



# Network 4 Kick-Off Presentation

## 2020 Home Dialysis and Transplant Waitlist Quality Improvement Activities

Presented by Project Lead: Kou Kha-Moua



Quality  
Insights

Renal Network 4

# 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>

# 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.

<https://aspe.hhs.gov/pdf-report/advancing-american-kidney-health>

# 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 . . .

Home Dialysis	Transplant
V458	V458
V512	V513
V553	V554
	V561

[https://www.qirn4.org/Files/Providers/Conditions-for-Coverage\\_2017.aspx](https://www.qirn4.org/Files/Providers/Conditions-for-Coverage_2017.aspx)

# 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; patient 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.

# Home Dialysis: 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.

# Home Dialysis: 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:

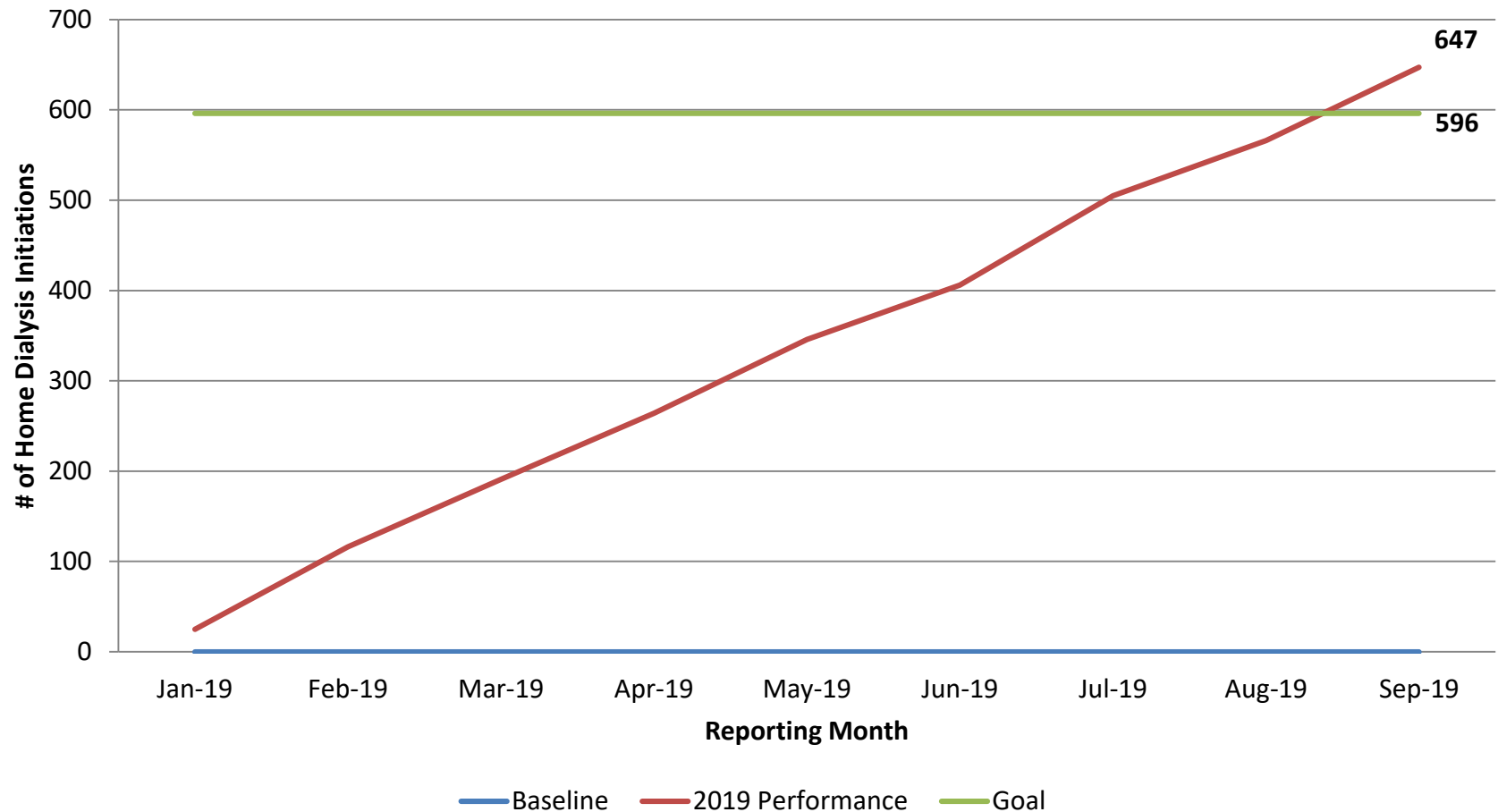
- The patient plan of care must reflect the information from the IDT evaluation of the patient's suitability for and level of interest in home dialysis modalities required under the Condition for Patient assessment at V512.
- Patient records must demonstrate that each patient was informed about all available 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

