Improve Education and Access to Empower Patient Choice of a Home Modality

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Quality Insights
Renal Network 3

Objectives

- Introduction
- Home Dialysis QIA Overview
- Model for Improvement
- QIA steps
- Interventions, resources and tools

Introduction

A Nationwide Effort to Improve Kidney Care

- In 2019, the U.S. Department of Health and Human Services launched the Advancing American Kidney Health Initiative
- 80 percent of patients newly diagnosed with ESRD receiving dialysis in the home or receiving a transplant by 2025

Goals

- Increase the number of incident (< 90 days) ESRD patients starting dialysis using a home modality
- Increase the number of prevalent ESRD patients moving to a home modality
- Increase the number of rural ESRD patients using telemedicine to access a home modality

Where does Network 3 stand?

Rate of Home Dialysis Among Incident Population

NW	2016	2017	2018	2019
3	**7.1%**	**6.8%**	**7.8%**	**8.1%**
4	9.4%	8.9%	11.2%	11.5%
5	9.1%	9.9%	10.3%	11.6%
US	9.9%	10.3%	11.3%	12.1%

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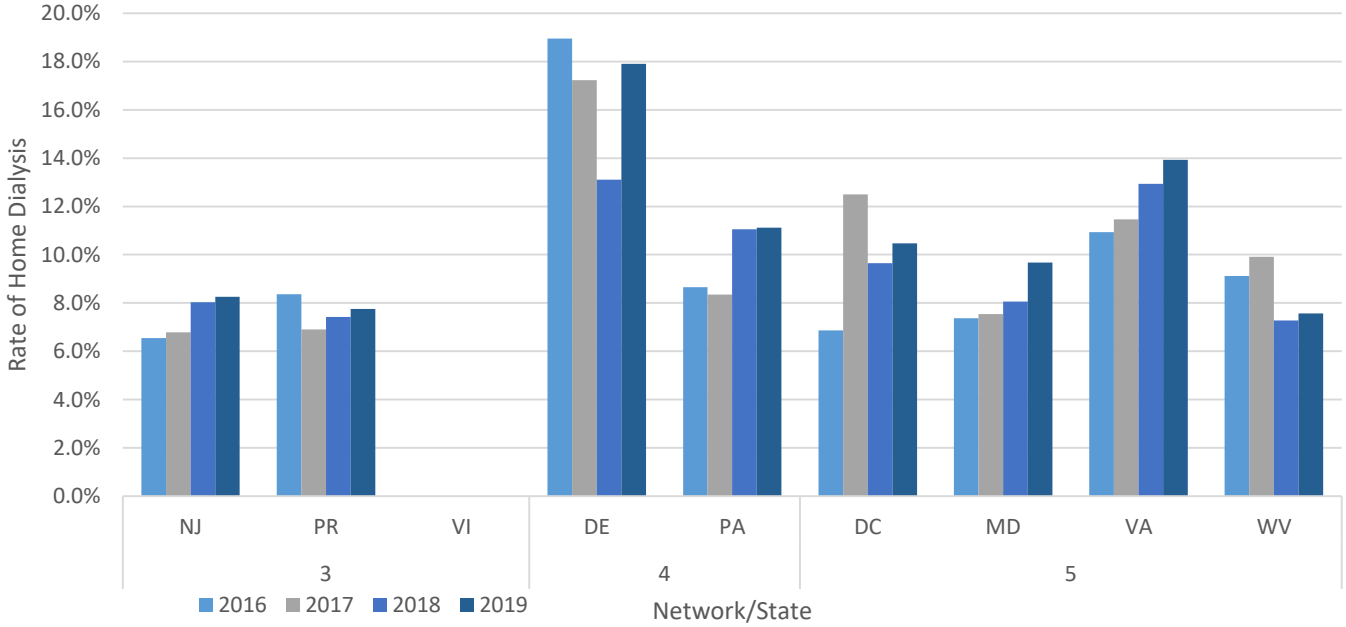

Note: Metrics reflective of Table 2: Characteristics of New Dialysis Patients, 2016-2019 (Form CMS-2728)
Source: Dialysis Facility Report for Fiscal Year (FY) 2021 Produced by The University of Michigan Kidney Epidemiology and Cost Center (July, 2020)

