
# Network 4 Kick-Off Webinar

## 2019 Home Dialysis Quality Improvement Activity

Quality Insights
Renal Network 4

Presented by Project Lead: Kou Kha-Moua

# Overview

- Background
- Conditions for Coverage Home Dialysis Vtags
- 2019 Home Dialysis Quality Improvement Activity
- Improvement Method
- Possible Interventions
- Next steps

# Background

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

## Patients who have home dialysis therapy benefit from:

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

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

# Background

- Home dialysis modalities are underutilized in the US with only 8% of the dialysis patients undergoing renal replacement therapy at home versus 92% being treated with in-center hemodialysis
- 11.3% 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

# 2019 ESRD Network 4 Scope of Work

- The Centers for Medicare and Medicaid Service (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)

- By the year 2023, increase the number of ESRD patients dialyzing at home to **16%** from the 2016 national average of **12%**

# 2019 Quality Improvement Projects

## 4 CMS Quality Improvement Activities

1. Reduce Bloodstream Infection
   - 50% of the highest BSI rate facilities (178) are included in the BSI reduction project
     Three (3) subsets:
     - 73 facilities for BSI reduction focus
     - 51 facilities for LTC reduction focus
     - 36 facilities for connection with health information exchange (HIE)
2. **Improve Home Dialysis Utilization in 30% of facilities**
   - **105 Facilities**
3. Improve Transplant Waitlist in 30% of facilities
   - 105 facilities
4. Population Health Focused Pilot Quality Improvement Activities (PHFPQ)
   Four projects to choose from:
   1. Improve Dialysis Care Coordination with a Focus on Reducing Hospital Utilization
   2. Positively Impact the Quality of Life of the ESRD Patient with a Focus on Mental Health
   3. **Support Gainful Employment of ESRD Patients**
      - Goal: Improve Vocational Rehabilitation (VR) and Employment Network (EN) Referral and VR/EN use in 10% of facilities
        - 35 facilities
   4. Positively Impact the Quality of Life of the ESRD Patient with a Focus on Pain Management

# Conditions For Coverage VTags

# Did you know?

V-Tags associated with home dialysis

- V458
- V512
- V553

https://www.qirn4.org/Files/Providers/Conditions-for-Coverage_2017.aspx

# V458

Regulation:

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

Interpretive Guidance:

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

# V512

Regulation:

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

Interpretive Guidance:

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

# V553

Regulation:

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

Interpretive Guidance*:*

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

# 2019 Home Dialysis QIA

Quality Insights
Renal Network 4

# 2019 Home Dialysis Quality Improvement Activity

- Project facilities: 30% of facilities in the Network service area
  - 105 facilities; approximately 5,582 patients
- Timeframe for project:
  - January 1st 2019 through September 30th 2019
- Goal:
  - Demonstrate a **2 percentage point** improvement in the natural trend of patients using home modality

| Aggregated Project Facility Baseline | Goal by September 2019 |
|---|---|
| 1.15.% | 3.15% |

- Facility Goal: add at least 7 patients to a form of home therapy by 9/30/19
- No exclusion criteria
- Baseline home dialysis data is from CROWNWeb
- Track the 7 steps leading to home dialysis
- Attend ESRD NCC Home Dialysis Learning and Action Network (LAN)

