ESRD Network of the South Atlantic 2020 Home Dialysis QIA Kick-off Webinar

January 3, 2020
Welcome

Michelle Lewis
Home Dialysis Quality Improvement Coordinator
Meeting Objectives

At the completion of this presentation, the participant will be able to:

- Understand the role of the ESRD Network in driving Quality Improvement Initiatives
- Identify CMS Focus Areas
- Summarize the dialysis facility responsibilities regarding CMS quality improvement
- List the requirements of the Home Dialysis Quality Improvement Activity (QIA)
- Identify a Home Therapy Navigator at the facility
- Understand the role and purpose of the Patient Facility Representative (PFR) in facility quality improvement initiatives
- Discuss project interventions and tools with Interdisciplinary Team
- Plan next steps
IPRO ESRD Network
Program Overview
ESRD Network Structure

• Centers for Medicare & Medicaid Services (CMS)
  – Contracted ESRD Network Statement of Work (SOW)

• 18 ESRD Networks
  – 50 States and Territories

• ESRD National Coordinating Center
  – Bi-Monthly Learning and Action Network (LAN) Calls
  – CROWNWeb Quality Improvement Data

• Quality Improvement Activities
  – ALL Medicare Certified Outpatient Dialysis Centers
IPRO ESRD Network 2019 Service Areas
(2018 Network Annual Reports)

Network 2
NY
Patients: 30,337
Facilities: 305
Transplant: 13

Network 1
CT, MA, ME, NH, RI, VT
Patients: 14,856
Facilities: 199
Transplant: 15

Network 9
OH, KT, IN
Patients: 33,890
Facilities: 639
Transplant: 14

Network 9
IN, KY, OH

Network 6
NC, SC, GA
Patients: 50,539
Facilities: 760
Transplant: 10

Network 6
GA, NC, SC

IPRO ESRD Program
129,662
ESRD Patients
1,903
Dialysis Facilities
52
Transplant Centers
## IPRO ESRD Network 6 Service Area by Facility Ownership (October 2019)

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Patients</th>
<th>Facilities</th>
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<tbody>
<tr>
<td>FKC</td>
<td>21,921</td>
<td>294</td>
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<tr>
<td>DaVita</td>
<td>17,658</td>
<td>286</td>
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<tr>
<td>US Renal Care</td>
<td>2,484</td>
<td>49</td>
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<tr>
<td>DCI</td>
<td>2,324</td>
<td>39</td>
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<tr>
<td>American Renal</td>
<td>2,331</td>
<td>32</td>
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<tr>
<td>Wake Forest</td>
<td>1,908</td>
<td>19</td>
</tr>
<tr>
<td>Independents</td>
<td>2,474</td>
<td>47</td>
</tr>
<tr>
<td>VA</td>
<td>99</td>
<td>3</td>
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<tr>
<td><strong>Totals</strong></td>
<td><strong>51,199</strong></td>
<td><strong>772</strong></td>
</tr>
</tbody>
</table>

- **FKC**: 21,921 patients, 294 facilities
- **DaVita**: 17,658 patients, 286 facilities
- **US Renal Care**: 2,484 patients, 49 facilities
- **DCI**: 2,324 patients, 39 facilities
- **American Renal**: 2,331 patients, 32 facilities
- **Wake Forest**: 1,908 patients, 19 facilities
- **Independents**: 2,474 patients, 47 facilities
- **VA**: 99 patients, 3 facilities

**Totals**: 51,199 patients, 772 facilities

- **236 Facilities**: 18,953 patients, 5 Transplant Ctrs
- **159 Facilities**: 10,395 patients, 1 Transplant Ctrs
- **374 Facilities**: 21,851 patients, 4 Transplant Ctrs
CMS ESRD Program Focus Areas

- **Patient and Family Engagement**
  - Incorporate the patient’s voice and perspective in all areas of quality improvement at the ESRD Network and facility level
  - Establishing patient support or new patient adjustment groups and incorporating patient, family and caregiver participation into the QAPI and governing body of the facility
  - Patient, family member and caregiver involvement in the development of the individualized plan of care/or plan of care meetings