Rate of Home Dialysis Among Prevalent Population

NW	2016	2017	2018	2019
3	**7.5%**	**7.3%**	**7.7%**	**8.3%**
4	11.3%	11.3%	11.8%	12.9%
5	11.6%	11.9%	12.3%	13.5%
US	11.8%	11.9%	12.5%	13.4%

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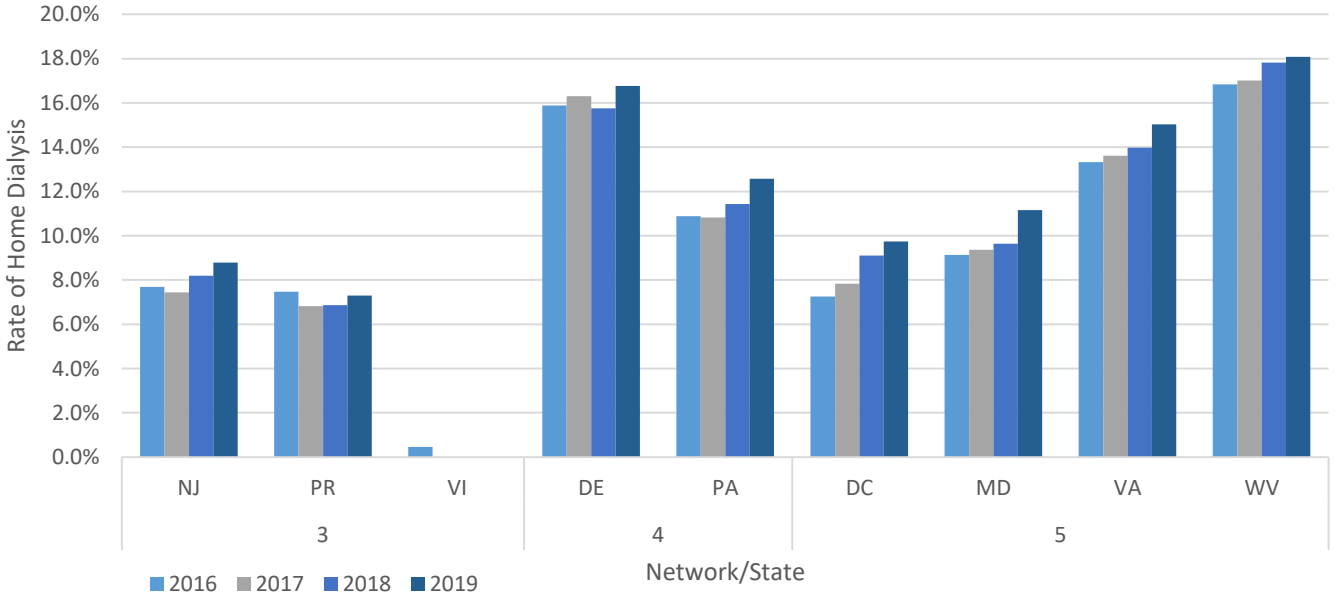
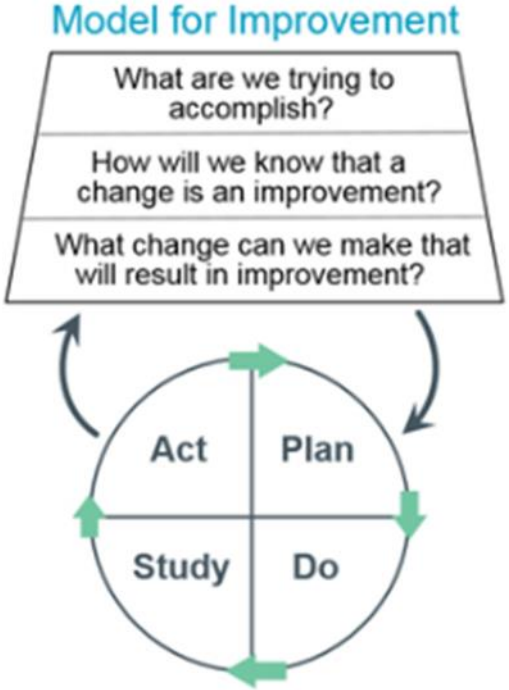


