

CMS Forms  
Compliance  
Requirements  
...page 2



Strategies to  
Increase  
Fistula Rates  
...page 3



Overview on  
Immunization  
...page 6



Hemodialysis  
Adequacy  
...page 7



Volume IV, Issue 3

# FMQAI Access

The Florida ESRD Network

## Decreasing Dialysis Patient-Provider Conflict (DPC) Tips on Cultural Awareness

America has long been called the “Melting Pot” of the world. This is truer today than ever in the general population as well as the dialysis population. Prevailing attitudes, past behaviors, customs and traditions comprise culture. Culture is learned and shared in families, in ethnic and gender groups, in geographic regions, by social class and even in universities. Behaviors that seem rude and obnoxious in one culture may be perfectly normal in another. So it is not uncommon for misunderstandings to arise between people of very different cultures. When cultural expectations of staff and patients differ significantly, conflict is likely to occur.

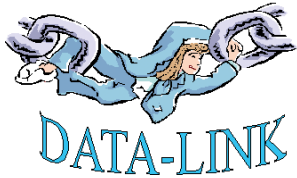
Sometimes, just enhancing sensitivity to these differences can reduce conflict. While this tip sheet cannot address the many components of Cultural Competency, highlights are provided with resources for more in-depth information that can be obtained to suit the diversity of your unit.

### Immigrants and Refugees

The reason a person came to the U.S. may be important in understanding how they will adjust to their illness and the dialysis setting. Sensitivity about immigration status may create tensions when in-depth assessments are performed. Fears of deportation or reporting may

drive refusal to provide information or raise suspicion of the staff’s asking questions. The Immigration and Naturalization Service (INS) defines the following: Immigrant - a nonresident alien admitted for permanent residence; Refugee - a person who is admitted outside of official quota restrictions based on a well founded fear of persecution because of race, religion, nationality, social group, or political opinion; Asylum-seeker - a person who comes to the U.S. applying for refugee status; Undocumented Persons - entrants who do not possess documents allowing them to legally reside in the U.S. This group is commonly referred to as “illegal aliens” or “illegals,” and people may take great offense to this term.

*(continued on page 4)*



# CMS Forms Compliance Requirements

There has been a significant drop in overall compliance rates during the last year. Network staff analyzed the compliance data from September 1, 2006 through August 31, 2007 with the following results:

For the 2728 (Medical Evidence) form, the analysis showed that 23.9% of the forms with errors were because Field 18d was not filled out completely. This is down from the rate of 33.3% it was a year ago, but is still a problem for many of you. This field reports data on the vascular access used at onset; whether there is a maturing AVF present; and if there is a maturing AVG present. Any time AVF is not the access being used for the first outpatient dialysis, it is necessary to answer both of the additional questions. The field should look like this if the patient was dialyzed using a catheter on the first treatment and has a maturing AVF:

d. What access was used on first outpatient dialysis:	<input type="checkbox"/> AVF	<input type="checkbox"/> Graft	<input checked="" type="checkbox"/> Catheter	<input type="checkbox"/> Other
If not AVF, then: Is maturing AVF present?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No		
Is Maturing graft present?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		

Another 13.9% (down from 19.3%) of the errors are for failing to fully complete Field 23. This is the field indicating the primary type of dialysis. When hemodialysis is selected it is required to indicate the number of sessions per week and the number of hours per session. When correctly completed the field should look something like this:

23. Primary Type of Dialysis
<input checked="" type="checkbox"/> Hemodialysis (Sessions per week <u>3</u> /hours per session <u>4</u> )
<input type="checkbox"/> CAPD <input type="checkbox"/> CCPD <input type="checkbox"/> Other

Two fields have seen an increase in the percent of errors over the last year. Surprisingly, Height and/or Dry Weight were omitted or incomplete on 11.8% and 11.9% of forms with errors, respectively. Both of these are required for every patient.

13. Height
INCHES _____ OR
CENTIMETERS _____

14. Weight
POUNDS _____ OR
KILOGRAMS _____

On the 2746 (Death Notification) form the most problematic area was the section regarding discontinuation of Renal Replacement Therapy. It is required that either Yes or No be checked for every form. If Yes is checked, you must indicate both the reason AND the last treatment date.

