End-Stage Renal Disease Network of the South Atlantic
909 Aviation Parkway, Suite 300
Morrisville, NC 27560
phone: (919) 463-4500
patient toll-free: (800) 524-7139
fax: (919) 388-9637
esrd.ipro.org

Would you like to help?

The Patient Advisory Committee (PAC) is an organization of patients and/or family members who volunteer their time to represent the Network in their dialysis or transplant unit, as well as representing their unit to the Network. The IPRO ESRD Network has a dedicated PAC that works to support the unique needs of the Network service area. These individuals are interested in improving the quality of life of renal patients and are willing to exchange information and ideas with patients and staff members. The three tiers of PAC membership offer opportunities for patients/family members/care partners to participate at a level at which they feel most comfortable.

Tier 1: PAC Members are individuals who are interested in learning about becoming better advocates for their care. This level of involvement is ideal for those who are interested receiving updates from the Network about educational seminars and learning more about ESRD. We encourage our PAC Members to:

- Take an active role in their healthcare team
- Educate themselves about renal disease and their treatment options
- Become familiar with the role of the ESRD Network
- Share this new information with family and friends
- Attend webinars and educational sessions held by the Network and other partner agencies

Tier 2: PAC Facility Representatives provide a link between the patients, the Network, and their facility staff promoting communication and sharing the patient perspective. They will act as an active part of the healthcare team within their facility by:

- Encourage fellow patients to be involved in their healthcare
- Share with fellow patients information provided by the ESRD Network and Facility
- Participate in your facility quality improvement initiatives and provide information to the quality team on your work with other patients. For example: contribute to the facility monthly QAPI meeting, partner with the facility social worker in the creation of support groups at the facility; contributes feedback on that support care planning activities.
- Collect and provide the Facility and Network with ideas and suggestions from other patients
- Assist the facility in developing support groups for education and adjustment to dialysis
- Attend webinars and educational sessions held by the Network and our partner agencies
- Participate in local or national committees focused on Quality Improvement Activities
- *Must be nominated by your Dialysis Facility*

Tier 3: PAC Advisors function at a variety of levels working at their facility level as well as on national patient groups, on the Network Board, or may advise other PAC Facility Representatives and PAC Members:

- Participate and provide a patient perspective in the Network board meetings or other Network supported meetings.
- Act as a subject matter expert working on national Quality Improvement Projects identified by CMS.
- Advise PAC Facility Representatives in their role and offer support.
- Coordinate regional conference calls to assist other PAC Facility Representatives

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with attention to: Patient Services Department

Patient Advisory Committee (PAC) Application Form

Please complete the following information to participate on the Network Patient Advisory Council (PAC)

About You			
I am (check one):	____Patient ____Family/Caregiver____Stakeholder		
I would like to participate in the role of (check one)	____ Member _____Facility Representative (must be nominated by facility)		
Name (First, Last)			
Address			
City, State, Zip			
Primary Phone		I agree to receive Text Messages ____Yes ____ No	
Cell Phone			
Email Address:_____	Date of Birth ____/____/_____		
I identify as:	____American Indian or Alaska Native ____Asian ____Black/African American ____Native Hawaiian or Other Pacific Islander ____White ____Other		
Ethnicity: I identify myself as	____Hispanic/Latino_____Not Hispanic or Latino		
I mainly speak:	____English	____Spanish	___Other:_____
About Your ESRD Experience			
Dialysis Facility CCN and Name			
Dialysis Facility Phone Number			
Name of Nominating Staff Member			
Nominating Staff Member Phone / Email Address			
Number of Years as a Dialysis Patient			
Current Treatment Type: (check one)	____In-Center Hemodialysis: ____M/W/F or____ T/T/S ____Peritoneal Dialysis _____Home Hemodialysis ____Caregiver/Family _____Transplant, if yes, number of years as a transplant		
Previous Treatment Types: (check all that apply)	___In-Center Hemodialysis ___Peritoneal Dialysis ____Home Hemodialysis ___Transplant		
Are you on a transplant waitlist?	____Yes ____ No		
Connecting With You			
Preferred Method of Contact	____Phone ____Email ____Mail		
How often do you check your email (check one):	____daily ____2-3 times/week ____only when expecting important messages ____don't have email		
Are you able to travel out of state for face- to-face meetings?	____Yes ____ No		
Are you able to attend 2 or more meetings by phone per year?	____Yes ____ No		

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Patient Advisory Committee (PAC)
Participation and Confidentiality Agreement

The Centers for Medicare & Medicaid Services (CMS) has contracted with the End Stage Renal Disease (ESRD) Network of the South Atlantic (Network 6) to promote education and resources to the ESRD patients and providers.

In order to support this endeavor, Network 6 maintains a PAC comprised of members, representatives and chairpersons for the purposes of lending perspective and giving feedback to the Network. The committee will be represented by peritoneal dialysis patients, hemodialysis patients, and transplant recipients, Care Partners and/or Family Members that represent all regions of Georgia, North Carolina and South Carolina. The Network's Community Outreach Coordinator will coordinate and supervise the committee.

While serving on PAC, I may have access to confidential and proprietary information, as well as protected health information (PHI). This may include information related to patients and their treatment. I must safeguard the confidentiality of PHI which is subject to Federal and State laws as well as certain privacy and security regulations pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

I understand that I must keep this information in strict confidence and can only access this confidential and proprietary information to the extent required to participate in the PAC. I will not retain such information or any copies thereof or disclose it to third parties or use it for any purpose other than the authorized function, service or activity assigned to me. I also agree that I will not now or at any time in the future, either directly or indirectly divulge, disclose, or communicate in any manner whatsoever to any person not employed or affiliated with the PAC any confidential or proprietary information that I obtain during the course of my participation without the prior written consent of ESRD Network 6.

I understand that IPRO takes its obligation to protect patient information, including my personal health information, very seriously. As an IPRO PAC member, I understand that I am also obligated to protect patient information. In the event that I breach this participation and confidentiality agreement, I understand that IPRO may terminate my participation in the PAC. I also acknowledge that IPRO has advised me that, under federal law, violations of confidentiality requirements may lead to fines from $100 per violation to $1,500,000 and up to ten years imprisonment.

I also consent to and authorize ESRD Network 6 to use my name and image on their website: esrd.ipro.org, in Network social media, in materials and other forms of communications. I understand that I will not receive any compensation for this. I give permission for my name, e-mail address and telephone number to only be given to my Regional PAC representatives, whom I serve as advisor to for direction. It is understood that the Network will not share any further information without my consent.

By signing this participation and confidentiality agreement, I agree to actively participate in the PAC as a PAC Chairperson, Member or Representative, and I agree to all of its terms and conditions.

Signature	Print Name	Date
_____	_____	_____

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