Summertime in Texas. Of course this means it is Hurricane Season, which runs from June 1 through November 30. Considering that it has been many years since the last major storm in Texas, we fear complacency in preparedness. NOAA predicts a 70% likelihood of 10 to 16 named storms, of which 4 to 8 could become hurricanes (winds of 74 mph or higher), including 1 to 4 major hurricanes (Category 3, 4 or 5; winds of 111 mph or higher). El Niño is dissipating and NOAA’s Climate Prediction Center is forecasting a 70% chance that La Niña, which favors more hurricane activity, will be present during the peak months of hurricane season.

PREPARE! Those of us who lived and worked through the devastation of prior hurricanes know all too well that it only takes one storm to significantly disrupt the lives of staff and our vulnerable patients. There are literally thousands of patients that have started dialysis since the last hurricane. Please take heed of the preparedness article in this newsletter.

The Network has experienced some important staff changes in the past few months, and we welcome Javoszia Sterling as Outreach Coordinator, Octavia Griffin as Patient Services Social Worker, Rechelle Brown as Patient Services Director, and Lydia Omogah as Quality Management Specialist.
From the Desk of the Executive Director

Continued from page 1

Our Information Management Department has been reorganized Sade Brister has assumed expanded responsibilities and is supported by Data Managers within our parent company, Alliant Health Solutions.

As always, our goal is to support you, the provider, in providing quality care for our ESRD patients in Texas. Within this newsletter, you will read about the many Quality Improvement Activities that are ongoing to improve care. An overarching goal embedded in all of our projects and activities is to achieve Patient-Centered Care and Patient-Family Engagement for each patient. As defined by the Kidney Patient Advisory Committee (KPAC) of the Forum of ESRD Networks, Patient-Centered Care is patient driven healthcare delivered in a way that is focused on

- An individual patient's values and preferences and
- Involves both sharing information and
- Active shared decision making with patient, family/caregivers, and medical professionals to
- Reach customized, individualized and realistically obtainable goals of care

This is an ongoing process; keep in mind these goals may change over time. Thank you for all you do for our patients and families in Texas as we work together to make this a reality. Always feel free to reach me via email gharbert@nw14.esrd.net or phone 469-916-3801.

Glenda Harbert, RN, CNN, CPHQ
ESRD Network 14 Executive Director
End State Renal Disease Network, Inc. of Texas is pleased to announce a one-page newsletter focusing on professional issues! The name of the newsletter is “THRIVE.” We anticipate it will help you thrive in moments of challenge, growth, and confirmation. Here you will find topics focused on professional development, quality of care and treatment topics related to dialysis, and how to engage patients. The letter will be sent out via fax on the last day of each month, beginning in June.

Each month will focus on a specific topic. Here are the coming attractions!

- Social Media in the Workplace—June
- Motivational Interviewing—July
- Letters of Concerns—August
- Treatment Times—September
- Involuntary Discharges—October
- Dry Weights—November
- Helpful Resources—December

This newsletter is intended to be interactive, so please feel free to contact the Network if you have any feedback. A Survey Monkey link will be created to give you an opportunity to provide feedback. As topics have already been selected for the remainder of the year, please feel free to offer suggestions on questions than can be addressed in the selected topics. Likewise, an archive of feedback and previous newsletters will be listed on the Network website at http://www.esrdnetwork.org.
Lack of professionalism is often a concern of patients who call the Network, and this could be due to a lack of understanding on the part of the clinic staff. This month’s newsletter will address the issue of patients who missed treatments for 30 days or more.

The Purpose

The purpose of letters of concern are to, first of all, show concern. Secondly, the letters aim to outline next steps and resources for the patient. Lastly, when patients know what to expect and procedures are consistent, trust is developed. Letters can result in re-engagement in treatment, loss to follow up, or withdrawal from care.

What is included in letters of concern?

