HOME MODALITY

THINK HOME ORIENTATION WEBINAR

JANUARY 14, 2019
2:00 PM CT

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NETWORK STAFF

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QIAs

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OBJECTIVES

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

*Please utilize the chat window for questions*
FREQUENTLY ASKED QUESTIONS AND THINGS TO NOTE

- Were can I find project material?
- What is my login for the website?
- Why am I in this project?
- If you are receiving emails in error please FWD the email to your colleague over the project then contact the network so that we can get you set up as the correct contact
- Every facility is given a call and an email prior to being place on the watch list
- Please be patient with my response time as we have several facilities in this year’s project
  - Examples
    - 200 late notices sent
    - 200 calls made
    - 100 watch list notices sent out
    - Received over 100 combined calls and emails with in 48 hours of notices being sent out.
Network 14 facilities eligible to report for all of 2017-2018 (n=673)

Network 14 selected one major LDO for 2019 Contract year (n=218)

CMS requires 30% of the Network service area to participate in 2019 Home QIA Project (n=202)

Selection of facilities below FKC overall rate (n=200). The Network selected a total 202

Selection of facilities oversampled (n=4)

Total number FKC Focus Facilities in Project (n=206)

Baseline Data: 60 months trend analysis
Focus Facilities: 206
Focus Facilities Rate: 0.00-3.03

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Focus Facilities Rate: 0.00-3.03

National Rate of Home Patients: 12%
CMS Goal by 2023: 16%
**Our Goal:** Increase Home Rates by at least 2 percentage points or by 400 patients or from .52% to 2.52%
PROJECT MAJOR COMPONENTS

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

1. Root Cause Analysis (RCA)
2. Disparity Assessment
3. Data Collection
4. Sustainability
5. Patient Engagement and Facility Patient Representative (FPR)
6. 7 step bundle & QAPI
2019 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 Home Referrals (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?
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.
   a) Steps 6 & 7 - Home Dialysis Training
   b) *Note* facilities are highly encouraged to report in CrownWeb the number of patients who begin 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
• Review of 7-Steps
• Plan of Action if patient(s) not progressing (PDSA)
• Document communication with Home 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...). ”.
FACILITY PATIENT REPRESENTATIVE (FPR)

- 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.
- Please have the patient fill out the application. Designated facility staff will appoint the patient as the FPR.
- All 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!
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 and 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
Using the Radar FPR Toolkit

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
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.
HOME QIA PATIENT ENGAGEMENT

OPTION 1

National Recognition Events

OPTION 2

Network’s Patient Engagement Calendar

OPTION 3

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

- World Kidney Day (March 14, 2019)
- Patient Experience Week (April 22-26, 2019)

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

- PE Activity:
  February - September 2019
  - Network Calendar Activity
  - Facility Planned Activity
  - ESRD NCC Activity

- Patient Engagement Activities are available on ESRD Network’s website
  - Network Calendar Activity
    https://www.esrdnetwork.org/patients-families/pfcc
**Patient Engagement & Patient- and Family-Centered Care**

2019 Patient and Family Subject Matter Expert (SME) for our Patient Advisory Committee (PAC) recruiting starts in October 2019.

**PATIENTS:** Are you interested in helping the Network understand how patients feel about different subjects? Would you like to be a voice for other patients?

**STAFF:** Do you have engaged patients and families and/or active Facility Patient Representatives (FPRs) that would like to speak up on behalf of your other patients?

What do patient SMEs, family members and caregivers do?

- Provide your voice as part of a larger whole, the entire ESRD patient population in the state of Texas.
- Represent patients of all treatment modalities.
- Share ideas to help improve patient-centered care and communication.
- Review patient education materials to ensure they are helpful for patients.
- Teach your fellow patients, providers and other stakeholders.
- Learn from your fellow patients, providers and other stakeholders.
- Celebrate the success of your efforts.

**Patient Engagement Calendars**

**CALENDARS**

- 2019 Patient Engagement Calendar - English - Spanish
- 2019 Facility Patient Representative guide for Patient Engagement Calendar - English - Spanish

**2019 Patient Engagement Handouts**

- 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
### 2019 Home QIA Project Timeline *(subject to change)*

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*Timeline is subject to change*
SUSTAINABILITY

SUSTAIN
STANDARDIZE
UTILIZE
SHARE
TRANSPARENCY
ACCOUNTABILITY
INTEGRATION
NEVER GO BACK

- 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
Home resources are available on our website.

https://www.esrdnetwork.org/home-modality

Home Modality

The ESRD Network of Texas has been directed by the Centers for Medicare and Medicaid Services (CMS) to collaborate with 30% of the outpatient dialysis facilities within the state of Texas and to support facility efforts to increase home referrals by 2 percentage points. Network 14 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:

Betrice Williams, Outreach Coordinator

office (469) 916-3807, email bwilliams@nw14.esrd.net

For resources please click here
NEXT STEPS

- Complete the Pre-Project Survey
  - *Was included in your project notification letter Due 1/31/2019*

- Complete the Project Root Cause Analysis Survey. **Due 2/28/2019**

- Have two project lead associates (Main and Back-up)
  - *Setup Prevention Process Measures to ensure continuity and accountability.*
  - *Complete the Facility Contact Form and return to the Network. Due 1/31/2019*

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

- **COMPLETE THE WEBINAR ATTESTATION** (Posted link in chat)

*All of these materials will be available on our website under the Home QIA section by Monday February 4, 2019*
WEBINAR EVALUATION & QUESTIONS

Questions?

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