
# AIM 2: Innovation Project

## Improve Transplant Referrals

February 16, 2017
1:00 PM EST

# Transplant Referral Quality Improvement Activity

Quality Insights Renal Network 4 (QIRN 4), under the direction of the Centers for Medicare & Medicaid Services (CMS), is to assist  dialysis and transplant facilities in improving the quality of care they provide to End Stage Renal Disease (ESRD) patients.

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# Transplant Referral Quality Improvement Activity

## Why are you here?

- QIRN4 was awarded the CMS - ESRD contract for 2016-2020
- We have be working on eight Quality Improvement Activities (QIA's) These projects are geared toward meeting CMS's three AIMs (also known as *the Triple Aim*):
  - AIM 1: Better Care through Patient Engagement
  - AIM 2: Better Health for ESRD Patients
  - AIM 3: Reduced Cost of ESRD Care by Improving Care
- CMS requires us to select one of the follow projects in AIM 2:
  - Improve Dialysis Care Coordination with a Focus on Reducing Hospital Utilization
  - Improve the Frequency to Transplant Referrals
  - Improve the Frequency of Home Dialysis Referrals
  - Improve the Quality of Life of ESRD Patients

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# Transplant Referral Quality Improvement Activity

- **Goal for this project:**
  - **Desire outcome:** Move towards achieving and sustaining a minimum 75% referral rate for eligible patients
  - Decrease the Identified **Female** Disparity
    - **Focus on Females**
    - For every new male patient referred, **DOUBLE** the number of new **female** referrals
  - Achieve individual minimum facility goal (10 percentage points from the baseline for 2017)

**Note:** This is a multi-year rolling project, facilities will continue with the project if they do not meet the desire outcome of 75% total referral rate and decrease the disparity

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# Transplant Referral Quality Improvement Activity

**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
- Reduces morbidity
- Offer better quality of life
- Are more cost effective than dialysis

Despite the benefits of kidney transplantation, according to the United States Renal Data System (USRDS), in 2013, 88.2 percent of all incident cases began renal replacement therapy with hemodialysis, 9.0 percent started with peritoneal dialysis, and 2.6 percent received a preemptive kidney transplant.

*United States Renal Data System. 2016 USRDS annual data report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2016*

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# Transplant Referral Quality Improvement Activity

**Background**:

A recent study concluded that “a majority of patients felt unprepared and ill-informed about the initiation of dialysis”.

From the same study about dialysis modality, 21.2 percent said that they had felt rushed to make a decision, 31.3 percent felt that the decision was made by the doctor, and only 13 percent felt the decision was made collaboratively between themselves and the doctor. Lack of modality education typically leads to in-center hemodialysis as the default dialysis modality, predominantly for late-referred patients.