# 2019 Home Dialysis QIA

## 7 steps leading to home dialysis utilization:

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

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

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

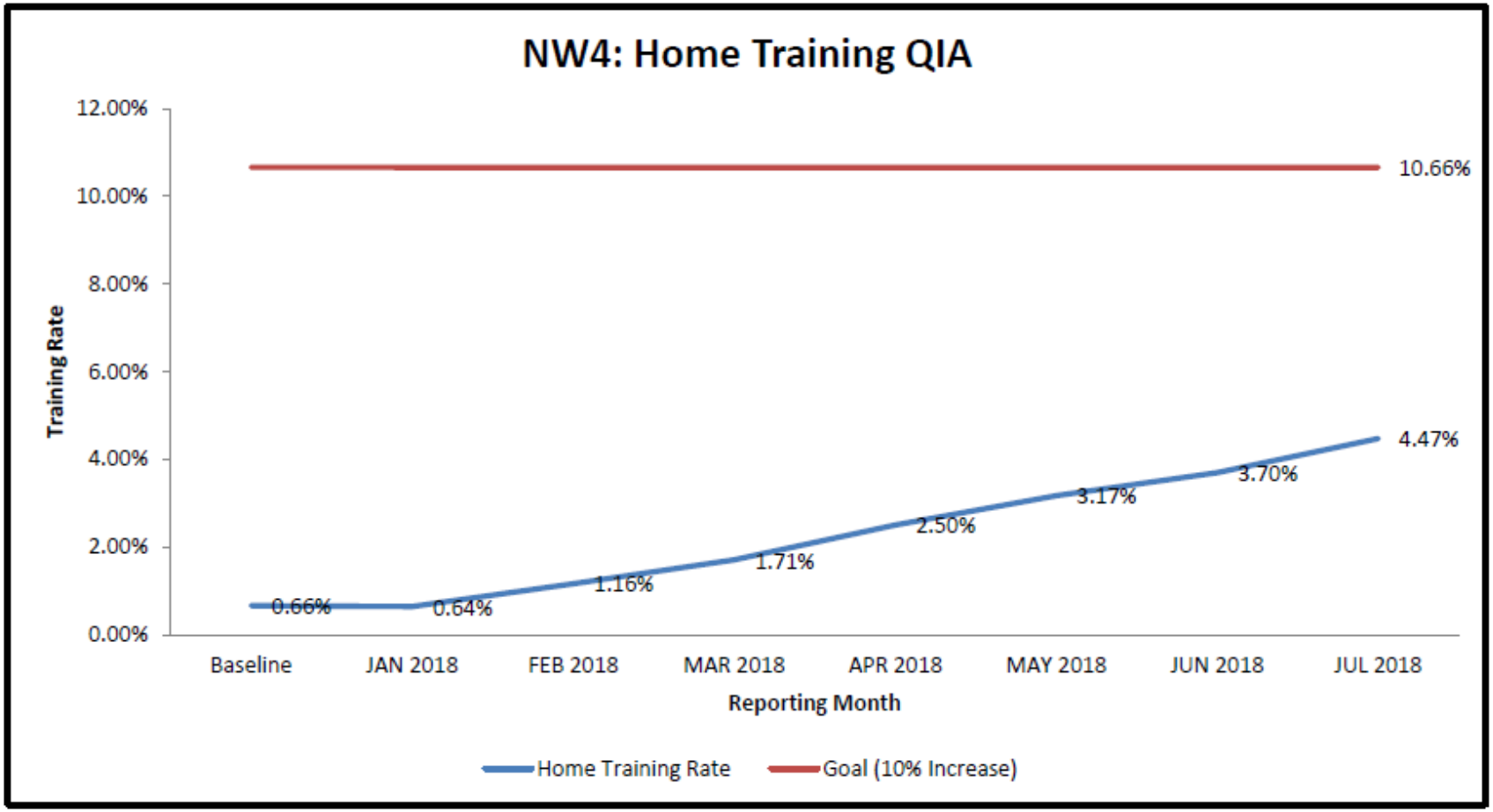
# Barriers and Interventions – 2018 QIA:

| Top Barriers | Interventions |
| --- | --- |
| 1. Educational Knowledge Gap<br>2. Lack of Home Support<br>3. Refused<br>4. Does not want responsibility<br>5. Do not have Home Dialysis Program near by | • Monthly Plan/Do/Study/Act<br>• Educational Campaign<br>• Collaboration with FMC Kidney Care Advocates<br>• Patient Advocate Initiative |

Quality Insights

# 2018 Home Dialysis QIA (n=100) *Monthly Performance Rates*

***Goal: 10 percentage point increase from the baseline***



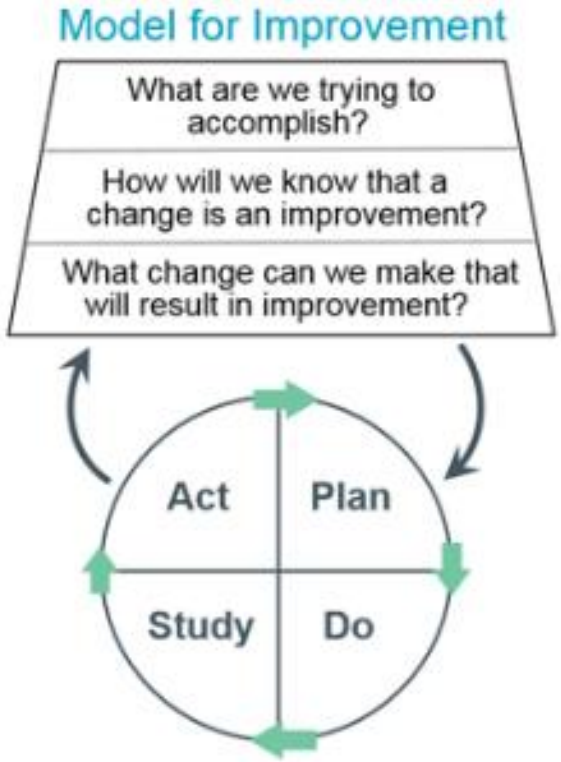

**Source**: NCC TxQIA_NW04_Baseline7Steps, Monthly Re-measure Databases
**Note**: Baseline = Oct 2016 to June 2017; Monthly rates count all patients currently on a waitlist attributed to QIA facilities; n=100 reflects 100 dialysis facilities enrolled in the QIA

Quality Insights
Renal Network 4

# Improvement Method

# Method on How to Improve

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



# Recommended Quality Improvement Videos

Quality Improvement in Healthcare

- Quality Improvement in Healthcare (11:08 Minutes)

Root Cause Analysis – Process to Identify Areas for Quality Improvement

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

PDSA Cycles – Process to Achieve Quality Improvement

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

# Completing a Root Cause Analysis (RCA)

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

# 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' home dialysis 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?
- Take a moment to think about your 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 to improve the home dialysis usage rate based on your plan and **update your plan** based on your success

# Where to document your work?

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

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?

