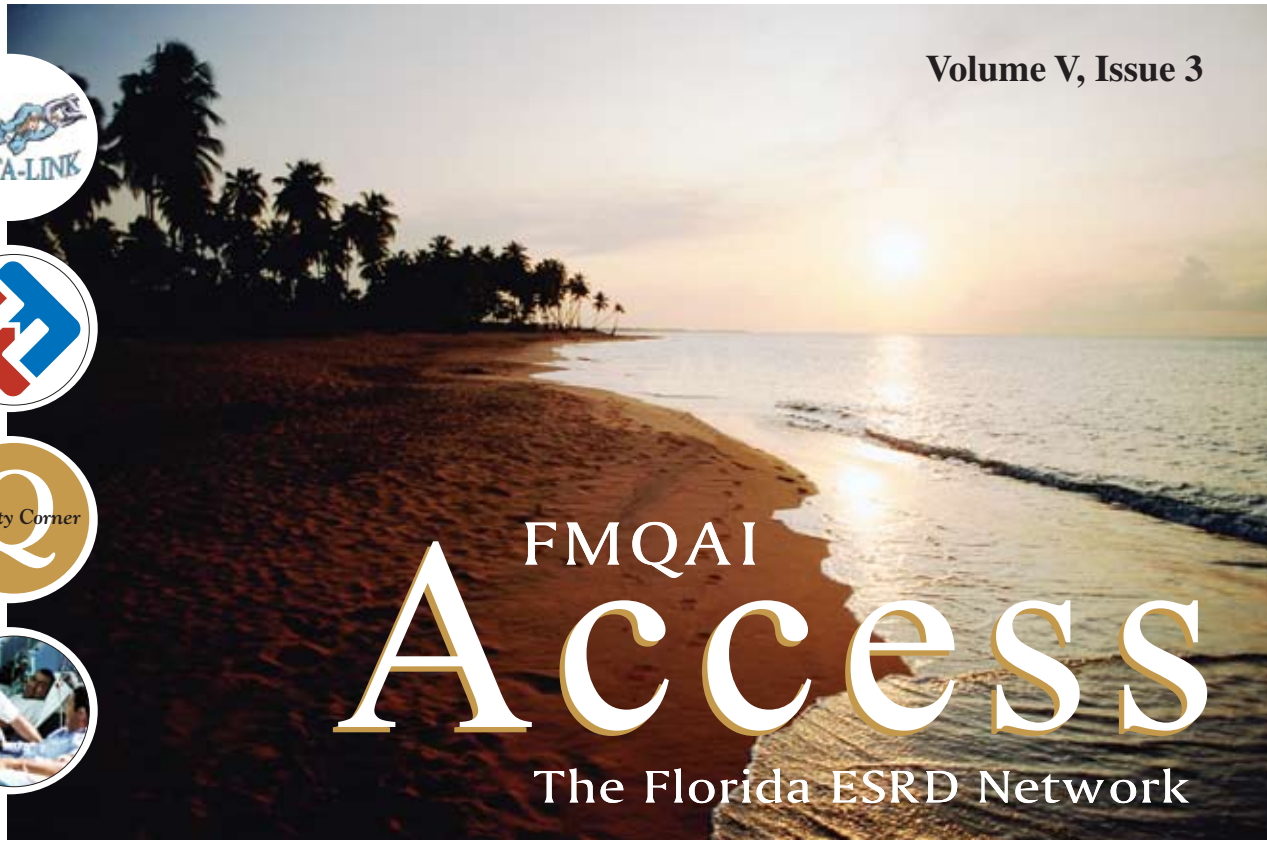

Volume V, Issue 3

FMQAI Access

The Florida ESRD Network

Returning Control to ESRD Patients Through Self-Care In-Center Hemodialysis

Susan H. Bray, MD, MBE, FACP

Self-care hemodialysis (HD) may be defined as a treatment modality that introduces the patient into an independent continuum of care by achieving greater knowledge of both the renal disease and the dialytic processes. It is a means by which patients can again achieve an active, meaningful lifestyle associated with a feeling of physical and emotional well-being.

Self-care HD is a mechanism of granting empowerment and control to patients who have entered Stage 5 chronic kidney disease (CKD), or end-stage renal disease (ESRD), and are beginning dialysis. The process of beginning a dialysis regimen has been very disempowering to many patients, and they often feel victimized and totally out of control due to the loss of their vital kidney function and the need to be kept alive by artificial means.

