End Stage Renal Disease of the Ohio River Valley
3201 Enterprise Pkwy, Suite 210
Beachwood, OH 44122
Phone: (216) 593-0001
Fax: (216) 593-0101
Network9.esrd.ipro.net

To: Medical Directors, Nurse Managers, and Facility Administrators
From: Deborah DeWalt, MSN, RN- Quality Improvement Director
Susan Swan-Blohm, BS, OCDT- Quality Improvement Coordinator
Amar Patole, MBA, BS- Quality Improvement Data Analyst
Date: 01/03/2018
RE: 2018 Appropriate Home Dialysis

Quality Improvement Activity Description

IPRO End Stage Renal Disease (ESRD) Network (NW) of the Ohio River Valley supports the national focus to promote appropriate home dialysis. The goal is to effect a change in ESRD population by increasing those whom are receiving home dialysis over the next five years to 16%. Currently 8%of the ESRD populations utilize home modalities, either home hemodialysis (HHD) or peritoneal dialysis (PD). The Network will work with 30% of the facilities in the Network service area to effect this change. The Network will collaborate with home dialysis programs, in center dialysis facilities, regional large dialysis organization leadership to overcome barriers, improve communication regarding the referral process and the progression of patients through the 7 Step Process outlined in the ESRD Networks Statement of Work (2017). These steps illustrate the navigation of the patient from initial interest through initiation of home training. The target facilities will participate in the National Coordinating Council (NCC) Home Dialysis Learning and Action Network (LAN).

7 Steps involved leading to home dialysis
1. Patient interest in home modality
2. Educational session to determine the patient's preference of home modality
3. Patient suitability for home modality determined by 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

Your facility has been chosen to participate in this activity based on the number patients participating in home modalities from your facility and the potential for growth. There are no patient exclusions in this project.

Project Background

End Stage Renal Disease requires choosing between several options for renal replacement therapy including in-center or home hemodialysis, peritoneal dialysis, and transplantation. Benefits of home dialysis include improved clinical outcomes, higher quality of life, decreased mortality and lowered healthcare costs. Meceier-Kriesche, Ojo, Port, Arndorfer, Cibrik, D. M., & Kaplan, 2010; Wolfe, et al., (1999). According to the Centers for Medicare and Medicaid Services (CMS) Conditions for Coverage

(CfC) for End Stage Renal Disease Facilities (2008), dialysis providers are responsible for educating their patients about treatment modalities, including HHD and PD. Despite the annual education only 8% of the ESRD patients in the United States are dialyzing at home.

When surveyed 500 medical directors, 88% stated they would chose a home modality as their personal choice if they required dialysis. Ninety-three percent of incident patients do not have an absolute contraindication that would prevent a home modality choice. Doctors practicing paternalism and not referring any less than perfect patient seems to be the largest gap between in-center and home modality patients. Rioux, et.al (2015)

Earlier modality education could promote interest and the start of home modality earlier in the patients' dialysis journey and many LDO organizations have implemented programs to achieve this goal. CMS also funds Kidney Disease Education for pre-dialysis patients but less than 2% of all Medicare eligible patients received the benefit in 2010 and 2011. Lockridge (2017)

Potential candidates are those patients and family members wishing to take control of their care, to work or go to school and those willing to learn that show motivation. Adults are goal oriented; finding the patients motivation to learn home modality will frequently expedite the initiation of training. Principles of Adult Learning (2017)

The opportunity for better clinical outcomes is greater in home modality patients; included in these outcomes are reduced mortality and morbidity, improved patient quality of life, and less cost and improved survival advantage than long-term dialysis (Meier-Kriesche, Ojo, Port, Arndorfer, Cibrik, D. M., & Kaplan, 2010; Wolfe, et al., 1999). According to the Centers for Medicare and Medicaid Services (CMS) Conditions for Coverage (CfC) for End Stage Renal Disease Facilities (2008) annually, all dialysis providers are responsible for educating their patients about treatment modalities including transplant. In spite of this requirement, gaps in transplant referral exist.

