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HOUSEKEEPING

- Call in on your phone:
  - 1-800-747-5150
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- You will be on mute until the end of the webinar/recording. You can post comments to the chat window and questions will be answered at the end of the webinar.

- This meeting will be recorded
HOME REFERRALS
THINK HOME
ORIENTATION WEBINAR
FEBRUARY 22, 2018
12:00 PM CT

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*denotes project lead
OBJECTIVES

- Goals of the project
- Focus Facility selection
- Project components
  - RCA
  - FPR Recruitment and Patient Engagement
  - NCC LAN
- Network Watch List
- Project Timeline
- Wrap up

*Please utilize the chat window for questions*
CMS SOW: 7 steps leading to home modality placement:
1) Patient interest in home dialysis,
2) Educational session to determine the patient’s preference of home modality,
   a) Steps 1 & 2 Patient Engagement piece - NW 14 PE calendar/handouts; discussion groups
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
   a) Steps 3 - 5 Nephrologist and Surgeon piece - communication, referral letters
6) Patient accepted for home modality training,
7) Patient begins home modality training.
   1) Steps 6 & 7 - Home Dialysis Training
7 STEPS

• Complete one Home Dialysis Tool for each patient:
  • Tracking each step monthly
  • Reporting # pts added to waitlist monthly

• Network developing Survey Monkey reporting tool
  • Goal: facilities will be able to report numbers through Survey Monkey every month
QAPI/QA REQUIREMENTS

- Review of 7-Steps
- Plan of Action if patient(s) not progressing (PDSA)
- Document communication with TP Centers (especially for steps 4-7)

CMS Statement of Work (SOW): “Facilities in the Home Dialysis QIA to incorporate the process steps into patient education, facility practice, and the facility QAPI process.”

“...incorporating patient, family and caregiver participation into the Quality Assurance Performance Improvement (QAPI) Program AND governing body of the facility; and with developing policy and procedures related to patient, family and caregiver participation in the patient’s care (e.g., policy establishing the dialysis facility’s position on patient, family member and caregiver involvement in the development of the individualized plan of care and plan of care meetings, QAPI. QI Projects...).”
Baseline Data: Oct 2016 – June 2017
Focus Facilities 189
Focus Facilities Rate 4.29

Network 14 facilities eligible to report for all of 2017
(n=624)

>=1 HT Patient or >0% HT Rate (n=417)

Excluded LDO facilities in Transplant Project (267)

Selection of facilities below FMC median rate (n=123)

Selection of facilities below NRAA+Others median rate (n=66)

Total number of remaining Focus Facilities in Project (n=189)

National Rate of Home Patients: 12%
CMS Goal by 2023: 16%
Our Goal: Increase Home Rates by at least 10% or by at least 1,751 patients or from 4.29% to 14.29%
PROJECT MAJOR COMPONENTS

- Patient Engagement and Facility Patient Representative (FPR)
- Root Cause Analysis (RCA)
- Sustainability
- 7 step bundle & QAPI
- Data Collection
- Disparity Assessment
PROJECT MAJOR COMPONENTS

- Root Cause Analysis (RCA)
- 7 step bundle & QAPI
- Disparity Assessment
- Data Collection
- Sustainability
- Patient Engagement and Facility Patient Representative (FPR)
2018 Home Referrals: Root Cause Analysis (RCA)

Read the following instructions carefully

1. Complete the questions below by selecting the root causes you think are barriers to transplant waitlist (multiple selections are allowed)
2. Describe any root cause(s) NOT listed by using the Other (comment) box

WARNING: DO NOT USE PATIENT SPECIFIC INFORMATION SUCH AS NAMES, DOB, SOC SECURITY #, ETC. IN THIS SURVEY. SECURITY VIOLATIONS WILL BE REPORTED TO CMS.

* 1. What are Facility Specific Barriers that you think are attributable to having a low Home Referrals in your facility?
   - [ ] Lack of staff training on talking to patients/providing information to patients about home referrals
   - [ ] Staffing issues: Short staffed, stress, turnover
   - [ ] Time constraints to be able to provide home referral advice
USING THE FPR TOOLKIT
Recruit: facilities should assess the patient population and find patients that are engaged and would be good facility patient representatives. Once one or more patients have been identified facilities will approach the patient(s) one on one and discuss the position with them. The goal should be for each facility to have at least one FPR per shift.