In the course of my many years of providing this treatment modality to qualified patients, I have developed a number of important points that should be helpful for those renal healthcare professionals who are considering initiating self-care HD in their own facilities.

Staff Commitment

Of primary importance is the dialysis facility staff. It is imperative that each staff member is totally committed to the concept of self-care in-center HD.

The teaching and provision of care needs to occur in a separate space, not intertwined with maintenance dialysis. That separate space can be an entire building, a different room in the facility, or even a different shift that's totally dedicated to self-care dialysis.

Educating the Patient

It is important to begin the patient's education on Day One of his or her outpatient dialysis treatment. If the patient is settled into a dialysis chair and is treated without first being educated, he or she very quickly settles into the "I am the patient, you take care of me" mentality. It is very difficult to give control to this person

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Don't Lose Your Patience… Help us Find Your Patients!

Where are Your Patients?

The last issue of Access highlighted changes in the new ESRD Conditions for Coverage. One of your activities related to Emergency Preparedness should be to ensure you have correct addresses for your patients.

Quarterly, the Network sends a roster of current patients to each facility for review. Among other things listed on the printout is the address for each patient. It is important that patient addresses are up-to-date and that any changes be reported to the Network. The Network uses the addresses to assist in emergency planning and resource management post-disaster. CMS uses the addresses provided to send an informational mailing to new ESRD patients.

Network Patient Activity Report (PAR)

This is a form used by the Network to collect information on patient events. Whenever a patient is admitted or discharged from your facility, changes modality, or receives a transplant, it needs to be recorded on the monthly PAR. We use information you provide on this report to create the Quarterly Patient Roster reports and the Annual Facility Survey (CMS-2744). The more accurately you complete the monthly PAR, the easier it will be for you to complete the 2744s.

- You need to enter date of birth and gender for each patient, especially those patients that don't have a social security number (SSN). If the patient is new to ESRD, we cannot create a record for them without that data. In the case of patients that have no SSN, it is often the only way to discern which of many similarly named patients you are referring to.
- Remember to enter the zip code. The form does not have room for complete addresses like the Quarterly Rosters do, but this will allow us to at least get the city, county and state into the initial record. In addition, when the zip code is different from what we have on file, we will know it is possible that the patient has moved, so we will not be sending mailings to the wrong address.
- It is crucially important that you enter a date for each event. Without a date, we cannot enter the event you are reporting into our data system.
- Along with the date, you must enter the modality of the patient at the time of the event. Modality is no longer reflected with a number code; just describe the modality (In-Center Hemo, Home Hemo, CAPD, CCPD, Frequent In-Center Hemo, etc.). We want to make sure we understand what you are telling us.

As always, you can get a copy of the instructions, a blank form or additional tips from our website at http://www.fmqai.com/ESRD.aspx or contact the Network office. If you are using the Excel spreadsheet Thank You! It really reduces problems reading handwriting. If you do not have Internet access and would like to receive the Excel version, please contact the Network office and we can email it to you or send it on a diskette.

Quick Links

Network Website
http://www.fmqai.com/ESRD.aspx

Download 2728, 2746, and 2744 forms and instructions directly from CMS http://www.cms.gov/CMSForms/CMSForms/list.asp and do a search for items containing the word ESRD.

BUTTONHOLE TECHNIQUE
Useful Information

MAKE A DIFFERENCE!
Adopt Fistula First Change Concepts and Tools.
www.fmqai.com/ESRD/FistulaFirst/FFT/

- For use with native AV fistulas only
- Used for over 25 years in Europe
- Fewer missed sticks, infiltrations and hematomas
- Scab removal is critical in preventing infection:
    - Moistening scabs make them easier to remove
    - Tweezers can be used, but should be disinfected prior to scab removal
    - Use 2 X 2s and soak with saline, an alcohol-based gel or whatever antimicrobial prep you use on the sites and place over sites until moist
    - Have the patient place an alcohol square over each site before coming to the dialysis unit
- Track formation requires the same angle and depth of entry with every cannulation
- Requires the same cannulator until the track forms
- Changing to blunt needles after the track is formed prevents cutting of the track
- Non-diabetics will form a track in approximately 8 days; diabetics in approximately twelve days
- Not everyone is a candidate for buttonhole:
    - Patients with heavily scarred fistulas are unlikely candidates
    - Patients with large amounts of subcutaneous tissue in the upper arm are unlikely candidates

The Renal Physicians Association presents Keeping Kidney Patients Safe, a web site designed for the nephrology professional to improve ESRD patient safety:

- Provides resources, tools and information to prevent the occurrence of the Five Adverse Patient Safety Events
- Assists nephrology professionals in meeting the quality assessment and performance improvement (QAPI) requirements in the CMS Conditions for Coverage for End Stage Renal Disease Facilities

Log on to www.kidneypatientsafety.org today, and do your part to help improve ESRD patient safety.