13. Renal replacement therapy discontinued prior to death	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, check one of the following:		
a	<input type="checkbox"/> Following HD and/or PD access failure	
b	<input type="checkbox"/> Following transplant failure	
c	<input type="checkbox"/> Following chronic failure to thrive	
d	<input type="checkbox"/> Following acute medical complication	
e	<input type="checkbox"/> Other	
f	<input type="checkbox"/> Date of last dialysis treatment	__ / __ / ____
		Month Day Year

As many of you have become aware, CMS has very strict requirements for submitting Medical Evidence (2728) and Death Notification (2746) forms in a timely and accurate manner. Any units falling below the 90% average annual compliance level are reported to CMS.

## 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 on the keyword ESRD.



# FISTULA FIRST

**MAKE A DIFFERENCE!**  
*Adopt Fistula First Change  
 Concepts and Tools.*  
[www.fmqai.com/ESRD/FistulaFirst/FFT/](http://www.fmqai.com/ESRD/FistulaFirst/FFT/)

## Proven Strategies to Increase Fistula Rates

Use this self-assessment guide to rate your facility's use of strategies designed to increase fistula rates

Does Your Facility . . .	✓
Have an assigned staff member responsible for monitoring facility vascular access (VA) outcomes?	
In collaboration with physician, evaluate all non-AVF accesses as part of the CQI process?	
In collaboration with physician, develop and document AVF plans for all potentially eligible patients?	
Trend vascular placement, by surgeon, monthly in QA?	
Evaluate the status of permanent vascular access placement plans within the first <u>three</u> treatments for new patients admitted with a “catheter only” and document findings?	
In collaboration with your physician, routinely evaluate all AVGs (prior to clotting episodes) for possible <u>secondary AVF</u> conversion and document findings?	
Refer to surgeons that are supportive and skilled in placing secondary AVFs?	
In collaboration with physician, refer patients for vessel mapping (if not already performed) to assist surgeon with access type placement evaluation?	
In collaboration with physician, select surgeons based on willingness, skill and outcomes with AVF's?	
In collaboration with physician, indicate in writing on all vascular access surgical referrals that the <u>preferred</u> permanent access type is an “AVF Only”?	
Provide written vascular access history information to surgeons / radiologists when patients are referred for evaluation?	
Discuss specific criteria with interventional radiologists / interventional nephrologists and surgeons for determining allowable degree of intervention before a new access should be considered?	
Request written post-surgical information from surgeon / radiologist – type / results of VA interventions, a description/drawing of access location, direction of blood flow & care instructions?	
Refer to surgeons who are willing to receive and track data on their vascular access rates and outcomes?	
In collaboration with physician, refer all AVFs with “failure to mature” at <u>4 weeks</u> post-op to a surgeon or radiologist?	
Routinely monitor AVF and AVG flow rates/pressures for stenosis using K/DOQI recommended procedures?	
Have a vascular access management plan for each patient that facilitates timely referral for complications?	
Provide routine in-services for staff on AVF cannulation techniques?	
Require that personnel use specific protocols during initial treatments for patients who have a new AVF? (e.g. needle size, BFR, tourniquet use)?	
Assign the most skilled staff to patients who have a new AVF?	
Offer the option of self-cannulation to patients willing to pursue this option?	
Have a procedure for treating VA infiltrations that includes written patient instructions?	

## DPC Tips on Cultural Awareness ...continued from page 1

### **Ethnic and Racial Groups**

Sometimes these two terms are confused, creating misunderstandings. Race was originally about biological differences. The most common races were Caucasian, African-American, and Mongoloid. Because there has been extensive racial mixing, there are now many more categories, and the biological differences are not as distinct. In a discussion about cultural differences, race has an impact mainly because of sensitivities and perceptions about racism, which is defined as “an oppressive system of racial relations, justified by ideology, in which one racial group benefits from dominating another.” (Krieger, et al 1993). Being called racist is very offensive, perhaps more so when a patient makes that accusation of the caregiver. Of course the feeling of being discriminated against because of race can create serious distrust that will undermine the caregiver-patient relationship.

