<table>
<thead>
<tr>
<th><strong>Reduce Rates of Long-Term Catheters</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>C.4.1.C AIM1 - Vascular Access Management</strong></td>
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</tbody>
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<table>
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<tr>
<th><strong>ESRD Network #</strong></th>
<th>Network 9</th>
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<tr>
<td><strong>ESRD Network Name</strong></td>
<td>IPRO ESRD Network of Ohio River Valley</td>
</tr>
<tr>
<td><strong>Contract Number</strong></td>
<td>Contract # HHSM-500-2016-00009C</td>
</tr>
<tr>
<td><strong>Title of the QIA</strong></td>
<td>Reduce Rates of Long Term Catheters</td>
</tr>
<tr>
<td><strong>Aim, Domain and Sub Domain</strong></td>
<td>C.4.1.C AIM1 - Vascular Access Management</td>
</tr>
<tr>
<td><strong>QIA Contact Person</strong></td>
<td>Deborah DeWalt, MSN, RN- Director of Quality Improvement</td>
</tr>
<tr>
<td></td>
<td>Susan Swan-Blohm, BS, OCDT- Coordinator of Quality Improvement</td>
</tr>
<tr>
<td><strong>Contracting Officer’s Representative</strong></td>
<td>Commander Todd Johnson, MSW, LCSW</td>
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<td>Dallas Division of Quality Improvement</td>
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<td></td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td><strong>Current Date</strong></td>
<td>December 27, 2016</td>
</tr>
<tr>
<td><strong>Submission Date / Version</strong></td>
<td>December 30, 2016/v1</td>
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**II Objectives**

*Topic* IPRO End Stage Renal Disease (ESRD) Network of the Ohio River Valley (the Network) will focus on reducing by at least two percentage points the number of long-term catheters (LTCs) in use among prevalent patients in dialysis facilities that have a greater than ten percent rate of LTC use in prevalent patients at baseline. The targeted facilities will be selected from the September 2016 Fistula First Catheter Last (FFCL) data available from the National Coordinating Council (NCC).

Based on comprehensive analysis of the data, the Network has selected 228 facilities with vascular access rates ranging from 10% to greater than 30% catheter usage amongst their prevalent patient populations. The Network LTC rate for baseline measure is 15.56%.

The goal of this project is to work with the targeted facilities to improve the Network's LTC rate to 13.56%.

**Root Cause Analysis Overview and Interventions**

The LTC reduction project will identify the root causes of LTC catheter usage, enabling the Network to work to reduce or eliminate identified barriers. The Network will seek best practices in the process to utilize and share within the entire Network community.

Project interventions will include, but are not limited to:
• Identifying and engaging a lead facility contact and a patient ambassador in each targeted facility to assist in creating opportunities for education, communication, and interventions to facilitate improvements at the facility level.

• Sharing educational materials and resources from access management specialists within the Network community and from national resources.

• Sharing best practices identified through the Plan-Do-Study-Act process.

• Creating a knowledge portal of compiled resources.

• Developing a template for RCA of LTC usage at the facility level. The RCA tool will assist providers in identifying and implementing interventions to decrease catheter usage.

• Implementing a monthly progress report that facilities will use to communicate to the Network the following:
  o Calculation of LTC rate in prevalent patients;
  o A list of interventions undertaken within the facility to reduce catheter rates;
  o A facility-based patient level action list to achieve catheter removal; and
  o Any key observations the facility discusses during QAPI meetings as barriers to achieving the facility goal of less than a 10% catheter rate.

• Communicating with regional operations managers and quality improvement personnel in each facility in the targeted group to increase participation and movement towards goals.

• Developing a vascular access patient ambassador program within at least 20 targeted facilities to measure the effectiveness of using peer mentoring techniques to achieve LTC reduction.

• Launched a regionally focused intervention model:
  o The Network has identified four metropolitan locations that account for more than 40% of the Network LTC burden. These include Cleveland, OH; Columbus, OH; Cincinnati, OH; and Indianapolis, IN.
  o The plan is to work with regional managers, medical directors and facility leadership in these areas to develop individualized focused interventions for each region to assist in catheter reduction and in removing barriers that are specific to that area of practice.
  o The goal of this focus is to create sustained changes in areas that contribute the most to the LTC count in Network 9.

• Developing a secondary focused approach plan for facilities that are part of
the Long-Term Catheter Reduction QIA project as well as the HAI-BSI project:
  
  o Twelve clinics are in both the 2017 LTC Reduction QIA and in the HAI-BSI project.
  
  o There is a known correlation between increased LTC use and an increased incidence of BSIs. Reducing these clinics' LTC rates should result in a corresponding improvement in their BSI rates.

