Network 4 Kick-Off Presentation
2020 Home Dialysis and Transplant Waitlist Quality Improvement Activities

Presented by Project Lead: Kou Kha-Moua
Overview

• Background
• Conditions for Coverage V-tags
• 2020 Transplant Quality Improvement Activities
• Home Dialysis QIA
• Transplant QIA
• Improvement Method
• Possible Interventions
• Next steps
Background
Background

Kidney transplantation offers advantages over dialysis for end-stage renal disease (ESRD) patients in both quality of life and survival. Studies show that kidney transplants:

- Improve life expectancy
- Reduce morbidity
- Offer better quality of life
- Are more cost effective than dialysis

Despite the benefits of kidney transplantation, according to the 2016 United States Renal Data System (USRDS) Annual Report:

- 87.3 percent of all incident patients began renal replacement therapy with hemodialysis
- 9.7 percent started with peritoneal dialysis
- 2.8 percent received a preemptive kidney transplant
Background

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](http://cjASN.asnjournals.org/content/early/2012/10/03/CJN.07080712.full)
Background

• **Home dialysis** modalities are underutilized in the US with only 8% of the dialysis patients undergoing renal replacement therapy at home versus 92% being treated with in-center hemodialysis

• 11.8% of the patient population utilized a form of home therapy in Network 4

• The long-term goal and impact of increasing home modality initiation aligns with CMS’ priorities, and results in better health and lower costs
2020 ESRD Network 4 Scope of Work

- The Centers for Medicare and Medicaid Services (CMS) has set a 5-year goal to improve the health of all people in the United States living with End Stage Renal Disease (ESRD)
- **Home Dialysis** – By the year 2023, increase the number of ESRD patients dialyzing at home to 16% from the 2016 national average of 12%
- **Transplant** – By the year 2023, increase the percentage of ESRD patients on the transplant waitlist to 30% from the 2016 national average of 18.5%.

*In addition . . .*

By 2025 – Support all the goals and initiatives detailed in the Executive Order especially the goal to improve kidney health by having 80% of new ESRD patients either receiving dialysis at home or receiving a transplant.  
2020 CMS Quality Improvement Activities

1. **Bloodstream Infection Reduction**
   ➢ Top 20% (73) of facilities with the highest number of NHSN Excess infections in 2018

2. **LTC Reduction** – All facilities

3. **Hospital Connectivity**
   ➢ 10% of Network 4 facilities (36) who currently do not have access to hospital records will obtain access via EMR or Healthcare Information Exchange (HIE)

4. **Improve Home Dialysis Utilization** – All facilities

5. **Improve Transplant Wait listing** – All facilities

6. **Population Health Focused Pilot Quality (PHFPQ) – Support Gainful Employment of ESRD Patients**
   ➢ 10% of Network 4 services area population (35 facilities) with a goal of:
   ➢ 95% patients screen for VR/EN interest
   ➢ 50% increase in the number of eligible patients referred for EN services
   ➢ 1% increase in the number of patients receiving EN and/or VR services
Conditions For Coverage VTags
Did you know?

V-Tags associated . . .

<table>
<thead>
<tr>
<th>Home Dialysis</th>
<th>Transplant</th>
</tr>
</thead>
<tbody>
<tr>
<td>V458</td>
<td>V458</td>
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<tr>
<td>V512</td>
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<td>V553</td>
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<tr>
<td>V554</td>
<td>V561</td>
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Transplant: 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.
Transplant: V513

Regulation:
**Evaluation of suitability** for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for non-referral must be documented in the patient’s medical record.

Interpretive Guidance:
- The IDT comprehensive assessment must demonstrate that each patient is evaluated for suitability for transplantation referral, using selection/exclusion criteria provided by the transplant center.
- The regulations for transplant programs require written selection criteria to be developed and provided upon request to patients and dialysis facilities. Selection criteria vary among transplant centers; if the dialysis facility refers patients to multiple transplant centers, the dialysis facility should have the selection criteria for each center on file and available to patients; patients are also free to select a transplant center other than the ones normally utilized by the dialysis facility for referrals.
- If the assessment finds a patient is not suitable for transplantation, the reason for the non-referral should be documented as part of the comprehensive assessment.
Transplant: V554

Regulation:

**Transplantation status.** When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient’s plan of care must include documentation of the—

- (A) Plan for transplantation, if the patient accepts the transplantation referral;
- (B) Patient’s decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or
- (C) Reason(s) for the patient’s non-referral as a transplantation candidate as documented in accordance with § 494.80(a)(10).