Note: Metrics reflective of Table 1: Summaries for All Dialysis Patients Treated as of December 31st of Each Year, 2016-2019; Rate of home dialysis patients include home hemodialysis, CAPD, and CCPD.
Source: Dialysis Facility Report for Fiscal Year (FY) 2021 Produced by The University of Michigan Kidney Epidemiology and Cost Center (July, 2020)

Model for Improvement

- Quality Assessment and Performance Improvement (QAPI) meeting is a place to start.
  - Identify the problem and define the goal
  - Decide on the measurement to monitor improvement
  - Brainstorm solutions based on barriers and root causes
  - Plan on intervention
  - Use Plan-So-Study-Act (PDSA) to implement the improvement project

Model for Improvement



- Institute for Healthcare Improvement (IHI)
- Widely used by healthcare industry

Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

Health Equity

- All Network initiatives have a health equity component that aims to close gaps in providing patients with greater access to care.
  - To help participants take up on health equity and social determinants, view e-learning activity below.

"Addressing Social Determinants in CKD: Quality Indicators for Patient-Centered Care"

- This 60-minute course will identify and discuss key social determinants of health (SDOH) for people with or at-risk for chronic kidney disease (CKD) among racial, ethnic and socioeconomic lines. It is estimated that key SDOH drive as much as 50% of health outcomes. Additionally, the practice can utilize SDOH tools with patients with CKD or at-risk to improve care and outcomes. **It offers one (1) free continuing education unit.**
- Click this link to access the course: https://www.ediscolearn.com/learn/course/external/view/elearning/103/AddressingSocialDeterminantsinCKDQualityIndicatorsforPatient-CenteredCare

QIA Steps

1. Complete an **initial** root cause analysis (RCA) of the problem
   - Tools: Root Cause Analysis: 5 Whys (4:44 Minutes)
     Five Why's PDF
2. Develop an improvement plan with the interdisciplinary team during QI meeting.
3. Implement a **monthly** mitigation plan to address identified barriers
   - May use organization resources
   - See Home QIA Interventions, Resources and Tools slide
   - Incorporate peer-to-peer mentoring intervention
4. Use Plan-Do-Study-Act (PDSA) cycles
   - Tools: Plan-Do-Study-Act (PDSA) Cycle (6:21 Minutes)
     PDSA PDF