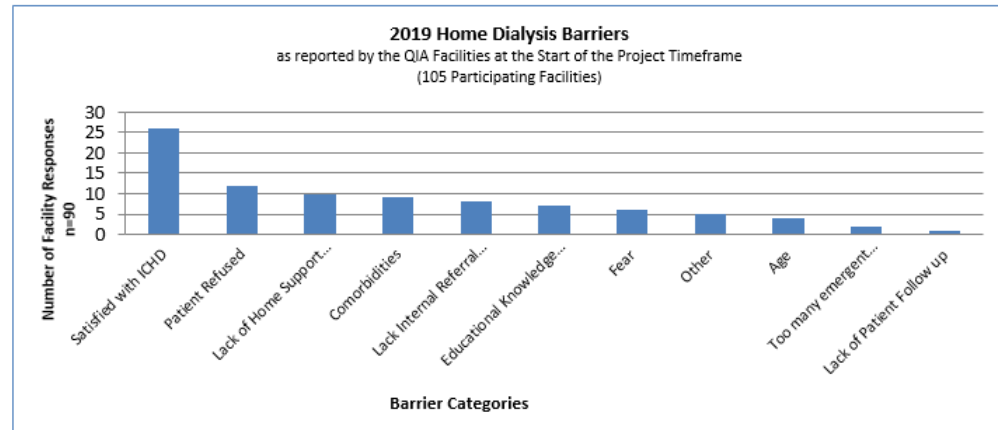
- **Project facilities:** All Network 4 facilities
  - 363 facilities; approximately 23,000 patients
- **Project Timeframe:**
  - January 1, 2020 through September 30, 2020
- **Facility Goal:** add at least **7 patients** to a form of Home Dialysis (PD/HHD) by 9/30/20
- No exclusion criteria
- Baseline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

