Quality Insights
Renal Network Three
2018 Home Dialysis QIA: Increase Rates of Patients Dialyzing at Home

January 23, 2018
2018 Home Dialysis Quality Improvement Activity (QIA):

*Increase Rate of Patients Dialyzing at Home*
Todays Objective

• Discuss components of QIA

*Increase Rate of Patients Dialyzing at Home*

• Project Goals
• Facility Selection
• Project Activities
• Data collection
• LAN
CMS Priorities and Goals: Improve Utilization of Home Dialysis

- AIM/National goal:
  - By 2023 increase the rate of ESRD patients dialyzing at home to 16% from the 2016 national average of 12%

- Rationale:
  - Home modalities are underutilized in the USA
  - 8% use a home RRT vs 92% in-center dialysis
QIA Goals: Increase Rates of Patients Dialyzing at Home

- Promote referral
- Identify and mitigate barriers to home referral
- Determine steps patients and providers can take to improve referral patterns
Activities: ESRD Network Statement of Work

- Selection: 30% of NW3 facilities (67)
- Identify candidates, refer, address and act on barriers to patient advancement at each of “Seven Steps”
- Track and report # patients @ each step in process
- Incorporate process steps into patient education, facility practice and facility QAPI process
- Share and learn-participate in Learning and Action Network (LAN) and project calls.
Requirements: ESRD Network Statement of Work

- Beyond Engagement-Patient and family, SME (Subject Matter Expert) engagement
- Participation in National Learning and Action Networks (LANs) for each QIA
- **Jan-Sept 2018:** 10 percentage point increase in patients starting home dialysis
- **2019:** Replacement of facilities in QIA achieving 40% of patients trained or in training and a satisfactory internal process to sustain
CMS Priorities and Goals: Improve Utilization of Home Dialysis

2018 Quality Improvement Activity: Increase Rates of Patients Dialyzing at Home
ESRD Network 3

<table>
<thead>
<tr>
<th>CCN:</th>
<th>Facility:</th>
<th>Affiliation:</th>
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<tbody>
<tr>
<td></td>
<td>Location:</td>
<td>Baseline Rate: 0.65%</td>
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<tr>
<td></td>
<td>NJ</td>
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Facility Services

<table>
<thead>
<tr>
<th>In-center HD</th>
<th>In-center PD</th>
<th>Home Training (HD)</th>
<th>Home Support (HD)</th>
<th>PD</th>
<th>CAPD</th>
<th>CCPD</th>
<th>Home Training (PD)</th>
<th>Home Support (PD)</th>
<th>Home IPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
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Source: CROWNWeb; HD = hemodialysis, PD = peritoneal dialysis

Based on average census from October 2016 to June 2017 of 119 patient(s), this would equate to 12 patient(s) starting home dialysis training during the course of this quality improvement project (i.e., by September 2018). The patients’ training date would have to be after 1/1/2018 for the facility to receive credit for the training during this project.
QIA Interventions: Increase Rates of Patients Dialyzing at Home

1. Ongoing census review
   – Determine suitability
   – Document appropriately in medical record
   – Proceed/continue referral and tracking process
   – Address/refer new admissions early
QIA Interventions: Increase Rates of Patients Dialyzing at Home

2. Survey methods

- Initial self-assessment of facility referral process
  - CMS Conditions for Coverage alignment
  - Recognized best practices
  - Use of educational materials

- As needed to provide feedback during project
- Facility sustainability plan
QIA Interventions: Increase Rates of Patients Dialyzing at Home

3. Tracking and monthly reporting to CMS

# of patients in each of 7 steps:

1. Patient interest 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.
QIA Interventions: Increase Rates of Patients Dialyzing at Home

4. Education/LAN Participation
   - “NCC” (Network Coordinating Center) call every other month TBD
   - NW project calls
   - Facility visits: review of facility process and documentation
   - Stakeholders-at minimum
     - Networks
     - Patients/families
     - Participating facilities
     - Transplant centers
     - Others-DOH, QIO
Home Dialysis QIA: Data Reporting

• By Facility
  ◦ Monthly PDSA Cycles:
    • Access of NW3 link to report barriers and interventions to address
    • Detailed Instructions to be provided

• Via Batch submission (LDOs)
  ◦ Number of patients in each of 7 steps each monthly
  ◦ Initiation of home dialysis (per CROWNWeb)
Potential Root Causes of Lower Home Dialysis Rates

Team: Network 3

Project: Increasing Rates of Patients Dialyzing at Home

1) Input the effect you’d like to influence.
2) Input categories of causes for the effect (or keep the classic five).
3) Input causes within each category.