Reporting Requirements

1. One time- complete the **online QIA Acknowledgement Form**

   Details will follow

2. Monthly - complete the **online Status Check Form** for the barrier and mitigation strategies.

   Details will follow

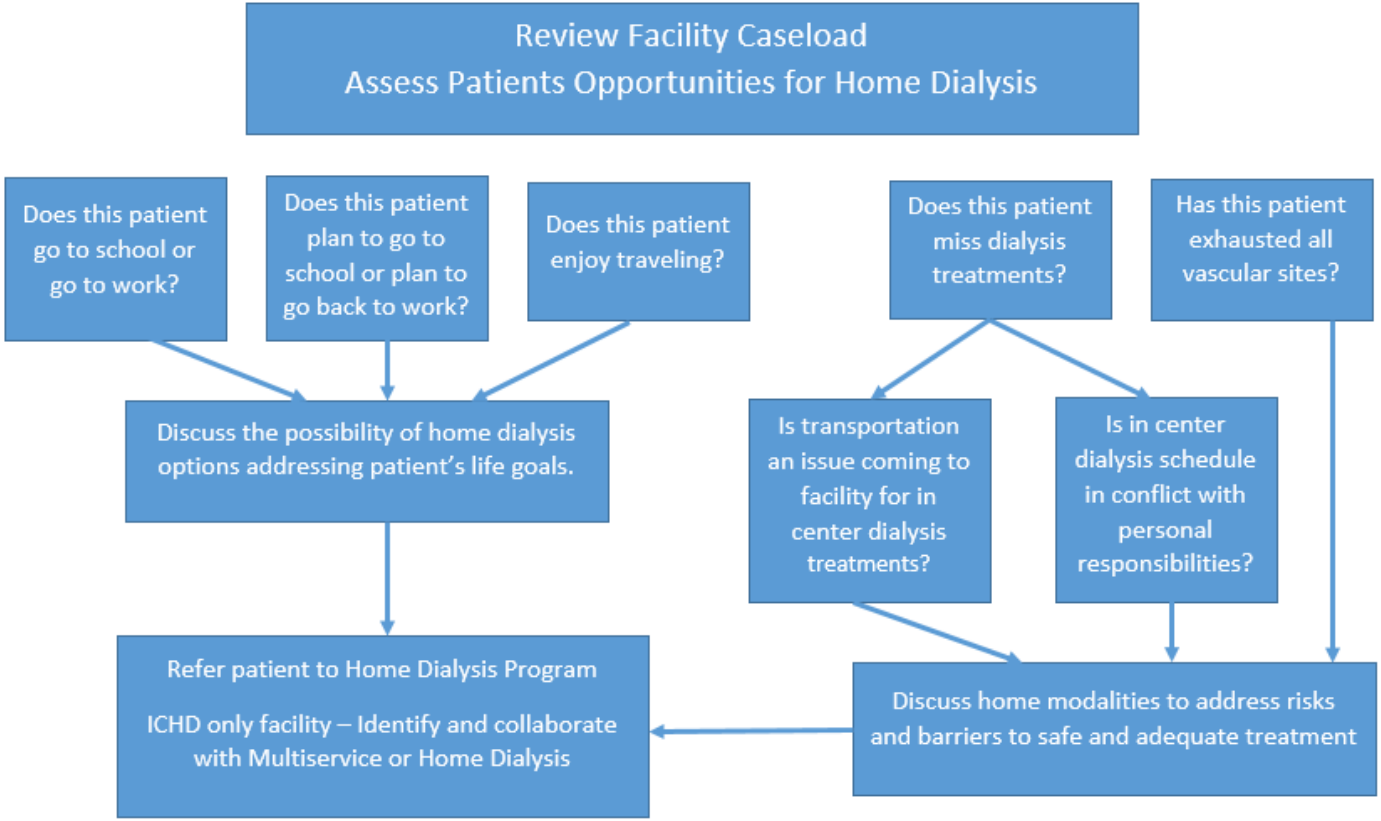
Network Support

- Individual technical assistance
- Coaching calls
- Educational webinars
- Project website

Home QIA Interventions, Resources and Tools

Barrier Specific Recommended Interventions

Identify Patient Opportunities for Home Dialysis



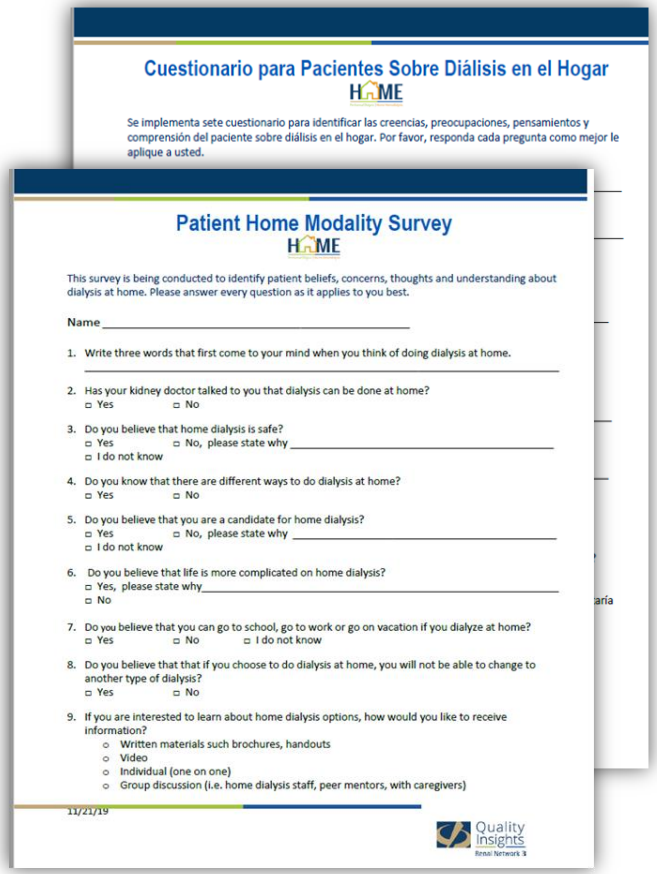
Patient Knowledge Assessment

Tool: Patient Home Dialysis Survey -(English / Spanish)

Provide targeted and meaningful home dialysis education based on assessment. Determine patient learning preference.