- **Decrease rates of Blood Stream Infections (BSIs)**
- **Reduce rates of Long-Term Catheters (LTC)**
- **Increase rates of Patients on a Transplant Waiting List**
- **Increase rates of Patients Dialyzing at Home**
ESRD Network Role & Responsibilities

• Improve Quality of Care for ESRD patients
• Promote patient engagement / patient experience of care
• Support ESRD data systems and data collection, analysis and monitoring for improvement
• Provide technical assistance to ESRD patients and providers
• Evaluate and resolve patient grievances
• Promote best practices
• Assist with emergency preparedness and disaster response
• Establish partnerships to improve ESRD care
Dialysis Facility Responsibilities

- **Participate in Network Quality Improvement Activities (QIAs)**
  - Attend webinars (Network & NCC LAN Calls)
  - Complete required documentation (surveys, attestations, etc.)

- **Inform patients of available Network resources**
  - Grievance resolution
  - Educational materials
  - Provide QIA resources to patients and family/caregiver
  - Patient Advisory Committee

- **Maintain accurate/timely data (NHSN/ CROWNWeb)**

- **Notify the Network of major events**

- **Respond to inquiries and requests for information**
  - Annual Critical Asset Survey
  - Data request
What’s New This Year in Quality Improvement?
Home Dialysis QIA Project Branding

- New Home Dialysis QIA Logo
- All Home Dialysis emails and surveys will be color coded in blue to distinguish between projects
Improving Survey Experience

Introducing REDCap:

• “Save & Return Later” feature
• Alerts user of survey completion to avoid duplication of work
• Sends confirmation email of completion
• Allows user to save and print completed survey in PDF
• Automatic reminders only if not completed
• HIPPA compliant
Home Dialysis Project Outlines

- Activities and supporting resources for the entire project cycle
- Important due dates
- To facilitate better facility planning
- To assist in keeping up with requirements
- Versions available for project lead, project navigator and patient facility representative
Freshdesk Platform

Network QIA Leads:

- Michelle Lewis – Home Dialysis
- Loretta Ezell – BSI & LTC
- Alexandra Cruz – Transplant

[Image of Freshdesk Platform interface]

http://help.esrd.ipro.org/support/home
Promote Appropriate Home Dialysis

2020 Home Dialysis QIA Goals and Measures
Medicare/ Medicaid Conditions for Coverage (CfC) for End-Stage Renal Disease Facilities

**Conditions for Coverage (CfC) are:**

- Medicare regulations for the care of End Stage Renal Disease patients in dialysis facilities

- Standards for the dialysis facility’s Federal survey and certification

- V-Tags are specific standards, conditions and guidance in the CfC that dialysis facilities should adhere by
Medicare/ Medicaid Conditions for Coverage (CfC) for End-Stage Renal Disease Facilities

V-Tags addressing treatment modality:

V458:
- Patients have the right to be informed about all treatment modalities and settings and to receive resource information about dialysis modalities not offered by the facility

V512:
- Evaluation of the patient’s preferred modality and setting and the patient’s expectations for care outcomes

V553
- 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
Current Dialysis Treatments by Modality in the United States

- 88% In-center Dialysis
- 10% Peritoneal Dialysis
- 2% Home Hemodialysis

2016 Chronic Kidney Disease (CKD) Centers for Medicare & Medicaid Services (CMS)
Increase Rates of Patients Dialyzing at Home

Purpose:
• Promote early referral / Identify and mitigate the barriers to a timely referral
• Determine steps patients and providers can take to improve referral patterns
• Increase communication between hospitals, in-center, and dialysis programs

National Goal:
• By 2025, 80% of new ESRD Patients will either be receiving dialysis at home or received a transplant

Criteria:
• Network Service Area – Tiered approach using baseline performance data

Baseline: October 2019/ Re-Measurement: October 2020
Timeline: January 1, 2020 thru September 30, 2020
CMS 7 Steps Leading To Home Dialysis Utilization

Step 1 – Patient interest in home dialysis (after assisting the patient to determine modality options that fit the patient’s lifestyle)

Step 2 – Educational session about home modality

Step 3 – Patient suitability for home modality determined by a nephrologist with expertise in home dialysis therapy

Step 4 – Assessment for appropriate access placement

Step 5 – Placement of appropriate access

Step 6 – Patient accepted for home modality training

Step 7 – Patient begins home modality training (Counts towards Goal)
How will the Network obtain the monthly 7 Step data?