Renal Physicians Association 1700 Rockville Pike, Suite 220, Rockville, Maryland 20852

Returning Control to ESRD Patients Through Self-Care In-Center Hemodialysis

(continued from page 1)

after the patient is settled into this way of thinking.

Beginning to educate the patient right away is important, even if the patient just sits, watches, and hears what the nurse or technician is doing and saying. As the patient becomes less uremic and more able to learn and retain what has been learned, he or she formally begins the education process. It is important that each staff member use similar teaching mechanisms and that they teach the aspects of dialysis in the same basic order. This method ensures both a continuity of teaching and retentive learning.

Expanding the Role of the Social Worker

Every member of the staff play key roles in providing and maintaining a successful in-center self-care HD training program. The social worker can do much more than try to get patient transportation or financial issues solved. The social worker can also help the patient in goal-setting, including returning to work or school or vocational training. The Office of Vocational Rehabilitation has been very helpful in getting some of our patients into training sessions and even into college, with the hope that the patient will return to the "work world" and therefore the "tax-paying world."

The social worker can also be helpful to the person staying at home to maintain the household. It is important that patients return to their hobbies. If they loved to travel before, they can continue to do so, since dialysis can be made available almost anywhere in the world.

The "Eating Police?"

Dietitians are not the "eating police!" Rather, they should serve as consultants and encourage patients to eat well and reasonably. The renal dietitian serves to educate patients about the risks of consuming potentially dangerous foods and fluids in excess, and to encourage them to control the fluids and foods that they ingest. Additionally, teaching patients to intravenously administer their own vitamin D analogs and erythropoietin (EPO) to control the effects of anemia can be very empowering. You would be amazed at how much in control patients feel when they can give themselves their own medications through the venous line!

The nurse-driven protocol includes educating patients on the mechanisms of action and possible interaction of the drugs they are taking and stressing the importance of adhering to taking the necessary drugs. We do not allow food to be eaten while the patient is dialyzing for a number of reasons, not the least of which is that it attracts critters. Also, the patient may be sending the blood flow to his or her gut to digest food, thereby allowing the blood pressure (BP) to drop. This, in turn, may cause the patient to cramp or become hypotensive (low BP).

From Cramping to Group Networking

During dialysis, the fluid loss is limited to approximately one kilogram per hour, allowing the patient to avoid cramping. Patients are educated on how to check their dialyzers and to confirm that they have the correct dialyzer. Then the patient, along with the nurse or technician, signs the chart affirming that these steps have been taken. Laboratory values are reviewed and discussed with the patient, and a copy is given to him or her. The patient is taught how to manually check his or her vascular access daily.

As the patient progresses in knowledge, individual tests are given for each step in setting up the machine and the monitoring of dialysis. After the patient has passed a test, he or she moves to the next stage of the learning process. Patients are also encouraged to participate in network activities through either the Internet, support group meetings, or such organizations as the Renal Support Network, the American Association of Kidney Patients, and the National Kidney Foundation.

(continued on page 5)

Barriers to Self-Care Dialysis

Initially, patients have many concerns about trying self-care HD. Over the years, these patients have been queried as to what some of those concerns are. The most common comment is that "no one ever told me about it." Therefore, I am convinced that continuous education is needed by both the medical care team and the patient, who is as an integral member of the team.

Other barriers to self-care HD include:

- Fear of self-cannulation (needle sticking)
- Being comfortable after settling into a maintenance dialysis facility
- Poor self-confidence
- Poor dexterity
- Limited vision
- Fear of machinery
- Drug or alcohol addiction
- Mental instability

Ongoing Education

The time frame for educating the patient in setting up his or her own machine, self-cannulation, and monitoring the treatment is variable. Some people can get it done in a matter of weeks. For others, it can take months.

Some patients are in an "ongoing education" scenario. They move back and forth in the continuum, but they are trying and are involved in their care to the extent that they can be.