A certified letter of concern should be completed with the following components:

- Letter voicing concern about missed treatments (has to be more than 30 days):
  - Include date of last treatment
  - Genuine concern for the patient
- Offer a deadline for the patient to return to the clinic
- Offer other clinics that could possibly serve the patient
  - Offer facilities inside and outside of YOUR company
  - Encourage the use of Medicare’s Dialysis Facility Compare (DFC) website [https://www.medicare.gov/dialysisfacilitycompare/](https://www.medicare.gov/dialysisfacilitycompare/)

Continued on page 5
August’s Professional Newsletter: 
**Letters of Concern**

*(Continued from page 4)*

- Encourage the patient to seek emergent dialysis care at local hospital(s)
- Hospice
  - Offer as an option should the patient choose to not continue treatment
  - Provide at least three companies to adhere to Medicare’s guidelines
- Offer additional resources
  - Transportation, mental health, etc.
  - Transportation via 211 Texas, [www.211texas.org](http://www.211texas.org)
- Behavioral Health Treatment locator
  - [https://www.findtreatment.samhsa.gov](https://www.findtreatment.samhsa.gov)

Contact us at:

Phone: 972-503-3215 | Email: info@nw14.esrd.net | Web: [http://www.esrdnetwork.org](http://www.esrdnetwork.org) | [Like us on Facebook](https://www.facebook.com)

Feedback: [https://www.surveymonkey.com/r/thriveaug](https://www.surveymonkey.com/r/thriveaug)
Facility Patient Representatives (FPRs) are the link between the other patients and the center’s managers and staff to improve patient- and family-centered care in the state of Texas. The ESRD Network encourages every facility to have at least one FPR available. The goal should be to have at least one FPR per shift.

What our FPRs are saying:

“...being a rep helps the patients understand what is going on with their care” – FA

“I was raised that when you enter a room or someone is home you always greet them, always. “Good morning” is something I have used coming into dialysis every Monday, Wednesday, and Friday, 5:30am...Whether they respond or not. A good morning is always in order.” - PE

What should FPRs do?

- Be a role model to other patients by learning information about treatments for kidney disease and following his/her own treatment plan.
- Read and answer patients' questions about information from their facility and the Network.
- Assist with the orientation and support of new patients.
- Go to the first 10 or 15 minutes of the monthly quality meeting (*Quality Assessment and Performance Improvement*) and/or *governing body* meetings to help staff understand patient concerns.
- Help with lobby day education.
- Work with staff to start and run patient and family groups like Patient Advisory Councils or support groups.
- Start a newsletter for your center.

What should FPRs NOT do?

There are some things that FPRs should avoid doing. You should not:

- Try to train or manage staff members
- Ask staff or patients about confidential patient information
- Post or share information that has not been approved by the clinic manager
- Share the concerns of another patient without the patient’s permission

Continued on page 7
Facility Patient Representatives (FPRs)

Continued from page 6

What our FPRs are saying:

“I am a FPR at a DaVita clinic and, for that rare occasion when a patient is having an issue with their treatment or a person at the center, I can help them resolve the problem. Sometimes it is just a matter of educating or informing the patient so they better understand the situation or why their treatment goes as it does. Other times I help them escalate their complaint to a higher level ... It is very rewarding if I can play a part in helping resolve a patient problem at the lowest level so it doesn't become a grievance and involve people outside the facility.” -DO

“Although FPRs are advocates for fellow dialysis patients, they also acquire the link for establishing positive and effective patient/staff relationships; by communicating and acknowledging the barriers of better quality of health and life.” -PM

Your next steps

Head over to our website and download our FPR toolkit. It’s filled with applications for your FPR to fill out as well as more resources and tools on the best way your facility and your FPR can work together to improve physician-patient relations and family and patient-centered care at your facility.
When it comes to managing your own care, having the opportunity to be involved in the decisions your professional healthcare team makes is a key element to having the best treatment outcomes. That’s what patient engagement in end stage renal disease (ESRD) at its best should look like.

It is not a surprise that many agencies and organizations have invested so many resources aimed toward the development of patient engagement strategies, especially in chronic diseases such as ESRD. The Patient Engagement Pyramid model presented on page 9 was designed to help patients engage more with their electronic health records, which in turn could positively affect their healthcare-related decisions.

Looking at the same Patient Engagement Pyramid model, we can see how this hierarchy of concepts can be applied to chronic diseases such as ESRD in a similar manner. The higher two levels in the pyramid clearly establish that having a patient proactively engaged as part of the healthcare team and actively managing their care are fundamental. ESRD patients that are motivated in being part of their care are more capable of making positive choices regarding their treatment options. An engaged patient is also a patient who’s going to be more compliant and therefore will be expected to have better outcomes.
Themore the healthcare industry starts looking at things like attainable goals and patient’s perspective, the more we will start seeing better outcomes. Once health professionals get past the “we know what’s best for you” attitude, we can expect to see real change in the way patient involvement was intended to be. Until then, we all have a task and a duty to continue to listen to the ESRD community, especially the patients and their families. Consequently, we will be able to incorporate the patient perspective into planning, developing, and managing their own care not only at home, but also at the facility level.

