Network 4 Kick-Off Webinar

Promote Appropriate Home Dialysis Quality Improvement Activity

Quality Insights
Renal Network 4

Presented by Project Lead: Kou Kha-Moua

Overview

- Background
- 2018 Network 4 Project Selection Process
- Review of the Project
- Method on How to Improve
- Next steps

Why the effort to get ESRD patients to utilize home dialysis?

Patients who have home dialysis therapy benefit from:

- Lower risk of death
- Improve blood pressure control
- Better quality of life
- Better phosphorus control to prevent bone disease
- More energy for daily tasks
- Better sleep
- Boosts independence, responsibility and confidence
- Continued employment
- Fewer and shorter hospital stays

Young BA, Chan C, Blagg C, et al. How to overcome barriers and establish a successful home HD program. 2012. http://cjasn.asnjournals.org/content/early/2012/10/03/CJN.07080712.full

Background

- Home dialysis modalities are underutilized in the USA with only 8% of the dialysis patients undergoing renal replacement therapy at home versus 92% being treated with in-center hemodialysis
- In Network 4 (as of December 2016 data) only 11.3% of the patient population utilized a form of home therapy
- The long-term goal and impact of increasing home modality initiation aligns with CMS' priorities, and results in better health and lower costs

2018 ESRD Network 4 Scope of Work

- A 5-year target has been set to guide national health promotion and management to improve the health of all people in the United States living with ESRD*: by 2023, increase the number of ESRD patients* ***dialyzing at home to 16%*** *from the 2016 national average of 12%*
- The intent of the Home Dialysis QIA is to promote referral to home dialysis modalities, identify and mitigate the barriers to timely referral, and determine the steps patients and providers can take to improve referral patterns

Sullivan et al. Sullivan C, Leon JB, Sayre SS, Marbury M, Ivers M, Pencak JA, Bodziak KA, Hricik DE, Morrison EJ, Albert JM, Navaneethan SD, Reyes CM, Sehgal AR. Impact of navigators on completion of steps in the kidney transplant process: a randomized, controlled trial. Clin J Am Soc Nephrol. 2012 Oct;7(10):1639-45. doi: 10.2215/CJN.11731111

2018 Project Selection by NW4

CMS reduced the number of QIA projects from 8 to 4

1. Reduce Bloodstream Infection
   - 50% of the highest BSI rate facilities (167) are included in the BSI reduction project; in addition, there are focus groups from the 167 facilities:
     - 67 facilities for additional focus BSI reduction
     - 42 facilities for catheter reduction
     - 34 facilities for connection with health information exchange (HIE)
2. **Improve Home Dialysis Utilization in 30% of facilities**
   - 101 facilities, composed of Fresenius facilities
3. Improve Transplant Waitlist in 30% of facilities
   - 101 facilities, composed primarily of DaVita(87) and DCI(14) facilities
4. PHFPQ – Improve Vocational Rehabilitation (VR) and Employment Network (EN) Referral and VR/EN use in 10% of facilities
   - Remaining facilities (34) were candidates for this project

Did you know?

V-Tags associated with home dialysis

- V458
- V512
- V553

V458

Regulation:

Be informed about all treatment modalities and settings, including but not limited to, transplantation, **home dialysis modalities** (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), and in-facility hemodialysis. The **patient has the right to receive resource information for dialysis modalities not offered by the facility**, including information about alternative scheduling options for working patients

Interpretive Guidance:

- Documentation in patient records must demonstrate that facility staff provide unbiased education to patients/designees about transplantation and all dialysis treatment options (modalities and settings) offered for kidney failure, whether or not those options are offered at the current dialysis facility. This includes alternate scheduling options for in-center hemodialysis patients who attend school or are working. Patients who work or attend school should be encouraged to continue doing so and facilities should recommend the most appropriate modality and setting for their dialysis. Examples of how facilities may meet this requirement include developing a resource information packet for patients or providing patients an existing resource list of facilities that offer alternate schedules or home dialysis treatment options can be found at Medicare's Dialysis Facility Compare, and Home Dialysis Central.
- The requirements for assessment of patients for home dialysis and transplantation are addressed at V512 and V513 and at V553 and V554 respectively under the Condition for Patient plan of care.

V512

Regulation:

Evaluation of the patient's abilities, interests, preferences, and goals, including the desired level of participation in the dialysis care process; the preferred modality (hemodialysis or peritoneal dialysis), and setting, (for example, home dialysis), and the patient's expectations for care outcomes.