# Home Dialysis QIA – 2019 Project Outcome:

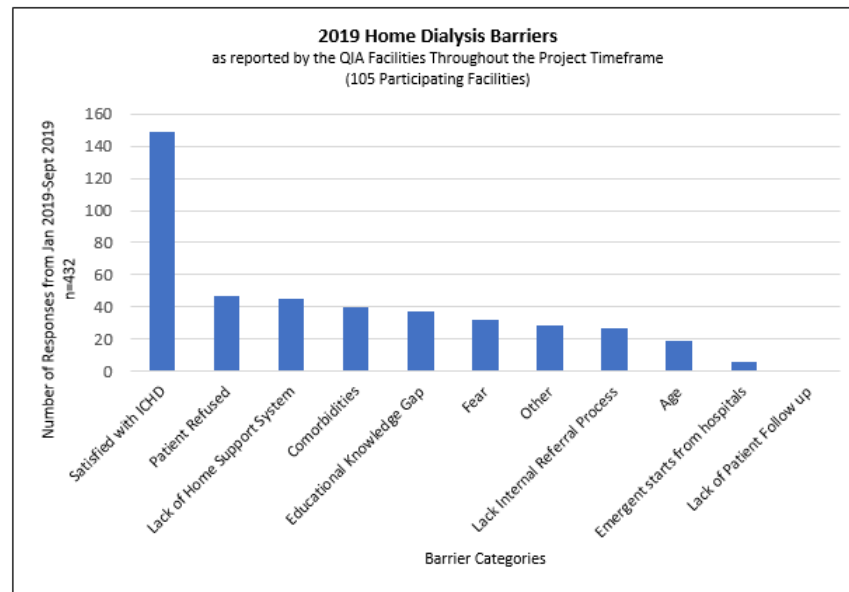


# 2019 Home Dialysis QIA - Barriers

Barriers at the  
start of the QIA

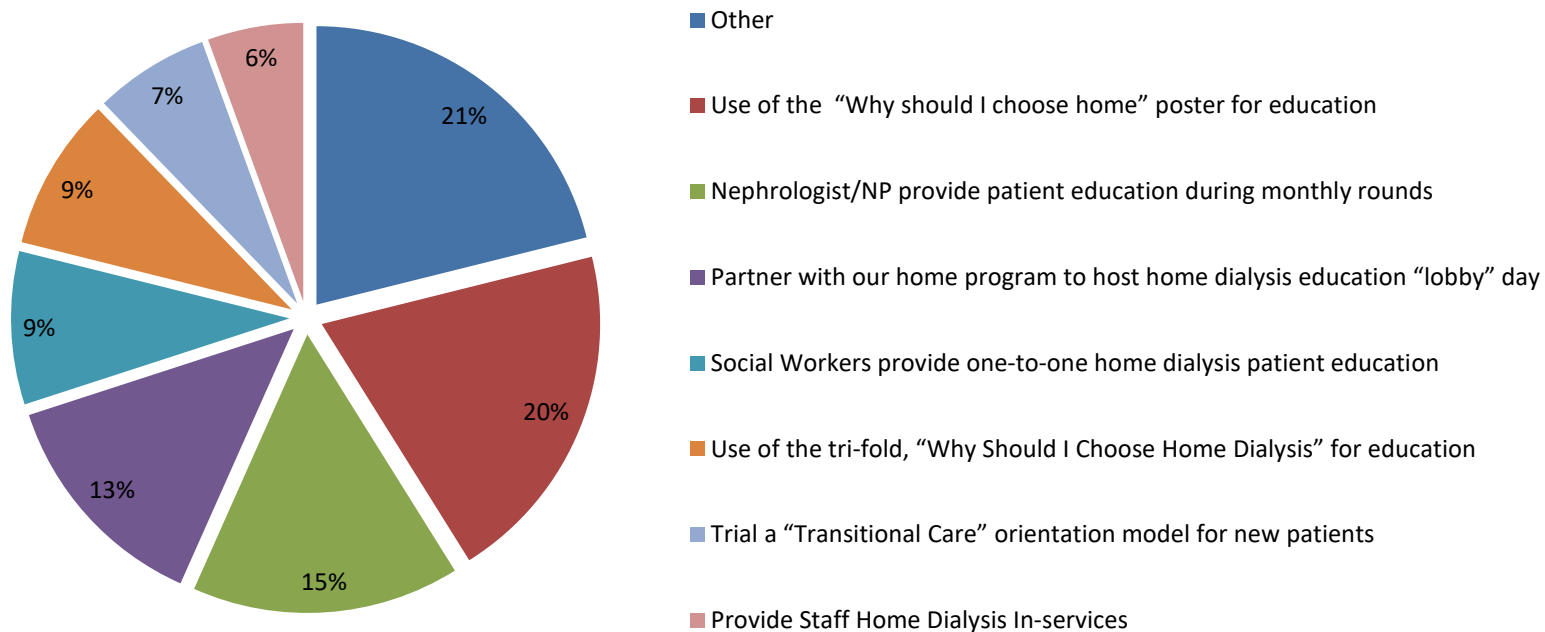


Barriers  
throughout the QIA



# 2019 Home Dialysis Interventions

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



# 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

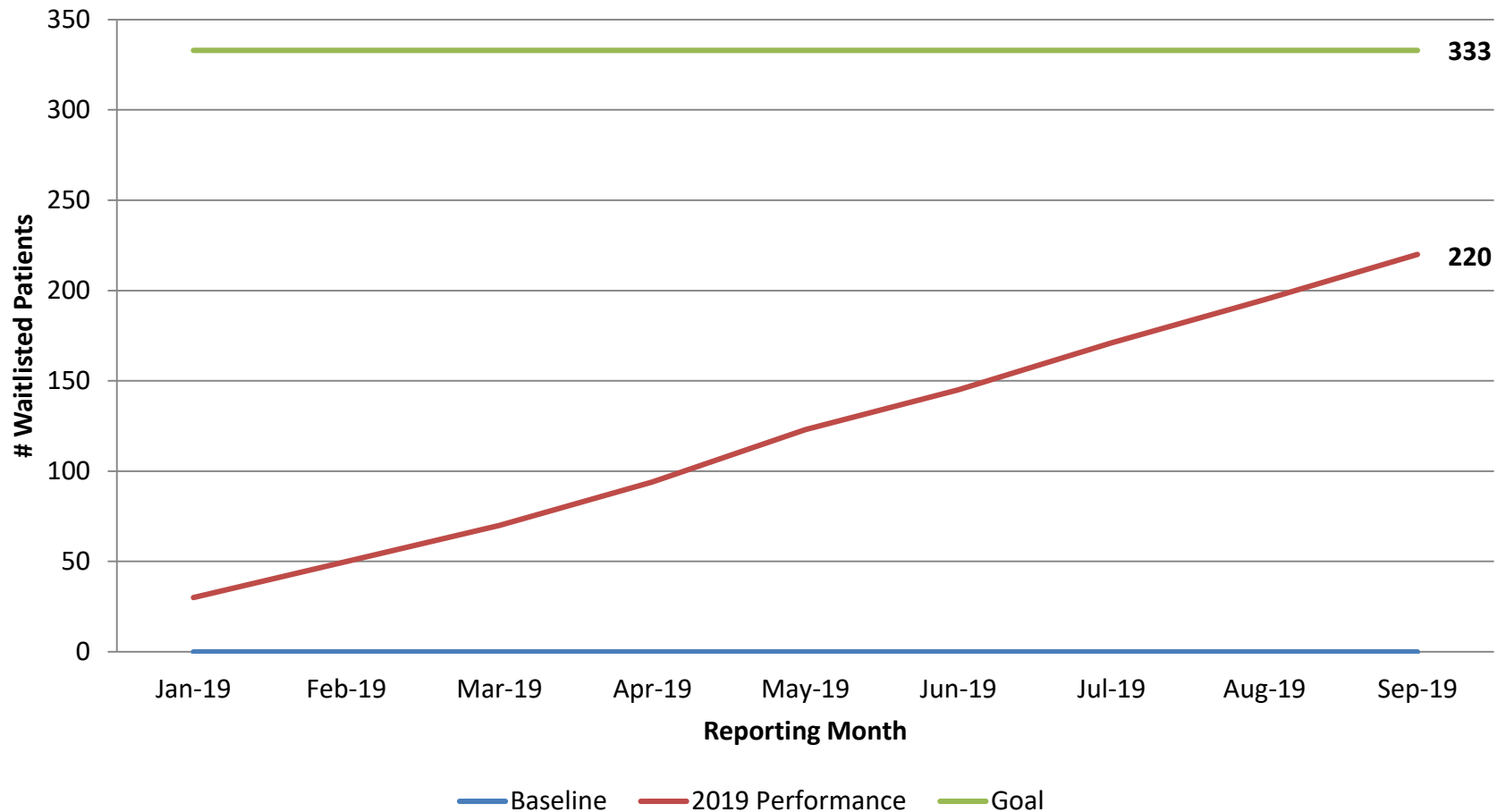
<https://www.qirn4.org/Ongoing-Projects/Home-Dialysis-Training.aspx>

