
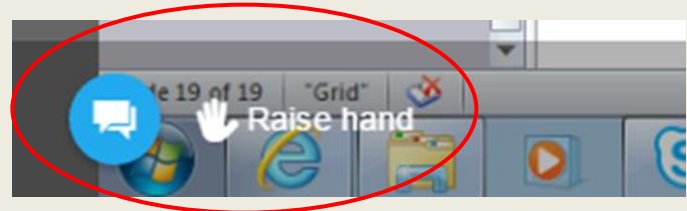
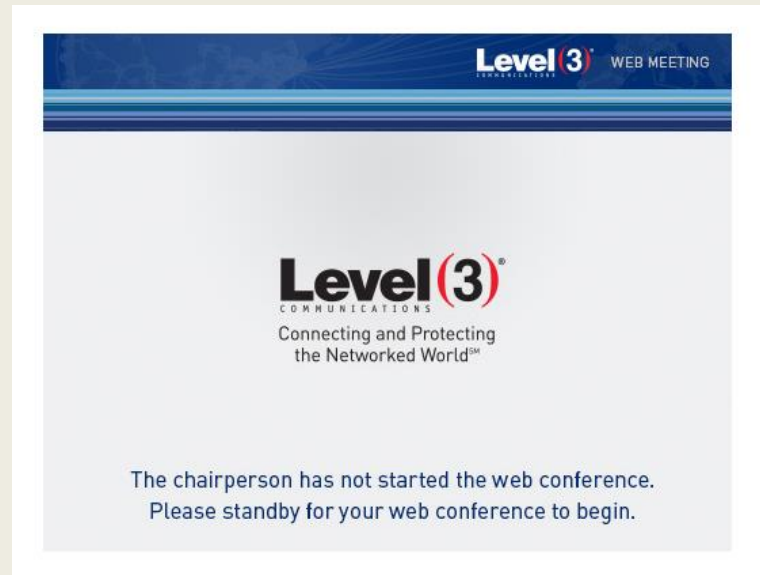


# PARTICIPANT: ONCE YOU'VE LOGGED IN

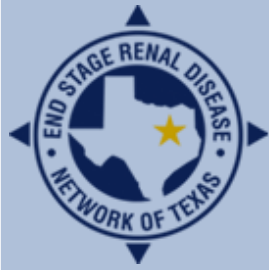
- If the webinar hasn't began yet you will see this screen. 
- If it has you will see the first slide or the presenter's slide deck.
- There is a Chat panel in the bottom left hand corner of your screen. Click the talk boxes to post a comment/question. Click the "raise hand" button for pressing comments/questions.



# HOUSEKEEPING

- **Call in on from your phone:**
  - **1-800-747-5150**
  - **Access Code 1073175**
- **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 a the end of the webinar.**
- **This meeting will be recorded and posted on our website under the QIA section.**