Sources
Patient engagement Pyramid [http://blog.hellohealth.com/The-Patient-Engagement-Pyramid](http://blog.hellohealth.com/The-Patient-Engagement-Pyramid)
The following article is reprinted from Measuring Patient Experience Primer/Brief, April 2012, published as part of Aligning Forces for Quality: Improving Health and Health Care in Communities Across America, by the Robert Wood Johnson Foundation and has been slightly modified for application in the dialysis setting.

Why Measure Patient Experience?

Patient centeredness is now widely accepted as a core diminution of health care quality. The use of surveys to query patients about their experience in the health care setting is the best and often only way to examine whether the experiences deemed essential for high-quality, patient-centered care actually take place. As with any dimension of quality, measure of patient experience provides a basis of information required for any effort to improve they system. Improving patient experience not only addresses those aspects of care that often matter most to patients – such as timely access to care, good communication, respect, and courtesy – but also has the potential to affect practice on a more comprehensive level. From a clinical perspective, studies have shown that good patient experience is associated with patients being more engaged in their care and willing to follow their providers; instructions, as well as with improvement patient outcomes. Good patient experience has also been associated with positive business outcomes, such as lower malpractice risk and greater patient loyalty.

How is Patient Experience Measured?

While various administrative and clinical practice data can be used to measure performance on most quality aims, patient centeredness is unique in that patients themselves typically are the best source of information to assess patient-centered aspects of care. Patients can serve as a source of information in several ways including: (1) as respondents to patient surveys; (2) as informants through focus groups and interviews; (3) as trained “mystery shoppers” to report on their observations and experiences in the shoes of a patient and (4) by volunteering their comments and opinions through the growing number of

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Measuring Patient Experience

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communication with doctors, responsiveness of clinic staff, and coordination with other care providers. Because they ask patients whether or not certain events or behaviors important to them actually occurred, or how often, patients experience surveys also can be useful in highlighting actionable areas that providers can focus on for improvement.

Patient Application of Chlorhexidine as a Patient Engagement Activity within the Bloodstream Infection Quality Improvement Activity

The selection of interventions that go into a quality improvement activity (QIA) can be an arduous task at times. New tasks can be developed according to recent research, or existing interventions can be utilized by learning from experience, and feedback from facilities that have performed the task previously also provide direction. The ideas then go through multiple layers of vetting in order to ensure that the task is meaningful and meets the intent of the QIA. These layers usually include Medical Review Board workgroups, internal cross-functional teams, and certainly the Patient Advisory Council (PAC). Sometimes these ideas pass with flying colors, while others see slight adjustments or can be “scrapped” altogether. Other times previously untapped ideas can arise.

Patient application of chlorhexidine is an example of a new idea that was created inside one of these workgroups. We know that patients’ involvement in their own care improves health outcomes. However, activities are often contested when it comes to providers putting these patient engagement activities into action.

Continued on page 12
Time constraints and monetary concerns are very real, so finding activities that facilities feel comfortable with can be challenging.

Chlorhexidine application by patients in the focus facilities was developed as one of the five patient engagement options for facilities to utilize in the Bloodstream Infection (BSI) QIA for the month of May. The intent of this intervention is for the patient to take over the task of applying the chlorhexidine to his/her access prior to insertion of the needles. While this still requires the time of the staff to observe the application, it does not take any additional time, and since facilities that would select this intervention already utilize chlorhexidine (or similar anti-septic), no additional monetary cost to the facility is experienced.