Interpretive Guidance:

- Evaluation of abilities, interests, preferences and goals would be demonstrated by at least one member of the team documenting an assessment of the patient's current interests in life and ability to pursue those interests, preferences for treatment, and goals, including what he/she expects from dialysis treatment. Patients must be encouraged to participate in their care, within the limits of their capacity and desire.
- If patients express a desire for enhanced participation in their own care (e.g., weighing themselves, monitoring blood pressure, holding needle sites, self-cannulation), the facility staff should evaluate and plan for applicable self-care training.
- Refer to the Condition for Care at home at V585.
- Evaluation of the preferred modality means that all options of modalities (hemodialysis, peritoneal dialysis) and settings (in-center, home) were presented to each patient, and that their goals, preferences, and expectations were given priority in decision-making.
- If a patient is determined not suitable for or declines home dialysis therapy, the reason must be documented in their plan of care, as required at V553.

V553

Regulation:

The interdisciplinary team must identify a plan for the patient's home dialysis or explain why the patient is not a candidate for home dialysis.

Interpretive Guidance*:*

- The patient plan of care must reflect the information from the IDT evaluation of the patient's suitability for and level of interest in home dialysis modalities required under the Condition for Patient assessment at V512.
- Patient records must demonstrate that each patient was informed about all available dialysis modalities and locations for home dialysis training if that service is not available at this facility. If the patient expressed interest in home dialysis and was determined to be a suitable candidate, the plan of care should list use of this modality as a goal and identify ways to achieve it (e.g., timeline for training in home dialysis at current facility, referral to a facility certified for home training and support). If the patient declined or was determined not suitable for home dialysis, the IDT must document their rationale for this decision.

Questions?

Home Dialysis Quality Improvement Activity

- Project facilities:
  - 101 facilities; approximately 5,620 patients
- Time frame for project:
  - January 1st 2018 through September 30th 2018
- Goal:
  - Improve the percentage of patients who begin home dialysis **training** by at least **10 percentage points**

Provider	# of Facilities	Baseline	Goal
FMC	101	0.63%	10.63%

- Baseline data is from CROWNWeb
- No exclusion criteria
- Track the 7 steps leading to home dialysis utilization
- ESRD NCC Home Dialysis Learning and Action Network (LAN)

  Participating facilities, 2 patients from DE, 2 patients from PA, representatives from 2 PA and 2 DE Home Programs are invited to every other month national calls (Dates TBD)

Home Dialysis Quality Improvement Activity

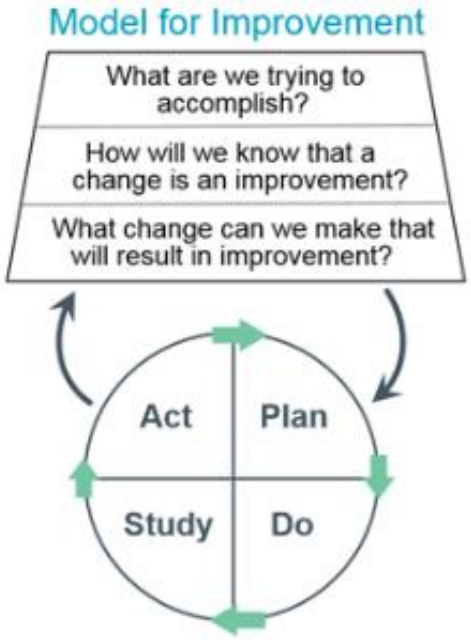
7 Steps Leading to Home Dialysis Utilization:

Track and report to CMS monthly the number of patients at each stage of the process

1. Patient interested in home dialysis
2. Educational session to determine the patient's preference of home modality
3. Patient suitability for home modality determined by a nephrologist with expertise in home dialysis therapy
4. Assessment for appropriate access placement
5. Placement of appropriate access
6. Patient accepted for home modality training
7. Patient begins home modality training

Method on How to Improve

- Institute for Healthcare Improvement (IHI) methodology for improvement
- Standard for healthcare industry



Recommended Quality Improvement Videos

Quality Improvement in Healthcare

- Quality Improvement in Healthcare (11:08 Minutes)

Root Cause Analysis – Process to Identify Areas for Quality Improvement

- What is a Fishbone Diagram? (3:08 Minutes)
- Root Cause Analysis: 5 Whys (4:44 Minutes)

PDSA Cycles – Process to Achieve Quality Improvement

- Plan-Do-Study-Act (PDSA) Cycle (6:21 Minutes)