Overview of this step

- Find patients engaged in their care
- Approach them one on one to discuss the position
Application - if the patient(s) are interested, the facility will present the patient with the FPR application that can be found in the FPR toolkit. Facility staff will have the patient fill out the application and then meet one on one with the patient to discuss the application and address any questions or concerns. The application will be filed away at the facility.

Overview of this step

- One on one meeting with FPR as needed to explain the FPR Toolkit
- Patient completes application in the FPR toolkit
- Application filed away at the facility
**Decide and Duties** - the facility will have one on one time with the FPR(s) they’ve chosen and together the facility and the FPR will come up with a list of duties or expectations that both satisfy the facility’s needs and the patient’s capabilities. After the duties have been written down and agreed to/signed by facility staff, FPR, and endorsed by corporate leadership, the patient will be inducted as the active FPR.

Overview of this step

- Choose an FPR (we suggest at least one per shift)
- One on one meeting with FPR to discuss what duties should be performed to best help your facility population. An effort should be made to include both facility needs and FPR expectations when deciding on and planning duties.
- The facility staff in charge of patient engagement and the FPR sign the agreement.
**Action** - it’s time to utilize your FPR. The facility and the FPR should have worked together in the last step to assess facility needs and working on a list of action items to complete each month, quarterly, semiannually, annually etc. This could be educational material for the patients, lobby days, discussion groups, support groups and other relevant activities or tasks. The FPR will put these activities into action, perform duties agreed upon earlier, and communicate with the facility patient population to address their needs.

Overview of this step

- FPR performs duties outlined in the last step
- Facility staff provides support to FPR when needed
**USING THE RADAR/FPR TOOLKIT**

**Reassess and sustain** - periodically, facility staff and the FPR will get together and discuss the progress of the goals they’ve set out to accomplish. They can also revisit FPR duties and responsibilities as well as expectations for the facility and the FPR to note and immediately address any concerns or misunderstandings. This step leads to and sets the FPR and the facility up for a sustainable partnership. The relationship between the FPR and the facility must be sustainable to work well. The FPR and the facility should make it a priority to work together cohesively to meet the patient population’s needs.
Every dialysis in Texas should have a FPR who will act as a link between patients and the facility staff.

- Recommend 1 FPR for every shift
- Consider diversity and predominant and secondary languages spoken by patients
- Use Network FPR Toolkit (RADAR Tool) to orient staff and patients to FPR role

Responsibilities

- Assist facility
  - Gather information and ideas from patients
  - Distribute information to patients
  - Share ideas from patients with facility staff
  - Co-design strategies to improve the delivery of care and patient information
  - Support Patient and Family Engagement activities, including QI activities
  - Promote Patient and Family Centered Care
What is a Facility Patient Representative (FPR)?

Every dialysis clinic in Texas should have a Facility Patient Representative (FPR) who will act as a link between patients and the facility staff. The attached handbook and tools will assist facilities with recruiting and training patients to become valuable members of the team.

To learn more about the FPR program, contact your facility social worker and read the information available in the FPR Toolkit!

FPR Toolkit - English - Spanish - Revised 01/2018

FPR FAQs

- FPR applications are for facility use.
- The patient fills out the application, designated facility staff will appoint the patient as the FPR.
- Application material and signed agreements should be kept at the facility as they are contracts containing personal patient information.
- FPRs should be entered into CROWNWeb so that the Network is aware of what facility has FPRs and who they are.

Please remember to delete FPRs out of CROWNWeb if they are no longer FPRs for your facility!
Facility’s Patient Clinic Committee members reviewing the Conversation Starter and the Lead Patient Committee member, Juan Morales, demonstrating teach back with the clinic staff.
HOME QIA PATIENT ENGAGEMENT

OPTION 1
National Recognition Events

OPTION 2
Network’s Patient Engagement Calendar

OPTION 3
Facility’s Patient Engagement Plan
Patient Engagement Activities will be promoted through the recognition and involvement of nationally recognized patient days.