The Network will focus on the identification and elimination of barriers that prohibit the start of home modality training within the time frame of the project. The root cause analysis of barriers that prohibit home modality initiation has led to the following interventions. These interventions have been created to overcome actual and perceived barriers in home modality initiation.

Process related to this activity includes maintaining and sharing accurate monthly records of the patients as they proceed through the seven steps to home modality training. REDCap reporting, and root cause analysis to determine barriers to home modality initiation outlining and implementing a plan to address these causes in collaboration with your facility team. **Mandatory conference calls will be hosted by the National Coordinating Council (NCC) on behalf of CMS.** Invitations will be sent for your participation in the Learning and Action Network- Home modality –LAN. These calls will be held in February, May, and August to discuss this activity in the promotion of home modalities. A timeline of these QI activities is noted below.

End Stage Renal Disease of the Ohio River Valley
3201 Enterprise Pkwy, Suite 210
Beachwood, OH 44122
Phone: (216) 593-0001
Fax: (216) 593-0101
Network9.esrd.ipro.net

Please be aware that e-mails about this QIA will be coming soon to those identified as representatives. Accurate contact information (including name, title, and email address) is critical to ensure appropriate contact and **documentation of your facilities attendance to the LAN events**. Thank you in advance for your assistance and participation in this initiative

Participation in this QIA is mandatory; failure to comply may result in sanction as outlines by Centers for Medicare and Medicaid Services (CMS).

If you have any questions or comments about the QIA, your involvement, participation in the Home Training education-LAN or future interventions please feel free to contact the Quality Improvement Department by email Deborah DeWalt, ddewalt@nw9.esrd.net or Susan Swan-Blohm, sswan-blohm@nw9.esrd.net we look forward to working with you in this coming year's activities!

2017 Facility / Network Timeline of Activities

January

- The Network will provide notification of participation in this activity, education of reporting tools and project paperwork.
- Facilities will return completed contact information by January 17, 2017.
- Facilities will participate in a kick off webinar outlining the facilities responsibilities for participation in the QIA, participation in the home training -LAN, patient ambassador program outline, project calendar, and REDCap education and responsibilities for reporting.

February

- The Network will provide an informational webinar featuring Dr. Marc Kraus outlining movement through the 7 steps to home training, process and provide tools to document the patient progress
- The Network will reinforce the use of RedCap reporting with a step by step usage guide
- Facilities will identify and provide contact information for a minimum of 2 patient ambassadors to participate in the QIA
- Facilities will provide reporting in recap identifying barriers and best practices through the completion of the project in July 2018
- The Network, facilities and patient ambassadors will participate in the Appropriate Home Training-LAN on a bi-monthly basis to promote sustainability starting in February 2018 through July 2018

March

- The Patient Ambassadors, the Network and facility representatives will participate in a kick off webinar identifying expectations, and project calendar for the patient SMEs identified
- The NW will provide a webinar on Patient Selection for home modalities
- The NW will distribute materials related to home modality options.

- The NW will review QAPI records of facility and patient data to monitor progress through the 7 steps to September 2018

April

- The NW will provide educational materials on barriers to beginning home modality training
- The NW will provide a webinar sharing best practices

May

- The NW will provide educational materials and stories of patients who have successfully transitioned to home modalities.
- The NW will provide a PAC call focusing on home modalities and success stories.

June

- The Patient Ambassadors will distribute patient stories of success on home modalities as provided by the NW.
- The NW will provide a webinar sharing best practices

July

- The NW will provide follow up articles for the NW periodicals PAC speaks, Kidney Chronicles and the Provider Insider to reinforce home modality education

August

- The NW will distribute articles in the *PAC Speaks*, *Provider Insider* and the *Kidney Chronicles*
- The NW will provide assistance with Rapid Cycle Improvement through the seven steps

September

- The NW will provide a Survey Monkey to beneficiaries and stakeholders to provide feedback on project materials, and areas for improvement.
- The NW will evaluate facilities for graduation and provide graduation celebration materials

End Stage Renal Disease of the Ohio River Valley
3201 Enterprise Pkwy, Suite 210
Beachwood, OH 44122
Phone: (216) 593-0001
Fax: (216) 593-0101
Network9.esrd.ipro.net

Appropriate Home Dialysis -Project Agreement

Dear Provider,

The Network shall achieve Centers for Medicare and Medicaid Services (CMS) goals through the development and implementation of quality improvement activities, such as the activity noted below. As directed by the Network governing bodies, 2018 performance goals have been set that every dialysis facility is expected to achieve.