# 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:

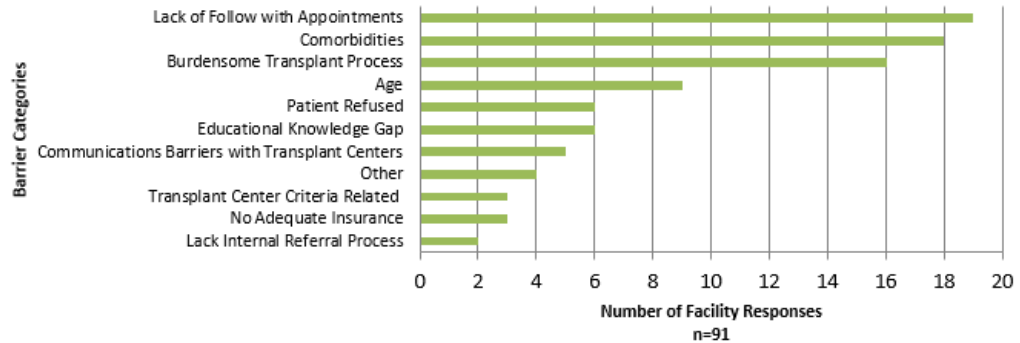


# Transplant Waitlist Barriers – 2019 QIA:

Barriers throughout QIA

## Transplant Waitlist Barriers

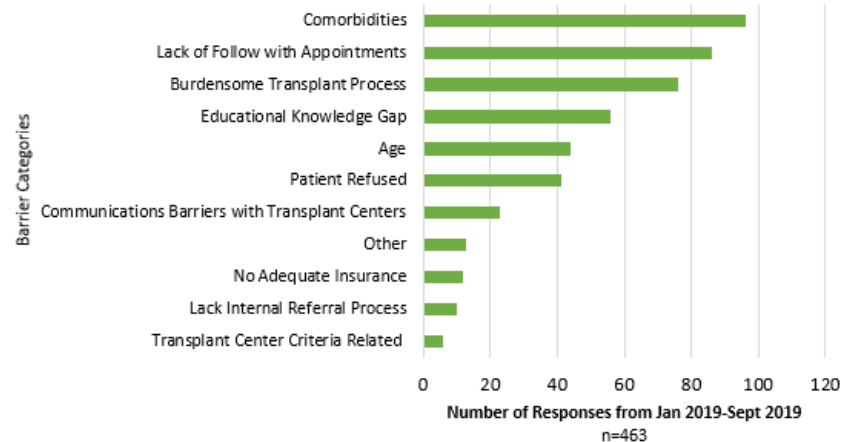
as reported by the QIA Facilities at the Start of the Project  
(105 Participating Facilities)