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# TRANSPLANT WAIT LIST

*TRANSPLANT IMPROVEMENT PROGRAM FOR SUCCESS (TIPS)*

**2018 EXIT WEBINAR**

**OCTOBER 29, 2018**

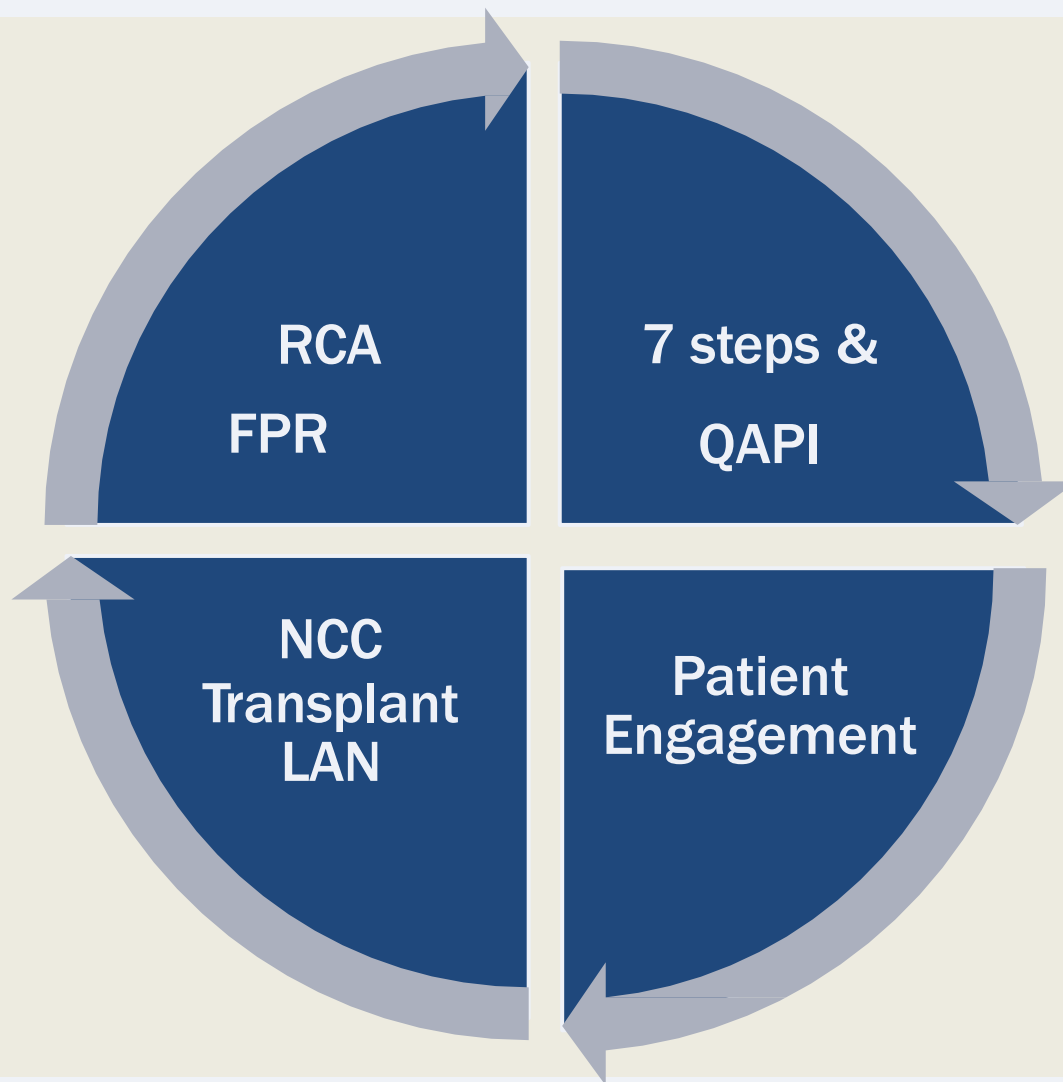
**2:00 PM CT**

**DANY ANCHIA, BSN, RN, CDN**  
**CLINICAL QUALITY MANAGER**

FIRST OF ALL...



# PROJECT MAJOR COMPONENTS



# SUSTAINABILITY & DISPARITIES

**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 (Survey Monkey)
  - Complete and submit a Sustainability Plan with signed copy to fax **972-503-3219** or **678-527-3727**
- Disparities
  - Identify and address as needed
  - Male 64% vs. Female 36%
  - Rural vs Metropolitan



# SUSTAINABILITY

- **Standardization:** In order for this to become the culture, standard, or usual business in your facility, please provide specific examples of how you will hardwire and prioritize these processes into your current system.
- **Examples:**
  - We utilize the CVC reduction protocol with all new admissions and existing CVC'S. We provide vascular access and modality choice education to each patient upon admission. We refer patients to vascular surgeons within one week of admission. VAM and CC do weekly follow up with patients and surgeons regarding updates on the patients progress through the 7 step process, as well as, possible issues with existing vascular accesses that could result in CVC conversions. Weekly updates to CVC one stop tool and weekly conference calls with Regional VAM and Corporate leadership. VAM has reached out to new Vascular Surgeons in the area, creating new and successful relationships with our facility.
  - All patients are educated on treatment options. We have a Kidney Care Advocate that provides education to new patients as well as established patients. The patient is evaluated by the physician for referral to home therapies. If physician approves patient for home therapies we begin a checklist process to ensure all requirements are met before patient starts home therapies. FKC has a goal of 20% of patient on home therapies by 2020. All FKC clinics participate.







# SUSTAINABILITY

- **Utilization: How will you utilize frontline staff and corporate leadership to implement these changes?**
- **Examples:**
  - The frontline staff and IDT will continue to make the nephrologists aware of the need to make HHD a modality option for dialysis as it appears that ICHD is the default choice for most of the patients especially those that are new to ESRD. Potential referrals will be discussed in QAPI meetings with the FA and Medical director to keep them informed of any potential barriers and successes. Frontline staff will notify IDT of any patients showing interest in HHD.
  - The kidney care advocate comes out to assist the clinic at a minimum of quarterly and annually the staff have a lunch and learn to teach about the MATCH - D program and how to make home referrals.
  - Specified DPC staff are assigned as the home therapy group and are educated on home therapy to ensure their knowledge for educating patients who qualify or have interest in home therapy Corporate leadership could assist those working at the clinic level, by allowing time for this undertaking to be put in place, practiced, and evaluated. Prioritizing and limiting the number of projects to be done, would be helpful.