Self-Care Criteria

Facilities also need to fulfill certain criteria for self-care dialysis. These include:

- Separate space exclusively for self-care
- Staff, including the medical director and nephrologists, who totally embrace the principles and expectations of self-care dialysis
- Dedicated teaching staff members
- Ongoing in-services for dialysis-related conditions

The Desire to Learn

There are certain selection criteria that we have developed over the years. The single most important criteria is the patient's desire to learn. As long as someone has this desire, the staff can creatively work with that patient. It helps greatly if the patient has a stable medical condition, a well-functioning vascular access, basic manual dexterity, some vision and an agreement to remain in compliance with the expectations of the nephrologist and other members of the renal healthcare team.

It would be beneficial if patients could begin their dialysis education before they reach Stage 5 CKD. This could go a long way toward allaying patient fears and clarifying what to expect when ESRD requiring dialysis or a kidney transplant is reached. Education leads to a sense of increased control and empowerment. It will also lead to better compliance and adherence with the dialysis and medication regimen. This, in turn, will pave the way to improved physical and emotional health and an overall better quality of life (QoL).

A Much Lower Mortality Rate

It has been our experience that the emotional and physical support of the patient during the education process has led not only to a better QoL in general, but also to fewer hospitalizations and to a much lower annual mortality rate.

In our self-care dialysis facility, there are 46-50 patients who live in an inner-city environment and who have a mortality rate of approximately 2% per year. They also have a transplantation rate that is above the norm.

Conclusion

Patients progressing through the stages of CKD can begin their education about kidney disease and dialysis before they become uremic. Self-care in-center HD can and should be proposed as a modality to all patients who voice an interest in learning about their disease and their care. Those who choose this modality should look forward to returning to a good QoL associated with return of a sense of control over their own healthcare.

It is also important to remember that the nephrology team helping to provide care and education for the patient includes not only the physician, nurse, patient care technician, social worker, dietitian, and other office staff members, but the patient him- or herself. Studies have shown that patients who take charge of their own healthcare live longer, healthier lives.

Reprinted with permission from the Renal Support Network's Kidney Times at www.kidneytimes.com

Improving Hemodialysis Adequacy

K/DOQI guidelines define adequacy for hemodialysis patients as a Kt/V of 1.2 or greater, or a URR of 65% or greater. Patients that are under-dialyzed may exhibit symptoms such as weakness, loss of body weight, poor appetite, nausea/vomiting, frequent infections, prolonged bleeding, anemia and premature death. The following are some tips for improving hemodialysis adequacy:

Quality Improvement (QI): The facility's QI team should include the medical director, social worker, dietitian, access manager and other relevant team members.

- ✓ Development of a facility specific quality improvement plan to address adequacy
- ✓ Identify root causes
- ✓ Develop an action plan for each root cause
- ✓ Evaluate actions implemented for effectiveness
- ✓ Trend monthly data and update the QI plan if improvement not met

Prescription / Physician Orders:

- ✓ Check the prescription orders each treatment to verify dialyzer and treatment time
- ✓ Efforts should be made to monitor and minimize the occurrence of missed or shortened treatments
- ✓ Verify the blood pump speed matches the dialysis prescription
- ✓ Verify correct dialysate flow rate setting
- ✓ Ensure adequate heparinization to prevent clotting of lines and dialyzers
- ✓ Ensure that procedures for pre and post blood sampling are performed correctly

Patient: **Identify individual patients repeatedly not meeting the adequacy goal.**

- ✓ Evaluate the patient's access for poor flow and notify physician for access evaluation
- ✓ Be proficient in proper access cannulation
- ✓ Monitor arterial pressures for signs of inadequate flow
- ✓ Monitor venous pressures for signs of excessive pressures
- ✓ Identify specific reason for inadequacy
- ✓ Develop a care plan to address the reason(s) that are impacting the adequacy rate
- ✓ Review the care plan with all team members and patient and their caregiver in the care planning process
- ✓ Monitor adequacy results for effectiveness
- ✓ Provide patient education
- ✓ Document in the medical record

A continuing education course "Improving Adequacy of Hemodialysis" is located at http://edu.flqio.org/. Information regarding an adequacy tool kit can be found at http://www.fmqai.com/esrd/QIP/QIT/. If you need additional assistance regarding hemodialysis adequacy, please contact FMQAI: The Florida ESRD Network at (813) 383-1530 X5.