Ethnicity relates to the grouping of people by social, cultural, and political characteristics. This may be based on ancestry, language or religion for instance. People may differ in how closely they relate to their ethnic group. Patients within the same culture may differ. These differences may be observed in each succeeding generation from the original immigrants, or even when religions modernize.

### **Social Class and Socioeconomic Status**

Social class and economic status are related to income, education, occupation and even geographic region. This factor may be more important in health status than any other. For a chronically ill person, economic status may well determine many quality of life issues (i.e. how well a patient will be able to adhere to the prescribed dialysis regime due to transportation issues, financial ability to purchase medications, and most certainly, diet). Staff or other patients that have never faced these challenges may not be able to comprehend why others simply will not do what the doctor says.

### **Sexual Orientation**

Several high profile cases of violence to homosexuals and the debate about gay marriage highlight the many societal differences that we all face. Matters of sexual orientation cross all racial and ethnic groups. This is a good example of how geography can impact cultural acceptance or

stigmatism of different groups; inner city San Francisco is very accepting of the gay lifestyle in contrast to a rural middle American city.

### **Areas of Common Cultural Differences**

**Conversational Style:** We have all interacted with people who seem abrupt, almost rude in their conversational style, and when we get to know them, we realize that nothing negative was intended; it is just their “way.” Initially, however, these differences can be very upsetting, especially if coupled with other cultural differences. In certain cultures silence may indicate respect, while in others it may mean “no” and in another culture it may be perceived as giving “the silent treatment.” Some cultures use loud voices for emphasis while others only raise their voice in anger. Conflicts that arise from conversational style differences may escalate quickly unless the caregiver can follow the conflict resolution steps like creating a calm environment and using a non judgmental approach until understanding can be reached.

**Personal Space:** Most people have had the experience of having a person get too close for comfort. Commonly this behavior is not malevolent, rather it just a difference in culture about personal space. Often there are differences in generations concerning personal space, with older persons being more sensitive. These differences are heightened in the dialysis environment with staff leaning over patients, sometimes touching them in a personal area, for instance high on the inner arm or the thigh or assisting a patient that is unsteady to the scale. Care should be taken to ensure that staff is sensitive to these differences.

**Eye Contact:** Perception of eye contact varies dramatically between cultures. While direct eye contact is presumptuous and rude to some, avoiding it is suspicious behavior to others. There are important cultural differences regarding eye contact between men and women and young and old that may be easily misinterpreted as negative personality characteristics.

**Touch:** It may seem obvious to some that touching is a particularly sensitive area; however, as caregivers we may forget how easily upset persons of particular cultures or religions may be regarding touching. There are prohibitions in some cultures regarding touching one

part of the body before the other. Touching the genitals or discussing a sexual issue may be taboo in many cultures.

**Time Orientation:** Time perception varies between people of the same family. These perceptions are magnified between cultures. While one person is tapping his/her foot waiting for the another person that is only two minutes late, someone else may not even notice that another is late until a half hour has passed. Matters regarding time can disrupt the dialysis facility schedule and create tremendous conflict. Time orientation problems must be recognized and addressed early on.

### Conclusion

Sometimes we all just need to be reminded of these differences and nudged to understand that the way we perceive certain behaviors and actions may be very different to the way others perceive them. This tip sheet can be handed out to staff, or it can be discussed in an open meeting. It is highly recommended that some research be done into cultures of patients whose cultures are very different from the culture of the staff, and then have discussions about those differences. If conflicts arise that may be related to cultural differences, suggest this as a possibility to staff and then ask the Social Worker or another staff member to do some research using the following resources.

### References

Lipson, J. G., Dibble, S. L. and Minarik, P.A. (1996). *Culture & Nursing Care: A Pocket Guide*. San Francisco: UCSF Nursing Press.