**Interpretive Guidance:**

- The patient’s plan of care must reflect the information from the interdisciplinary team’s evaluation of the patient's suitability for transplantation referral, required under the Condition for Patient assessment at V513.
- The patient record must show evidence that the patient was informed about transplantation as an option, living and deceased kidney donation, area transplant center(s) and each transplant facility's selection criteria. Each patient's record must reflect the IDT's determination about the patient’s suitability and whether the patient accepted or declined referral for transplantation and reason for non-referral.
- If a patient was determined as suitable for transplantation referral, the IDT must document making the referral and providing applicable information to the transplant center as appropriate or when requested.
- Documentation in patient records should agree with the patient’s understanding of their status as a transplant candidate. Patients may independently contact a transplant center for an appointment for more information and evaluation. If this is the case, the IDT should be aware of the self-referral. A patient’s insurance coverage and a transplant center’s selection criteria may dictate which transplant center(s) the patient can access.
Transplant: V561

**Regulation:** **Standard: Transplantation referral tracking**
- The interdisciplinary team must—
  - (1) Track the results of each kidney transplant center referral;
  - (2) Monitor the status of any facility patients who are on the transplant wait list; and
  - (3) Communicate with the transplant center regarding patient transplant status at least annually, and when there is a change in transplant candidate status.

**Interpretive Guidance:**
- Requiring the facility to track patients' transplant referrals and their status on the transplant wait list is intended to enhance the communication and coordination between the transplant center and the dialysis facility so that patients do not get "lost" along the way in the transplant referral, work up and waiting period.
- Tracking completion of the tests and evaluations required for a transplant work up and waiting list active status is primarily the responsibility of the patient in partnership with the transplant center. However, by communicating and coordinating activities with the transplant center, the dialysis facility IDT may be able to adjust their plan of care to facilitate the patient's transplantation goal. This communication should be systematic and documented.
- A “change in status” refers to a medical or psychosocial event that could either temporarily or permanently change a transplant patient’s status. The “change” could either enhance or limit a dialysis patient’s opportunities to receive a transplant. Examples of “change” events are cardiac events, weight loss, cessation of smoking, or identification of a new potential living organ donor. The transplant center should be notified at the time of any change in status.
- The facility's patient transplant referral/waiting list status tracking may be centralized, but must also be documented in each referred patient's medical record.
Home Dialysis: 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.
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.
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.
2020 Home Dialysis QIA
2020 Home Dialysis Quality Improvement Activity

- **Project facilities**: All Network 4 facilities
  - 363 facilities; approximately 23,000 patients
- **Project Timeframe**:
  - January 1, 2020 through September 30, 2020
- **Facility Goal**: add at least 7 patients to a form of Home Dialysis (PD/HHD) by 9/30/20
- No exclusion criteria
- Baseline data is from CROWNWeb
- A representative must attend ESRD NCC Home Dialysis Learning and Action Network (LAN) call
Home Dialysis QIA – 2019 Project Outcome:

![Graph showing the number of home dialysis initiations from January to September 2019. The baseline and the goal are constant at 600 initiations per month. The 2019 performance shows a steady increase from 40 initiations in January to 647 initiations in September.](image-url)
2019 Home Dialysis QIA - Barriers

Barriers at the start of the QIA

Barriers throughout the QIA
2019 Home Dialysis Interventions

Monthly Plan/Do/Study/Act – Emerging Practices from the Focus Facilities

- Use of the “Why should I choose home” poster for education
- Nephrologist/NP provide patient education during monthly rounds
- Partner with our home program to host home dialysis education “lobby” day
- Social Workers provide one-to-one home dialysis patient education
- Use of the tri-fold, “Why Should I Choose Home Dialysis” for education
- Trial a “Transitional Care” orientation model for new patients
- Provide Staff Home Dialysis In-services