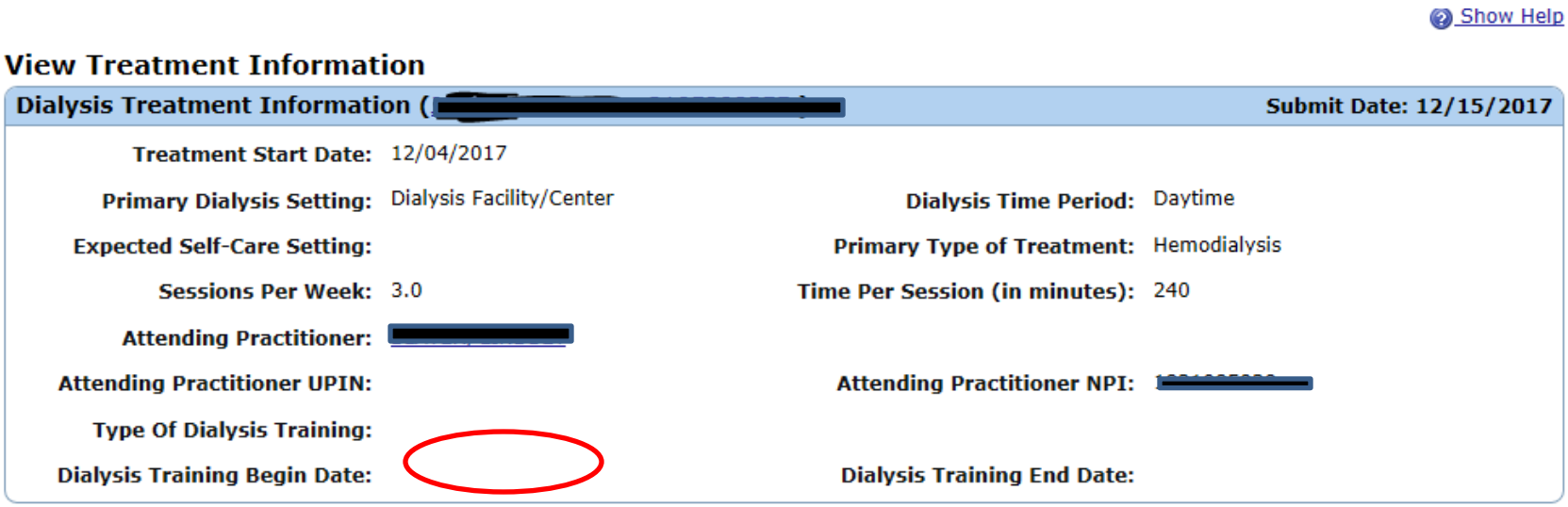
Completing a Root Cause Analysis (RCA)

- Remember as you complete your RCA
  - Every Process is completely designed for the results it gets
- Get your team together
  - People familiar with the process
  - People who touch the process
  - Include your patient representative
- Use Tools to help you discover your root causes!
  - Fishbone Diagram
  - Ask “5 Whys”

Example: What are some "Data" Root Causes and *WHY, WHY, WHY, WHY, WHY*

- Data in CROWNWeb is not accurate
  - Who enters it?
  - When is it entered?
  - Where is it entered?
  - Is it entered correctly?
    - Is it batched correctly?
- Is there a process to ensure the data is correct?
  - Who looks at it/who performs QA on the data?
  - When do they look at it?

Where is the home dialysis training date documented in CROWNWEB?



Note: If you find that training dates are not batching to CROWNWeb, contact your FMC corporate support

Develop the plan (PDSA Cycle)

PLAN: Plan a specific intervention(s)

- You and your team will build an improvement plan that makes it **easy to do the right thing and hard to do the wrong thing**
  - Describe your monthly plan to improve an identified barrier from the RCA (include details such as Who, What, When)?
  - Keep it simple and focused; do not over-reach
- **Your plan should be based on improving your PROCESS**

  (Again, keep in mind: every system (process) is perfectly designed for the results it gets)
  - Goal: to build a process that can be a hard wired = "System Redesign"

PDSA Cycle

DO: Implement the intervention

- Describe the intervention(s) you did this month to improve patients' starting home dialysis training and what did you observe?
- This step allows your team to "test" interventions that will lead to an improvement
- Allows you to find out if your plan works
- Remember: failure always teaches something and is just as valuable as success
  - If it isn't working try something different

PDSA Cycle

Study: Examine results and re-evaluate with your team. Is the process working? If not, why not? What is working well?