• Providing ongoing data surveillance and communication regarding accomplishment to goal through the end of September 2017.

**Outcome Objectives**

The objective of this project is to reduce the usage of LTCs in prevalent patients.

The project baseline will be derived from NCC FFCL data from September 2016, the intervention period of six months from January through September 2017, ending with re-measurement in September 2017.

The goal of this project is to implement the interventions and targeted approach and strategies described above to improve rates in the 228 targeted facilities, ultimately leading to the reduction of the LTC rate in Network 9 to 13.56%.

### III Background

The use of indwelling catheters has doubled in the last two decades (Wilcox, 2009). A significant number of ESRD patients initiate dialysis emergently, with 80% of the incident population starting with a catheter (CDC, 2013, para. 4).

If a plan for insertion of a permanent access is not initiated at the time of catheter placement, the length of time for the catheter to remain in place longer than 90 days increases. Among the most commonly cited reasons for this are that the patient has become complacent with the use of a catheter over a fistula or graft, and secondary health issues have arisen that block access placement.

As delays in permanent access placement occur, the risks for complications associated with LTC use increase. These risks include, but are not limited to:

- tunnel site infection,
- septicemia,
- thrombosis,
- fibrin sheath formation, and
- impaired adequacy of the dialysis treatment (Baserab, 2011).

Prolonged use of indwelling catheters coupled with the high risks associated with catheter placement explains why catheters are the leading cause of hospitalization and death among ESRD patients (CDC, 2014). 2013 data from the Center for Disease Control and Prevention (CDC) cites approximately 37,000 BSIs associated with central
venous catheter with a 51% increase in hospitalizations (CDC, 2013, para. 5). The average cost of hospitalization to treat catheter related infection is approximately $23,451 (Wilcox, 2009).

It is imperative to eliminate the use of LTCs in the dialysis patient to promote the patient’s health and well-being, decrease complications, lower health care costs, and provide a safe access for dialysis. Ongoing education, communication, and support by the dialysis professional at the chair side is necessary to assist the patient in understanding the risks associated with catheter usage and to help them follow through with a plan for catheter removal and permanent access placement.

IV
Methodology:

- The Network will utilize the NCC FFCL data from September 2016 to identify facilities to be included in the QIA.
- Facilities identified through this process will be notified of their participation via a communication sent via United States mail, which will include a project agreement.
- Target facilities will sign and return the project agreement to the Network.
- The Network will provide a template to the targeted facilities for performing an RCA to identify the barriers to catheter reduction.
- The Network will request that each facility initiate a monthly review of RCA findings and interventions and fill out a summary form to report to the Network on actions and interventions utilized to address RCA findings as well as the results of these actions.
- The Network will evaluate monthly summary reports and FFCL data to trend LTC reduction efforts and work with facilities and regional focus areas to create sustainable improvement efforts.
- The Network does not foresee facilities refusing to participate.
- The Network will update the COR on progress monthly and report any situations that may arise with facility compliance during this project.

Project Timeline (January 2017 - October 2017)

December 2016

- The Network will identify facilities for participation and regional focus as well as HAI-BSI target facilities. The Network will prepare the QIA and initiate development of resources for use in the QIA.

January 2017

- The Network will provide notification to the facilities of participation in this activity, RCA algorithm and project tools for review and signature, and will ask for these to be returned to the Network by January 24, 2017.
- **The Network will** provide education and training on project goals and objectives and paperwork completion guidelines.
- **The Network will** provide technical instruction for correct reporting of monthly CROWNWeb data entry.
- **The Network will** make contact with facility leadership and to regional leadership within areas identified as regional “hot spots” to perform individualized RCA and engage the full leadership team.
- **The Network will** reach out to facility and regional leadership in each of the 12 clinics identified to be in both the LTC and HAI-BSI QIAs. The Network will schedule a collaborative meeting between Network staff and the QAPI team.
- Facilities will complete the RCA and submit Catheter Reduction Tool and Vascular Access Monthly Worksheet by February 6.

**Data Collection/Analysis**

Network arterial fistula count, access reporting rate, and LTC rate will be obtained from the NCC FFCL report monthly.

**March through end of September 2017**

- **The Network will** report monthly LTC rates on the Dashboard Input Form (DIF).
- **The Network will** report arterial fistula rate and facility reporting rate of LTC on the Monthly COR report.
- **The Network will** analyze monthly reports received from facilities and provide observations to facilitate rapid cycle improvement in their catheter reduction efforts.
- **The Network will** collect and share best practices learned from participating facilities.
- **Facilities will** identify and report barriers and discuss solutions in monthly QAPI meetings, and will provide the Network with a written summary of those discussions.
- **The Network will** track the real time catheter reduction rate across targeted facilities and will track and trend results.
- **Facilities that do not meet stated improvement goals will** develop individualized patient level plans of removal of LTC and send that plan back to the Network to monitor results.

