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## Heartland Kidney Network Network Patient Representative (NPR) Application

### Overview

Heartland Kidney Network's Patient Advisory Committee (PAC) developed the Network Patient Representative (NPR) program to help spread educational information to patients and provide them with additional support by a fellow patient in their dialysis clinic. The Network's NPR program is made up of NPRs from across Iowa, Kansas, Missouri, and Nebraska. NPRs are individuals that are on dialysis or have had a kidney transplant. They volunteer at their dialysis clinic working with staff to help improve the patient experience, share patient education, and represent the patient voice. NPRs can also serve as peer mentors to fellow patients by sharing their experiences and providing support and encouragement. NPRs are role models in their clinic because of their positive outlook and their desire to learn as much about their kidney disease and treatment as they can to improve their quality of life.

### Membership expectations and responsibilities:

It is really up to the NPR how involved they want to get, but at minimum we ask that NPRs do the following:

- Share educational materials from the Network and their clinic with other patients (such as posting info on a bulletin board)
- Work with your facility on patient engagement activities and Network projects
- Be available to give support to new and current patients by phone, email, or in-person
- Join the NPR Connection Calls to receive Network updates and to discuss ideas with other NPRs
- Refer patients with questions or concerns to appropriate clinic staff (avoid giving medical advice)

### Additional activities that NPRs are doing to serve their dialysis clinics and the Network:

NPRs do all sorts of things at their clinic depending on how much time and interest they have. You can get creative but here are some examples:

- Maintain the patient bulletin board with announcements, education, and recipes
- Work with their social worker to welcome new patients
- Organize patient social gatherings and/or outings
- Write articles for the clinic's monthly newsletter
- Talk with new patients or other patients that are having a difficult time with dialysis
- Helping staff plan fun activities at the clinic
- Assisting clinic staff with implementing network quality improvement projects and providing the patient perspective to improve care
- Serving as a Patient Subject Matter Expert as a Network 12 representative on a national level

To apply: please complete the Patient Subject Matter Expert Application Forms (page 1 and 4) and the Supplemental Information forms (Part 2 and 3) with the assistance of a facility staff representative.

# Patient Subject Matter Expert Application Form

Please complete the following information for consideration to participate on the Network Patient Advisory Council (PAC) and/or as a **Network Patient Subject Matter Expert**.

<b>About You</b>	
I am (check one):	<input type="checkbox"/> Patient <input type="checkbox"/> Family/Caregiver <input type="checkbox"/> Stakeholder
Name (First, Last)	
Address	
City, State, Zip	
Primary Phone	
Email Address	
I identify as:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other
Ethnicity: I identify myself as	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic or Latino
I mainly speak:	<input type="checkbox"/> English <input type="checkbox"/> Spanish Other: _____
<b>About Your ESRD Experience</b>	
Dialysis Facility Name	
Dialysis Facility Phone Number	
Name of Referring Staff Member (must be included if staff member is referring candidate)	
Number of Years as a Dialysis Patient	
Current Treatment Type: (check one)	<input type="checkbox"/> In-Center Hemodialysis: M/W/F or T/T/S <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant, if yes, number of years as a transplant recipient _____
Previous Treatment Types: (check all that apply)	<input type="checkbox"/> In-Center Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant
Are you on a transplant waitlist? (circle one)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Connecting With You</b>	
Preferred Method of Contact	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Mail
How often do you check your email (check one):	<input type="checkbox"/> daily <input type="checkbox"/> 2-3 times/week <input type="checkbox"/> only when expecting important messages <input type="checkbox"/> don't have email
Are you able to travel out of state for face- to-face meetings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you able to attend 2 or more meetings by phone per year?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART 2: Background and Interests** (please print clearly).

Help Heartland Kidney Network get to know you and tell us a little about yourself:

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Why are you interested in becoming an NPR for your dialysis clinic?

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What are you looking forward to doing the most with your new role as NPR?

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Are you interested in serving as a Patient “Subject Matter Expert” for the Network or at a National level?

Yes  No

Please mark at least one topic are you interested in helping the Network to improve:

- |  |   |
|--|---|
| <input type="checkbox"/> Emergency Preparedness  | <input type="checkbox"/> Home Dialysis      |
| <input type="checkbox"/> Transplant Coordination | <input type="checkbox"/> Mental Health      |
| <input type="checkbox"/> Patient Safety          | <input type="checkbox"/> Patient Engagement |

Thank you for completing your portion of the NPR application. Now ask a staff member at the dialysis facility/transplant center if they would provide a recommendation for you to serve as a NPR and complete Part 3 of the application and include their signature on the PSME Application Form before submitting it by fax.

**PART 3: Staff Recommendation (please print clearly)**

Heartland Kidney Network would like for dialysis/transplant facility staff to help us get to know the patient/family member applying to serve on as a Network Patient Representative. Please complete the information below if you believe your patient would be a good candidate for this role.

Patient Name						
<b>Dialysis Facility or Transplant Center Information</b>						
Facility name				Medicare Provider Number (6-digit #)		
Address						
City			State			
				Zip		
Phone			Fax			
<b>Facility Staff Coordinator Contact Information</b>						
Name				Title		
Phone			Email			

Why do you think your patient nominee would make a good Network Patient Representative (NPR) for your clinic? \_\_\_\_\_

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By nominating (insert patient nominee) \_\_\_\_\_, I agree to encourage their involvement at our clinic and support their efforts to improve the patient experience. I will also be the Facility Staff Coordinator for the Network regarding the NPR Program at our clinic.

Thank you for your recommendation and commitment to work with the NPR program.

**Please sign the staff signature on page 4 and return the completed application to the Network via fax at (816) 880-9088.** For questions, you may contact the Network at 816-880-9990.

# Patient Subject Matter Expert Application Form

Please complete the following information for consideration to participate on the Network Patient Advisory Council (PAC) and/or as a **Network Patient Subject Matter Expert**.

**Please read the following statements (*all must be checked to be considered*):**

- I have read the PAC member or **Network Patient Representative** responsibilities and participation/membership policy and agree to fulfill them to the best of my ability.
- I authorize the Network 12 and my dialysis center (*if applicable*) to utilize my name and email address for specific PAC and **SME** communications.
- I further authorize my Network to use my name where necessary in PAC and **SME** meeting minutes and in listing PAC and **SME** members in reports to the Centers for Medicare and Medicaid Services (CMS) and other business documentation.

**Applicant Signature** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Staff Signature (if Applicable):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Submit completed form to Heartland Kidney Network (Network 12). You may fax it to 816-880-9088 or mail it to 920 Main, Suite 801, Kansas City, Missouri 64105. If you have any questions, please contact us at 800-444-9965.

**(Note: If we receive more applications than there are available slots, we may refer to your application at a later date, if additional SME participants are needed.)**