Other
2020 Home Dialysis Interventions

- Introduction presentation
- Medical Director Letter
  - Home Dialysis QIA summary sheet with “asks” for medical director to support
  - Facility baseline/historical data report
- Patient Level Report (provide quarterly)
- Toolkit
  - Patient advocate recruitment flyer
  - Why Should I Choose Home poster
  - Why Should I Choose Home brochure
- PDSA Review
  - Network 4 Patient Advocates’ one-to-one mentoring
  - Network Patient Advocates’ education “lobby” days
  - Facility visits
- Assist with Support Group Start Up

2020 Transplant Waitlist QIA
2020 Transplant Waitlist Quality Improvement Activity

- **Project facilities:** All Network 4 facilities
  - 363 facilities; approximately 23,000 patients
- **Time frame for project:**
  - January 1, 2020 through September 30, 2020
- **Facility Goal:** add at least 5 patients to the waitlist by 9/30/20
  - Adding a patient to a second transplant center’s list (i.e. multi-listing) counts in this metric
  - Data shows that patients who are multi-listed, especially in different OPOs, increase their chances of receiving a kidney transplant more quickly
- **No exclusion criteria**
- **Baseline Transplant Waitlist data is from UNOS**
- **A representative must attend ESRD NCC Transplant Learning and Action Network (LAN) call**
Transplant Waitlist QIA – 2019 Project Outcome:

![Graph showing the number of waitlisted patients from January to September 2019. The baseline is indicated with a blue line, 2019 performance with a red line, and the goal with a green line. The number of waitlisted patients ranges from 0 to 350, with peaks at 333 in March and 220 in September.](image-url)
Transplant Waitlist Barriers – 2019

QIA:

Barriers throughout QIA

Transplant Waitlist Barriers
as reported by the QIA Facilities at the Start of the Project
(105 Participating Facilities)

<table>
<thead>
<tr>
<th>Barrier Categories</th>
<th>Number of Facility Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Follow with Appointments</td>
<td>18</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>16</td>
</tr>
<tr>
<td>Burdensome Transplant Process</td>
<td>15</td>
</tr>
<tr>
<td>Age</td>
<td>8</td>
</tr>
<tr>
<td>Patient Refused</td>
<td>7</td>
</tr>
<tr>
<td>Educational Knowledge Gap</td>
<td>6</td>
</tr>
<tr>
<td>Communications Barriers with Transplant Centers</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Transplant Center Criteria Related</td>
<td>3</td>
</tr>
<tr>
<td>No Adequate Insurance</td>
<td>2</td>
</tr>
<tr>
<td>Lack Internal Referral Process</td>
<td>1</td>
</tr>
</tbody>
</table>

Barriers at the start of the QIA
Transplant QIA Interventions – 2019 QIA:

Monthly Plan/Do/Study/Act – Emerging Practices from the Focus Facilities

- Dedicated Staff follow up with patient needs
- Follow up with Transplant Centers
- IDT provide education during monthly rounds
- Other
- Partner Network 4 Patient Advocates to host transplant education day and/or one-to-one patient mentoring
- Partner with transplant representatives to host transplant education “lobby” day
- Use of the tri-fold, A “Guide to Understanding the challenges of a Kidney Transplant Evaluation and Workup” for education
2020 Transplant QIA Interventions

• Introduction presentation and recording
• Medical Director Letter
  – Transplant QIA summary sheet with “asks” for medical director to support
  – Facility baseline/historical data report
• Patient Level Report (provide quarterly)
• Toolkit
  – Patient advocate recruitment flyer
  – Talking About Transplant: Guide for Dialysis Technicians brochure
  – The Road to Transplant brochure
  – Understanding the Challenges brochure
  – Stitches of Hope Toolkit: letter, poster, consent form, patient participation form, caregiver testimony
• PDSA Review
  – Network 4 Patient Advocates’ one-one patient mentoring
  – Network 4 Patient Advocates’ education “lobby” days
  – Facility visits

[Link to website](https://www.qirn4.org/Ongoing-Projects/Improving-Transplant-Waitlists-QIA.aspx)
Improvement Method
Improvement Methodology

- 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”
Develop The Plan (PDSA Cycle)