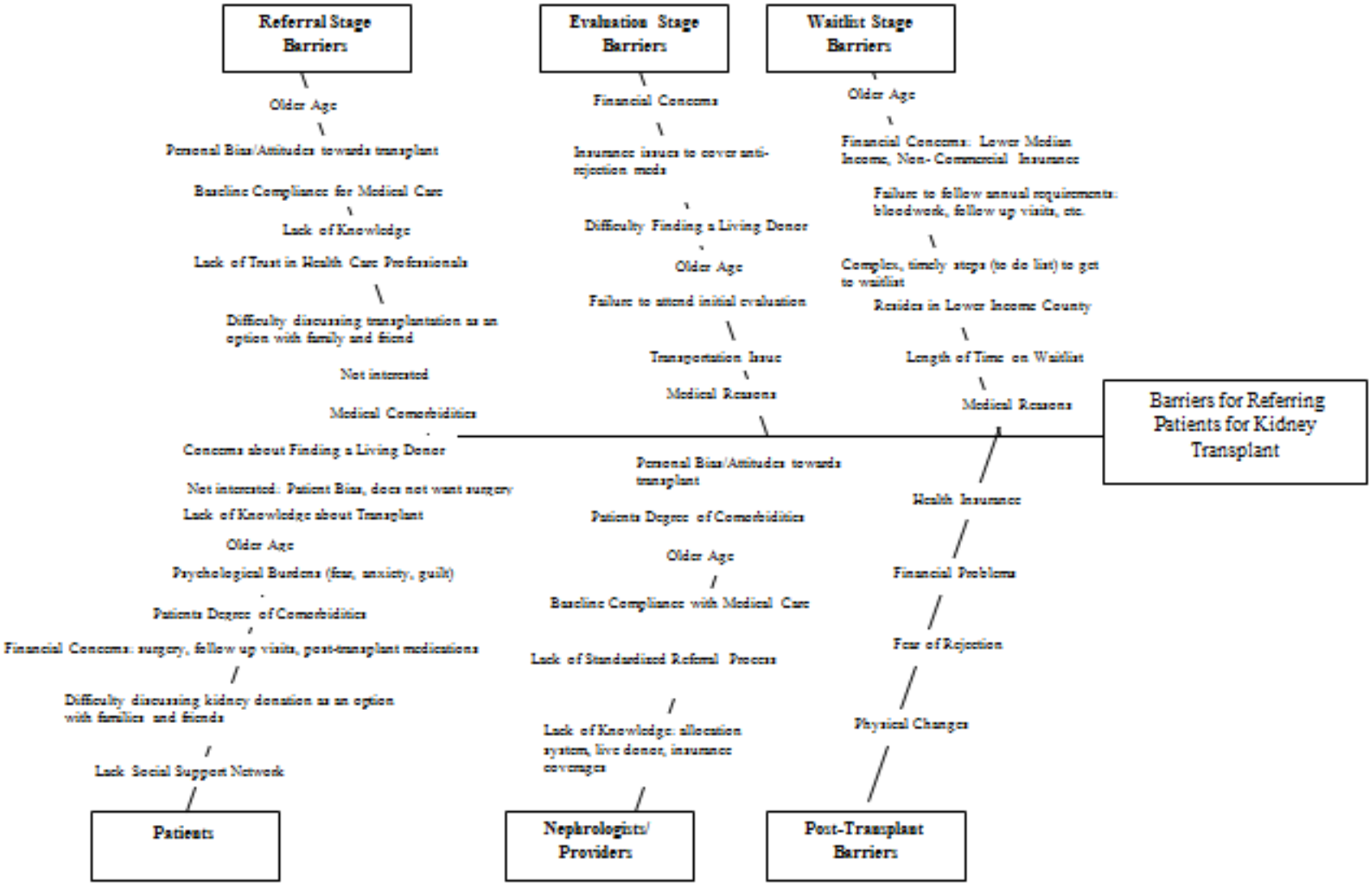
Song MK, Lin FC, Gilet CA, Arnold RM, Bridgman JC, Ward SE. Patient perspectives on informed decision-making surrounding dialysis initiation. 2013. http://ndt.oxfordjournals.org/content/28/11/2815.full. Accessed January 18, 2016

# Transplant Referral Quality Improvement Activity

**Background**:

QIRN 4 conducted a root cause analysis (RCA) to find possible barriers to referring patients for transplant

A patient stated that, “the only time you really hear about transplant is when the patient first come to the facility. Education and follow-up is the key. Make sure patients get a full understanding of transplant (good and bad).”


Barriers for Referring Patients for Kidney Transplant
Referral Stage Barriers
Older Age
Personal Bias/Attitudes towards transplant
Baseline Compliance for Medical Care
Lack of Knowledge
Lack of Trust in Health Care Professionals
Difficulty discussing transplantation as an option with family and friend
Not interested
Medical Comorbidities
Concerns about Finding a Living Donor
Not interested: Patient Bias, does not want surgery
Lack of Knowledge about Transplant
Older Age
Psychological Burdens (fear, anxiety, guilt)
Patients Degree of Comorbidities
Financial Concerns: surgery, follow up visits, post-transplant medications
Difficulty discussing kidney donation as an option with families and friends
Lack Social Support Network
Patients
Evaluation Stage Barriers
Financial Concerns
Insurance issues to cover anti-rejection meds
Difficulty Finding a Living Donor
Older Age
Failure to attend initial evaluation
Transportation Issue
Medical Reasons
Personal Bias/Attitudes towards transplant
Patients Degree of Comorbidities
Older Age
Baseline Compliance with Medical Care
Lack of Standardized Referral Process
Lack of Knowledge: allocation system, live donor, insurance coverages
Nephrologists/ Providers
Waitlist Stage Barriers
Older Age
Financial Concerns: Lower Median Income, Non-Commercial Insurance
Failure to follow annual requirements: bloodwork, follow up visits, etc.
Complex, timely steps (to do list) to get to waitlist
Resides in Lower Income County
Length of Time on Waitlist
Medical Reasons
Health Insurance
Financial Problems
Fear of Rejection
Physical Changes
Post-Transplant Barriers