Large Dialysis Organizations (LDOs) will batch the 7 step data to the National Coordinating Center (NCC) who will then send the monthly data to the ESRD Network.

- FKC, DaVita, DCI

Independent facilities will provide the 7 step data monthly to the ESRD Network via survey, then the Network will submit facility reported step data to the NCC.

- All other independent dialysis organizations that do not batch monthly to the NCC

The ESRD Network and ESRD NCC exchange data.
CROWNWeb – Updating Treatment Modality and Setting

Peritoneal Dialysis (PD):

• Change *modality* to *home* – First day of training with an Exchange
• Change *setting* to *home* – First day of dialysis in the Home

Home Hemodialysis (HHD):

• Change in *modality* to *home* – First day of training when the HHD machine is used for treatment
• Change in *setting* to *home* – First day of dialysis in the Home

*Treatment Setting is the QIA Marker in CROWNWeb Documentation*
Benefits, Interventions, Tools and Resources
Healthcare Benefits of Home Dialysis

• **Improved Clinical Outcomes**
  – Ability to achieve higher Kt/V
  – Symptom reduction of co-morbid states, sleep apnea, restless legs, improved cardiac output
  – Improved blood pressure control

• **Decreased Mortality**
  – Increased frequency of dialysis lowers mortality rates
  – Slow continuous fluid removal is less stressful on the heart

• **Lower Healthcare Costs**
  – Decreased hospitalizations
  – Fewer infections
  – Home modality patients have a higher incidence of kidney transplant over ICHD
Patient Benefits of Home Dialysis

- Increased flexibility in treatment schedule
- Ability to travel
- Can continue to work or go to school
- Shorter post-dialysis recovery time
- Increased energy
- Fewer diet and fluid restrictions
- Decreased dialysis complications – hypotension, nausea/vomiting, cramping, etc.
- Possibly take fewer medications
- Better quality of life
Who is a Potential Candidate?

- Patients that are motivated and willing to learn
- Patients who want to be in control of their treatments, continue to work or go to school, or want to maintain a flexible and active lifestyle
- Physical and cognitive ability to manage tasks of treatments (or have support who can assist)
- Patients who have difficulty adjusting to the in-center schedule
- Patients who want more flexibility with their diet and fluid intake
- Patients that don’t tolerate ICHD very well and experience low BP, nausea/vomiting, cramps, etc.
- Patients who experience excessive recovery time after conventional ICHD
Develop a Team Approach to Quality Improvement

Form your QI Team – Get Everyone involved in the Project!

• Facility Administrator/Clinic or Nurse Manager
• PCT/CCHT’s
• Patient’s/Family Members/Caregivers
• Social Worker
• Dietitian
• Administrative Assistant
• Medical Director/ NP

Don’t forget the Patient and Family Members/ Caregivers when forming your TEAM!
Home Therapy Navigator Role

Facilities will identify at least **one** staff member to be a Home Therapy Navigator during the 2020 Home Dialysis project cycle

- Empower patients with knowledge, skills, and tools
- Encourage patients to take an active role in their healthcare decisions
- Share training(s) with fellow staff members
- Bridge the communication gap between the patient and healthcare team
- Build trusting relationships with patients and family/caregivers
- Ideally this role is for a PCT, CCHT, Administrative Assistant or Charge Nurse who has the most contact with patients
Patient Facility Representative Role

Facilities will identify at least one patient per facility to be a Patient Facility Representative (PFR)

- Partner with Project Lead and Home Therapy Navigator to support the implementation of targeted interventions for the Home Dialysis QIA.
- Collaborate with the Project Lead and Home Therapy Navigator on the creation of an Education Station and/or hosting a Lobby Day.
- Discuss QIA activities from the patient perspective during QAPI meetings.
- Foster positive relationships between patients, providers, ESRD stakeholders and the Network.
- Ideally this role is for a patient who interacts easily with other patients and staff members, could fill an advocacy role and enjoys educating and sharing their experience with others.
Does your Team have a missing link?