# MONTHLY ON-LINE REPORTING TOOL

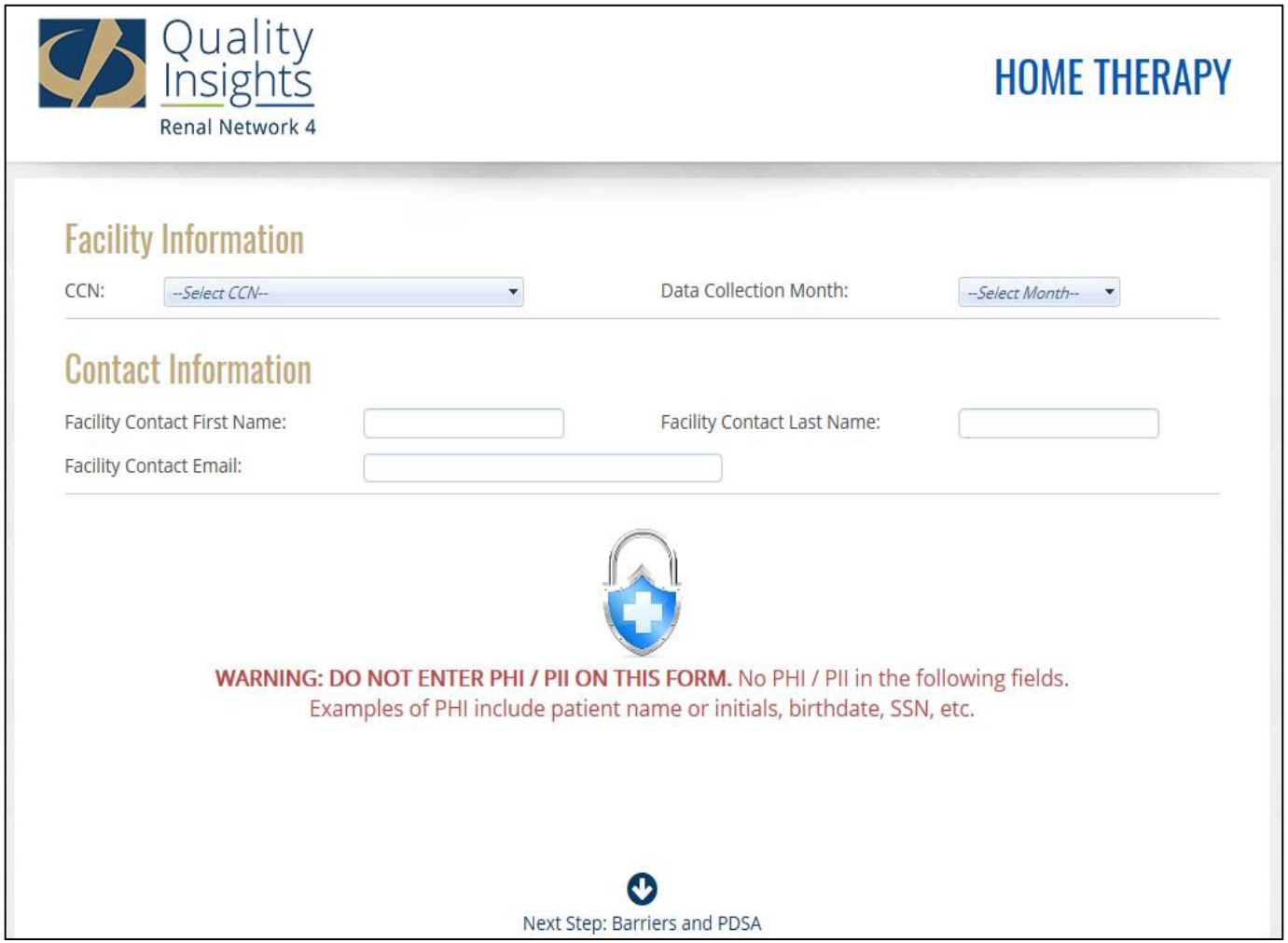
- Network will send the link
- Monthly online reporting tool will be available to go live for February's reporting month

# Monthly On-line Reporting Tool

****NOTE****

Select the Data Collection Month you are reporting for.