**PLAN**: Plan a specific intervention

- 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”
PDCA Cycle

**DO:** Implement the Intervention

- Describe the intervention you did this month to improve patients’ transplant waitlist status and what did you observe?
- This step allows your team to “test” the 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 your 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?
- What did you learn about the effectiveness of the intervention?
- What barrier(s) (if any) did you discover when implementing the intervention?
- 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 for improvement based on your plan and **update your plan** based on your success
PDSA On-Line Reporting Tool

*Facilities who are required to COMPLETE and SUBMIT the PDSA On-Line Reporting Tool will be notified by a separate email throughout the project period*

Due: Submit On-Line PDSA Reporting Tool by the last week of the reporting month

Summarize:

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: Evaluate the intervention?
5. Act: What you are going to do next month?
**NOTE**
To ease documentation burden
- Some fields with drop down options

After answering all questions:
- Review your summary
- Submit form

PDSA On-Line Reporting Tool Example

Facilities who are required to complete the on-line reporting will be notified by a separate email.

What is the top barrier you believe prevents patients from being placed on the transplant waitlist at your facility? (this will be the focus of your monthly PDSA cycles)

Barrier: 

Identify which of the 7 Steps in the Transplant Waitlist Process you are addressing in the identified barrier?

Monthly 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’ transplant waitlist status 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 PDSA cycle NEXT month?

How many of your patients are on the transplant waitlist (active and inactive)?

How many patients were added to the transplant waitlist this collection month?
Intervention Highlights
2020 Quality Improvement Activity

- ESRD National Coordinating Center (NCC) Home Dialysis and Transplant Learning and Action Network (LAN) national calls
  - Calls are scheduled every other month (first call begins in January)
  - Meeting details, registration link and call overview will be provided prior to each call
  - Attendance will be taken by your registration log in information
- A representative from the project facilities must attend these calls
  - If unable to attend the call, she/he must review the recordings. I will send the presentation and recordings when I received them from the NCC.
- Network will reach out to facilities to assess evaluation/implementation of identified best practices

Learning and Action Network (LAN) Call Dates – Coming Soon
Patient Advocate Program Intervention

- Network 4 Patient Advocate Program started with 2018 projects
- Goal is to build a pipeline of patients helping patients
- Partner with Network 4 patient advocates to host transplant education “lobby” days and or one-to-one patient mentoring

-Q7 On a scale of 1-5, my patients were interested in Transplant and/or Home Dialysis PRIOR to the Patient Advocate’s visit?

-Q8 On a scale of 1-5, my patients were interested in Transplant and/or Home Dialysis AFTER the Patient Advocate’s visit?
## Network 4 Patient Advocate Program Intervention

<table>
<thead>
<tr>
<th># of Facilities</th>
<th># of Patients Spoken to</th>
<th># of Patients Interested</th>
<th># of Patients Waitlisted or in a Home Program in the 32 Facilities</th>
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</table>
| 32              | >531                    | 167                      | Total=114  
Start of QIA=12 (HD=7; TR=5)  
End of QIA=114 (HD=72; TR=42) |

### Facility Counts

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<td>0</td>
<td>3</td>
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<td>5</td>
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Example of Dialysis Center Patient Level Report

Transplant Waitlist Project Patient List, Waitlist and Active Status and 6 Step Status

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<thead>
<tr>
<th>Patient Name</th>
<th>DOB</th>
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From UNOS

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<th>Where Waitlisted*</th>
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<th>Date Removed**</th>
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Transplant Center Information

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<tr>
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<th>State</th>
<th>Center Phone</th>
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<td>MD</td>
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<td>Brooklyn</td>
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<td>PATJ</td>
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<td>Hospital of the University of Pennsylvania</td>
<td>Philadelphia</td>
<td>PA</td>
<td>215-662-4000</td>
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</table>
### Example of Transplant Center Report

#### Transplant Center Waitlist Report
**Patients on Dialysis in US**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB</th>
<th>Date Admitted</th>
<th>Admission Type</th>
<th>Date Waitlisted (UNOS)</th>
<th>Active on Your Waitlist?</th>
<th>Also Listed At...</th>
<th>Contact Information</th>
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<td>Administrator:</td>
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Procurement Organizations (OPOs)

Find your OPO

http://www.aopo.org/find-your-opo/

New York

Register to be a Donor

Center for Donation & Transplant*
Michael Thibault, Executive Director
Albany Medical Center, 218 Great Oaks Boulevard, Albany, NY 12203
Ph: (518) 262-5606 – Fax: (518) 262-5427