# Transplant Referral Quality Improvement Activity

**Facility Selection Process**:

- The first step to selecting participating facilities was an analysis of the facility's outcome on the Dialysis Facility Compare report looking at each facility's percentages of patients on the waitlist.
- We identified 15 facilities where less than 25 percent of patients were waitlisted. These 15 facilities consisted of 1,066 patients from the 20,000 hemodialysis patient populations in Network 4.

# Transplant Referral Quality Improvement Activity

**Facility Selection Process**:

- In order to calculate the referral rate, QIRN 4 downloaded a CROWNWeb Patient Population Report for each of the 15 facilities and faxed each facility the report with current patient data as of September 2016 and requested the facility to review the patient list and answer the following questions:
  - Has the patient been referred to a transplant center?
  - Is the patient currently on the waitlist?
- The activity with these focus facilities was to gather the transplant referral rate and disparity. We received data from all 15 facilities which were used to establish the transplant referral baseline rate and disparity.
- We confirmed a total referral rate of 23.9 percent which is less than the 25 percent required by the SOW to continue with the project. The disparity is gender: female (19.8 percent) vs male (27.0 percent).

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Disparity assessed in the following order:

1. Race (African American vs. White or Groups Other than White vs. White)
2. Ethnicity (Hispanic vs. Non-Hispanic)
3. Facility Location (Rural vs Urban)
4. Gender (Female vs. Male)
5. Age (65 and older vs. Younger than Age 65)

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# Transplant Referral Quality Improvement Activity

**Transplant Referral Baseline & Gender Disparity Rates**

| | Female | Male | Total Referrals |
|---|---|---|---|
| Numerator | 91 | 164 | 255 |
| Denominator | 459 | 607 | 1066 |
| Percentage | 19.8% | 27% | 23.9% |

| Rates | Baseline | Goal (by Sept 30, 2017) |
|---|---|---|
| Total Referral Rate | 23.9% | 33.9% |
| Disparity Rate | 7.2% | 6.2% |

*Data Source: 2017 15 Participating Facilities*

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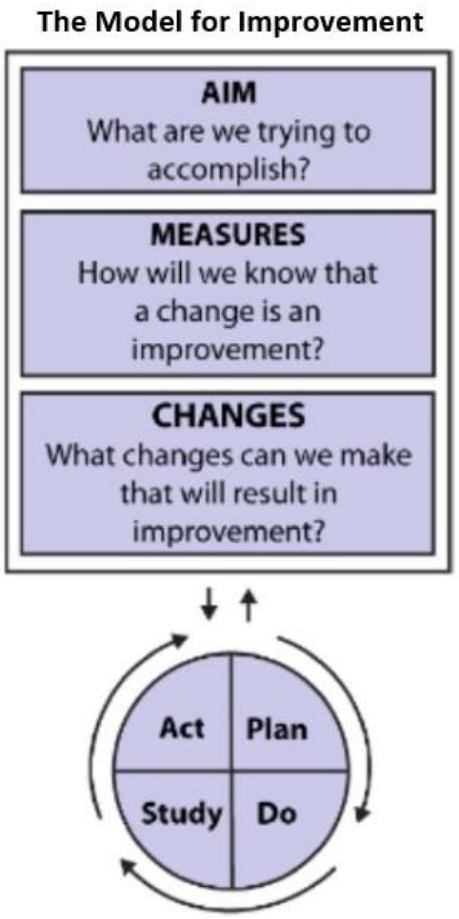
# How to Improve

Institute for Healthcare Improvement (IHI) Model for Improvement
http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx




The Model for Improvement has two parts.