- World Kidney Day (March 8, 2018)
- Patient Experience Week (April 23-27, 2018)

(Network 14 strongly encourages participation of facility patient representatives)
HOME QIA PATIENT ENGAGEMENT ACTIVITY

PE Activity: March 2018
- Network Calendar Activity
- Facility Planned Activity

PE Activity: April 2018
- Network Calendar Activity
- Facility Planned Activity

PE Activity: June 2018
- Network Calendar Activity
- Facility Planned Activity

PE Activity: July 2018
- Network Calendar Activity
- Facility Planned Activity
Patient Engagement: Patient and Family Subject Matter Centered Care

**2018 Patient and Family Subject Matter Centered Care**

**Patient Engagement Activity**

**What do patient SMEs, family members and patients do?**

- Provide your voice as part of a larger whole.
- Share ideas and concerns with patients of all treatment modalities.
- Share ideas and concerns with providers and other stakeholders.
- Learn from your fellow patients.

**PAC Activities**

*What projects does the PAC work on? How?*

**Patient Engagement Calendars**

**2018 Patient Engagement Calendar**

- **January** - Take part in your care
  - English - Spanish
  - Addendum English - Spanish
- **February** - Plan ahead for emergencies
  - English - Spanish
- **March** - Attend a patient and family group meeting
  - Fundamentals - English - Spanish
- **April** - Get to know your Care Team
  - English - Spanish
- **May** - Learn about patient responsibilities
  - English - Spanish
- **June** - Participate in your Plan of Care meetings
  - English - Spanish
- **July** - Learn about different dialysis treatments
  - English - Spanish
- **August** - Cherish your vascular access
  - English - Spanish
- **September** - Get your vaccinations
  - English - Spanish
- **October** - Know the 6 tips to prevent dialysis infections
  - English - Spanish
- **November** - Take care of your emotional health
  - English - Spanish
- **December** - Plan for end of life
  - English - Spanish
The ESRD NCC Home LAN has three primary purposes.

- The first is to improve information communication across care settings, with emphasis on communication between in-center dialysis centers and home dialysis centers to promote and support transition of care for ESRD patients.
- The second is to promote and support communication internally between in-center and home modality staff to educate patients.
- The third is to increase awareness of and ways to support the patient through training for a home modality.

Facility Responsibility

- Attend the ESRD NCC Home LAN every other month
- Share identified interventions to improve the Home modality rates from each LAN meeting with patients and staff.
Facilities failing to submit required documents for projects will receive:
- One written or emailed notice
- One notification via phone

If no response received from facility, the facility will be placed on the Network Watch List, which will include:
- Report of non-compliance to corporate leaders
- Report of non-compliance to DSHS as needed
- Report of non-compliance to CMS
TIMELINE

COMING SOON!
SUSTAINABILITY

SUSTAIN

- Sustain the improvements made during the project after the project has ended
  - Start early, at the beginning of the project with the end goal in mind
  - Use SUSTAIN mnemonic to remember the seven steps of sustainability
  - Complete and submit a Sustainability Plan for each project to Network toward end of project

- Role of organizational culture and leadership in successful sustainability activities
We will be adding home resources to our website through the project.

**Home Referrals QIA**

Network 14 AIM 2 QIA is aimed at developing and implementing a quality improvement project utilizing home dialysis data in order to improve referral rates for home modalities with an emphasis in reducing disparities.

**Network Project Lead:**
Quality Improvement Department

For resources please click [here](#)
Complete the Pre-Project Survey
  ▪ Was included in your project notification letter

Complete the Project Root Cause Analysis Survey

Have two project lead associates (Main and Back-up)
  ▪ Setup Prevention Process Measures to ensure continuity and accountability

Begin to recruit a Facility Patient Representative. If you have one, inform them on how they can assist with this project

COMPLETE THE WEBINAR ATTESTATION (Post link in chat)

All of these materials will be available on our website under the Home QIA section by Monday Feb 26, 2018
WEBINAR EVALUATION & QUESTIONS

Questions?

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