Unyts*
Mark Simon, President/CEO
110 Broadway, Buffalo, NY 14203
Ph: (716) 853-6667 – Fax: (716) 853-6674

LiveOnNY*
Helen M. Irving, President/CEO
460 W. 34th Street, 15th Floor, New York, NY 10001
Ph: (646) 291-4444 – Fax: (646) 291-4600

Maryland

Register to be a Donor

The Living Legacy Foundation of Maryland*
Charles Alexander, President/CEO
1730 Twin Springs Road, Suite 200, Baltimore, MD 21227
Ph: (410) 242-7000 – Fax: (410) 242-1871

Washington Regional Transplant Community*
Lori Brigham, President/CEO
3190 Fairview Park Drive, Suite 700, Falls Church, VA 22042
Ph: (703) 641-0100 – Fax: (703) 658-0711

NJ Sharing Network*
Joseph Roth, President/CEO
691 Central Avenue, New Providence, NJ 07974
Ph: (908) 516-5400 – Fax: (908) 516-5501

Finger Lakes Donor Recovery Network
Rob Kochik, Executive Director
Corporate Woods Brighton, Building 30, Suite 220, Rochester, NY 14623
Ph: (585) 272-4930 – Fax: (585) 272-4956
Improve Transplant Waitlist QIA – Interventions

Helpful Resources

United Network for Organ Sharing (UNOS)
Information and referrals about organ donation and transplant history
Website: www.unos.org

National Kidney Foundation
Information and resources on kidney disease
Website: www.kidney.org

Coalition on Donation
Information on how to become an organ and tissue donor
Website: www.organdonor.org

People considering a kidney transplant are often overwhelmed by the multiple steps involved. For dialysis providers, the challenge becomes even bigger because different transplant centers often evaluate patients differently. Ultimately, the goal of every evaluation is to ensure that kidney transplantation is a safe form of treatment for a patient’s End-Stage Renal Disease (ESRD).

Why are there so many appointments for the evaluation?
Transplantation is a complex procedure. Transplant centers must provide patients with the education necessary to understand the entire process, including: risks and benefits of transplant; alternative treatments to transplant; testing necessary to be considered a candidate; surgical risks; post-transplant management; and the list goes on. Patients are often overwhelmed with the amount of information they receive. For this reason, it’s best to give information in a more manageable way. This usually requires several appointments at the transplant center and reinforcement through telephone calls.

Why are tests ordered at different times?
Tests are ordered by priority in which they occur for the patient. For example, if the patient has cardiac risk factors that may prevent him or her from being a transplant candidate, the cardiac workup will be scheduled first. This is done so that the patient does not have to undergo multiple "routine" tests if they are found to be ineligible for transplant based on the cardiac testing.

Can diagnostic tests for transplant be done at the local hospital?
This depends on the transplant center’s preferences. Many centers do require testing to be completed at the transplant center, or an affiliated outpatient center, because it allows the provider to get the results in a timely manner. If testing is done outside the transplant center, the results may not be sent quickly to the transplant center. When this happens, transplant center staff spend a significant amount of time trying to get the results. This can delay patients getting placed on the transplant list.

Another major reason to have testing done at the transplant center is the billing process. Transplant billing is very specialized. The Centers for Medicare & Medicaid Services (CMS) has regulatory requirements for transplant evaluation testing. CMS requires that all bills for the transplant evaluation be sent to the transplant center. When tests are performed outside the transplant center, they often get billed incorrectly because most local hospitals do not understand transplant billing requirements. Unfortunately, bills usually get sent to the patient’s insurance instead of being sent to the transplant center. This can create additional steps to rectify the situation and the patient usually gets stuck in the middle. This issue rarely occurs when patients have testing done at the transplant center.

How can dialysis staff help patients move through the process?
Encourage patients to be proactive in their evaluation. Help them create and maintain good communication with transplant center staff. Encourage patients to keep scheduled appointments and ask questions. The more a patient knows about the process, the less overwhelming it becomes. As an advocate for your patients, you can help them be successful with transplant.
Improve Transplant Waitlist QIA – Interventions

Are you “active” or “inactive” on the transplant waiting list?