- Did you achieve the plan's goal with the intervention(s)?
- Take a moment to think about your intervention(s). What did you learn about the effectiveness of the intervention(s)?
- What barrier(s) (if any) did you discover when implementing the intervention(s)?
- If necessary, re-evaluate the root causes/barriers as well as your interventions

PDSA Cycle

ACT: If you did not achieve your goals, begin again with your new plan. If you met your goals, expand to another aspect of the problem.

What are you going to do for your PDSA cycle NEXT month?

- **ACCEPT** = Continue with the same plan
- **ADAPT** = Change the plan for next month
- **ABORT** = We need to start all over with a new plan

Work each month to improve your home dialysis training rate based on your plan and **update your plan** based on your success

Where to document your work?

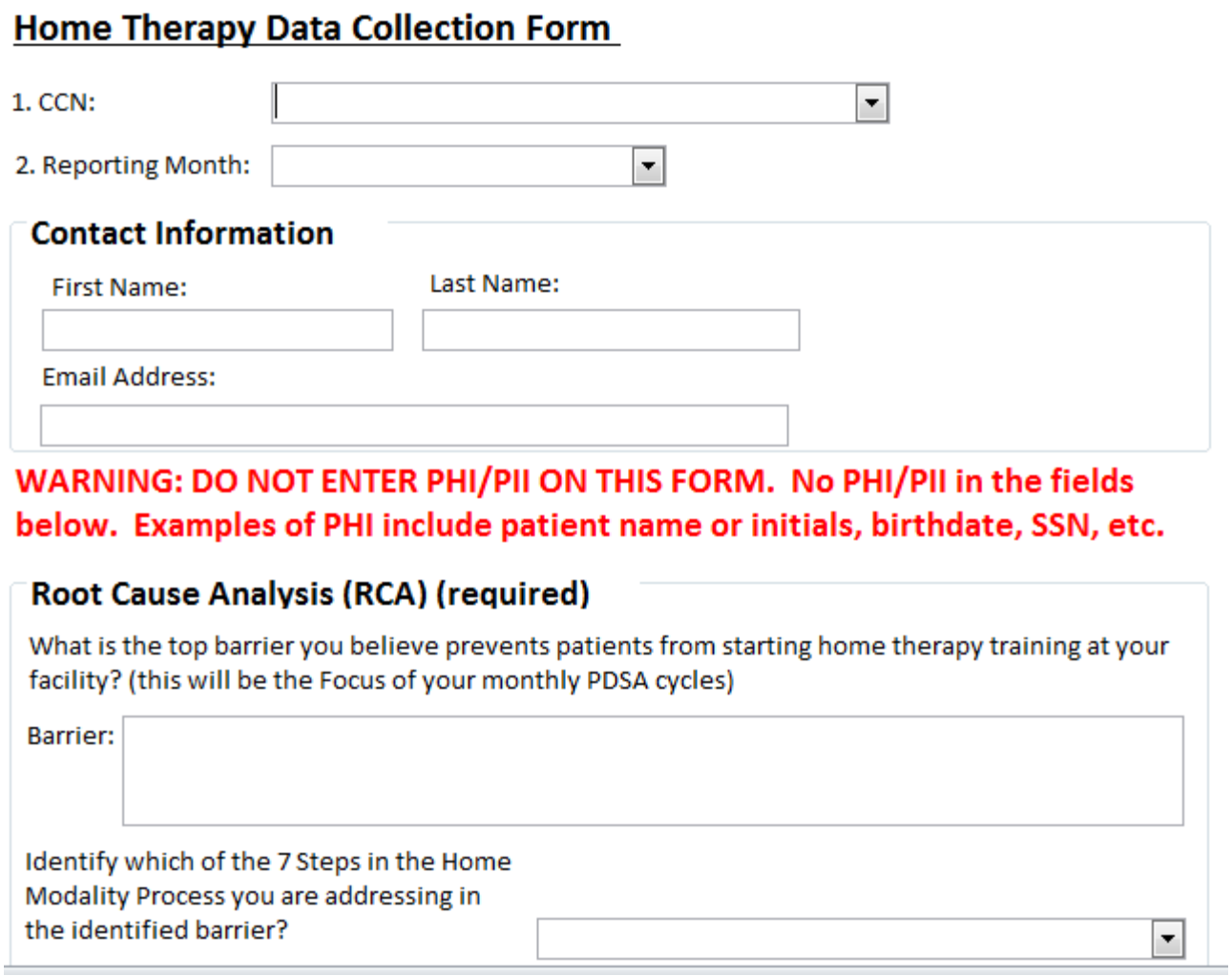
Submit a MONTHLY report **online** by the *last week of the of the reporting month* (starting the last week of February and continues until the last week of September)

1. RCA result: list a barrier you will address
2. Plan: What is the plan for improvement?
3. Do: What is the intervention?
4. Study: Evaluation of the intervention?
5. Act: What you are going to do next month?