The first part looks at key questions to help guide our thinking about our improvement effort. Those questions are:

1. What are we trying to accomplish?
   This provides direction and is the AIM of our work
2. How will we know that a change is an improvement?
   This is about how we MEASURE where we are now and where we want to be
3. What changes can we make that will result in an improvement?
   These are the CHANGES we can make to achieve our goal

The second part is about how we TEST the changes we came up with.
It's called the Plan-Do-Study-Act cycle or the PDSA cycle for short.

It is a tool to help us learn the best way to make changes and continually improving how we work.

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# Next Step . . .

**Providers**:

- Evaluate your transplant referral process. Is there a formal/written policy/procedure? (Network will provide one time questionnaire. Due by February 23, 2017)
- **Monthly Review of Facility Referral Report (Only for February, Network will FAX** and provider is to **FAX** report back by February 28, 2017.

  Note: For **March – September reporting**, patient names will be removed for emailing purposes. Due to kkha-moua@nw4.esrd.net by the **end of the month** for the reporting month

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# Transplant Referral Quality Improvement Activity

## One time FAX -- Facility Referral Report Recap

- Network will initially **Fax** patient list (only for Feb)
- Provider review patient list (include all current patients not on the list)
- Any patient not referred – list reason(s), be specific for listing "refused" or "medical"
- **FAX** to Network by **February 28, 2017**

**Do Not Email Patient Information**

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# Next Step . . .

**Providers**:

- Complete a root cause analysis (RCA) and identify the barriers for referring patients for transplant (Do NOT need to submit to Network)
- Carry out interventions targeting the barriers
- Document the PDSA cycles to test the effectiveness of the monthly interventions (Network will provide template)
- Submit monthly PDSA cycle interventions for Network review and feedback to ensure interventions are addressing RCA barriers(s)
- Update and submit monthly referrals using the Monthly Facility Referral Report edited for emailing purposes (Network will provide report)
- Engage facility patient representative to be a patient champion
- Assign a facility transplant "Navigator" to assist, educate and ensure patients receive adequate information on the transplant option in order for patients to make informed decisions

# Next Steps . . .

**Network:**

- Provide monthly progress reporting tool which will show the facility's referral rates
- Design educational campaign materials addressing possible female specific barriers such as the following:
  - greater female sense of responsibility, altruism or even coercion
  - higher sensitization to HLA antigens, gender-bias on part of physicians or institutions
  - lack of social support networks, and differences in health-seeking behaviors with the conceptual aim of empowering the female patients' to make informed decision on transplant referral

  *Contact Kou at kkha-moua@nw4.esrd.net if you would like to assist in with the design of these educational materials.*
- Promote the National Kidney Foundation's Kidney Early Evaluation Program (KEEP) in Network 4 service area
- Spread the use of peritoneal dialysis in the interim as patients wait for transplant. Provide to facilities and medical directors with supportive research articles and recruit speaker for webinar opportunities
- Work one-on-one with the focus facilities by means of either site visits and/or phone calls for individual coaching and mentoring

# Next Step. . .

- Convene a Network 4 Transplant Mentor Support Group to be available for patient-to- patient sharing of experiences with the goal of encouraging other patients to explore transplant as an option
- Invite transplanted patients to be mentors for other patients considering transplant
- Have selected patients go through the National Coordinating Center's (NCC) Peer Mentoring program in preparation for being a part of the Network 4 Transplant Mentor Support group

Goal: To successfully recruit, train, and implement the support group

*If you have know of potential candidates (especially female patients) to be consider for this mentor support group, contact Kou, 610-265-2418,ext 2820*

# Transplant Referral Quality Improvement Activity

Research of promising practices resulted in two comprehensive decision aid resources which may assist facilities with transplant referral:

- **PREPARED** Materials developed by a multidisciplinary research team, led by Dr. L. Ebony Boulware. The PREPARED video and book are designed to help patients make treatment options for kidney disease, specifically transplant.

- **Talking about Living Kidney Donation (TALK**) Materials designed by the faculty at the Johns Hopkins School of Medicine and the leaders of the National Kidney Foundation of Maryland. The TALK guide may help patients talk about kidney disease with their families and friends. Small talk could possibly make a big difference later.

