Facility Representative Quarterly Report to the Network

Email (akaranja@nw12.esrd.net) or fax (816-880-9088) the completed form to the Network quarterly.
Due Dates: April 15th, July 15th, October 15th and January 15th

Facility Medicare Provider #:_____ Date: _____

Report Quarter (circle): Jan-Mar Apr-Jun Jul-Sept Oct-Dec Year: _____

Facility Representative: _____ Phone: _____

Medical Director Signature: _____

Instructions:
Please complete the series of questions below and fax or email it back to the Network by the required date.
Example: the April - June report is due by July 15th.

"Yes" answers signify that the facility is meeting this requirement, and "no" answers signify that the facility is not meeting Network goals. ***If the answer to any question is "no," please provide a detailed explanation and contact the Network for technical assistance.** You may attach documents and "blind" proprietary materials as necessary. Your answers should be an accurate attestation of the facility current conditions.

The Heartland Kidney Network offers technical assistance and resources to all CMS certified facilities to assist in achieving your clinical outcomes and facility goals. Please contact the Network office at 816-880-9990 or visit our website, www.heartlandkidney.org, for copies of this form, information, and other resources.

The Seventeen Network Best Practices

1. Is your the facility meeting the **Network/CMS AVF goal** of 66%? Yes ___ No*___	2. Is your facility meeting the **Network/CMS catheter goal** of ≤10%? Yes ___ No*___
1a. List your **facility's AVF %** _____ % (As of the last day of March, June, September, or December).	2a. List your **facility's catheter %** (>90 days) _____ % (As of the last day of March, June, September, or December).
3. If not meeting one or both of these vascular access goals, do you have a **corrective action plan (CAP)** in place? Please note the Network may request a copy of the CAP. Yes ___ *No ___	

4. My facility is survey-ready and adhering to the **Conditions for Coverage.** Yes ___ *No ___
5. My facility has a **comprehensive emergency plan** specific to **emergencies/disasters** that could affect my geographical area. Yes ___ *No ___
5a. When were your last emergency drills was conducted? (Date(s):_____)
6. My facility has contacted the **local emergency management agency**. (Documented) Yes ___ *No ___
7. Your facility is participating in **Network Emergency Council activities**. Yes ___ *No ___
8. The facility uses **Quality Assessment and Performance Improvement** (QAPI) to assure our achievement of Network/CMS performance goals. Yes ___ *No ___
9. Your facility identifies performance opportunities and challenges using **root cause analysis**. Yes ___ *No ___
10. Your **Network contact poster** with telephone number is currently on display in public view. Yes ___ *No ___
11. Your Network **patient educational materials** were distributed to all of the patients. Yes ___ *No ___
12. Your facility is using **patient/provider conflict resolution** (DPC) resources. Yes ___ *No ___
13. Your Network patient **rights and responsibility poster** is currently on display in public view. Yes ___ *No ___
14. Your Network **Facility educational materials** were distributed to the staff members. Yes ___ *No ___
15. Your facility is following the **Network Annual Facility Scorecard** suggestions. Yes ___ *No ___
16. Your facility has completed all requirements for **CROWNWeb** implementation. Yes ___ *No ___
17. Your facility has a **signed affiliation agreement** with the Network. Yes ___ *No ___

Thank You!