Office of Minority Health, Health Resources and Services Administration. *Cultural Competence in Cancer*

*Care: A Health Care Professionals Passport.*

Salimbene, S. (2000). What Language Does Your Patient Hurt In?: A Practical Guide to Caring for Patients from Other Cultures. *Inter-Face International*. Available at <http://www.inter-faceinter.com>.

Spector, RE. (2000). *Cultural Diversity in Health and Illness*. 5th ed.

### Websites

**Health Resources & Services Administration** <http://erc.msh.org/mainpage.cfm?file=5.4.0.htm&module=provider&language=English>.

This site has sections on the following cultural groups: African Americans, Arab Americans, Asian Americans, Central Asians, Hispanics/Latinos, Muslims, Native Americans, Pacific Islanders, South Asians.

**Trans-cultural Nursing: Basic Concepts and Case Studies** <http://www.culturediversity.org/mide.htm>.

This site offers information on treating patients of the Islamic faith, using real-life examples to illustrate key points.

### Institute of Druze Studies

<http://www.druzestudies.org/druzes.html>.

This site provides a background and demographics of the Druze minority in the Middle East.

### Harborview Medical Center

<http://ethnomed.org/ethnomed/cultures>.

This site provides a cultural profile on the Ethiopian, Eritrean and Somali people.

Source: The Forum of ESRD Networks' website at: [www.esrdnetworks.org](http://www.esrdnetworks.org)

## FREE CEU OFFERING – Water Treatment for Dialysis

Complete this on-line continuing education course & receive 1 FREE CEU!



### Course Objectives:

- State why water needs to be properly treated prior to use in hemodialysis applications
- Identify four different water treatment system components
- List the three stages of water treatment
- Match four treatment actions to their component and stage of water treatment

Access the water treatment course at

<http://learning5.flqio.org/course/category.php?id=7>

Water Treatment for Dialysis

# Q

## Quality Corner

### Overview on Immunizations

Approximately 50,000 adults die each year from vaccine-preventable diseases in the U.S. Pneumonia and influenza are the fifth leading cause of death in older adults in the U.S. According to the Centers for Disease Control and Prevention (CDC), 1.25 million people are infected with the hepatitis B virus, which attacks the liver and can cause liver cancer, liver failure and death.

#### General Facts:

- **Influenza**, also called the “flu,” is a contagious respiratory illness caused by influenza viruses. There are over 200,000 hospitalizations from influenza on average every year. An average of 36,000 Americans die annually due to influenza and its complications – most are people 65 years of age and over. The best way to prevent the flu is to get vaccinated each year during the fall season. Because flu viruses change from year to year, it is important to get a flu shot each year. Medicare pays for the influenza immunization or “flu shot.”
- **Pneumococcal pneumonia** is the most common type of bacterial pneumonia. There are over 40,000 cases of invasive pneumococcal disease in the U.S. and approximately one-third of these cases occur in people 65 and older. Over half of the more than 5,000 annual deaths from invasive pneumococcal disease occur in persons 65 years of age and older. Medicare covers one pneumococcal vaccination for all Medicare beneficiaries. One vaccine at age 65

generally provides coverage for a lifetime, but for some high-risk persons, a booster vaccine is needed. Medicare will also cover a booster vaccine for high-risk persons, if 5 years have passed since their last vaccination.

- **Hepatitis B** virus can cause serious liver disease, including cirrhosis, liver cancer, liver failure and death. The virus is found in the blood and body fluids of infected people and can be spread through sexual contact or the sharing of needles. The hepatitis B vaccination can protect high-risk persons, such as people with renal disease or hemophilia, from contracting the disease. The vaccine is delivered in a series of 3 shots. Medicare pays for hepatitis B vaccination for people considered to be at high risk for the disease.