- Printed materials
- Video or online education
- One on one (home dialysis staff, home dialysis peer mentor)
- Group

For specific educational resources, visit: https://www.qirn3.org/Ongoing-Projects/Home-Dialysis-Initiation-QIA.aspx



Cuestionario para Pacientes Sobre Diálisis en el Hogar

HOME

Se implementa sete cuestionario para identificar las creencias, preocupaciones, pensamientos y comprensión del paciente sobre diálisis en el hogar. Por favor, responda cada pregunta como mejor le aplique a usted.

Patient Home Modality Survey

HOME

This survey is being conducted to identify patient beliefs, concerns, thoughts and understanding about dialysis at home. Please answer every question as it applies to you best.

Name _____

1. Write three words that first come to your mind when you think of doing dialysis at home.
   _____
2. Has your kidney doctor talked to you that dialysis can be done at home?
   ▫ Yes ▫ No
3. Do you believe that home dialysis is safe?
   ▫ Yes ▫ No, please state why _____
   ▫ I do not know
4. Do you know that there are different ways to do dialysis at home?
   ▫ Yes ▫ No
5. Do you believe that you are a candidate for home dialysis?
   ▫ Yes ▫ No, please state why _____
   ▫ I do not know
6. Do you believe that life is more complicated on home dialysis?
   ▫ Yes, please state why _____
   ▫ No
7. Do you believe that you can go to school, go to work or go on vacation if you dialyze at home?
   ▫ Yes ▫ No ▫ I do not know
8. Do you believe that that if you choose to do dialysis at home, you will not be able to change to another type of dialysis?
   ▫ Yes ▫ No
9. If you are interested to learn about home dialysis options, how would you like to receive information?
   - Written materials such brochures, handouts
   - Video
   - Individual (one on one)
   - Group discussion (i.e. home dialysis staff, peer mentors, with caregivers)

11/21/19

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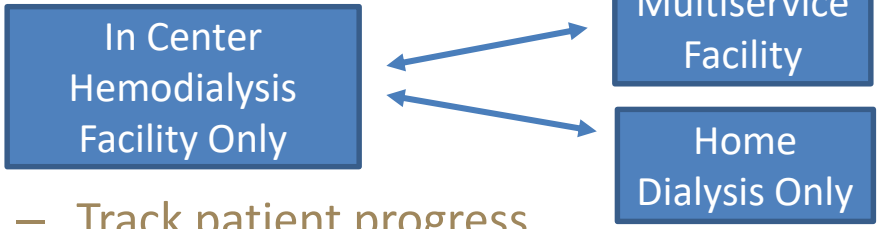
Facilitate home dialysis referrals