# Transplant Referral Quality Improvement Activity

## Definitions:

- Eligible for referral – all patients regardless of modality
- A patient is considered "referred" when all **4 steps** are completed:
  1. Discussed transplant option with the patient
  2. Patient agreed to pursue further
  3. Provided patient with the Network 4 Transplant Centers List; encouraged patient to contact the transplant center(s) of his/her choice
  4. Completed a follow up discussion with patient to see if the patient made contact with a transplant center(s)

**Note:** for #3, providers may need to contact the transplant centers if the transplant centers policy requires the initial contact be from the dialysis facility

# Example: MONTLY FACILITY REFERRAL REPORT (ONE TIME ONLY - FEBRUARY WITH NAMES **FAX (610) 783-0374**)

| | | | 12345-ABC Dialysis Facility | | | |
|---|---|---|---|---|---|---|
| **Baseline: 17.6% Goal 27.6%** | | | | | | |
| | | | | YES | | NO |
| UPI | Patient Names (Made up) | Gender | Was the patient referred for transplant? Answer YES or NO then (If Yes, answer the questions under Yes at right, starting at column E; If NO, answer the question under No, in column G | When was the patient referred? List the Month/Year if you do not know the exact date | Did the referral lead to waitlisting? Yes/No | If NO, list the reason(s) why the patient was not referred. If patient "refused" list reason(s) for refusal if known. If listing "medical" as a reason, be specific. |
| 123456780 | Best, Baby | F | | | | |
| 210005879 | Blue, Jean | M | | | | |
| 500451122 | Bye, Cat | F | | | | |
| 400567493 | Cool, June | M | | | | |
| 598444736 | Creek, Middle | F | | | | |
| 1238765322 | Custom, Kitchen | M | | | | |

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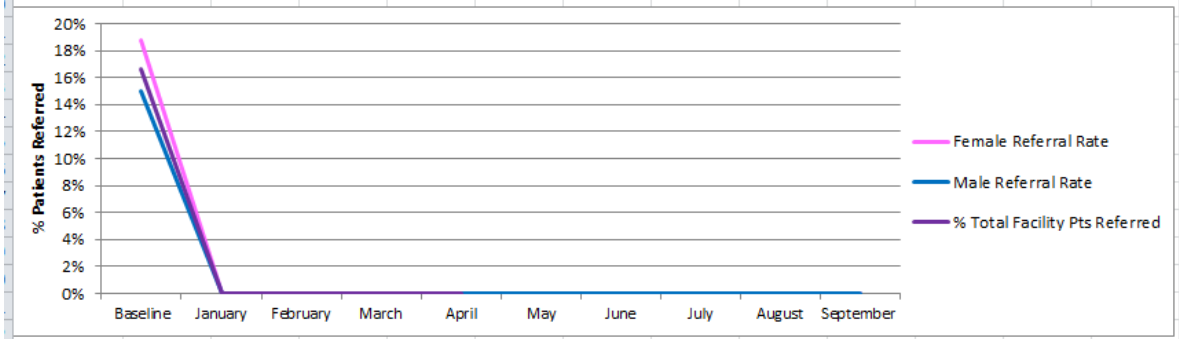
# Example: Monthly Rates Report

**Directions: Provider enters Transplant Navigator name, email and phone contact information**
**Network will calculate the monthly rates from the monthly Facilty Patient Report**

| | | | | | |
|---|---|---|---|---|---|
| **Facility Name:** | **ABC Dialysis Facility** | | | **CCN:** | **12345** |
| **September 2017 Goals:** | **Facility Total** | | **Transplant Navigator:** | | |
| **Total Facility Referral Rate** | **26.7%** | (10 percentage point increase) | **Email:** | | |
| | | | **Phone:** | | |

**Focus on FEMALES: For every new MALE pateint referred, DOUBLE the number of new FEMALE referrals**

| | Female Patients | | | | Male Patients | | | | Total Facility Patients | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # of Female Patients Referred | # of Female Patients Not Referred | Total Female Patients | Female Referral Rate | # of Male Patients Referred | # of Male Patients Not Referred | Total Male Patients | Male Referral Rate | # of Total Facility Patients Referred | # of Total Facility Patients Not Referred | Total Facility Patients | Total Facility Referral Rate |
| **Baseline** | 3 | 13 | 16 | 18.8% | 3 | 17 | 20 | 15.0% | 6 | 30 | 36 | 16.7% |
| January | | | 0 | | | | 0 | | | | | |
| February | | | 0 | | | | 0 | | | | | |
| March | | | 0 | | | | 0 | | | | | |
| April | | | 0 | | | | 0 | | | | | |
| May | | | 0 | | | | 0 | | | | | |
| June | | | 0 | | | | 0 | | | | | |
| July | | | 0 | | | | 0 | | | | | |
| August | | | 0 | | | | 0 | | | | | |
| September | | | 0 | | | | 0 | | | | | |