TELL US WHAT YOU'RE DOING!

Newsletter Submittals

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

Contact: Cindy Woodward, QI/Community Services
By phone: (813) 383-1530 ext. 3882 or
E-mail: cwoodward@nw7.esrd.net

Newsletter Submittals

FROM THE PROJECT DIRECTOR

The 2008 Dialysis Facility Report (DFR), which was mailed to all dialysis clinics in July, is distributed on an annual basis in an effort to stimulate quality improvement efforts and assist with the quality improvement process at the facility level. The DFR allows you to compare the characteristics of your facility's patients, patterns of treatment, and patterns in transplantation, hospitalization, and mortality to local and national averages. These comparisons help you to evaluate patient outcomes and to account for important differences in the patient mix, including age, sex, race, and patients' diabetic status. The following is an overview of some of the outcomes reported in the 2008 DFR:

- Standardized Mortality Ratio (SMR)
  - Network: 1.11
  - US: 1.0
- Percent of hospitalized patients with a diagnosis of septicemia upon admission
  - Network: 14.4%
  - US: 11.6%
- Percent of patients with a URR $\geq$ 65%
  - Network: 95.8%
  - US: 95.4%
- Percent of HD patients with hemoglobin 10-12 g/dL
  - Network: 50.6%
  - US: 53.7%
- Standardized Transplantation Ratio (STR)
  - Network: 0.99
  - US: 1.01

Much of the data used in the DFR is based on Medicare claims and other CMS data, such as CMS Forms 2728, 2746, and 2744. The following points will help your facility to ensure the data reported in the DFR is accurate:

- Staffing counts provided in the DFR are reported based on the CMS-2744 (Annual Facility Survey). If your facility does not submit the 2744 to the Network, or fails to submit it in a timely manner, the information will be reported as "0".

- The SMR compares the observed death rate in your facility to the death rate that was expected based on national death rates for patients with the same characteristics as those in your facility. SMR is adjusted for risk based on age, race, ethnicity, sex, diabetes, duration of ESRD, nursing home status, co-morbidities at incidence, BMI at incidence, and population death rates. Some of this data, such as co-morbidities and BMI, are based on information documented on the CMS-2728 (Medical Evidence). Be sure to enter in all fields thoroughly when completing the 2728 as this can affect measurements adjusted for risk.

The comment period for the 2008 DFR ended on September 7, 2008. However, if any of your facility characteristic information on the Dialysis Facility Report is incorrect, please submit corrections for these items to the Network office at any time. If you have other questions about these reports, or would like to receive another copy, please contact Cindy Woodward at (813) 383-1530 ext. 3882. As always, thank you to all providers for your support and dedication to improving the quality of care in Florida.

Kelly M. Mayo, MS

Vaccinations for Adults

You're NEVER too old to get immunized!

Getting immunized is a lifelong, life-protecting job. Don't leave your healthcare provider's office without making sure you've had all the vaccinations you need.

Age ▶ / Vaccine ▼	19–49 years	50–64 years	65 years & older
Influenza	You need a dose yearly if you have a chronic health problem,* are a healthcare worker, have close contact with certain individuals,* or you simply want to avoid getting influenza or spreading it to others.	You need a dose every fall (or winter).	
Pneumococcal	You need 1–2 doses if you have certain chronic medical conditions.*		You need 1 dose at age 65 (or older) if you've never been vaccinated. You may also need a 2nd dose.*
Tetanus, diphtheria, pertussis (Td, Tdap)	If you haven't had at least 3 tetanus-and-diphtheria-containing shots sometime in your life, you need to get them now. Start with dose #1, followed by dose #2 in 1 month, and dose #3 in 6 months. All adults need Td booster doses every 10 years. If you're younger than age 65 years and haven't had pertussis-containing vaccine as an adult, one of the doses that you receive should have pertussis (whooping cough) vaccine in it—known as Tdap. Be sure to consult your healthcare provider if you have a deep or dirty wound.		
Hepatitis B (HepB)	You need this vaccine if you have a specific risk factor for hepatitis B virus infection* or you simply wish to be protected from this disease. The vaccine is given as a 3-dose series (dose #1 now, followed by dose #2 in 1 month, and dose #3, usually given 5 months later).		
Hepatitis A (HepA)	You need this vaccine if you have a specific risk factor for hepatitis A virus infection* or you simply wish to be protected from this disease. The vaccine is usually given as 2 doses, 6–18 months apart.		
Human papillomavirus (HPV)	You need this vaccine if you are a woman who is age 26 years or younger. The vaccine is given in 3 doses over 6 months.		
Measles, mumps, rubella (MMR)	You need at least 1 dose of MMR if you were born in 1957 or later. You may also need a 2nd dose.*		
Varicella (Chickenpox)	If you've never had chickenpox or you were vaccinated but only received 1 dose, talk to your healthcare provider about whether you need this vaccine.		
Meningococcal	If you are a young adult going to college and plan to live in a dormitory, you need to get vaccinated against meningococcal disease. People with certain medical conditions should also receive this vaccine.*		
Zoster (shingles)			If you are age 60 years or older, you should get this vaccine now.