- Collaboration



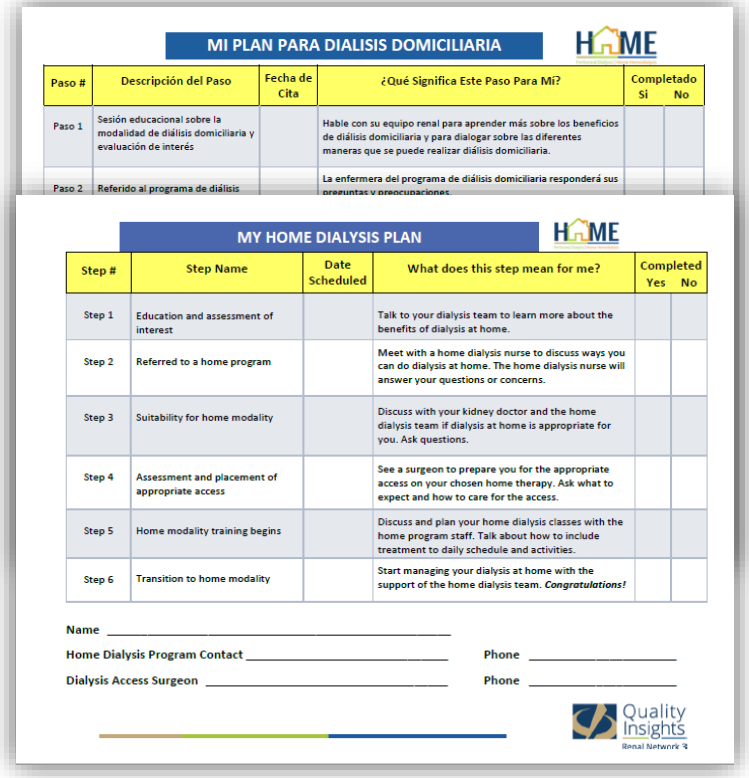
- Track patient progress

Address any identified patient related <u>modifiable</u> barriers

- Fear
- Fact vs. myth
- Knowledge Gap

Tools: My Home Dialysis Plan - (English / Spanish)

Modalities Tracker Tool (available upon request)



MI PLAN PARA DIALISIS DOMICILIARIA

Paso #	Descripción del Paso	Fecha de Cita	¿Qué Significa Este Paso Para Mí?	Completado Si	Completado No
Paso 1	Sesión educacional sobre la modalidad de diálisis domiciliaria y evaluación de interés		Hable con su equipo renal para aprender más sobre los beneficios de diálisis domiciliaria y para dialogar sobre las diferentes maneras que se puede realizar diálisis domiciliaria.		
Paso 2	Referido al programa de diálisis		La enfermera del programa de diálisis domiciliaria responderá sus preguntas y preocupaciones		

MY HOME DIALYSIS PLAN

Step #	Step Name	Date Scheduled	What does this step mean for me?	Completed Yes	Completed No
Step 1	Education and assessment of interest		Talk to your dialysis team to learn more about the benefits of dialysis at home.		
Step 2	Referred to a home program		Meet with a home dialysis nurse to discuss ways you can do dialysis at home. The home dialysis nurse will answer your questions or concerns.		
Step 3	Suitability for home modality		Discuss with your kidney doctor and the home dialysis team if dialysis at home is appropriate for you. Ask questions.		
Step 4	Assessment and placement of appropriate access		See a surgeon to prepare you for the appropriate access on your chosen home therapy. Ask what to expect and how to care for the access.		
Step 5	Home modality training begins		Discuss and plan your home dialysis classes with the home program staff. Talk about how to include treatment to daily schedule and activities.		
Step 6	Transition to home modality		Start managing your dialysis at home with the support of the home dialysis team. ***Congratulations!***		

Name _____

Home Dialysis Program Contact _____ Phone _____

Dialysis Access Surgeon _____ Phone _____

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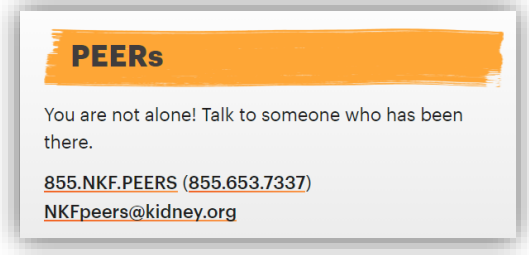
Peer-to-Peer

- Network 3 Peer-to Peer-Program
  - Contact your ESRD Network Patient Engagement Specialist:

    Yessi Cubillo at (609) 490-0310 Ext. 2431 or ycubillo@qualityinsights.org
- NKF Peers