Staff Related
- Less time to educate
  - Knowledge deficit

Process Related
- Staff turnover
  - Lack of follow up
- Lack of support
- Poor communication
  - Poor documentation
- Poor/no support system
- Medical/social conditions
- Refusal/noncompliant
  - Knowledge deficit
- Underinsured
- Inadequate environment

Patient Related
- Financial
- Other
Potential Actions to Address Root Causes

- **Staff Related:**
  - Initial and annual education about home dialysis program
  - Team approach (RN/PCT), rather than individual

- **Process Related:**
  - Review and educate staff on P&P
  - Revise what is not working—seek all levels of input
  - Audit

- **Patient/Financial/Other Related:**
  - Educate, engage family, appointment reminders
  - Refer appropriate: behavioral, financial
  - Regular review for situational changes
Home Dialysis QIA: PDSA

- [https://esrdiqc.wvmi.org/authentication/login.aspx](https://esrdiqc.wvmi.org/authentication/login.aspx)
- Log in> Choose facility from Drop down list (CCN# and Name)
- Complete monthly. Based on RCA-PDSA
## Home Dialysis QIA: RCA-PDSA

### Stage 1: What is the top barrier you believe prevents patients from starting home therapy training at your facility? (This will be the focus of your monthly PDSA cycles)

<table>
<thead>
<tr>
<th></th>
<th>RCA</th>
<th>Barrier</th>
<th>Text Field</th>
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</thead>
<tbody>
<tr>
<td>8</td>
<td>7 Steps to Home Modality Training</td>
<td>Identify which step you are addressing:</td>
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</table>

### Monthly PDSA Cycle Documentation

<table>
<thead>
<tr>
<th></th>
<th>Plan Described</th>
<th>Plan: Describe your monthly plan to improve the identified barrier (include details such as Who, What, When)?</th>
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</thead>
<tbody>
<tr>
<td>9</td>
<td></td>
<td>2000 Character Max</td>
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<table>
<thead>
<tr>
<th></th>
<th>Do Described</th>
<th>Do: Describe the intervention(s) you did this reporting month to improve patients’ starting home therapy training and what did you observe?</th>
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<tr>
<td>10</td>
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<td>2000 Character Max</td>
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<table>
<thead>
<tr>
<th></th>
<th>Study Was Goal Achieved</th>
<th>Study: Did you achieve the plan’s goal with this reporting month’s intervention(s)?</th>
</tr>
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<tbody>
<tr>
<td>11</td>
<td></td>
<td>Dropdown List 0=No 1=Yes</td>
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</table>
### Home Dialysis QIA: RCA-PDSA

<table>
<thead>
<tr>
<th>12</th>
<th><strong>StudyLearnAboutEffectiveness</strong></th>
<th><strong>Study</strong>: Take a moment to think about your intervention(s) this reporting month. What did you learn about the effectiveness of the intervention(s)?</th>
<th><strong>Text Field</strong></th>
<th><em>Required Field</em></th>
</tr>
</thead>
<tbody>
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<td>2000 Character Max</td>
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<tr>
<td>13</td>
<td><strong>StudyBarriers</strong></td>
<td><strong>(Child field of Study)</strong> What Barriers (if any) did you discover when implementing the intervention(s) this reporting month? (Enter NA if none)</td>
<td><strong>Text Field</strong></td>
<td><em>Required Field</em></td>
</tr>
<tr>
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<td>2000 Character Max</td>
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<tr>
<td></td>
<td><strong>Label: Act</strong>: What are you going to do for your PDSA cycle the upcoming month?</td>
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</tr>
</tbody>
</table>
| 14 | **ActChoice**                    | **Act**: What are you going to do for your PDSA cycle NEXT month? **Drop Down**
|    |                                  | ACCEPT = Continue with the same plan
|    |                                  | ADAPT = Change the                                                                                | **Required Field** |
Timeline-Expectations

• Project timeframe January-September 2018 (June CW data availability)
• Mandatory attendance at Rollout Call-1/23/2018
• Appoint project contact; inform NW lead of any changes
• Facility self assessment of referral process: ”Survey Methods”-date and deadline TBA (late January-early Feb)
• Monthly reporting: link and instructions for RCA and PDSA reporting to be provided when available.
  – Top barrier, plan to address, evaluation
  – “Seven Step” progress via batch
Timeline-Expectations

• SME –Beyond Engagement
• Be ready to demonstrate facility engagement in project during NW audit/facility visit to review project activities: (Maintain binder/folder with outcomes, reports, documentation of patient engagement, project activities, calls attended, etc.)
• Bi-Monthly LAN Calls (every other month-schedule TBA)
• Mandatory Mid point Call (TBA)
• Facility evaluation of education/project activities as requested: “Survey Methods”-TBA
• Mandatory: Wrap up call (TBA)
Questions?
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kripkey@nw3.esrd.net

Visit our website: www.qirn3.org