The Network will work with facility and regional "hot spot teams" identified at
project initiation to support interventions created and to address issues affecting LTC rates within the region.

- **The Network will** provide education and training on project goals and objectives and paperwork completion guidelines.
- **The Network will** provide technical instruction for correct reporting of monthly CROWNWeb data entry.
- **The Network will** make contact with facility leadership and to regional leadership within areas identified as regional “hot spots” to perform individualized RCA and engage the full leadership team.
- **The Network will** reach out to facility and regional leadership in each of the 12 clinics identified to be in both the LTC and HAI-BSI QIAs. The Network will schedule a collaborative meeting between Network staff and the QAPI team.
- **Facilities will** complete the RCA and submit Catheter Reduction Tool and Vascular Access Monthly Worksheet by February 6.

**December 2017**

**The Network will** report final data in the DIF and Monthly COR Report for the re-measurement period (September 2017).

**Data Collection/Analysis**

Network arterial fistula count, access reporting rate, and LTC rate will be obtained from the NCC FFCL report monthly.

<table>
<thead>
<tr>
<th>Intervention Tools and Strategies</th>
<th>Providers</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff education – webinars, brochures, and materials</td>
<td>●</td>
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</tr>
<tr>
<td>Technical assistance for lowest performing providers</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Identification of best practices</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Development of change concepts</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Address barriers</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Facility Level - Patient Ambassador</td>
<td>●</td>
<td>●</td>
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**V Expected Results**

The expected results of this project include, but are not limited to:

- Maintaining CROWNWeb reporting of vascular access at 95% in eligible facilities,
- Lowering the Network LTC rate,
- Increasing fistula rates,
- Raising awareness of vascular access planning with patient involvement,
- Providing access education as well as education to treatment alternative to
assist in lowering prevalent catheter rate,
- Improving LTC rates in identified regional locations and focused facilities, and
- Establishing a patient SME/ambassador within each facility to assist with vascular access education and support for LTC reduction efforts.

**VI Appendixes**
Attachment A: Project Inclusion Letter

TO: Medical Director; Nurse Manager / Administrator

FROM: Deborah DeWalt, RN, MSN – Quality Improvement Director
       Susan Swan-Blohm, BS, OCTD – Quality Improvement Coordinator

DATE: January 3, 2017

SUBJECT: 2017 Vascular Access Goals – Mandatory Inclusion in Quality Improvement Activity

As the ESRD Network of the Ohio River Valley (Network 9), we are tasked by the Centers for Medicare & Medicaid Services (CMS) to support your facility’s goals in providing safe, effective, efficient, patient-centered, timely, and equitable care.

Increasing the number of patients receiving dialysis via arteriovenous fistulas (AVF) and reducing long-term catheter (LTC) use for dialysis access is key to providing optimum care for your patients. A dialysis patient is identified as having a LTC when he or she has been dialyzed with a catheter for 90 days or greater, regardless of whether the catheter has been replaced.

We want to help you deliver excellent care to your patients and to meet these important goals. These efforts:

✓ Result in improved patient care;
✓ Minimize loss of revenue due to hospitalizations related to catheter complications;
✓ Help ensure that your facility receives maximum reimbursement through the Quality Incentive Program;
✓ Improve your facility’s rating on the Dialysis Facility Compare website.

CMS has set quality goals for each dialysis facility:

1. LTC rate should be less than or equal to 10%. (Network QIA Focus)
2. AVF rate should be equal to or greater than 68%.
3. Vascular Access reporting rates should be greater than or equal to 95% in CROWNWeb.

Data on AVF and LTC rates for your facility, the state, and dialysis facilities nationwide, as of September 30, 2016 are available in the attached report. Facility goals for each of these measures are also included. These goals are to be achieved by the end of September 2017. Data in these reports is no longer available for editing in CROWNWeb. If you believe that the rates listed in the attached are incorrect, please verify your data for accuracy prior to CROWNWeb clinical month closure dates throughout 2017 (steps for review are included below).