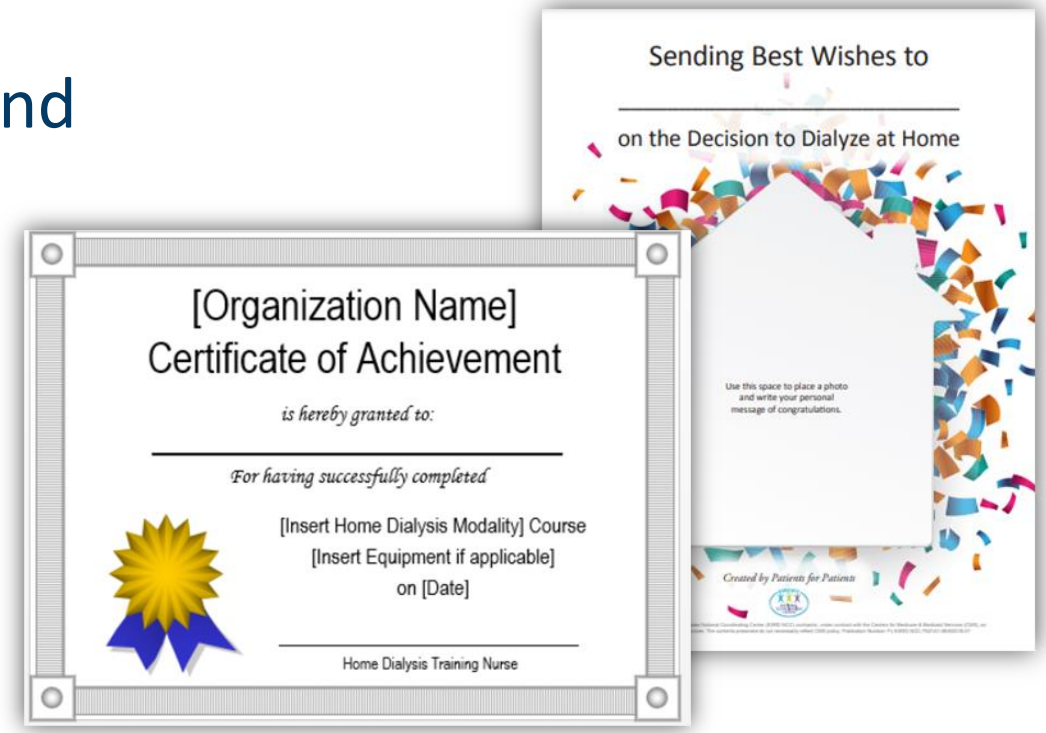
Doing Our Part 6ft NATIONAL KIDNEY FOUNDATION®



- Home Dialyzors United

Celebrate and Recognize Patient Success!

- To make a decision and commitment to do home dialysis is an achievement worth celebrating and recognizing.

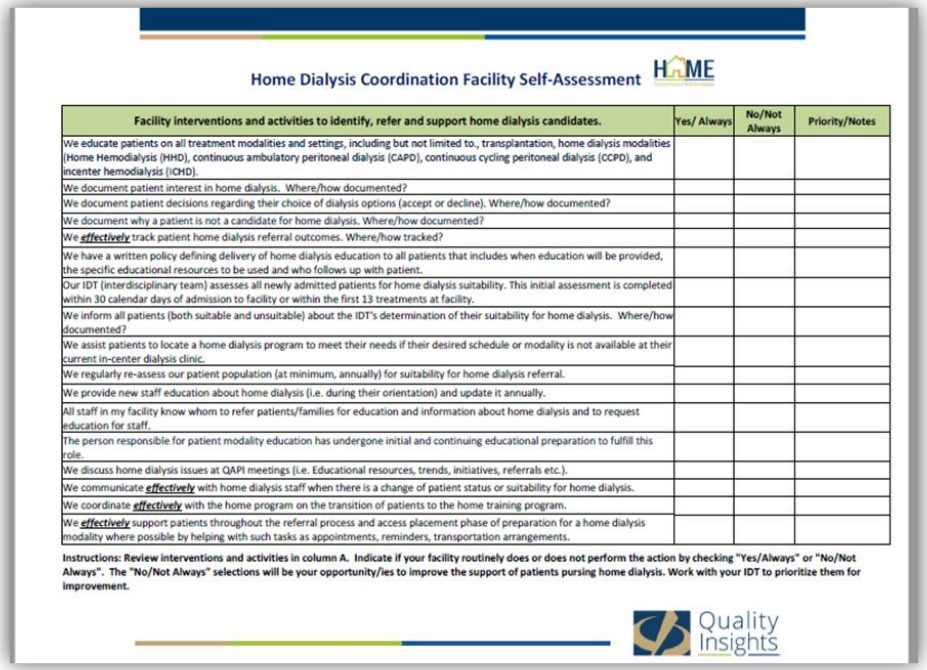


Barrier Specific Recommended Interventions

Facility self- assessment

[Home Dialysis Coordination Facility Self-Assessment Tool]