Source: Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/AdultImmunizations/>

Newsletter  
Submittals

### TELL US WHAT YOU'RE DOING!

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](mailto:cwoodward@nw7.esrd.net)



## 2006 NKF K/DOQI Clinical Practice Guidelines for Hemodialysis Adequacy

*When dialysis adequacy is assessed by using pre-dialysis and post-dialysis BUN measurements, blood samples should be drawn by using certain acceptable procedures.*

- ✓ Both samples (pre-dialysis and post-dialysis) should be drawn during the same treatment session.
- ✓ The risk of underestimating pre-dialysis BUN level because of saline dilution or by sampling blood after treatment has begun should be avoided.
- ✓ The risk of underestimating the post-dialysis BUN level because of access recirculation (AR) should be avoided by first slowing the blood flow through the dialyzer to a rate at which AR is expected to be minimal (100 ml/min) for a period long enough to ensure that unrecirculated blood has advanced to below the sampling port (usually 15 seconds).
- ✓ An alternative method is to stop the dialysate flow for a period long enough to increase the dialysate outlet BUN level close to that of the blood inlet BUN level (3 minutes) before obtaining the post-dialysis sample.

### *Recommended Pre-Dialysis Blood-Drawing Procedure*

#### **When using an AV fistula or graft**

- ✓ Obtain the blood specimen from the arterial needle prior to connecting the arterial blood tubing or flushing the needle. Be sure that no saline and/or heparin is in the arterial needle and tubing prior to drawing the sample for BUN measurement.
- ✓ Do not draw a sample for use as a pre-dialysis measure of BUN if HD has been initiated.

#### **When using a venous catheter**

- ✓ Using sterile technique, using a 5 ml syringe, withdraw any heparin and saline from the arterial port of the catheter, along with blood, to a total volume of 5 ml. Discard the contents of this syringe.
- ✓ Connect a new syringe or collection device and draw the sample for BUN measurement.
- ✓ Complete the initiation of HD per dialysis clinic protocol.

### *Slow-Blood-Flow Method for Obtaining the Post-Dialysis Sample*

- ✓ At the completion of HD, turn off the dialysate flow and decrease the UFR to 50 ml/hr, to the lowest TMP/UFR setting, or off. If the dialysis machine does not allow for turning off the dialysate flow, or if doing so violates clinic policy, decrease the dialysate flow to its minimum setting.
- ✓ Decrease the blood flow to 100 ml/min for 15 seconds (longer if the bloodline volume to the sampling port exceeds 15 ml). To prevent pump shut-off as the blood flow rate is reduced, it may be necessary to manually adjust the venous pressure limits downward. At this point, proceed to obtain your sample. You can either shut off the blood pump before sampling, or leave it running at 100 ml/min while the sample is being drawn.
- ✓ After the sample has been obtained, stop the blood pump (if not already stopped) and complete the patient disconnection procedure as per dialysis clinic protocol.

Please visit <http://www.kidney.org/professionals/KDOQI/>  
for a complete set of Clinical Practice Guidelines.



---

## FROM THE PROJECT DIRECTOR

---

Over the last several years, Network 7 has been working to increase the Standardized Transplantation Ratio in Florida. In an effort to increase the number of transplant referrals in the state, FMQAI: The Florida ESRD Network and the National Kidney Foundation of Florida, held a Transplant Liaison Summit on June 19<sup>th</sup> in Tampa. The goals of this program were to maximize synergies between dialysis facilities, the transplant team and the Network; enhance provider community involvement in achieving Network goals; assure the evaluation for transplant medical suitability of all patients at the initiation of ESRD treatment or during the pre-end stage evaluation; identify and define the role of the Transplant Liaison and implement learned process to enhance renal transplant referrals in the state of Florida.

In collaboration with Transplant Centers and Organ Procurement Organizations, an exciting program was provided to more than 100 renal professionals. Presentations regarding referral, evaluation, waitlist, and living donation, among others, were key to teaching dialysis staff about kidney transplantation and how their patients can utilize this modality for ESRD care. Another important take-away point from the Summit was the role of the Transplant Liaison. The Network encourages each dialysis facility to identify a Liaison with responsibilities that include:

- ✓ Facilitate communication between patient, nephrologist and transplant team,
- ✓ Understand the transplant center's selection criteria and referral process,
- ✓ Assure transplant candidacy evaluation at initiation of treatment and annually,
- ✓ Refer all potential candidates to a transplant center, in conjunction with the physician and patient care team,
- ✓ Provide patients with information on transplant options to include living and deceased donations,
- ✓ Follow-up with monthly labs and annual immunizations, and
- ✓ Reinforce the need for patient to maintain overall wellness, and provide these updates to the transplant center.