# SUSTAINABILITY

- **Share: How will these new changes, or changes to existing processes, be communicated with existing staff, new staff, PRN staff, patients, and family members? How will feedback be obtained and addressed from each group?**
- **Examples:**
  - Communication to staff of changes will be communication via written communication and verbal communication during regularly scheduled team meeting with leadership and staff. New staff will receive orientation that includes the corporate culture and standards.
  - The entire IDT team will continue to provide education and positive encouragement to all staff and family members concerning home modalities. Lobby days will continue with invites to include staff, family and patients with new topics chosen quarterly. This will also include our clinic Kidney care advocate champions from the area. I have communicated my plan to the other social workers in the region - though each social worker is able to develop and implement their own strategy for the PHQ2 at their facilities.





# SUSTAINABILITY

- **Transparency: How can you and/or management make these changes transparent to support and foster a culture of trust between management, staff, and patients?**
- **Examples:**
  - As part of our current culture and standards that is listed as “Neil’s Deal” we strive to create a positive environment for all staff and patients. Our facility is open to sharing ideas from all team members in all disciplines of our IDT team and open to implementing changes, providing feedback to pt and staff, and resolving issues that may be presented.
  - We create a safe place with continued communication with each individual patient surrounding any issues, concerns and or needed education to alleviate any fears or anxiety regarding permanent access placement and other lifestyle changes related to ESRD. We invite all patients to monthly Patient care conferences with the IDT to cover any concerns. IDT members are individually familiar with each patient and provides availability, compassion, and empathy for each patients needs.



# SUSTAINABILITY

- **Accountability: How will you build accountability and escalation steps into this sustainability plan to alert you when problems arise that will keep you from sustaining performance and meeting goals?**
- **Examples:**
  - Performance will be measure in QAI meetings on a monthly basis and addressed with action plans by the IDT for any problems not meeting goals. . Weekly growth skype meetings are scheduled weekly with each Home Therapy region to discuss, monitor and track patients' status.
  - Currently we build accountability via our monthly QA meeting in which the social worker reports on the status of patients and provides feedback related to performance and goal. Our continued efforts to provide bi-annual education and education during assessments will assist with accountability and a measure to ensure sustainability





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# SUSTAINABILITY

- **Integration:** How will these processes be integrated into daily work and how will you align them with organizational or departmental goals? For example: How can you make these processes blend smoothly with your existing practices?
- **Examples:**
  - Our team has been incorporating Home Therapy as daily topic, whether it is in the break room, huddles, or conversations with patients. This aligns with our goals of promoting Home Therapy to anticipate the surge of patients in the upcoming years. It also fosters an environment of allowing patients to have the freedom of choice with their therapy
  - 1) Ongoing coordination between AA and LMSW to monitor the status of the patients. 2) Weekly Core team Meetings: a forum for sharing information about patients and ensuring that everyone is aware of any changes 3) Monthly FHR meetings: To track and trend patient census



# SUSTAINABILITY

- **Never Go Back: How will your staff, patients, and corporate leaders maintain the gains and continue the interventions learned in this QIA?(For example: Identify the most effective tools or interventions from this QIA that will be used to maintain the gains. How will you visually display progress sustained? What role will the staff, patients, and corporate leaders have in supporting these interventions?)**
- **Examples:**
  - A few of the most effective tools use during the project for our clinics success is the continued education provided to Non- Home Therapy staff, The patient handouts provided on the network website the clinic provided to the patients and the Lobby days provided with the different topics for education provided to patients and families. We plan to continue with all the above resources in our clinic with the total support from or leaders.
  - We will continue to use visual aids to show progress in our growth, educate patients and staff. FKC employees will continue to collaborate with each other and patients to maintain gains. We will continue to encourage patients to participate in their care and improve their quality of life through empowerment.