MONTHLY ON-LINE REPORTING TOOL

- Network will send link
- Monthly online reporting tool will be available to go live for February's reporting month

Monthly On-line Reporting Tool



Home Therapy Data Collection Form

1. CCN:

2. Reporting Month:

Contact Information

First Name:

Last Name:

Email Address:

WARNING: DO NOT ENTER PHI/PII ON THIS FORM. No PHI/PII in the fields below. Examples of PHI include patient name or initials, birthdate, SSN, etc.

Root Cause Analysis (RCA) (required)

What is the top barrier you believe prevents patients from starting home therapy training at your facility? (this will be the Focus of your monthly PDSA cycles)

Barrier:

Identify which of the 7 Steps in the Home Modality Process you are addressing in the identified barrier?

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Monthly On-line Reporting Tool

PDSA Cycle Documentation

Plan: Describe your monthly plan to improve the identified barrier (include details such as Who, What, When)?

Do: Describe the intervention(s) you did this reporting month to improve patients' starting home therapy training and what did you observe?

Study: Did you achieve the plan's goal with this reporting month's intervention(s)?

Study: Take a moment to think about your intervention(s) this reporting month. What did you learn about the effectiveness of the intervention(s)?

What Barrier(s) (if any) did you discover when implementing the intervention(s) this reporting month? (Enter NA if none)

Act: What are you going to do for your next PDSA cycle?

Document your adjusted plan HERE and on next month's report

(shown if ADAPT is selected)

Document your new plan HERE and on next month's report

(shown if ABORT is selected)

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Additional Resources

- ***My Life, My Dialysis Choice*** decision aid to assess modality which may best fit the patient's value https://mydialysischoice.org/
- **5-Diamond Patient Safety Program Home Therapy Module** developed provide in-center dialysis staff the opportunity to learn more about home therapy
- **Your FMC Advocates**

Additional Resources

Patient Advocate Program (in development)

- Timmy Nelson, Subject Matter Expert
- The goal is to build a pipeline of patients helping patients

We need your help!

- Looking for 3 facilities and 3 home dialysis patients to assist with the development of the program
- Contact Kou if you are interested (610-265-2418 ext. 2820)

Impact of Navigators on Completion of Steps in the Kidney Transplant Process: A Randomized, Controlled Trial
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3463214/

Next Step:

Facility activities:

- Complete an initial Root Cause Analysis (RCA) before the end of January; Do NOT have to submit to Network; select one barrier and document on the online reporting tool which is due by the last week of the reporting month
  - What are the root causes (barriers) at your facility preventing you from attaining these goals?
- Create a plan to improve based on your RCA using PDSA format for rapid cycle change
- Report on progress of your plan (PDSA cycles) each month
  - Due the last week of each reporting month
- Attend ESRD National Coordinating Center (NCC) Home Dialysis Learning and Action Network (LAN) national calls. Calls will be scheduled every other month. Dates TBD

Network will email an Electronic Facility Tool Kit:

- QIRN4 Introductory Presentation
- Web links to quality improvement training videos
- Related articles
- Home Therapy Resources
  - *My Life, My Dialysis Choice* decision aid to assess modality which may best fit the patient's value https://mydialysischoice.org/
  - 5-Diamond Patient Safety Program Home Therapy Module developed provide in-center dialysis staff the opportunity to learn more about home therapy

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Work for Success

- If you get stuck….
  - Review videos in the tool kit
  - Call the Network project lead

- QIRN4's commitment to facility support
  - Provide Home Dialysis "Toolkit" to all participants
  - Send out Outlook "Meetings" calendar
    - To remind you for reporting your activities; will contain links to the on-line monthly reporting tool
  - Send appropriate reminder emails
  - Provide learning opportunities via webinar
  - Provide coaching
    - Email or phone calls as needed

Questions/Feedback

Your feedback is valuable! Questions 9 & 10 on the questionnaire is for your facility's name and provider number for attendance and/or acknowledgement that you have attended and/or reviewed the presentation and understand the expectation of the project.

https://www.surveymonkey.com/r/R39GXDH

Contact Kou Kha-Moua, BSN, RN
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