"It is understood that participation in Network activities is a condition of approval to receive Medicare reimbursement for the provision of End Stage Renal Disease (ESRD) services. The dialysis facility must cooperate with the ESRD Network designated for its geographic area in fulfilling the terms of the Networks current statement of work. Each facility must participate in ESRD activities and pursue Network goals"

Please carefully review the notification letter and attached objectives for the Promote **Appropriate Home Dialysis (**Home Modality QIA). After review, please complete the necessary fields and return the contact information to the Network office via **fax at (216) 593-0101 by January 17, 2018**.

****Please note, regardless of assigned Project Lead, Medical Director and Facility Administrator/Nurse Manager are responsible for ensuring completion of project objectives**

In anticipation to your timely response, we thank you for your ongoing support and cooperation with the Network.

Sincerely,

Victoria Cash, MBA, BSN, RN
Executive Director

Deborah DeWalt, MSN, RN
Quality Improvement Director

End Stage Renal Disease of the Ohio River Valley
3201 Enterprise Pkwy, Suite 210
Beachwood, OH 44122
Phone: (216) 593-0001
Fax: (216) 593-0101
Network9.esrd.ipro.net

Appropriate Home Dialysis-Project Agreement
January 2018-October 2018

The undersigned hereby agrees to participate and cooperate with the goals and activities, including quality improvement projects, as set forth by IPRO ESRD Network of the Ohio River Valley (Network 9) (42 CFR Part 494.180. V772 (i) of Centers for Medicare & Medicaid Services (CMS) regulations).

It is imperative that all fields be completed below; all parties will be invited to participate in the mandatory NCC Home Modalities LAN This information must be returned to the Network via fax 216-593-0101 by January 17th

Facility Name____ CCN#_ _ _ _ _ _

Project Lead________________________________ Project Lead Title____________________

Project lead email ___________________________________

Medical Director____

Medical Director Email ____

Facility Manager/ Facility Administrator_____________________________________

Facility Manager/ Facility Administrator email address________________________________

Regional Director/ Area Administrator______________________________________

Regional Director/ Area Administrator email address____

Regional vice President____

Regional vice President email address____

Any changes to the above listed contacts must be reported to the Network and corrected in CROWNWeb within 5 business days to ensure continuity with project implementation and communications between the Network and Facility. Plans are reviewed periodically, and are subject to change based on the CMS Statement of Work (SOW).

End Stage Renal Disease of the Ohio River Valley
3201 Enterprise Pkwy, Suite 210
Beachwood, OH 44122
Phone: (216) 593-0001
Fax: (216) 593-0101
Network9.esrd.ipro.net

Patient Subject Matter Expert Agreement

CMS believes that you- the patient are the most valuable player on the healthcare team. Building interventions centered on the patient is the goal of every CMS project.

How can you help? We would like you to become a vital member of the healthcare team. You will be requested to participate in webinars or calls to support the goal of increasing the number of patients to initiate home modality training in your facility. You will assist by helping to educate patients on the benefits of home modality. Your efforts will be shared with facility management in their monthly governing body meetings.

I, ___________________________, (patient or patient family member) agrees to represent,

my unit, ____CCN#_____________
(This line will be filled in by your facility staff)

in the Appropriate Home Dialysis project. This project will run through September 2018.

SIGNATURE____

PRINTED NAME___________________________DATE______________________

PHONE:____________________________EMAIL__________________________--

FAX TO: 216-593-0101 DO NOT SCAN OR EMAIL