# TRANSPLANT QIA GOALS



**National Rate: 18.50%**  
**CMS Goal by 2023: 30%**  
**Baseline: 12.44%**  
**Our Goal: 22.44%**

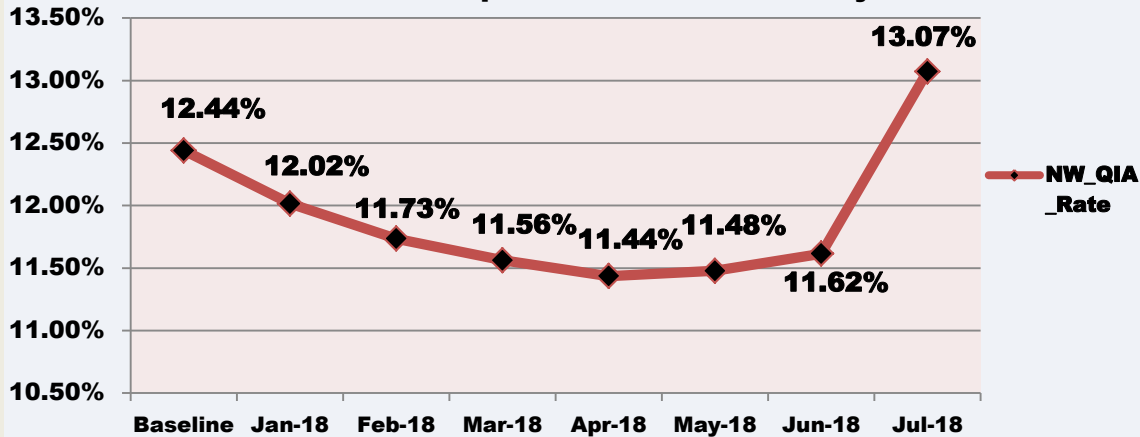
**Increase TP Waitlist Rates by at least 10%**



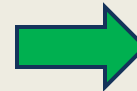
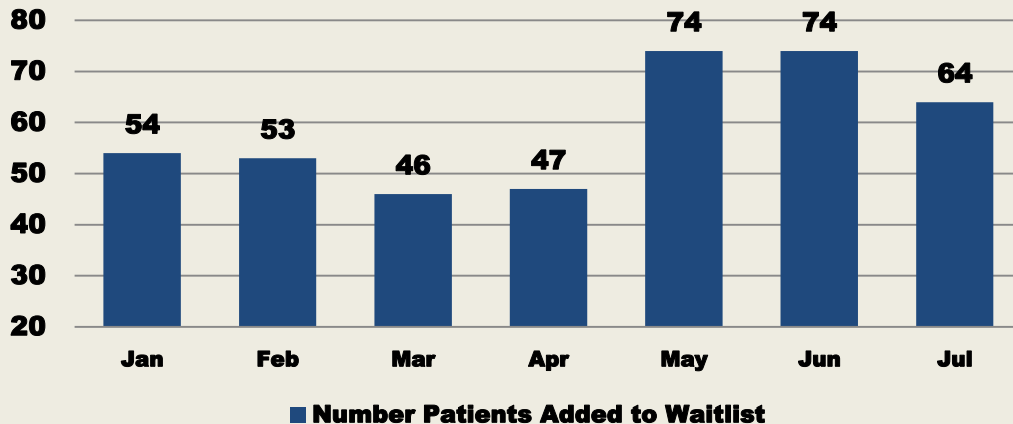
# OUTCOMES



**Network 14 Transplant Waitlist QIA Facility Rate**



**Number of Unique Patients Added by Project Facilities Per Month**



Month Added	# Pts. Added to Waitlist
Jan	54
Feb	53
Mar	46
Apr	47
May	74
Jun	74
Jul	64
<b>Total:</b>	<b>412</b>



# CMS 2019 CHANGES/UPDATES

## 2018

- Demonstrating at least a **10 percentage point** increase in the rate of patients placed on a waitlist for transplant based on data available in October.

## 2019

- Demonstrate a **2 percentage point** improvement in the natural trend of the Network of patients on the transplant waitlist in 30% of facilities in the Network service area.
- Tracking of 6 steps instead of 7

# ATTESTATION & POST-SURVEY

- Please take a moment to complete the Attestation/Post-Survey to receive credit for attending this exit webinar
- You need to complete this task to be released from the 2018 transplant project
- Make sure you select the correct CCN number from the dropdown list
- If you missed this presentation, it will be posted on our website along with the link for the Attestation/Post-Project Survey

<https://www.surveymonkey.com/r/RB3FQLT>



# QUESTIONS

**Transplant Wait List QIA Project Lead**

**Dany Anchia, BSN, RN, CDN**

**Clinical Quality Manager**

**469-916-3813 [danchia@nw14.esrd.net](mailto:danchia@nw14.esrd.net)**



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