Monthly Rates | Montly Facility Referral Report | PDSA Cycles | PDSA Example | Resources

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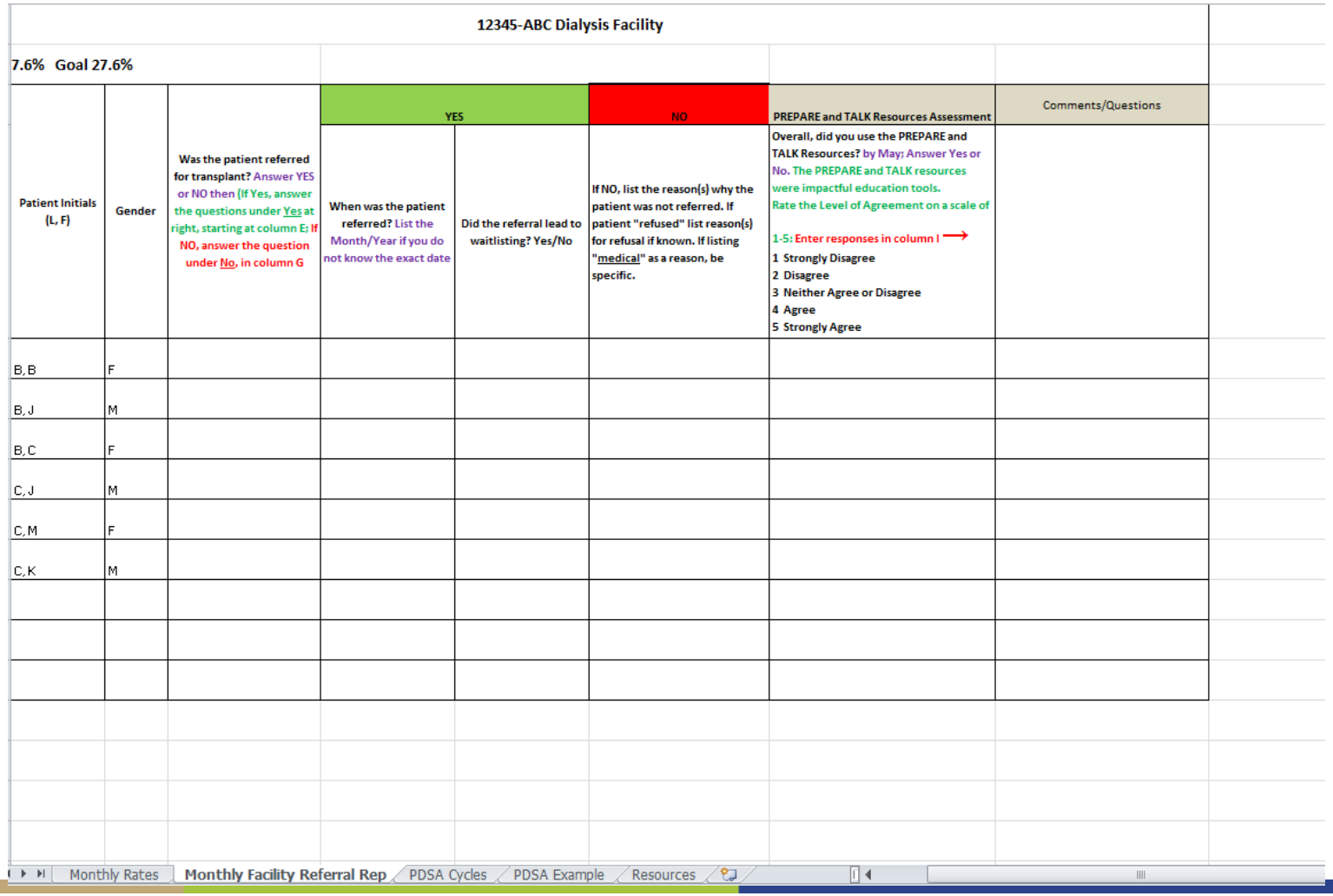
# Example: Monthly Facility Referral Report for emailing