CMS has made improving the rehabilitation and independence of ESRD patients a significant goal for the Networks. The Network believes that the 2007 Transplant Liaison Summit and implementation of a Transplant Liaison at each facility is a great way to continue moving toward reaching the goal, which will improve patient quality of life.

As always, the Network values your dedication and passion for serving Florida's kidney patients.

*Kelly M. Mayo, MS*

# Flu Vaccine

## Facts & Myths



Department of Health  
and Human Services

Centers for Disease Control  
and Prevention

**MYTH** “The flu isn’t a serious disease.”

**FACTS** Influenza (flu) is a serious disease of the nose, throat, and lungs, and it can lead to pneumonia. Each year about 200,000 people in the U.S. are hospitalized and about 36,000 people die because of the flu. Most who die are 65 years and older. But small children less than 2 years old are as likely as those over 65 to have to go to the hospital because of the flu.

**MYTH** “The flu shot can cause the flu.”

**FACTS** The flu shot cannot cause the flu. Some people get a little soreness or redness where they get the shot. It goes away in a day or two. Serious problems from the flu shot are very rare.

**MYTH** “The flu shot does not work.”

**FACTS** Most of the time the flu shot will prevent the flu. In scientific studies, the effectiveness of the flu shot has ranged from 70% to 90% when there is a good match between circulating viruses and those in the vaccine. **Getting the vaccine is your best protection against this disease.**

**MYTH** “The side effects are worse than the flu.”

**FACTS** The worst side effect you’re likely to get from a shot is a sore arm. The nasal mist flu vaccine might cause nasal congestion, runny nose, sore throat and cough. The risk of a severe allergic reaction is less than 1 in 4 million.

**MYTH** “Only older people need a flu vaccine.”

**FACTS** Adults and children with conditions like asthma, diabetes, heart disease, and kidney disease **need to get a flu shot**. Doctors also recommend children 6 months and older get a flu shot every year until their 5th birthday.

**MYTH** “You must get the flu vaccine before December.”

**FACTS** Flu vaccine can be given before or during the flu season. The best time to get vaccinated is October or November. **But you can get vaccinated in December or later.**

For more information, ask your healthcare provider or call  
**800-CDC-INFO (800-232-4636)** Website [www.cdc.gov/flu](http://www.cdc.gov/flu)

## September is National Preparedness Month

The Florida Kidney Disaster Coalition has joined forces with the National Preparedness Month Coalition to encourage preparedness activities and to support and disseminate preparedness information.

National Preparedness Month is a nationwide effort to encourage Americans to take simple steps to prepare for emergencies in their homes, businesses and schools. Throughout September, the U.S. Department of Homeland Security (DHS) works with a wide variety of organizations to highlight the importance of emergency preparedness and promote individual involvement through events and activities across the nation.

The goal of National Preparedness Month is to increase public awareness about the importance of preparing for emergencies and to encourage individuals to take action. We should all take simple steps to prepare ourselves and families for emergencies, including getting a family emergency supply kit, making a family emergency plan, being informed about different threats and getting involved in preparing their communities.

As a dialysis or transplant provider in Florida, there is no doubt you play a crucial role in disaster preparedness of your staff, patients, and your facility. You may be called upon to work longer hours or in stressful situations to care for your patients. Because emergencies affect each person differently, it is important to understand the basics of mental health in disasters. It is normal to feel anxious, sad, or angry. To cope with disasters, you must focus on your strengths and be able to ask for and accept help.

Even if a person's home is not destroyed, and they or their family and friends were not injured by disaster, they are still at risk from the negative mental health impacts of disasters. When adults have the following signs, they might need crisis counseling or stress management assistance:

- Difficulty communicating thoughts.
- Difficulty sleeping.
- Difficulty maintaining balance in their lives.
- Low threshold of frustration.
- Increased use of drugs/alcohol.
- Limited attention span.
- Poor work performance.
- Headaches/stomach problems.
- Tunnel vision/muffled hearing.
- Colds or flu-like symptoms.
- Disorientation or confusion.
- Difficulty concentrating.
- Reluctance to leave home.
- Depression, sadness.
- Feelings of hopelessness.
- Mood-swings and easy bouts of crying.
- Overwhelming guilt and self-doubt.
- Fear of crowds, strangers, or being alone.