Barriers at the start of the QIA

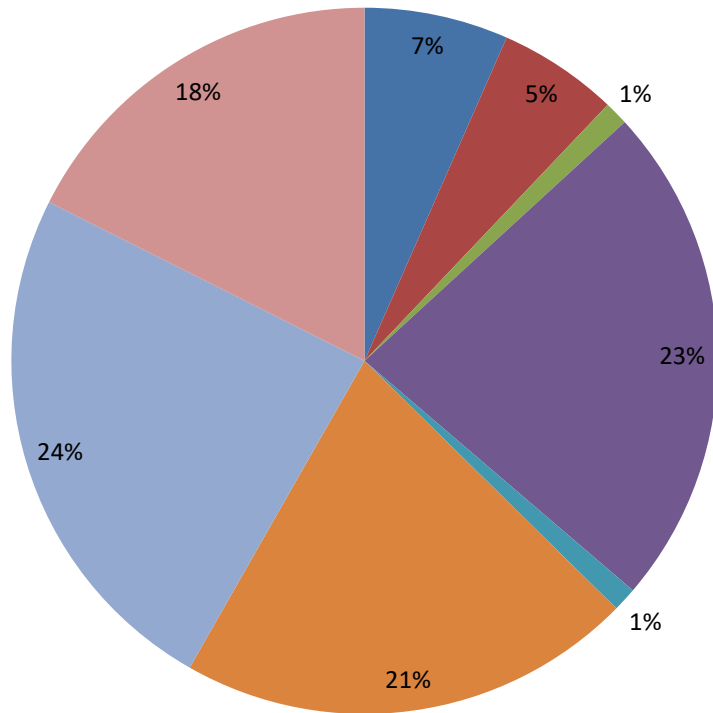
## Transplant Waitlist Barriers

as reported by the QIA Facilities throughout the Project Timeframe  
(105 Participating Facilities)



# 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-on 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
- Use of the tri-fold, "Talking About Transplant -- Questions to Ask Your Patients: A Guide for Dialysis Technicians" 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
  - Stiches 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

<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”

# PDSA 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

# PD<sup>S</sup>A 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?

# PDSA On-Line Reporting Tool Example

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

## **\*\*NOTE\*\***

To ease documentation burden

- Some fields with drop down options

After answering all questions:

- Review your summary
- Submit form



Previous Page

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?

-Select One-

## 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)?

-Select One-

**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?

-Select One-

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?



Next Step: Summary

# 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



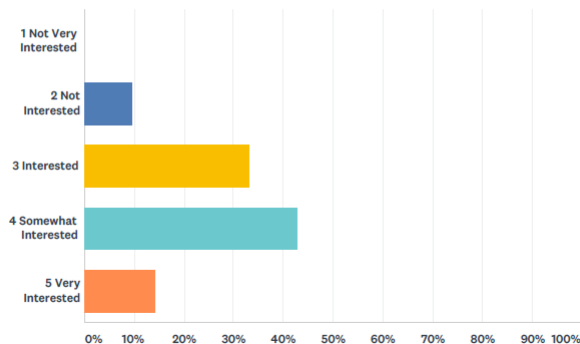
Diana Headlee-Bell



Timmy Nelson

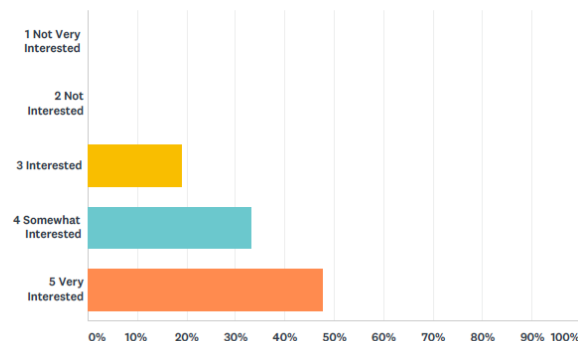
Q7 On a scale of 1-5, my patients were interested in Transplant and/or Home Dialysis PRIOR to the Patient Advocate's visit?

Answered: 21 Skipped: 0



Q8 On a scale of 1-5, my patients were interested in Transplant and/or Home Dialysis AFTER the Patient Advocate's visit?

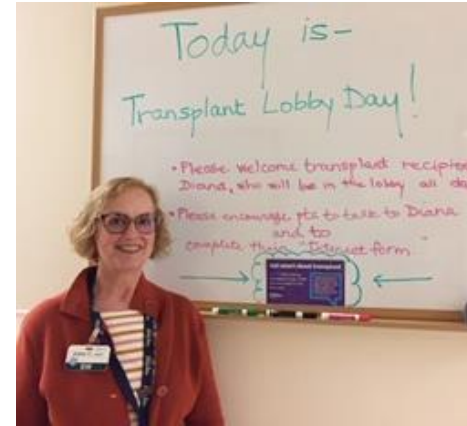
Answered: 21 Skipped: 0



# Network 4 Patient Advocate Program Intervention



# of Facilities Education Lobby Days	# of Patients Spoken to	# of Patients Interested	# of Patients Waitlisted or in a Home Program in the 32 Facilities
32 (10 HD Focus; 22 TR Focus)	>531	167	Total=114 Start of QIA=12 (HD=7; TR=5) End of QIA=114 (HD=72; TR=42)



Facility	2018 Total WL Count	Jan-19 WL Count	Feb-19 WL Count	Mar-19 WL Count	Apr-19 WL Count	May-19 WL Count	Jun-19 WL Count	July-19 WL Count	Aug-19 WL Count	Sept-19 WL Count	Expected WL Count	2019 Total WL Count	2019 NW Goal	Goal Status
A	3	0	2	0	1	0	1 (PA ED day)	0	0	1	1	5	5	Met
*B	4	0	0	1	0 (PA ED day)	3	0	1	0	0	3	5	5	Met