12345-ABC Dialysis Facility

7.6% Goal 27.6%

| Patient Initials (L, F) | Gender | Was the patient referred for transplant? Answer YES or NO then (If Yes, answer the questions under Yes at right, starting at column E; If NO, answer the question under No, in column G | YES | | NO | PREPARE and TALK Resources Assessment | Comments/Questions |
|---|---|---|---|---|---|---|---|
| | | | When was the patient referred? List the Month/Year if you do not know the exact date | Did the referral lead to waitlisting? Yes/No | If NO, list the reason(s) why the patient was not referred. If patient "refused" list reason(s) for refusal if known. If listing "medical" as a reason, be specific. | Overall, did you use the PREPARE and TALK Resources? by May; Answer Yes or No. The PREPARE and TALK resources were impactful education tools. Rate the Level of Agreement on a scale of<br>1-5: Enter responses in column I →<br>1 Strongly Disagree<br>2 Disagree<br>3 Neither Agree or Disagree<br>4 Agree<br>5 Strongly Agree | |
| B, B | F | | | | | | |
| B, J | M | | | | | | |
| B, C | F | | | | | | |
| C, J | M | | | | | | |
| C, M | F | | | | | | |
| C, K | M | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Monthly Rates | Monthly Facility Referral Rep | PDSA Cycles | PDSA Example | Resources

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# Where to document the PDSA Cycles

**PLAN DO STUDY ACT (PDSA)**

| Months | For each month, list the top barrier/reason for transplant referral refusal: | **PLAN:** Describe your monthly plan to improve the identified barriers | **DO:** Describe the intervention(s) you DID this month to reach your improvement? | **STUDY** | | **ACT:** What are you going to do for your next PDSA Cycle? Accept (continues with the same plan; Adapt (change the plan for next month; or Abort (we need to start all over with a new plan). If Adapt or Abort, document your changes/new plans in column C for the next month. | Other comments: |
|---|---|---|---|---|---|---|---|
| | | | | **YES,** achieved the goal! What did you observe? What were your success for this month about the effectiveness of your intervention(s)? | **NO,** did NOT achieve the goal. What did you observe? What were your barriers for this month about the effectiveness of your intervention(s)? | | |
| February | NA | NA | NA | NA | NA | NA | NA |
| March | | | | | | | |
| April | | | | | | | |
| May | | | | | | | |
| June | | | | | | | |
| July | | | | | | | |
| August | | | | | | | |
| September | | | | | | | |

Monthly Rates | Monthly Facility Referral Rep | PDSA Cycles | PDSA Example | Resources