Patient Engagement Focus Areas

• Including patients in the QAPI process can provide the missing link which influences your daily work that drives quality improvement measures.

• Establishing a patient support or new patient adjustment group can provide patients with ways to cope with their diagnosis, communicate better with the healthcare team, and educational opportunities.

• Implementing a peer mentorship training program can improve communication, foster personal growth and provide support.
Supporting Facilities in QAPI and Patient Support Groups

Training Opportunities and Resources:

• Network hosted webinar to assist facilities with incorporating patients, family members/ caregivers into the monthly QAPI. *(webinar on 2/20/20 1-2pm)*
  - Importance of patient engagement in QAPI
  - Tips on how to involve patients

• Network hosted webinar to assist facilities with establishing a patient support group or new patient adjustment group. *(webinar on 4/23/20 1-2pm)*
  - Supportive formats
  - Tips on identifying interest

• Supportive resources for success!
Share QIA Project Responsibilities throughout the Team

How to Avoid Staff Burnout:

• **One person can’t do everything**
  – Delegate tasks to the right staff members, Home Therapy Navigator or Patient Facility Representative

• **Assigning important tasks to teammates will make them a valuable part of the team**
  – Provides experience and opportunities to team members

• **Eliminate stress by spreading the workload**
  – Too many tasks on one person can lead to excessive stress and burnout

• **Quality Improvement Initiatives will improve**
  – Get everyone involved by assigning specific tasks for the QI project
  – Make sure team members understand their tasks, roles and responsibilities
  – Share challenges or barriers to completing task during QAPI or huddle meetings
2020 Intervention Strategies

• Pairing ICHD and home program units within geographic regions

• Increase Early Referrals
  – Foster relationships and provide education with hospital discharge planners/ care coordinators
  – Collaborate with transitional care units and other early referral models

• Educate and develop Home Therapy Navigators through professional training modules, educational resources and other training opportunities.

• Involve Patient Facility Representatives with engaging and supporting patient outreach and facility quality improvement initiatives.

• Spread best practices and implement interventions from National LANs/Network webinars.
2020 Interventions

Patient Engagement
- Patient Facility Representative (PFR)
- Invite patient/family/caregiver to QAPI
- Implement Patient Support Group
- Patient Education Station/Lobby Day Contest

Knowledge and Practice Assessment
- Root Cause Analysis
- Sustainability

Progress Report
- Quantitative Data
- Facility Achievement Levels “Bring Home the Gold”

Provider Education
- Professional training modules
- Acute Resource
- Network Webinars
- MATCH-D – Method to Assess Treatment Choices for Home Dialysis

Virtual Collaborative Meetings
- Share best practices
- Leadership Performance Calls

NCC LAN Calls
- 1 staff member mandatory participation – Home Modality LAN
- 1 CEU provided per call upon registration
Home Modality ICHD/ Acute Resources

- Patient Education Resources
  - Home Dialysis Poster
  - Treatment Options Brochures
- Acute Care Non-Proprietary Patient Education resources on Home Modalities
Patient, Family/ Caregiver Education

- Colorful bulletin board
- Bright posters in waiting area
- Educational resource “booth” on the floor
- Dedicated peer mentoring area
- Patient Stories
Progress Report – “Bring Home the Gold”

- Keeps goals at the center
- Review and discuss during QAPI
- Provides structure for quality improvement strategies
- Aligns facility objectives with CMS goals and priorities
- Keeps your quality improvement strategies front and center by reviewing with interdisciplinary team on a monthly basis
Professional Training Module – Home Therapy Navigator

• Encourage patients to be engaged and active in healthcare decisions

• Empower and support patients in achieving personal health goals

• Encouraging patients to feel safe to openly discuss questions or concerns with you and other members of their healthcare team
Professional Training Module – Home Therapy Navigator

• Knowledge of Home Modality Options
• Identifying who is a potential candidate
• Utilization of Educational Resources
• Empowering patients to be engaged and active in healthcare decisions
Leadership Performance Calls

- Open discussion among providers within same organization
- Open platform to drive meaningful and productive conversations
- Review project goals and objectives
- Share best practices to overcome barriers
- Focus on progress, performance, and expectations
ESRD NCC Home Modality LAN