For example, if you are reporting for February but you are filling our the report in March, then the Data Collection Month is February



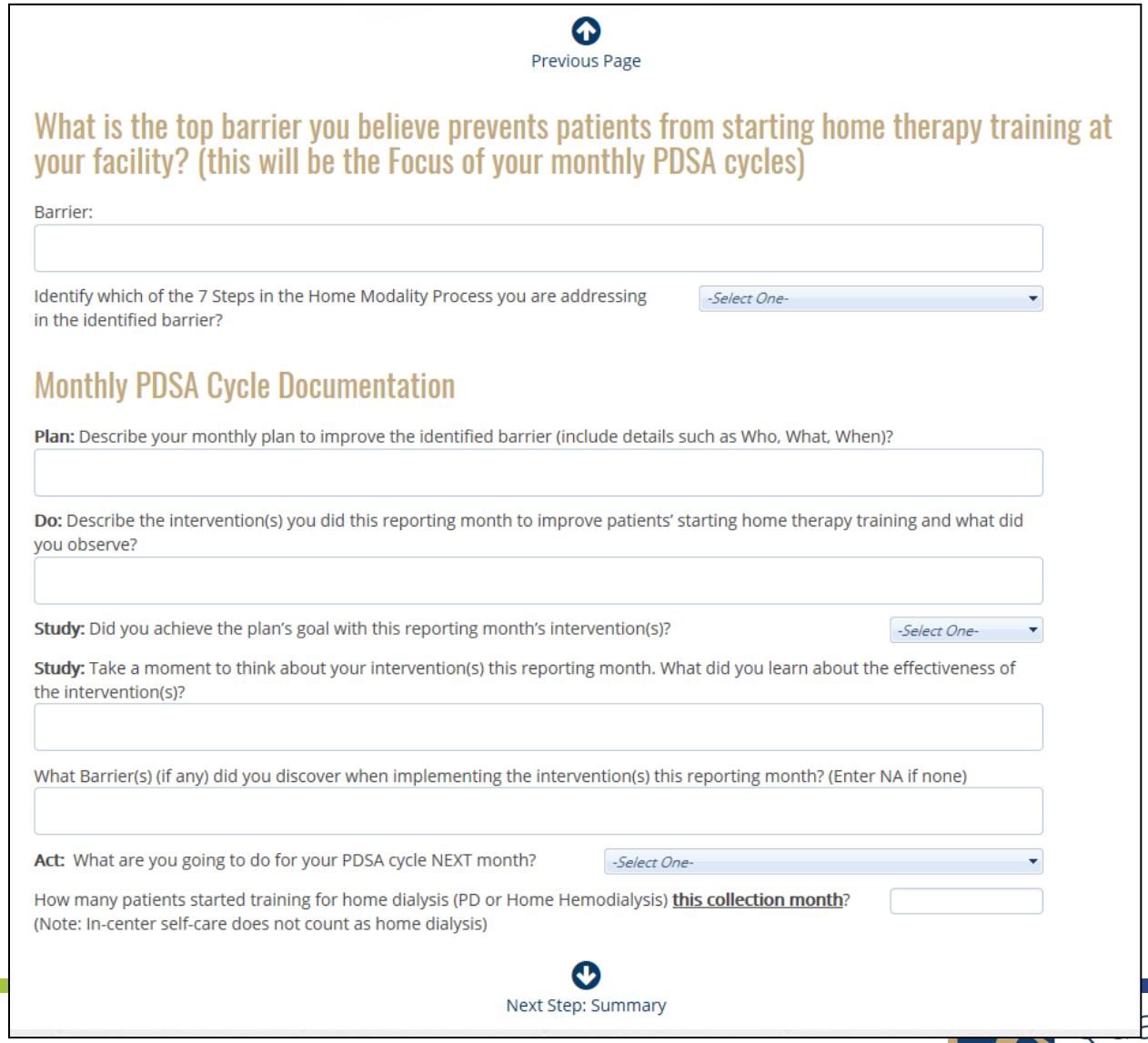
# Monthly On-line Reporting Tool

****NOTE****

To ease documentation burden

- the previous month **Barrier** and **Monthly PSDA** responses will be prepopulated
- Some fields with drop down options

Make changes as needed. Do not have the same intervention and PDSA for more than 2 months if it is not working



# Monthly On-line Reporting Tool

## What's new?

**Metric Questions** (will **NOT** prepopulate previous responses):

How many potential candidates do you have for home dialysis referral?

How many patients changed modality (PD or HHD) this collection month?

Does your staff need additional home therapy education? If yes, what topic?

How many **patients provided feedback** on this month's intervention?

Describe patient's feedback on this month's intervention?

Do you have processes established for sustaining the home modality rate in your facility?

What action item have you put in place for sustainability?