Your facility’s LTC rate is above 10% as of September 2016. As a result, per CMS mandate, your facility is required to participate in the Network’s Vascular Access Quality Improvement Project. This activity runs from January through the end of September 2017. The requirements for this project are detailed in the attached Vascular Access Project Guide. The Network will support your efforts and follow your progress.
How to Run the Vascular Accesses in Use Report from the QualityNet Secure Portal

Centers for Medicare & Medicaid Services (CMS) has tasked all dialysis facilities with ensuring that clinical data is accurately entered, tracked, and reported in CROWNWeb. To assist with this process, the Network encourages all facilities to compare their internal clinical reporting of vascular access data (patient level) with what has been entered in CROWNWeb on a monthly basis. (Please note data in both systems should be the same).

Please use the following steps to run the Vascular Accesses in Use Report in CROWNWeb, which will support data validation. If you have any questions, please go to http://esrd.ipro.org/ to contact your local Network for technical assistance.

- Open your browser and go to the QualityNet Secure Portal at https://www.qualitynet.org
- Select the Log In button

Select the End-Stage Renal Disease Quality Reporting System link in the menu

- Read the Terms and Conditions
- Select I Accept
- Enter your User ID
  (usually email address)
- Select Next

- Enter your Password
- Select the desired MFA Device Type
  from the drop down menu
  (Depending upon the MFA Device
  Type selected, you may need to
  select Send in order for the code
to be sent to your selected device)
- Enter the MFA Security Code and
  then select Log In

- Select Quality Programs tab, from
  Welcome screen
- Select End Stage Renal Disease
  Quality Reporting System from the
  drop down list

Select CROWNWeb SUI

Select the CROWN Reports tab
- Scroll down to the Vascular Access Reports section under the Reports header
- Select Vascular Accesses in Use Report link

- Specify the Start Month/Year and End Month/Year
- Select the Facility
- Select Layout to Compare (state, Network, nation)
- Select Patient Grouping (All HD patients)
- Select Report Format (Excel)
- When complete, click Finish

Select Ok (It takes a few minutes to generate the report)

- Report will appear by name under My Reports tab
- Select the XLS file link to download the Vascular Accesses in Use Report
Vascular Access Project Guide

When reviewing your September data, consider the following:

- How do your AVF and LTC rates compare to the CMS AVF goal of 68% and LTC goal of less than 10%?
- Will your facility get maximum reimbursement in 2018 based on your performance for 2017 on the QIP?
- How does your AVF and LTC rate compare to the Network and National averages?
- What are the AVF/LTC goals for your facility? What steps might you take to maintain/improve rates?
- What access types may need to be corrected prior to the closure of the next clinical month on 1/31/17?

1. Develop a Catheter Reduction Tool (CRT) 2017 - *Monthly*
   - Review the root cause algorithm provided.
   - Complete all sections of the CRT (Attached) – If you have a corporate plan you may send this instead if it includes the same information.
   - Identify barriers and develop an action plan for each root cause.
   - Develop a performance measure to use during monthly QAPI meetings to ensure the action plan is being completed or is yielding the outcome desired.
   - Return the completed CRT to the Network no later than February 1, 2017 and monthly thereafter

2. Use the [Vascular Access Tracker](#) to monitor your patient’s progress - *Monthly*

3. Attend the mandatory webinar series:
   - Kickoff webinar to be held in January 2017
   - April and June webinars – dates to be determined
   - [Verify your data](#) monthly comparing your facility system and CROWNWeb

Submission of Catheter Reduction Tool and Vascular Access Tracker:
Initial submission due February 1, 2017 and monthly thereafter

Fax the information to – *(216) 593-0101*

For Questions: email [quality@nw9.esrd.net](mailto:quality@nw9.esrd.net) or phone (216) 755-3053
Vascular Access - Project AGREEMENT

Dear Provider,

The Network shall achieve the Centers for Medicare and Medicaid Services (CMS) goals through the development and implementation of quality improvement activities (QIAs), as stated in the Vascular Access Project Guide. As directed by Network 9 and its Governing Bodies, 2017 performance goals have been set and every dialysis facility is expected to achieve these goals.

Please carefully review the notification letter and attached objectives for the Vascular Access Quality Improvement Activity. After review, please complete the necessary fields and have the Project Lead, Facility Administrator/Nurse manager, and Medical Director sign and return the form to the Network office via email at quality@nw9.esrd.net or by fax at (216) 593-0101 by January 29, 2017.

**Please note, all parties, the Project Lead, Medical Director, and Facility Administrator/Nurse Manager are responsible for ensuring the completion of project objectives.

In anticipation of your timely response, we thank you for your ongoing support and cooperation with the Network. If you have any questions or need additional information regarding these goals, please contact the Quality Improvement Department at quality@nw9.esrd.net.