* Consult your healthcare provider to determine your level of risk for infection and your need for this vaccine.

This information was shared by the Immunization Action Coalition at www.vaccineinformation.org.
The content was reviewed by the Centers for Disease Control and Prevention in April 2008.

ATTENTION: ESRD Complaint and Grievance Process

Under Federal Medicare Law, End Stage Renal Disease (ESRD) Networks are authorized to implement procedures for evaluating and resolving patient complaints or grievances about the quality or adequacy of the care they receive in dialysis facilities. Subsequently, facilities are required to display the ESRD Network contact information for their patient's viewing.

In Florida, the ESRD Network is:
FMQAI: The Florida ESRD Network
5201 West Kennedy Boulevard, Suite 900
Tampa, Florida 33609
Telephone (813) 383-1530
For Patients Only 800-826-3773 • Fax (813) 354-1514
www.fmqai.com/ESRD/

If patients have a complaint or grievance about the quality or adequacy of care they are receiving in their facility, initially, the Network encourages them to discuss the problem with their physician, nurse or facility administrator. Such discussions with caregivers usually resolve the problem.

In the event the patient is still dissatisfied, the Network can assist in resolving complaints or grievances by providing an impartial review. However, patients have the right to file a formal grievance with the Network as the first step if they prefer.

All calls received from both patients and facility staff members are confidential. This information is logged and, subsequently, trended to determine areas of need for future quality improvement activities. Should you need more information about how the Network complaint and grievance process works, call the Network at (800) 826-3773.

WHAT DO YOU KNOW ABOUT KIDNEY TRANSPLANTS?

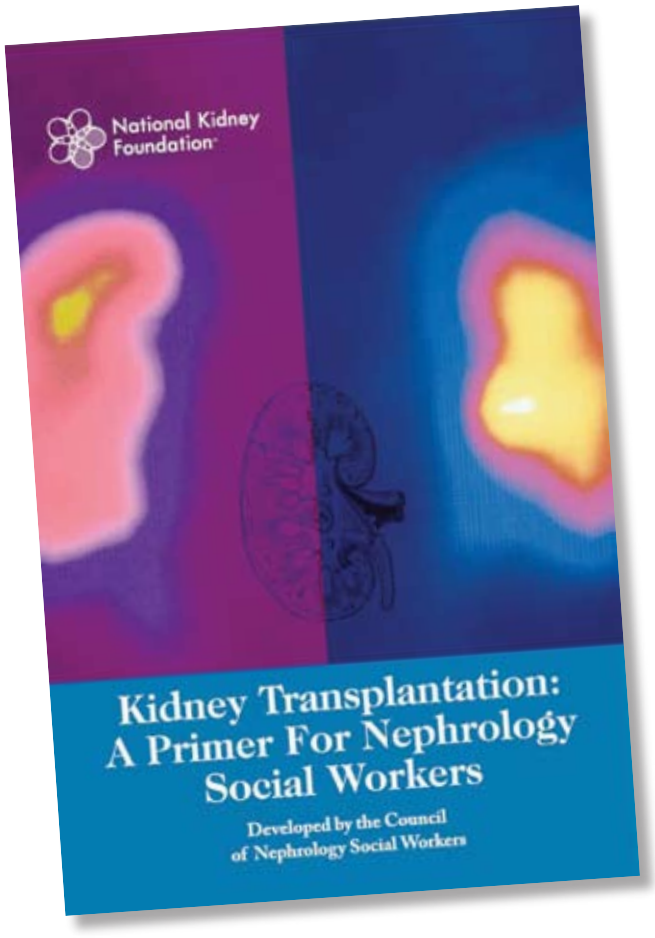
CNSW is pleased to announce the publication of our newest booklet:

"Kidney Transplantation: A Primer for Nephrology Social Workers"

You can read important information about:

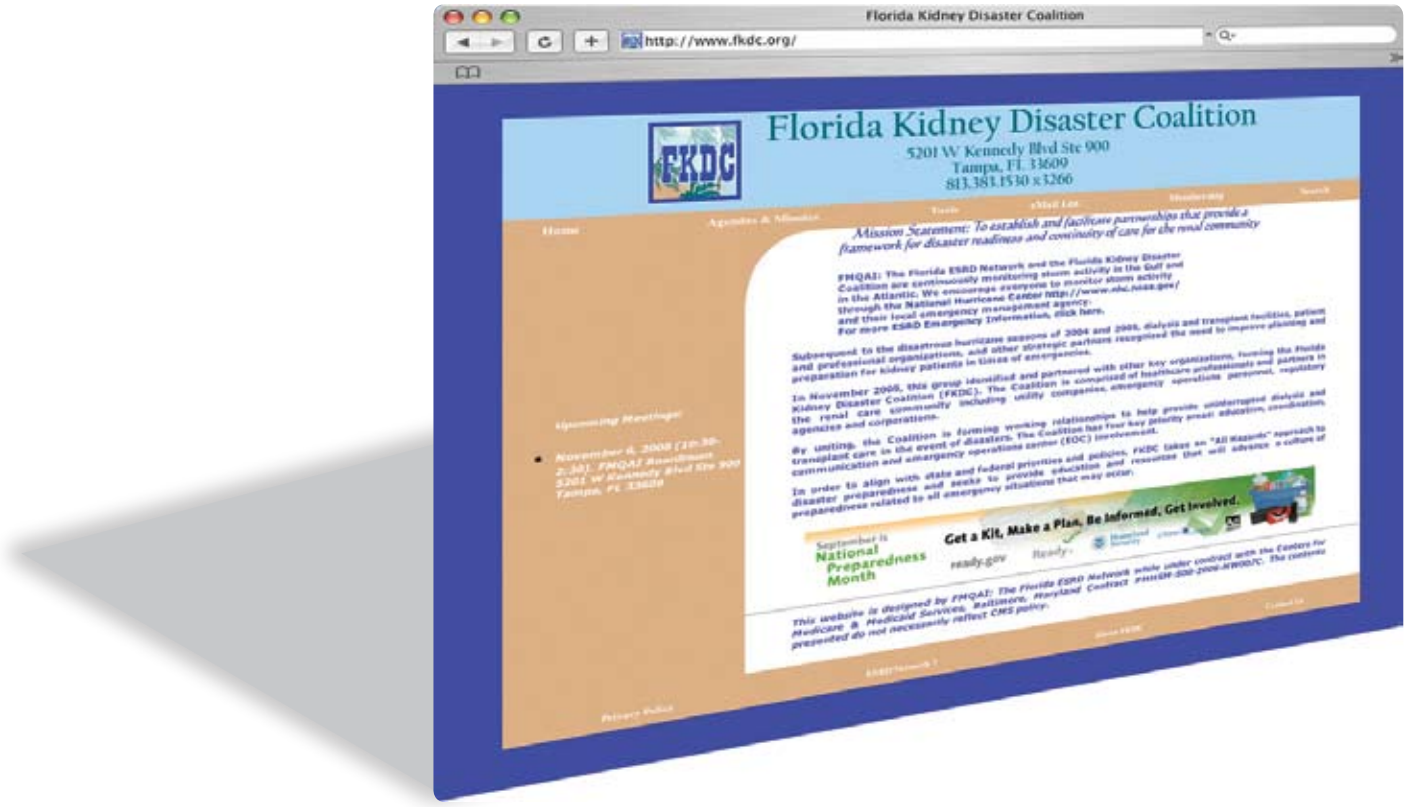
- Kidney Transplant vs. Dialysis
- Being Evaluated For A Kidney Transplant
- The Waiting List
- Living Donor vs. Deceased Donor
- Psychosocial Consideration-The Psychosocial Evaluation
- Approval/Denial Process
- Financial Considerations

The cost for this booklet is just $15 for national CNSW members, and $25 for non-members. Order your copy online at the CNSW website at www.kidney.org/professionals/cnsw/ or call the National Kidney Foundation at 1-800-622-9010