# Example of Dialysis Center Patient Level Report

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

Per CMS QIP specification for the new  
transplant waitlist measure, this report  
does not include patients >=75 years old  
unless they are waitlisted



						From UNOS			
Patient Name	DOB	Age	UPI	DOFD	Last 4 SSN	Date Waitlisted	Where Waitlisted*	Active?	Removal Code and Reason
		47		9/22/2015		3/21/2018	PATJ	Yes	
		47		9/22/2015		3/29/2018	MDJH	Yes	
		78		6/21/2013		10/27/2015	MDJH	No	
		51		5/29/2008		3/8/2010	DECC		6/18/2015 Candidate condition deteriorated, too sick
		49		10/16/2018					
		54		10/7/2014					
		58		10/24/2014					
		69		12/30/2017					
		66		8/23/2014					
		36		8/16/2016		10/9/2018	PAUP	Yes	

### Transplant Center Information

Code	Transplant Center Name	City	State	Center Phone
DECC	Christiana Care Health Services	Newark	DE	866-682-6792
ILNM	Northwestern Memorial Hospital	Chicago	IL	312-926-2000
ILPL	Rush University Medical Center	Chicago	IL	312-942-5000
MDJH	Johns Hopkins Hospital	Baltimore	MD	410-955-5000
NYDS	State University of New York, Downstate Medical	Brooklyn	NY	718-270-1000
PAHM	Hahnemann University Hospital	Philadelphia	PA	215-762-7000
PALV	Lehigh Valley Hospital	Allentown	PA	610-402-8000
PATJ	Thomas Jefferson University Hospital	Philadelphia	PA	215-955-6000
PAUP	Hospital of the University of Pennsylvania	Philadelphia	PA	215-662-4000

# Example of Transplant Center Report

## Transplant Center Waitlist Report Patients on Dialysis in US

#Pts On Report: 408  
#Facs On Report: 169



Network 3: 609-490-0310 Network 4: 610-265-2418

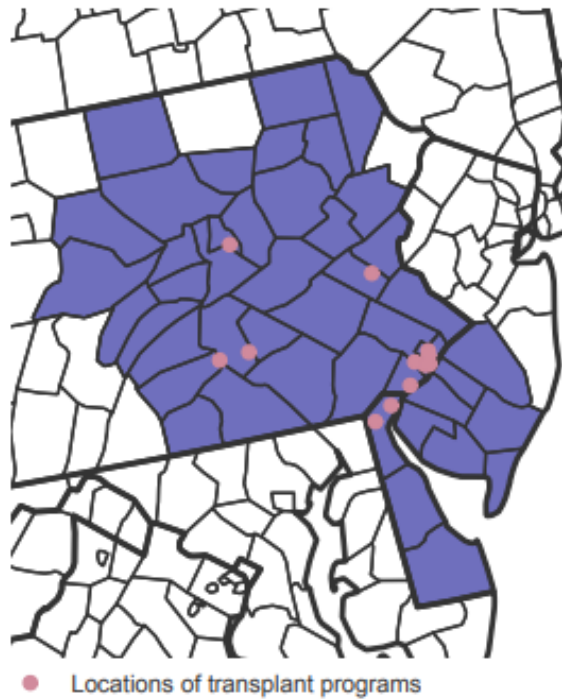
Network 3: 609-490-0310 Network 4: 610-265-2418

			Admission Type	Date Waitlisted (UNOS)	Active on Your Waitlist?	Also Listed At...
Patient Name	DOB	Date Admitted				
Kennedy Dialysis Center Washington Twp			Sewell, NJ	856-218-4990	Opened:	#Days/Wk 6
Medical Director: Anthony Brown			Administrator: Yvonne Berwick	Social Worker: Heather Hamilton		
		6/29/2010	Transfer In	5/24/2010	No	
		10/3/2014	Transfer In	4/28/2008	Yes	NJLL
		4/27/2011	Transfer In	8/11/2010	No	
Kew Gardens Dialysis Center			Kew Gardens, NY	718-793-3341	Opened:	#Days/Wk
Medical Director:			Administrator:	Social Worker:		
				3/12/2014	Yes	
				8/5/2014	No	
Kingsbrook Jewish Medical Center			Brooklyn, NY	718-604-5591	Opened:	#Days/Wk
Medical Director:			Administrator:	Social Worker:		
				10/3/2012	No	
Knickerbocker Dialysis			Bayside, NY	718-224-2398	Opened:	#Days/Wk
Medical Director:			Administrator:	Social Worker:		
				5/20/2019	Yes	