- Assess, identify and address facility processes needing improvement.
  - No/Not Always: area of opportunity
- Assess ICHD staff knowledge and beliefs on home modalities and address educational needs.
  - Staff education



Home Dialysis Coordination Facility Self-Assessment HOME

Facility interventions and activities to identify, refer and support home dialysis candidates.	Yes/ Always	No/Not Always	Priority/Notes
We educate patients on all treatment modalities and settings, including but not limited to., transplantation, home dialysis modalities (Home Hemodialysis (HHD), continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), and incenter hemodialysis (ICHD).			
We document patient interest in home dialysis. Where/how documented?			
We document patient decisions regarding their choice of dialysis options (accept or decline). Where/how documented?			
We document why a patient is not a candidate for home dialysis. Where/how documented?			
We ***effectively*** track patient home dialysis referral outcomes. Where/how tracked?			
We have a written policy defining delivery of home dialysis education to all patients that includes when education will be provided, the specific educational resources to be used and who follows up with patient.			
Our IDT (interdisciplinary team) assesses all newly admitted patients for home dialysis suitability. This initial assessment is completed within 30 calendar days of admission to facility or within the first 13 treatments at facility.			
We inform all patients (both suitable and unsuitable) about the IDT's determination of their suitability for home dialysis. Where/how documented?			
We assist patients to locate a home dialysis program to meet their needs if their desired schedule or modality is not available at their current in-center dialysis clinic.			
We regularly re-assess our patient population (at minimum, annually) for suitability for home dialysis referral.			
We provide new staff education about home dialysis (i.e. during their orientation) and update it annually.			
All staff in my facility know whom to refer patients/families for education and information about home dialysis and to request education for staff.			
The person responsible for patient modality education has undergone initial and continuing educational preparation to fulfill this role.			
We discuss home dialysis issues at QAPI meetings (i.e. Educational resources, trends, initiatives, referrals etc.).			
We communicate ***effectively*** with home dialysis staff when there is a change of patient status or suitability for home dialysis.			
We coordinate ***effectively*** with the home program on the transition of patients to the home training program.			
We ***effectively*** support patients throughout the referral process and access placement phase of preparation for a home dialysis modality where possible by helping with such tasks as appointments, reminders, transportation arrangements.			

Instructions: Review interventions and activities in column A. Indicate if your facility routinely does or does not perform the action by checking "Yes/Always" or "No/Not Always". The "No/Not Always" selections will be your opportunity/ies to improve the support of patients pursing home dialysis. Work with your IDT to prioritize them for improvement.

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QIRN3 Home Dialysis QIA website

- Hosts patient, staff, facility focused, tools and resources

https://www.qirn3.org/Ongoing-Projects/Home-Dialysis-Initiation-QIA.aspx

ESRD NCC Resources

- ESRD NCC: A Change Package to Increase Home Dialysis Use
  - Key Change Ideas for Dialysis Facilities to Drive Local Action
- Universal Staff Education
  - Modules designed to improve awareness and understanding around home dialysis options. CEUs available.
- Home Dialysis-It Could Be the Right Treatment for You (Video)
- Patient Education Resources

Telemedicine

- ESRD NCC Telemedicine Toolkit
  - Kidney Patient Care: Your Guide to Using Telemedicine
  - Benefits of Telemedicine
  - How to Start Using Telemedicine
  - What Technology Needed? Commonly Used Apps?
  - How to Prepare for Telemedicine Visit
  - Appointment Tracker
- From Coverage to Care (C2C) Telehealth Resources

Questions?

- Contact:

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