- After your evaluation, you will receive a letter from the center letting you know the outcome. If you are on the transplant waiting list and all testing is complete, you are “active” and may receive organ offers.
- If additional testing is needed, you may be considered “inactive” on the list. This means you are accruing time but you will not receive organ offers until testing is complete.
- It is important to complete all testing as soon as possible so the transplant team can determine if transplant will be a safe option for you.

Are you providing a blood sample every month?

- A blood sample is important for matching your blood with the donor’s blood to make sure they are compatible.
- If your transplant center hasn’t asked you to send in a monthly sample, you may not be considered “active” on the waiting list.

Why should you stay in touch?

Your transplant coordinator can keep you updated about your status on the transplant list and answer questions you may have. Tell your coordinator about any health problems, hospitalizations, changes in your insurance or medication coverage and if you get any blood transfusions.

Are you on a transplant waiting list?

- A transplant can eliminate the need for dialysis.
- Blood pressure is easier to manage post-transplant.
- Fluid restrictions are usually no longer necessary after transplant.
- Diet restrictions are less strict.
- You can travel and return to work.

Do you know how to get on a transplant waiting list?

- Select a transplant center. Ask about the center’s outcomes.
- Are you aware that you can be on more than one transplant list?
- Call and make an appointment for an evaluation for kidney transplant.
- Complete any needed follow-up testing.
- Ask your social workers, nurses or kidney doctors for more information.

Do you know how to stay active on the list?

- Attend your annual evaluations at the transplant center.
- Never miss dialysis appointments.
- Take all medications as prescribed.
- Avoid alcohol and drug abuse.
- Maintain a healthy weight and lifestyle.
Improve Transplant Coordination QIA - Interventions

Continuing to have hope . . . . “Stitches of Hope” Quilt

We have created a “Stitches of Hope” Quilt – the quilt is a celebration of patients who were waitlisted during the project period and patients who have maintain their transplant status

Provide opportunity to add patient’s name

Toolkit:

• Stitches of Hope Quilt poster
• Submission form
• Patient consent form
• Examples of what patients wrote
• Caregiver testimony
Improve Transplant Coordination QIA - Interventions
Home Dialysis QIA - Interventions

Why should I choose HOME?

- Has no needles
- Has fewer side effects
- Is easy to do
- Is gentle on your heart
- Makes it easier to travel
- Helps you keep your job
- A partner may not be required
- Improves your quality of life
- Has fewer dietary and fluid restrictions
- Allows you to set your own schedule
- Has fewer medications
- Allows you to spend more time with your loved ones
- Has 24-hour remote nurse support

Peritoneal Dialysis (PD)  |  Home Hemodialysis (HHD)

Peritoneal Dialysis (PD)
Why it may work for you:
- Needleless and not used in your blood
- PD is more independent and control of treatment and the choices.
- Your body, not a dialyzer, does your blood.
- You don’t have to travel to a center to receive treatment; it can be performed at your home, school, or work.
- Many, many patients say they have more energy after these treatments compared to how they feel after in-center dialysis.
- Dialysis staff members are available to answer questions on the phone.
- You decide how to fit your exchanges into your day or night schedule.
- PD may make it easier to return to work or school.
- You may have less diet restrictions than with in-center dialysis.
- PD allows you to travel.

Home Hemodialysis (HHD)
Why it may work for you:
- HHD uses your existing arterial access or graft site.
- HHD allows more independence and control of treatment and the choices.
- HHD permits more frequent or longer treatments than can be provided with in-center dialysis. This can lead to more waste products being removed and better lab results.
- You don’t have to travel to a center to receive treatment.
- Many patients say they have more energy after treatments compared to how they feel after in-center dialysis.
- Dialysis staff members are available to answer questions on the phone.
- HHD may make it easier to return to work or school.
- HHD allows you to travel.
- Supplies can be shipped to you anywhere in the United States, and the machine can go on an airplane.

NEXT STEPS
- Ask your dialysis team.
- Ask about treatment options.

For more information, please visit www.mydialysis.org or call (800) 548-9265.