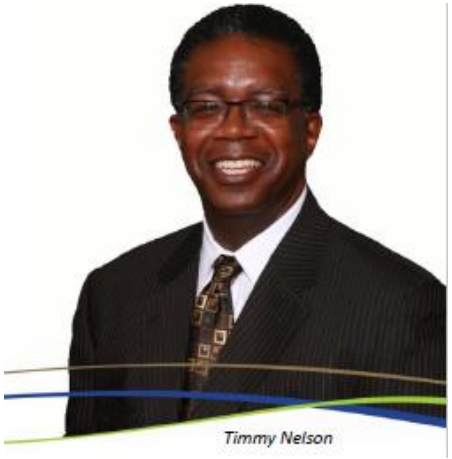
After answering all questions:
- Have a chance to review your summary
- Submit form

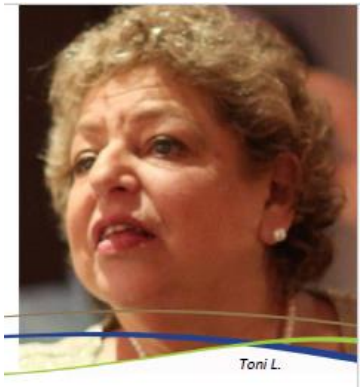
Quality Insights

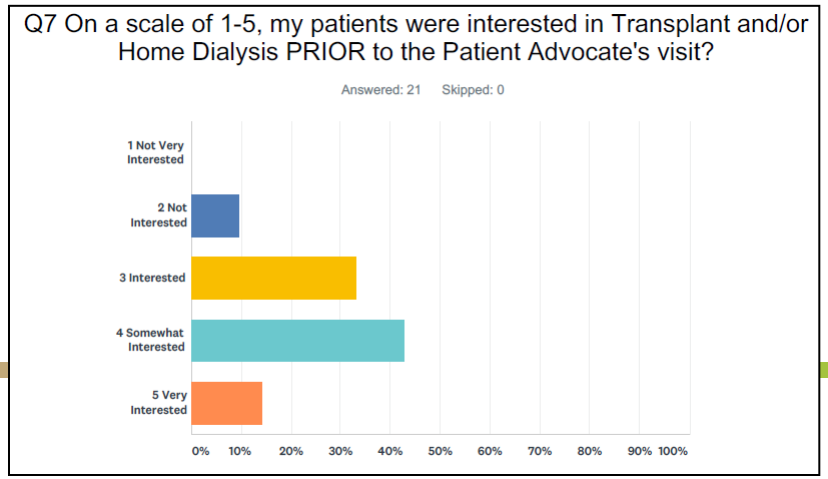
# Possible Interventions

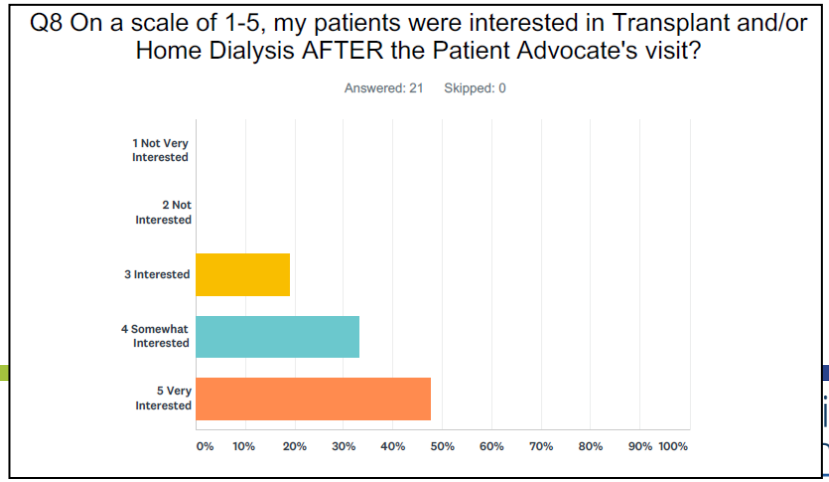
# Patient Advocate Program Intervention

- 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 home dialysis education “lobby” days and or one-to-one patient mentoring