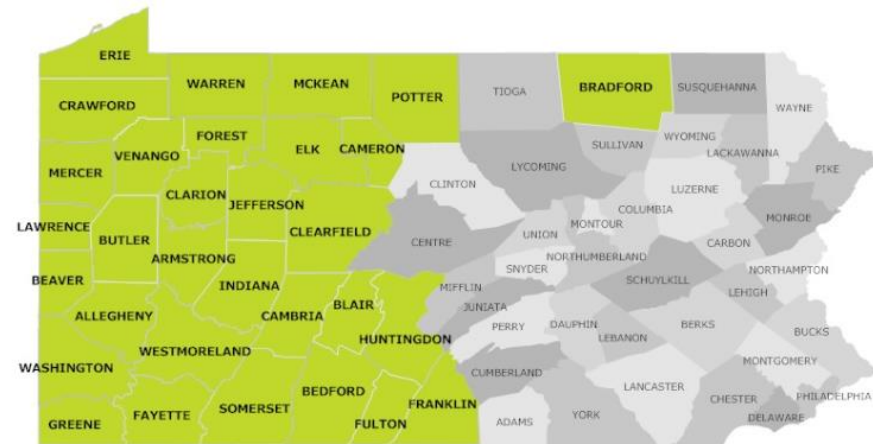
# Organ Procurement Organizations (OPOs)



Figure A2. Counties served by PADV



<https://www.donors1.org>



<https://www.core.org/>

# Procurement Organizations (OPOs)

Find your OPO

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

## 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**

## 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**

### **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 pamphlets about organ donation and transplant, transplant waiting lists and statistical information  
Toll free phone number: 1-888-894-6361  
Website: [www.unos.org](http://www.unos.org)

**National Kidney Foundation**  
Information and resources on kidney disease and transplant  
Website: [www.kidney.org](http://www.kidney.org)

**Coalition on Donation**  
Information on how to become an organ and tissue donor  
Phone number: 1-804-782-4920  
Website: [www.shareyourlife.org](http://www.shareyourlife.org)



610 Freedom Business Center, Suite 102  
King of Prussia, PA 19406  
(610) 265-2418  
(610) 783-0374 (Fax)  
(800) 548-9205 (Patient Toll-Free Line)  
[www.qim4.org](http://www.qim4.org)

This material was prepared by Quality Insights Renal Network 4 under contract with the Centers for Medicare & Medicaid Services (CMS). The contents do not necessarily reflect CMS policy. Publication No. 2012-07-2011B



## Understanding CHALLENGES

*A Guide to Understanding the Challenges of a Kidney Transplant Evaluation and Workup*



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?

Often 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 preference. 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 records. 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 cumbersome 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 new health problems, hospitalizations, changes in your insurance or medication coverage and if you get any blood transfusions.



## Talking About TRANSPLANT

Questions to Ask Your Patients:  
A Guide for Dialysis Technicians

## 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.



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(610) 265-2418

(610) 783-0374 (Fax)

(800) 548-9205 (Patient Line)

[www.qim4.org](http://www.qim4.org)

## Acknowledgement

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# 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

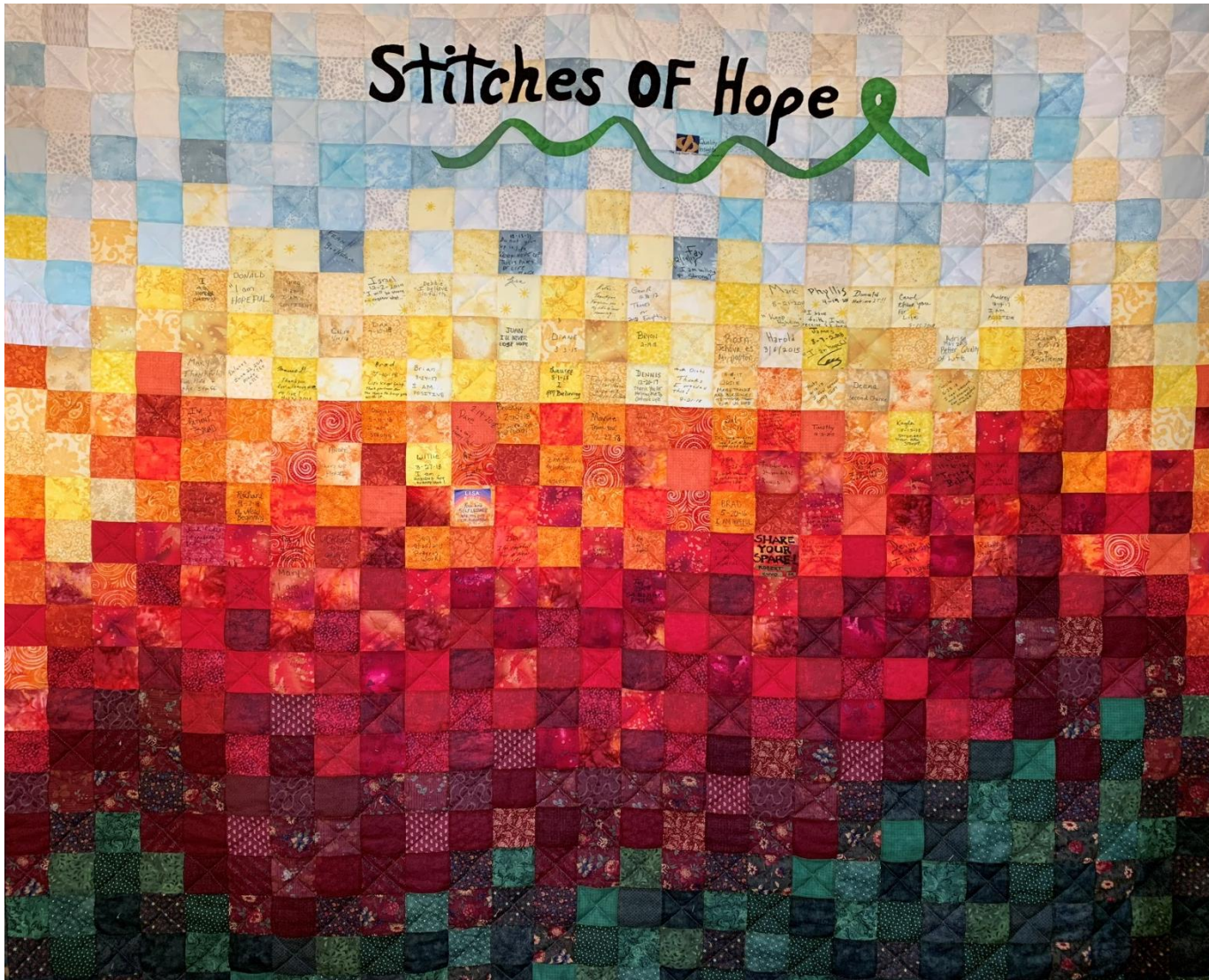
### Provide opportunity to add patient’s name