Citation: American Society of Nephrology (ASN) (2015). An Evidence-Based Approach to Home Dialysis: Executive Summary. ASA-201500036374-06.
Next Steps
**ALL Facilities Next Steps . . .**

**For ALL Facilities to Complete:**

- **Patient Caseload Report** – A packet containing the project materials for the start of the [HOME DIALYSIS](#) and [TRANSPLANT](#) QIAs was mailed to your facility. It is important that you review the materials and follow up with the action items. Complete the Patient Caseload questionnaires *(due 12/13/19)* if you have not done so. See link below:

  Patient Caseload Report Survey Monkey Link
  [https://www.surveymonkey.com/r/GT73TPF](https://www.surveymonkey.com/r/GT73TPF)

  Patient Caseload Report Survey Monkey Link – for [HOME ONLY Facilities](#)
  [https://www.surveymonkey.com/r/PVW9W9X](https://www.surveymonkey.com/r/PVW9W9X)

- **Root Cause Analysis (RCA)** – Complete an initial RCA for each of the QIAs: Transplant and Home Dialysis before the end of January.
  - What is the barrier you believe prevents patients from being placed on the transplant waitlist or moving to home dialysis at your facility?
  - The response is for patients on the Facility Caseload Report you identified as realistic candidates for referring to the transplant waitlist or moving to home dialysis usage.
  - These identified patients will be the focus of your interventions along with patients newly admitted or transferred into your facility.
  - Do **NOT** have to submit RCA to Network
ALL Facilities Next Steps . . . Continued

For ALL Facilities to Complete:

• **Improvement Plan** – Create a plan to improve based on your RCA using PDSA format for rapid cycle change
  – Use the interventions/tools provided in this presentation, you may produce your own interventions, or use your corporate interventions if the ones provided do not meet your needs

• **PDSA Cycle** -- Document on the progress of your plan – Do Not need to submit to Network.
  – (optional) may use the Network PDSA form which may be use as evidence of Network QIA participation to satisfied DOH survey if ask by DOH
  – Depending on the facility’s results, you may be notified in a separate email throughout the project period if you are required to complete the On-Line PDSA Reporting Tool

• Attend the Transplant and Home Dialysis Learning and Action Network (LAN) Calls – *dates will be coming*
Selected Facilities Next Steps . . .

For SELECTED Facilities to Complete:
(The first wave of selected facilities will be notified no later than December 20, 2019)

• **Patient Caseload Report** – A packet containing the project materials for the start of the HOME DIALYSIS and TRANSPLANT QIAs was mailed to your facility. It is important that you review the materials and follow up with the action items. Complete the Patient Caseload questionnaires (due 12/13/19) if you have not done so. See link below:
  
  Patient Caseload Report Survey Monkey Link
  https://www.surveymonkey.com/r/GT73TPF

• **Root Cause Analysis (RCA)** – Complete an initial RCA for each of the QIAs: Transplant and Home Dialysis before the end of January.
  
  – What is the barrier you believe prevents patients from being placed on the transplant waitlist or moving to home dialysis at your facility?
  
  – The response is for patients on the Facility Caseload Report you identified as realistic candidates for referring to the transplant waitlist or moving to home dialysis.
  
  – These identified patients will be the focus of your interventions along with patients newly admitted or transferred into your facility.
  
  – Do NOT have to submit RCA to Network; select **one barrier** AND document on the PDSA On-Line Reporting Tool
For **SELECTED** Facilities to Complete:

(The first wave of selected facilities will be notified no later than December 20, 2019)

- **Improvement Plan** – Create a plan to improve based on your RCA using PDSA format for rapid cycle change
  - Use the interventions/tools provided in this presentation, you may produce your own interventions, or use your corporate interventions if the ones provided do not meet your needs AND document on the PDSA On-Line Reporting Tool

- **PDSA Cycle** -- Report on the progress of your plan (PDSA cycles) every month on the PDSA On-Line Reporting Tool. I will be sending the reporting link in a separate email.
  - (optional) may use the Network PDSA paper form as needed

- Attend the Transplant and Home Dialysis **Learning and Action Network (LAN) Calls** – *dates will be coming*
Questions?

Link to QIRN4 website for the 2020 Home Dialysis QIA materials including the PowerPoint:

Link to QIRN4 website for the 2020 Transplant QIA materials including the PowerPoint:

Contact Kou Kha-Moua, BSN, RN
610-265-2418 ext. 2820
Kkhamoua@qualityinsights.org