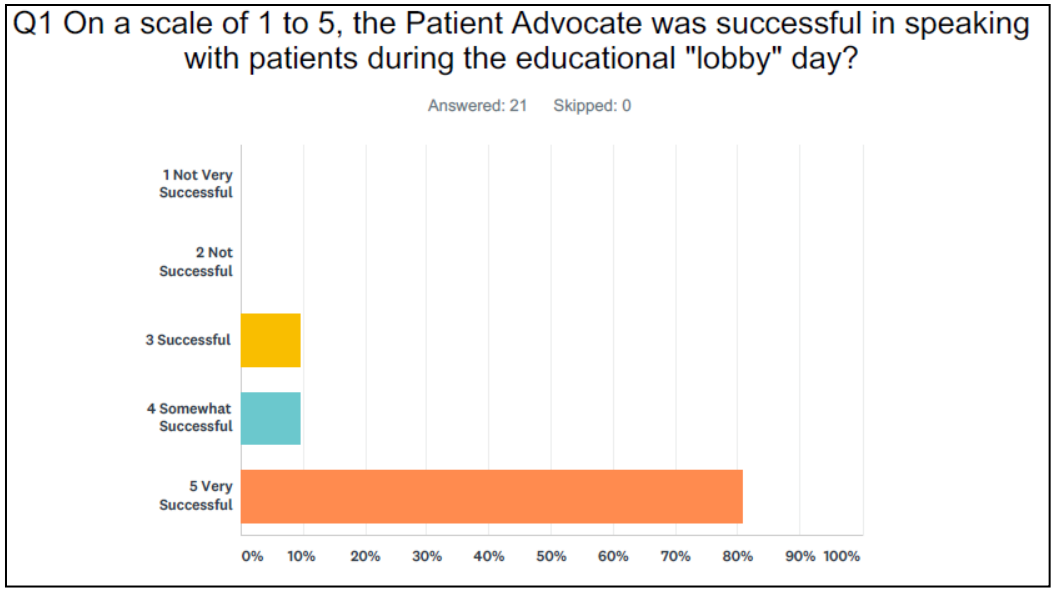



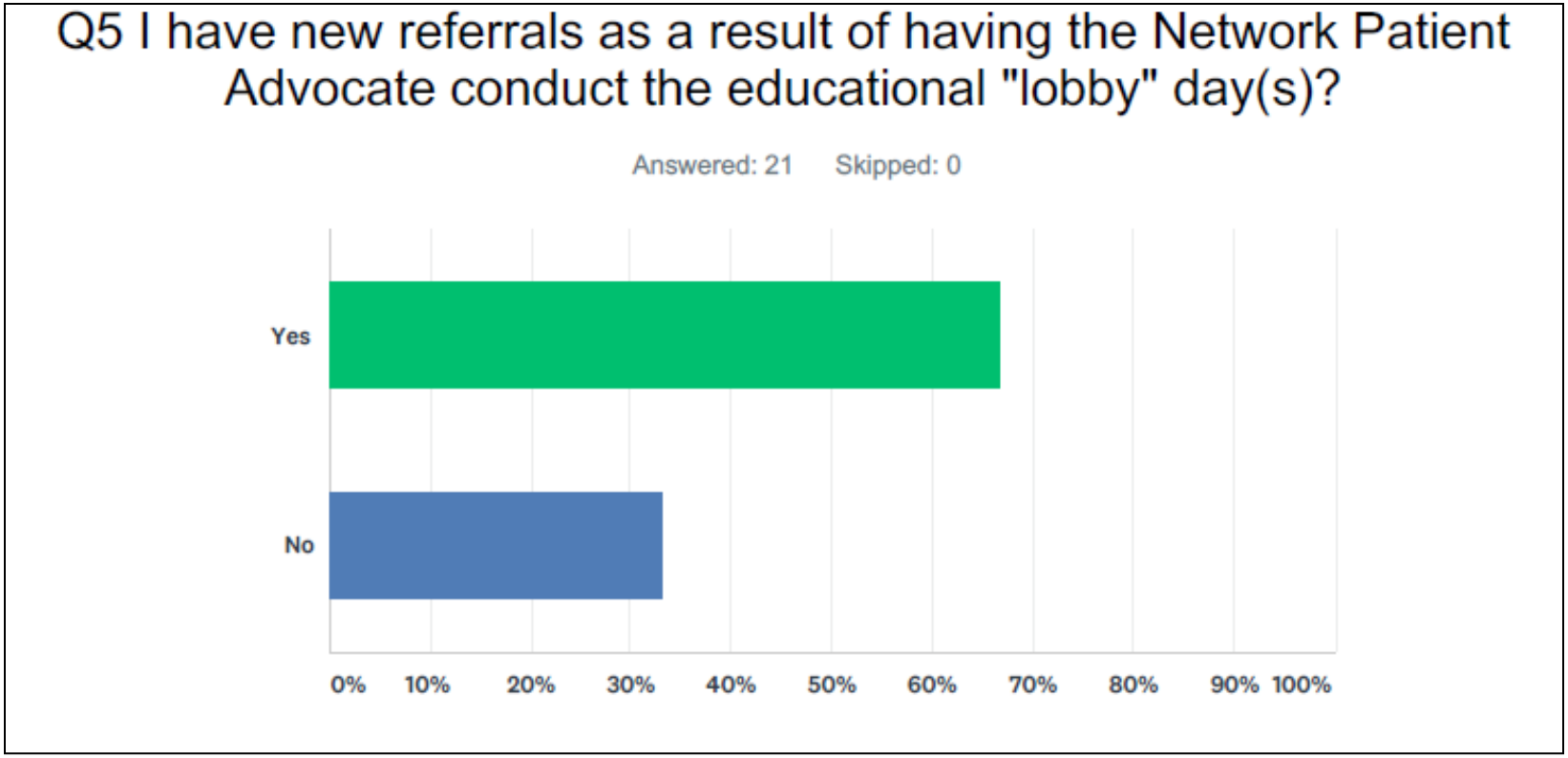
# Patient Advocates in Action

- Visited 34 facilities
- Spoke to > 550 patients




Quality Insights

# Patient Advocate Initiative – Impact




Quality Insights

# Interventions . . . continued

Continue the Patient Advocate program

- NEW this year! Recruit and train facility patient advocates to promote home dialysis
  - Call me with names of patients you think will be good candidates
    - Minimum criteria for facility home dialysis patient advocate consideration:
      - ✓ Must have previous or current home dialysis PD and/or HHD) experiences and,
      - ✓ have a positive outlook
  - Start training in March