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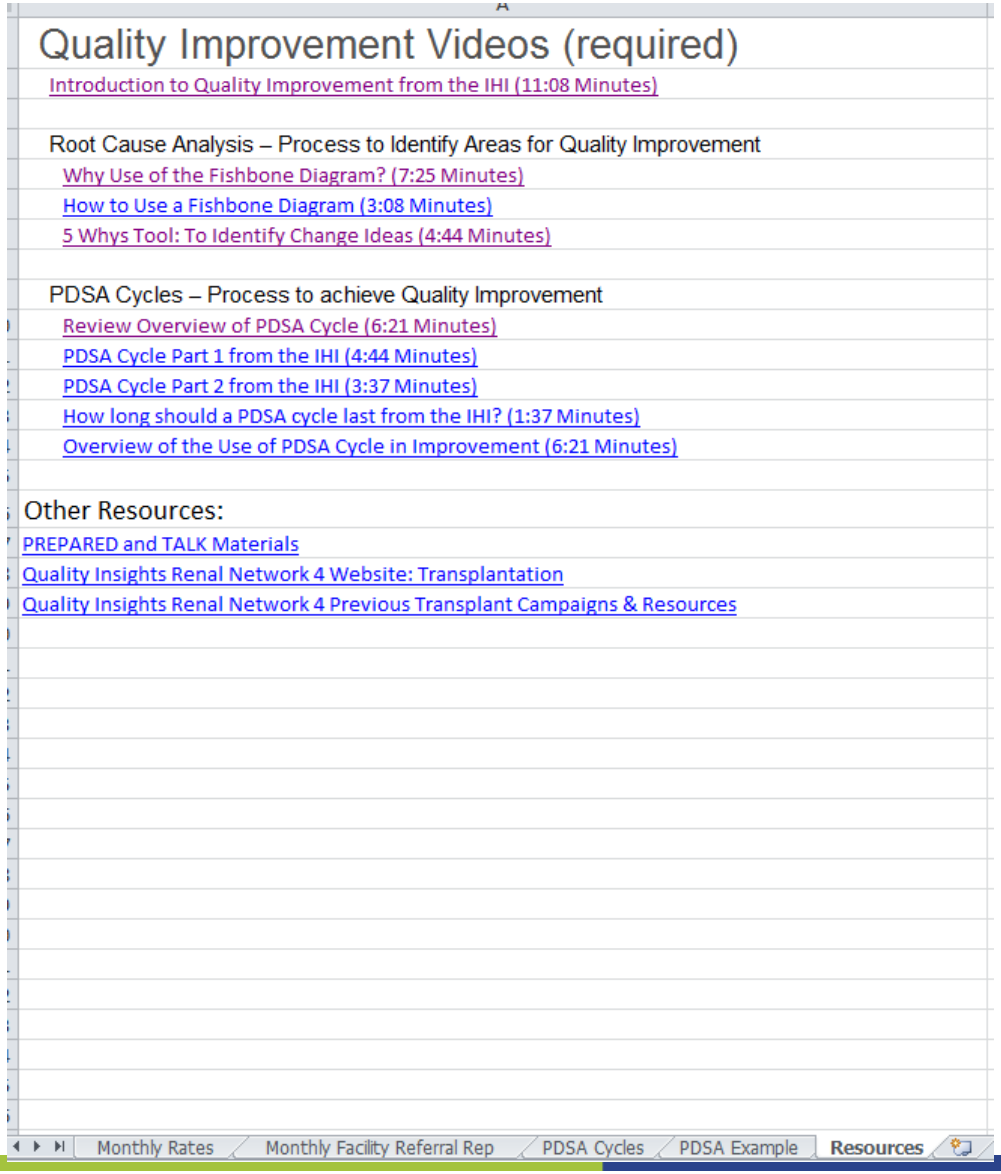

# Quality Improvement Videos (required)

Introduction to Quality Improvement from the IHI (11:08 Minutes)

Root Cause Analysis – Process to Identify Areas for Quality Improvement

- Why Use of the Fishbone Diagram? (7:25 Minutes)
- How to Use a Fishbone Diagram (3:08 Minutes)
- 5 Whys Tool: To Identify Change Ideas (4:44 Minutes)

PDSA Cycles – Process to achieve Quality Improvement

- Review Overview of PDSA Cycle (6:21 Minutes)
- PDSA Cycle Part 1 from the IHI (4:44 Minutes)
- PDSA Cycle Part 2 from the IHI (3:37 Minutes)
- How long should a PDSA cycle last from the IHI? (1:37 Minutes)
- Overview of the Use of PDSA Cycle in Improvement (6:21 Minutes)

## Other Resources:

PREPARED and TALK Materials

Quality Insights Renal Network 4 Website: Transplantation

Quality Insights Renal Network 4 Previous Transplant Campaigns & Resources



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# Transplant Referral Quality Improvement Activity

**What has worked?**

- Partnership with Transplant Centers
  - Schedule Lobby Days for
    - May
    - June
    - July
    - August

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# Coming your way . . .

By this week

by **Email**:

1. The presentation
2. Transplant referral process questionnaire

by **Fax**:

1. Monthly Facility Referral Report

In the beginning of March

by email

1. Excel spreadsheet

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# Transplant Referral Quality Improvement Activity

- Kou Kha-Moua, Quality Improvement Coordinator

  610-265-2418, ext. 2820  kkha-moua@nw4.esrd.net

Fax: 610.783.0374 | Web: www.qirn4.org

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