Sincerely,

Victoria Cash, MBA, BSN, RN
Executive Director

Deborah DeWalt, RN, MSN
Quality Improvement Director

CC: Medical Director, Facility Administrator/Nurse Manager, Regional Operations Manager
Vascular Access - Project AGREEMENT

January 2017 – October 2017

The undersigned hereby agrees to participate and cooperate with the goals and activities, including quality improvement projects, as set forth by IPRO ESRD Network of the Ohio River Valley (Network 9) (42 CFR Part 494.180.V772 (i) of Centers for Medicare & Medicaid Services (CMS) regulations).

Facility Name (DBA): __________________________ Medicare Provider # (CCN): _________

Project Lead Name: __________________________ Project Lead Title: _________________________

Project Lead Signature: __________________________ Date: ___________________

Project Lead Email: __________________________

Medical Director: __________________________

Medical Director’s Signature: __________________________ Date: ___________________

Medical Director Email: __________________________

Facility Administrator/Nurse Manager Name: __________________________

Facility Administrator/Nurse Manager Signature: __________________________

Regional Director/Area Administrator: __________________________ Phone: __________________

Regional Director/Area Administrator Email __________________________

**Identify a patient ambassador** __________________________ Phone: ___________

Any changes to the above listed contacts must be reported to the Network and corrected in CROWNWeb within 5 business days to ensure continuity with project implementation and communications between the Network and Facility. Plans are reviewed periodically, and are subject to change based on the CMS Statement of Work (SOW).
QUALITY IMPROVEMENT ACTIVITY

Project Description
This project will focus on reducing long-term catheters (LTC)

- Primary project measures:
  - LTC Rate
- Primary project goals:
  - Reduction in LTC rates in facilities that had a rate >10% at baseline (September 2016)

Action Items / Facility Requirements
Complete monthly Catheter Reduction Tool and Vascular Access Tracker.

INFORMATION MANAGEMENT / DATA REPORTING

CROWNWeb (CW)
Electronic submission/verification of clinical data before the close of clinical months in CROWNWeb. Ensure Vascular Accesses are accurately reported in CROWNWeb and the facility EMR. Maintain accurate list of staff contact information, especially email addresses, in CROWNWeb.

Selection of a Patient Ambassador for LTC Reduction QIA Project (see Project Agreement)
Research and best practices have demonstrated that units with active participation of patients as members of the health care team achieve better clinical outcomes more readily. This year, the Network is requesting that each facility in the LTC Reduction QIA designate at least one patient, or preferably, one patient per shift to take the lead on special projects. We will provide training for these patients to supervise these programs in the clinic. Patients should be viewed as role models in the unit as far as the ability to lead and become “the unofficial spokesman” on the care team.

In this role, the patient will:
- Provide contact information to the Network
- Participate in educational and informational web conference presentations with the Network
- Review educational materials designed for patients in the target facilities and throughout the Network community
Attachment B: Management of Patients with Central Venous Catheter Algorithm
Attachment C: Catheter Reduction Tool

**Catheter Reduction Tool 2017**

**Long Term Catheter Rate (LTC) Monthly progress measure**

Facility CCN# _______________ Month _______________

Staff member completing the form__________________________

<table>
<thead>
<tr>
<th>Please answer the following questions</th>
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<tbody>
<tr>
<td>1. How many chronic, non-transient, in-center hemodialysis patient did you have on the last day of the month? Clinic census</td>
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<tr>
<td>2. Of the patients in #1 above, how many were using a catheter for the vascular access?</td>
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<tr>
<td>3. Of the patients in #2 above, how many have been using a catheter for 90 days or more?</td>
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<tr>
<td>4. Catheter rate (divide the number from #2 by the number of patients in Number 1)</td>
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<tr>
<td>5. Catheter rate &gt; 90 days (divide the number from #3 by the number of patients in number #1)</td>
</tr>
<tr>
<td>6. Is this an increase or a decrease?</td>
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If there is an increase in your facility’s LTC rate discuss the reasoning and include excerpts from your QUAPI discussion

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

Discuss the barriers and actions planned in your facility to decrease the LTC rate.

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Actions planned</th>
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## Vascular Access Monthly Worksheet

**Clinic** __________________________  **CCN#** __________________________  **Project Lead** __________________________

**Document and track each patient with a Long term catheter (LTC) monthly utilizing the RCA provided**

**Month** __________________________

<table>
<thead>
<tr>
<th>Patient Initials</th>
<th>Days with Y or N</th>
<th>Permanent Access in Place? Y or N</th>
<th>Reason for delay of access placement</th>
<th>Date of VA Appointment</th>
<th>Date of Permanent Access Placement</th>
<th>Date of Confirm of adequate function</th>
<th>Date of Catheter removal</th>
<th>Comments/Plan</th>
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