Ideally, we will be able to analyze BSI data for each of the 110 focus facilities. This data set will be able to be categorized by month, comparative to the baseline, and also by selection of patient engagement activity. Close to 33% of focus facilities and their patients (36 facilities out of 110) selected patient application of chlorhexidine. The fact that so many facilities chose this new activity is intriguing, and we look forward to digging into the outcomes. The first set of data that may show an impact of this intervention is expected on July 1, 2016. We look forward to keeping you informed of this promising intervention as the year goes on.
The ESRD Quality Incentive Program (QIP) uses a Performance Score Certificate (PSC) to publicly report both clinical and reporting measures. The purpose of the ESRD QIP is to promote the delivery of high-quality services to all dialysis patients, and is comprised of measures that dialysis facilities must report to receive a score. Your facility’s score will show on your PSC, which should be downloaded every December and posted in your facility.

The PSC is a result of the work this facility performed two calendar years prior. For example, this December you will download the 2017 Certificate, which represents performance of this facility from the 2015 calendar year. The score you receive could dictate a Medicare payment reimbursement reduction of up to 2%. The ESRD Network of Texas receives calls yearly in December where facilities inquire as to how they may contest these outcomes. Unfortunately, the answer is that December is simply too late.

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While facilities should be critical of data provided via DialysisData.org throughout the year, the month of August presents the prime opportunity to be critical of the QIP Preliminary Payment Year Performance Score Reports (PSRs). The PSRs will be available on August 15, when facilities will be able to access, review, and submit a formal inquiry about these reports by the September 16 deadline. CMS encourages facilities to submit formal inquiries by August 31 to all CMS time to review and determine answers.

For more information, visit the QIP section of the ESRD Network of Texas website: www.esrdnetwork.org/professionals/qip

Partner with the Network to Get the Most Out of ICH CAHPS

One of the Network’s goals is to provide all facilities with a roadmap for using the ICH CAHPS* process as a foundational measurement piece for a patient-centered care environment where patients and providers are engaged and a patient’s experiences with care are captured, explored, and used for quality improvement activities. Several years ago, the ESRD Network of Texas was one of four ESRD Networks to work with the Agency for Healthcare Research and Quality (AHRQ) to test the ICH CAHPS survey tool through a pilot project involving several Texas dialysis facilities. Since then, the Network has continued to collaborate with facilities by administering the ICH CAHPS survey tool to patients in English and Spanish (prior to its inclusion in the ESRD QIP), analyzing results, and assisting facilities with results interpretation and action planning for improvement through feedback and coaching sessions. Additionally, the Network designed and launched an ICH CAHPS Resource Matrix to assist dialysis facilities in the development of interventions and action plans to improve the patient experience of care and to foster a patient-centered culture.

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Partner with the Network to Get the Most Out of ICH CAHPS

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It is an online tool that maps resources to each of the ICH CAHPS survey questions. By clicking on each hyperlink matched to the ICH CAHPS question, you can access a variety of online resources to assist you improve survey scores. In 2016, we are building on our collaborative approach with facilities to get the most out of their ICH CAHPS results in QIAs with a QIA called Be the Voice, Be The Change. In this project, the Network has partnered with 25 Texas dialysis facilities to improve patient scores on the ICH CAHPS question that patients scored the lowest which states, “In the last 12 months, did either your kidney doctor or dialysis center staff talk to you about peritoneal dialysis?”

Although not required by the CMS contract with the Network, all facilities are encouraged to submit their ICH CAHPS results to the Network on a voluntary basis for assistance with interpretation of results, including identification and prioritization for improvement, action plan development, and trend analysis including disparities in care. With your permission and consent, the Network will work with you and your vendors in order to obtain the data, review and perform analyses, and guide you in the development of action plans to improve results. ICH CAHPS facility-level results are confidential and will not be shared with others unless agreed upon by the dialysis facility leadership. This is a free service offered by the Network to all facilities. If you would like to participate, please contact Kelly Shipley, QI Director, at kshipley@nw14.esrd.net for more information.

Examples of improved outcomes on a facility’s ICH-CAHPS score through collaboration with the Network are shown on the following page.