#### 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

### Helpful Resources

**End-Stage Renal Disease (ESRD) National Coordinating Center (NCC)**  
[www.esrdncc.org](http://www.esrdncc.org)  
 Provides support and coordination at the national level for ESRD Networks

**Home Dialysis Central**  
[www.homedialysis.org](http://www.homedialysis.org)  
 A one-stop, online source of up-to-date information about home dialysis for people with kidney disease, their families, and the health care professionals who provide kidney disease care

**Alliance for Home Dialysis**  
[www.homedialysisalliance.org](http://www.homedialysisalliance.org)  
 Promotes activities and policies that facilitate treatment choice in dialysis care while identifying and addressing barriers that limit access for patients and their families to the many benefits of home dialysis therapy

### Acknowledgements

Most content from this brochure can be found on the ESRD National Coordinating Center website at [www.esrdncc.org](http://www.esrdncc.org).



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[www.qirn4.org](http://www.qirn4.org)



### Why Should I Choose HOME DIALYSIS?





### Did You Know?

More than 90% of kidney professionals would choose home therapy as the initial treatment option if they were a dialysis patient.

Source: Schiller, B., Neizer, A., Davis, S. (2010). Nephrology News Issues. (24) 36-44.

### Peritoneal Dialysis (PD)

Why it may work for you:

- Needles are not used and your blood does not leave your body.
- PD allows more independence and control of treatment and life choices.
- Your own body, not a dialyzer, cleans your blood.
- You don't have to travel to a center to receive treatment. It could be performed at your home, school, or work.
- 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. Supplies can be shipped to you anywhere in the United States.

### Home Hemodialysis (HHD)

Why it may work for you:



- HHD uses your existing arterial fistula or graft site.
- HHD allows more independence and control of treatment and life 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.


## Why should I choose HOME?

Has no needles	PD	<p><i>More than 90% of kidney professionals would choose home therapy as the initial treatment option if they were a dialysis patient.</i></p> <p><small>Source: Schiller, B., Neizer, A., Davis, S. (2010). Nephrology News Issues. (24) 36-44.</small></p>
Has fewer side effects	PD / HHD	
Is easy to do	PD / HHD	
Is gentle on your heart	PD / HHD	
Makes it easier to travel	PD / HHD	
Helps you keep your job	PD / HHD	
A partner may not be required	PD / HHD	
Improves your quality of life	PD / HHD	
Has fewer dietary and fluid restrictions	PD / HHD	
Allows you to set your own schedule	PD / HHD	
Has fewer medications	PD / HHD	
Allows you to spend more time with your loved ones	PD / HHD	
Has 24-hour remote nurse support	PD / HHD	

### Peritoneal Dialysis (PD) | Home Hemodialysis (HHD)

#### NEXT STEPS

 Ask your dialysis team.
  Ask about treatment options.



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Patient Phone: (800) 548-9205  
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# 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>

Patient Caseload Report Survey Monkey Link – for **HOME ONLY Facilities**

<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

# Selected Facilities Next Steps . . . Continued

## 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:

<https://www.qirn4.org/Ongoing-Projects/Home-Dialysis-Training.aspx>

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

<https://www.qirn4.org/Ongoing-Projects/Improving-Transplant-Waitlists-QIA.aspx>

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