Most importantly, you must be able to recognize that you or a loved one needs help. The following are ways to ease disaster-related stress:

- Talk with someone about your feelings - anger, sorrow and other emotions - even though it may be difficult.
- Seek help from professional counselors who deal with post-disaster stress.
- Do not hold yourself responsible for the disastrous event or be frustrated because you feel you cannot help directly in the rescue work.
- Take steps to promote your own physical and emotional healing by healthy eating, rest, exercise, relaxation and meditation.
- Maintain a normal family and daily routine, limiting demanding responsibilities on yourself and your family.
- Spend time with family and friends.
- Participate in memorials.
- Use existing support groups of family, friends and religious institutions.
- Ensure you are ready for future events by re-stocking your disaster supplies kits and updating your family disaster plan.

# DID YOU KNOW???

*The ESRD Network of Florida is Available to Provide Technical Assistance!*

## **Quality Improvement**

- Assist, facilitate, educate and clarify CMS QI Projects for facilities as they implement the projects.
- Assist with the development/implementation of CQI Projects in facilities.
- Assist, clarify, educate on completion of QI related forms (CPM, CDC, etc.)
- Encourage the development of emergency preparedness policies & procedures at the facility level (to include a backup plan).
- Available to review Corrective Action Plans for completeness/accuracy before facilities submit them to AHCA.
- Available to educate on the Conditions of Coverage and its interpretation as well as the Network's Criteria & Standards.

## **Information Systems**

- Assist, educate, facilitate and clarify information for the completion of CMS Forms (2728, 2746, 2744, Patient Activity Report).
- Assist, facilitate, educate on reports sent to facilities from the Network (Missing Forms Report, Vocational Rehabilitation Survey, Compliance Report, etc.)
- Assist with data requests from facilities, insurance providers.
- Supply facilities, by request, with 2746 forms.

## **Patient Services**

- Assist, clarify and educate on grievance procedure & due process.
- Mediate between patients & facilities via telephone.
- Assist with the provision of community resource information and materials as available.
- Develop and host patient education workshops throughout the state.
- Provide Vocational Rehabilitation and emergency preparedness information to facilities and patients.
- Assist patients to locate facilities when traveling or as needed (we can not force a facility to accept a patient, just identify the ones available in the area).
- Maintain an 800 # for patient use throughout the state of Florida.
- *Accept collect calls from patients only.*

## **Administrative**

- Assist, clarify and educate facilities with CMS requirements.
- Communicate changes in CMS that will impact facilities via Fax Blast, e-mail (where available), informational mass mailings, workshops/professional meetings and Annual Meeting.
- Represent the needs of our community to CMS.
- Develop partnerships with organizations to address quality as an outcome in ESRD.
- Facilitate involvement in Network boards and activities from all aspects of the ESRD community.
- Involve the community proactively in the improvement of care in the State of Florida.
- Communicate with facilities on the status of the Network and its activities.

Contact the Network at (813) 383-1530 or [info@nw7.esrd.net](mailto:info@nw7.esrd.net)



**FMQAI: The Florida ESRD Network**  
5201 West Kennedy Boulevard  
Suite 900  
Tampa, Florida 33609

**ACCESS**

**ACCESS**

is written, designed and distributed by FMQAI: The Florida ESRD Network.

This newsletter is published while under contract with the Centers for Medicare and Medicaid Services, Baltimore, Maryland  
Contract #  
HHSM-500-2006-NW007C

FMQAI: The Florida ESRD *Presents...*  
**2007 ANNUAL FORUM**

**KIDNEYOPOLY**

**“Meeting the Challenge of Continuous Improvement in ESRD”**

November 14-16, 2007

HILTON St. Petersburg Bayfront  
333-1st Street South  
St. Petersburg, FL 33701

**GO**