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*Consumer Assessment Healthcare Providers and Systems In-Center Hemodialysis Survey

In 2010, leaders from Texas dialysis facilities that were part of the Network’s vascular access (VA) QIA were asked to complete a questionnaire on VA Coordinators/Managers. Respondents of the survey said 85% of VA Coordinators are given dedicated time to coordinate and oversee the facilities vascular access processes. Fast forward to 2016, in a recent poll of 120 leaders from in-center hemodialysis facility participating in the Network’s Catheter Operation Reduction and Elimination (CORE) QIA, the following were the top four causes respondents cites as dialysis–related factors attributable to a high long-term catheter utilization, ALL of which can be impacted by a VA Coordinator:

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- Staff turnover
- Lack of staff knowledge about vascular access guidelines
- Fistula maturation/healing graft monitoring system in place, but not being followed or used as intended (e.g., inconsistently used, not documented, incomplete)
- Catheter monitoring system in place, but not being followed or used as intended (e.g., inconsistently used, not documented, incomplete)

Additionally, several of these same facilities cited the hiring, training, and/or re-assigning of the VA Coordinator/Manager as an improvement strategy in their action plans submitted to the Network. So on one hand, leaders say that the VA Coordinator is given time to do their job, but on the other hand, as an industry, we see issues of training, staff turnover, and staff engagement as constant challenges for this important role.

Although the job descriptions vary from place to place in format and wording, the core job duties of a VA Coordinator/Manager range from team and relationship building among dialysis staff members, the dialysis center VA team, patients, family members, vascular access surgeons, and nephrology or radiology interventionists to scheduling appointments, engaging patients by using the shared decision-making framework and teach-back tools, monitoring and tracking vascular accesses, and a host of other activities including documenting and participating and or leading quality improvement VA-related initiatives. Listed on page 18 is a role description by Intermountain ESRD Network 15 as part of the Fistula First Project.

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Vascular Access Coordinator Role

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Reports to: Facility Administrator, Medical Director, VA Team

PURPOSE OF VASCULAR ACCESS COORDINATOR ROLE:

• Primary source of vascular access information and care coordination for designated facility (provider)
• Focus on vascular access care and management to increase access longevity
• Maintain vascular access data to assure tracking and trending of dialysis therapy and outcomes
• Provide leadership and communication among caregivers
• Oversee and direct vascular access planning for current and future accesses

SUMMARY OF BASIC ROLE:

• Collection of accurate and complete vascular access data
• Coordination of the care and management of patients’ vascular accesses
• Communication and collaboration with the Multidisciplinary Access Care Team

ROLE QUALIFICATIONS:

• Experienced hemodialysis professional
• Certification in nephrology or hemodialysis preferred
• Demonstrated proficiency in vascular access care and management
• Demonstrated commitment to continuous quality improvement (CQI)
• Excellent communication, writing, and organization skills
• Empowered by the facility administrator, medical director, and Multidisciplinary Access Care Team

ESSENTIAL JOB FUNCTIONS:

1. Collaborate with medical director, facility administrator, and others to identify and continuously re-evaluate the members of the Multidisciplinary Access Care Team.

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2. Proactively collect and report accurate and complete data and assessments of the accesses to facility, teammates, patients, and other care providers (the Multidisciplinary Access Care Team) for baseline and ongoing outcomes.

3. Educate teammates, provider partners, and hemodialysis patients and family members in the care and management of vascular accesses, with particular attention to opportunities for improvement.

4. Monitor vascular access and hemodialysis care delivery with particular focus on identifying access dysfunction and opportunities to increase arteriovenous fistulas (AVFs) and reduce catheters.

5. Facilitate process of referral for diagnosis for accesses with dysfunction or other pathology.

6. Support referral for interventional or surgical treatment appropriate for diagnosed vascular access dysfunction.

7. Ensure documentation of care and outcome, and communicate vascular access-related outcomes and status.

8. Participate in Continuous Quality Improvement of Vascular Access care and management to improve patient and facility outcomes.

9. Facilitate routine Multidisciplinary Access Care Team meetings to identify opportunities for vascular access related improvements.

10. Complete other vascular access-related tasks as directed.

While this article features the significance of a singular position at the dialysis facility, the Network and the dialysis community recognize that the VA Coordinator/Manager is but one of several key staff members who contribute toward the achievement of excellent vascular access outcomes and a culture of patient-and family-centered

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Vascular Access Coordinator Role

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care. If you are a new VA Coordinator/Manager or need a refresher on some of the best practices and tools to assist the VA Coordinator/Manager succeed in his/her role, there are several vascular access resources available. We recommend you start with Lifeline for a Lifetime and the ESRD Forum’s Catheter Reduction Toolkit.