- Use of My Life, My Dialysis tool to assess modality options that fit the patient's lifestyle

- Partnership with the home dialysis team

# Interventions . . . continued

**Helpful Resources**

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

**Home Dialysis Central**
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
*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.*

Quality Insights
Renal Network 4

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.qirn4.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. ESRD4-060818*



Why Should I Choose
**HOME DIALYSIS?**

Quality Insights
Renal Network 4


**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., Doss, S. (2010). *Nephrology News Issues.* (24) 36-44.

**Peritoneal Dialysis (PD)**

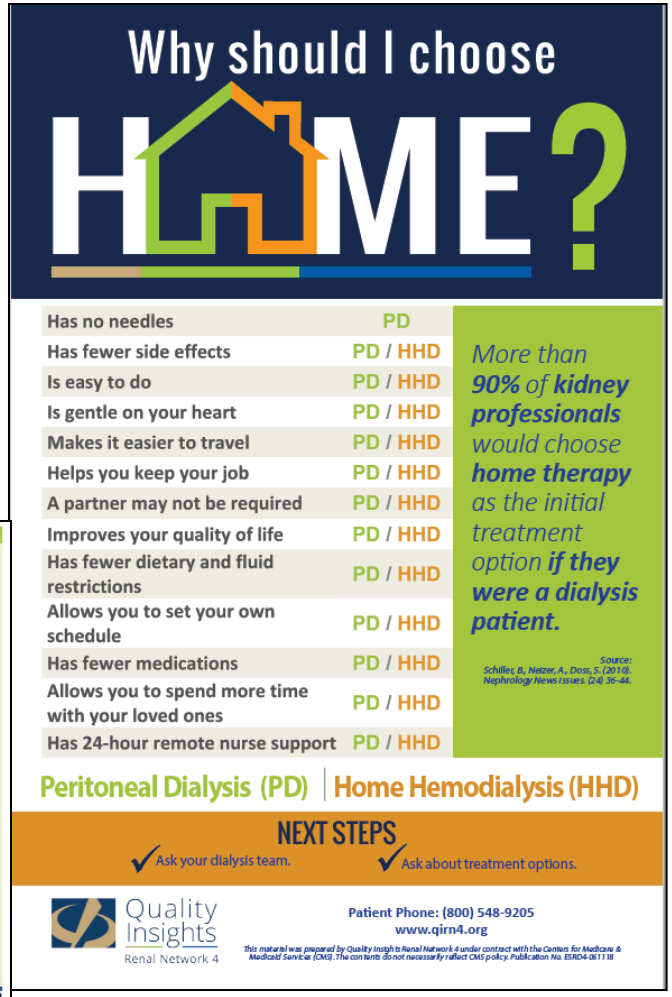
Why it may work for you:

- 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.