• **Primary Purpose**
  – Improved communications across healthcare settings
  – Promote and support communication internally between in-center and home modality staff to educate patients
  – Increase awareness of home treatment options and identify ways to support the patient through home training

• **Attendance Requirements**
  – Invitations will be sent to all providers in the Network Service Area
  – Attendance is mandatory for home dialysis QIA facilities and will be tracked by the Network and the NCC
  – Your facility will be asked to report on the interventions you have implemented form the NCC Home Modality LAN Call
Recap of Home Dialysis Project Requirements

- Educate patients about all home treatment options
- Identify a Home Therapy Navigator *(Staff Role)*
- Identify a Patient Facility Representative *(Patient Role)*
- Invite patient(s) and/or family/caregiver to the facility’s Quality Assurance & Performance Improvement (QAPI) meeting
- Establish a patient support group/ new patient adjustment group
- Attend the bi-monthly CMS established, ESRD NCC hosted National LAN Call for Home Modality *(1 CEU provided per call upon registration)*
- Create a home treatment options education station/bulletin board and/ or host educational lobby day
- Complete Network requested surveys and/or attestations
- Participate in Leadership Performance Calls as requested
Upcoming and Next Steps
Network Educational Resource Mailing

Arriving at your facility the last week in December

Transplant Referral is an Option Regardless of Your Age

A kidney transplant can offer a better lifestyle to patients of all ages, including those over 65. Benefits include:
- Better quality of life
- Increased life expectancy
- Increased independence
- Increased self-esteem

South Atlantic Area Kidney Transplant Center Referral Guide

If you are aware of a patient that needs a kidney transplant, please contact the dialysis facility to arrange for a referral.

Home Dialysis Treatment Options

Peritoneal Dialysis (PD) vs. Home Hemodialysis (HHD)
- In-center Dialysis...
- Home Hemodialysis (HHD)

You are never too old for a kidney transplant.

Home Dialysis Benefits Highlights

Control
- Eat, drink, and have normal treatments

Hand Hygiene
- The #1 way to prevent infections

Donation Service Area

Access for Hemodialysis

Graft Alternate Choice
- Immediate access
- High flow
- No surgery

Catheter EMERGENCY OR TEMPORARY ONLY
- Immediate access
- High flow
- No surgery
Patient Education Contest

• **Focus Area Topics:**
  - Home Modality Treatment Options
  - Transplant as a Treatment Option
  - Blood Stream Infection (BSI) Reduction
  - Vascular Access Planning

• Take a multi-disciplinary approach by including facility leadership, floor staff, and patient representatives in your planning.

• Set a Goal and measure your success!

• **Dates:** January 1st – March 31st

Winners will be announced at the Network Annual Meeting in May!
On the Horizon:

- New Network Staff Email Addresses!
  - Changing to firstname.lastname@ipro.us Example: Michelle.Lewis@ipro.us

- Network Annual Meeting: **Wednesday May 20th and Thursday May 21st**
Important Dates and Next Steps

- Complete the Key Facility Staff Contact Information – **DUE 1/2/20**
- Watch the Home Dialysis Kick-off Webinar Recording – **DUE 1/13/20**
- Attend the ESRD NCC Home Modality QIA LAN Call – **1/14/20 3PM - 4PM**
- Complete Knowledge & Practice Assessment – **DUE 1/17/20**
- Identify at least one Home Therapy Navigator (Staff Role)
- Identify at least one Patient Facility Representative (Patient Role)
  - Patient information will be collected in the HIPAA compliant **REDCap Tool** – **DUE 1/31/20**
- Update CROWNWeb staff and emergency contact information
- **Independent** facilities complete the 7 Step monthly data collection for January – **DUE 2/4/20**
Stay in Touch!

- **Freshdesk**
  - [http://help.esrd.ipro.org/support/home](http://help.esrd.ipro.org/support/home)

- **Website**
Thank You!

Michelle Lewis
Home Dialysis Network Lead
Phone: 919-463-4510
Fax: 919-388-9637
Michelle.Lewis@ipro.us

IPRO ESRD Network of the South Atlantic
909 Aviation Parkway, Suite 300
Morrisville, NC 27560
http://network6.esrd.ipro.org/

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
http://ipro.org