Ebola Surveys

The recent U.S. experience with Ebola highlighted the critical importance of infection prevention programs in protecting both healthcare personnel and patients. With funding from the Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS) has begun a pilot project to meet identified joint priorities related to assessing the continuum of infection prevention efforts between hospitals and nursing homes in order to prevent transmission of infections in both settings. Translating lessons learned from the Ebola outbreak, including the importance of core infection prevention practices, to every setting where individuals receive health care is a significant opportunity to increase the safety of U.S. healthcare facilities.

The role of nursing homes in health care delivery has expanded significantly. Over three million Americans receive care in U.S. nursing homes each year. The Centers for Medicare & Medicaid Services (CMS) has begun a three-year pilot project to improve assessment of infection control and prevention regulations in nursing homes, hospitals, and during transitions of care.

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All surveys during the pilot will be educational surveys (no citations will be issued) and will be conducted by a national contractor. New surveyor tools and processes will be developed and tested, focusing on existing regulations as well as recommended practices (such as those for antibiotic stewardship and transitions of care). Ten pilot surveys to be conducted in Fiscal Year (FY) 2016 will occur in nursing homes. Surveys in FY17 and FY18 will be conducted in nursing homes and hospitals. Some of the project outcomes are to develop new surveyor infection control tools and survey processes that can be used to optimize assessment of new infection control regulations. While this does not specifically include dialysis, dialysis long-term catheter infections will likely surface in this study.

National Healthcare Safety Network (NHSN)

NHSN Enrollment and Reporting Decision Tree

ALL Dialysis Facilities (In-center, Home)

Is your facility enrolled in NHSN?

NO

Steps to Enroll your facility in NHSN, Set-up, Join the Network 14 group and Confer Rights
- Enrollment Checklist: In-center facility
- Enrollment Checklist: Home only facility
- Enrollment Instructions
- Set-up
- Join Network 14 group and confer rights
  (Group ID: 21949 and password: esrd+)
  *See Footnotes*

YES

Activate Components & Begin Reporting

What modalities does your facility offer?

In-Center only Facility

Begin reporting according to the HCP Influenza vaccination Summary Protocol

Home Only facility

In-center and Home Facility

Begin reporting according to both Dialysis Component and HPS component

FOOTNOTE:
1) If your facility does not share a CCN with any In-center Outpatient Hemodialysis facility (i.e. Home Only Facility), then enroll your facility in NHSN and activate the HPS Component and report HCP Influenza vaccination data only.
2) If your home HD/PD facility shares a CCN with an In-center Outpatient Hemodialysis facility that is already enrolled in NHSN, do not enroll your home HD/PD facility separately. Instead report your HCP Influenza vaccination data along with the in-center facility's HCP Influenza vaccination data.
Annual Disaster Plan Checklist

√ **Disaster plan.** Does your facility have an updated and current disaster plan for both medical and non-medical emergencies?

√ **Staff training.** Is your staff being oriented to disaster plan annually? There should be written procedures in place for all hazards and staff must demonstrate the ability to follow and use the plan, as well as emergency equipment.

√ **Facility roster.** Do you have a roster with all staff and physicians to be called in case of an emergency? The roster should be located at both the facility and at the administrator’s home.

√ **Staff assignments.** Has your facility assigned responsibilities to staff and does it maintain a list of assignments?

√ **EMResource:** Has a staff member been trained and designated to update EMResource in an emergency?

√ **Patient disaster preparedness.** Does your facility have written disaster instructions to give to all patients for obtaining emergency medical care, what to do in the case of a disaster, the emergency diet, and resources available in the event of a disaster?

√ **Preparing patients for a disaster.** Are your patients trained annually on the disaster plan?

√ **Purple wrist bands.** Have the purple wristbands been ordered for all of your patients?

√ **Drills.** Does your facility conduct periodic mock drills to ensure that patients and staff are prepared?

√ **Transfer agreements.** Does your facility have a transfer agreement with another dialysis facility and one or more local hospitals?

√ **Notify utility companies.** Does your facility maintain a list of utility providers to notify annually of utility needs in a disaster situation?

√ **Mechanical and technical support:**. Does your facility have a generator or contract and maintain a list of providers and contact information for mechanical and technical support during an emergency situation?

Every element of this disaster checklist should be documented and visible when looking through your disaster plan packet.
## ESRD Network 14 Staff Contacts

Do NOT Email Patient-specific Information. Fax Only.

<table>
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