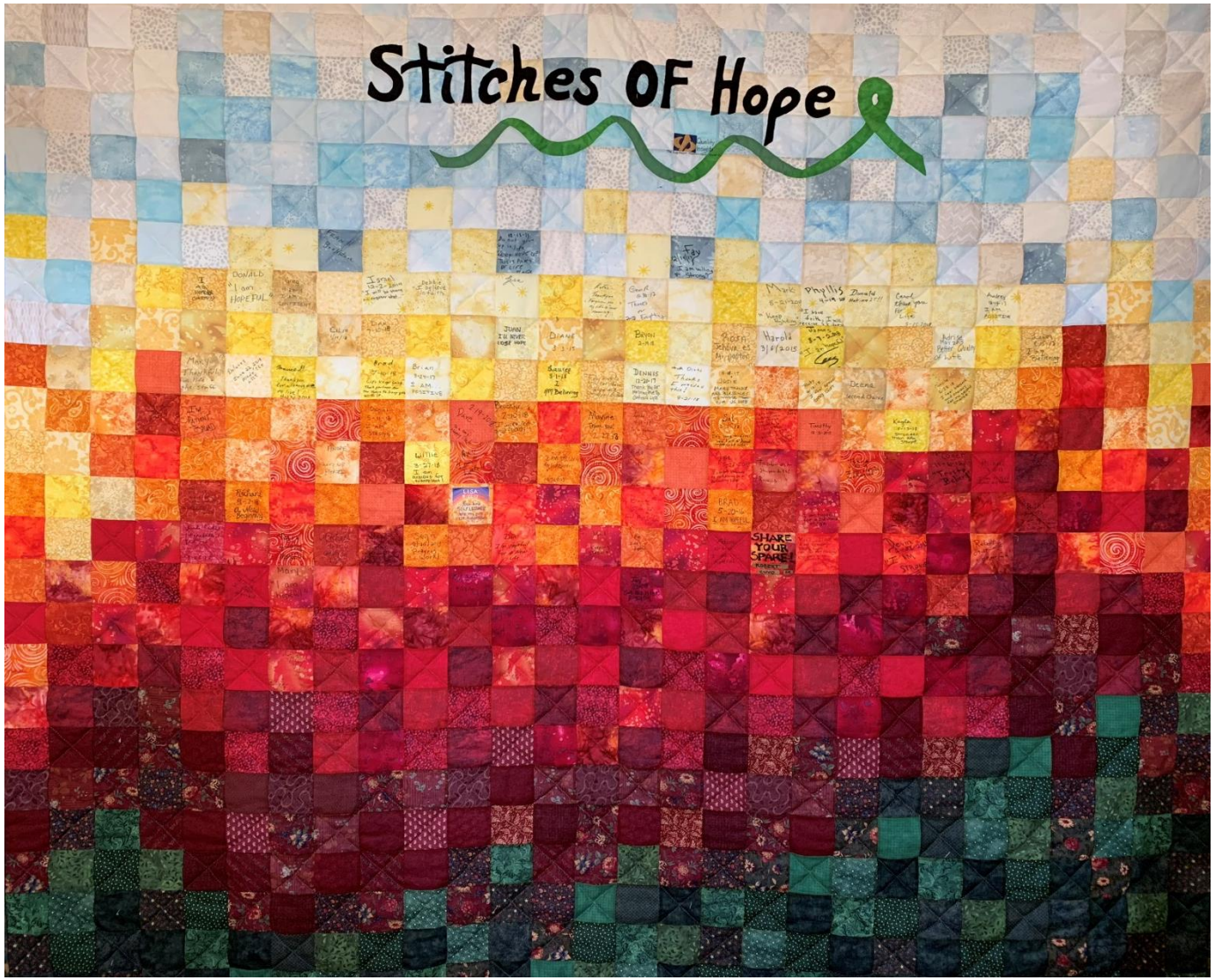


# Interventions . . .

**Looking for an innovative idea to celebrate patients who changed to home modality during 2019 project period**

Quality Insights

# 2018 Improve Waitlist QIA -- Intervention




Quality Insights

# Next Steps

# Network will Provide . . .

**Reporting Template:**

- Network will email a template for reporting at least 7 patients you are working with to move to a home modality. **DO NOT EMAIL COMPLETED FORM; FAX to Kou at 1 (610) 783-0374**

**Link to QIRN4 website for the 2019 Home Dialysis QIA materials:**

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

- Presentation/recording
- Resource "Toolkits"
  - Interventions
  - Patient advocate's education "lobby" days tools
  - Web links to quality improvement training videos
  - *My Life, My Dialysis Choice* decision aid to assess modality which may best fit the patient's value https://mydialysischoice.org/
  - 5-Diamond Patient Safety Program Home Therapy Module developed to provide in-center dialysis staff the opportunity to learn more about home therapy
  - and more

**Mailings in February/March:**

- Why should I choose home poster
- Patient advocate program poster
- Facility medical director letter

Quality Insights

# Facility Next Steps . . .

- Complete an initial Root Cause Analysis (RCA) as soon as possible, before February on-line submission
  - Do NOT have to submit RCA to Network; select one barrier and document on the online reporting tool

- Create a plan to improve based on your RCA using PDSA format for rapid cycle change. Document on the online reporting tool.
  - Use the interventions provided or you may come up with your own interventions if the ones provided do not meet your needs

- Report on the progress of your plan (PDSA cycles) each month on the online reporting tool

**On-line Reporting Tool Due Date:**
**the last week of each reporting month**

**NOTE: Once you have at least 7 patients changed to a home modality and I have confirmed them, you do not have to continue monthly reporting! Remember sustainability!**

# Facility Next Steps . . . Continued

- Attend **ESRD National Coordinating Center (NCC) Home Dialysis Learning and Action Network (LAN) national calls**. Calls are scheduled every other month. Meeting details, including registration link and call overview, to 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

- Network will send survey monkey link for evaluation/implementation of identified best practices from these calls one month after each calls

| Home Modality QIA LAN | |
|---|---|
| **Date (2nd Tuesdays)** | **Time** |
| January 15, 2019 | 3:00pm-4:00pm ET |
| March 12, 2019 | 3:00pm-4:00pm ET |
| May 14, 2019 | 3:00pm-4:00pm ET |
| July 9, 2019 | 3:00pm-4:00pm ET |
| September 10, 2019 | 3:00pm-4:00pm ET |
| November 12, 2019 | 3:00pm-4:00pm ET |

# Facility Next Steps . . . Continued

**Required to complete:**

https://www.surveymonkey.com/r/XF7THZ9

Note: Questions 7 & 8 on the questionnaire is for your facility's name and provider number for attendance or acknowledgement that you have attended or reviewed the presentation and understand the expectation of the project

Quality Insights

# Questions?

Contact Kou Kha-Moua, BSN, RN
610-265-2418 ext. 2820
Kkha-moua@nw4.esrd.net