Florida Kidney Disaster Coalition

www.fkdc.org



Access to continuously updated tools, resources and links to help your facility comply with the new Medicare Conditions for Coverage and maintain year-round preparedness:

- FKDC Toolkits & Education: Implementing **best practices**, conducting **disaster drills**, communicating with **community partners** & conducting **education for patients & staff**
- Helpful Links: Patient & professional organizations, disaster **planning & readiness**, public service announcements & **instructional videos**
- Regulations & Guidelines: Florida's **Special Needs Shelter Rule** & the Medicare **Conditions for Coverage**
- State Resources: Statewide **shelter database**, statewide road status, FEMA Independent Study Program & free online **continuing education units**

Go Ask The Social Worker

Sarah Knott, LCSW
Tampa, Florida

Want to know something about a patient? Go ask the social worker! The social worker can tell you if the patient is compliant with treatment; can understand written or spoken instructions; can afford food or medications; is insured well enough to receive an access or other surgical procedure; can get to the clinic by transportation; or is doing better or worse than they were a year ago.

CMS, in one of their wiser decisions, mandated that all dialysis patients have a trained social worker available to help them negotiate the difficult transitions due to end stage renal disease (ESRD). They recognized that patients often go from normal life stresses to facing overwhelming financial losses and possible depression. This, without assistance, is a formula for failure.

During the initial interview, social workers attempt to determine what type of support system the patient has, and enlists that system as much as possible in the education of the complexities of treatment. They determine if the patient has adequate insurance to allow them access to medical care that may be needed outside of the dialysis center and transportation, if needed. If that coverage is not available, the social worker uses their knowledge of Medicare, Medicaid and employee group health plans to enroll the patient in the proper coverage. They also get a sense of the patient's goals and aspirations, whether the patient is capable and interested in returning to work, and if the patient is a good candidate transplant.

Assisting with compliance with treatment has become a key role in nephrology social work. Adherence to the patient's plan of care includes medication, diet, fluid intake, and coming to and staying on for the prescribed treatment. The patient's well being is severely compromised if all of these elements are not present. The social worker discusses with the patient issues associated with non-compliance and helps them problem solve ways to be more adherent. Often developing and reminding a patient of their personal goals may be enough for them to understand what they are sacrificing by not following the treatment regime. The social worker can provide access to patient assistance programs if the patient is unable to afford medication or the proper diet. Depression is often the cause of non-adherence to treatment, because the patient doesn't have the energy to follow the doctor's orders or has not made the commitment to life to make the appropriate changes. Social workers have the training to identify and treat or refer the patient for appropriate counseling.

New challenges arise as the patient continues with treatment over months and years. The social worker is continually assessing the patient and assisting where needed. If the patient makes the determination to discontinue treatment, the social worker may be the only person that they feel they can confide in. End of life issues are often difficult for family members to discuss.

So the next time you see a social worker "chatting" with a patient, think about what discussions regarding fishing trips or grandchildren can reveal to a social worker about a patient's goals and activity level. The key to effective social work is "listen, listen, listen!"

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ACCESS

ACCESS

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2008 ANNUAL FORUM

A KICKOFF TO QUALITY

"Scoring Points for Patient Care"

FMQAI: The Florida ESRD Network is pleased to announce its 2008 Annual Forum at the Renaissance Tampa Hotel International Plaza on October 27-29, 2008. The 2008 Annual Forum will provide you with excellent opportunities to learn about the new Conditions for Coverage, share best practices and meet with the leaders in the renal community. Please join the Network, while we focus on the CMS goal of protecting patient safety, enhancing ongoing quality improvement, and improving patients' experience of dialysis care.

Some Presentations Include:

- ✓ New Conditions for Coverage
- ✓ Patient Participation & Care Planning
- ✓ Quality Assessment and Performance Improvement Programs
- ✓ Infection Control
- ✓ Water Treatment
- ✓ Emergency Preparedness

Make Your Reservation Now!

Sleeping rooms at the Renaissance are currently available at a rate of $125.00 a night. To make your reservations, call the hotel directly at 1-813-877-9200 or toll free 1-800-468-3571 and identify yourself as a **FMQAI: Network 7 2008 Annual Forum** attendee. Please be sure to book your reservations **no later than Friday, October 17, 2008.** You can also reserve your room online at www.renaissancetampa.com.

If you need any assistance please call Kolina Ford at the Network at (813) 383-1530 x3884.
Thank you for your support. We look forward to seeing you there!