End Stage Renal Disease(ESRD) Network Learning and Action Network (LAN) Series: Home Modality Quality Improvement Activity

June 12, 2018

Note: *Computer speakers or headphones are necessary to listen to streaming audio or get dial-in information from registration confirmation email.*

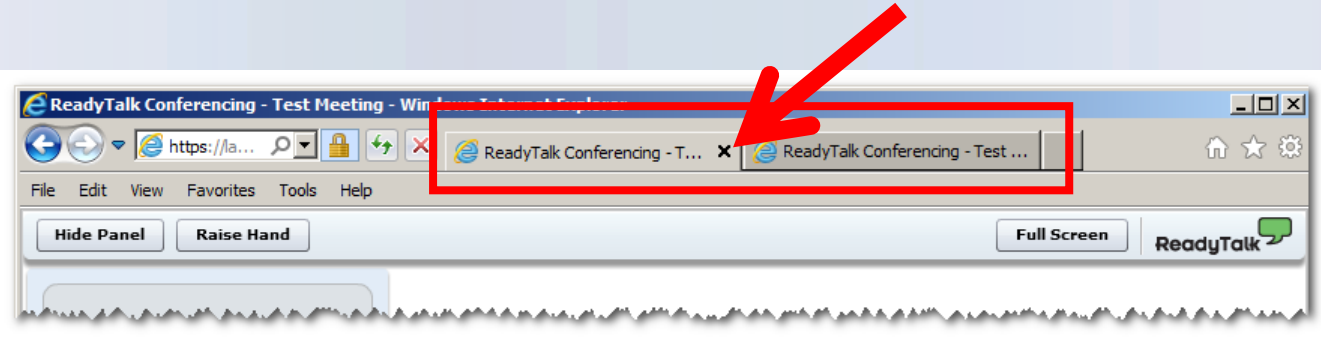
Streaming Audio

- **Audio for this event is available via INTERNET STREAMING - No telephone line is required.**
- **<u>Computer speakers or headphones are necessary to listen to streaming audio</u>**.
- NOTE: A limited number of phone lines are available if you are experiencing poor audio quality – send us a chat message!

Note: *<u>Computer speakers or headphones are necessary to listen to streaming audio.</u>*

Troubleshooting Echo

- Hear a bad echo on the call?
- Echo is usually caused by multiple connections to a single event.
- Close all but one browser/tab and the echo will clear up.

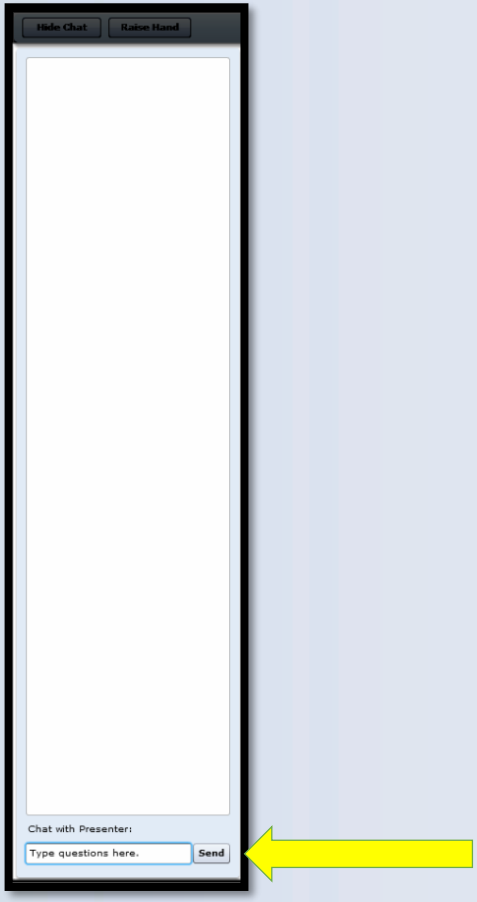


Example of Two Connections to Same Event

Note: *Computer speakers or headphones are necessary to listen to streaming audio.*

Submitting Questions

Type questions in the “Chat with Presenter” section, located in the bottom-left corner of your screen.



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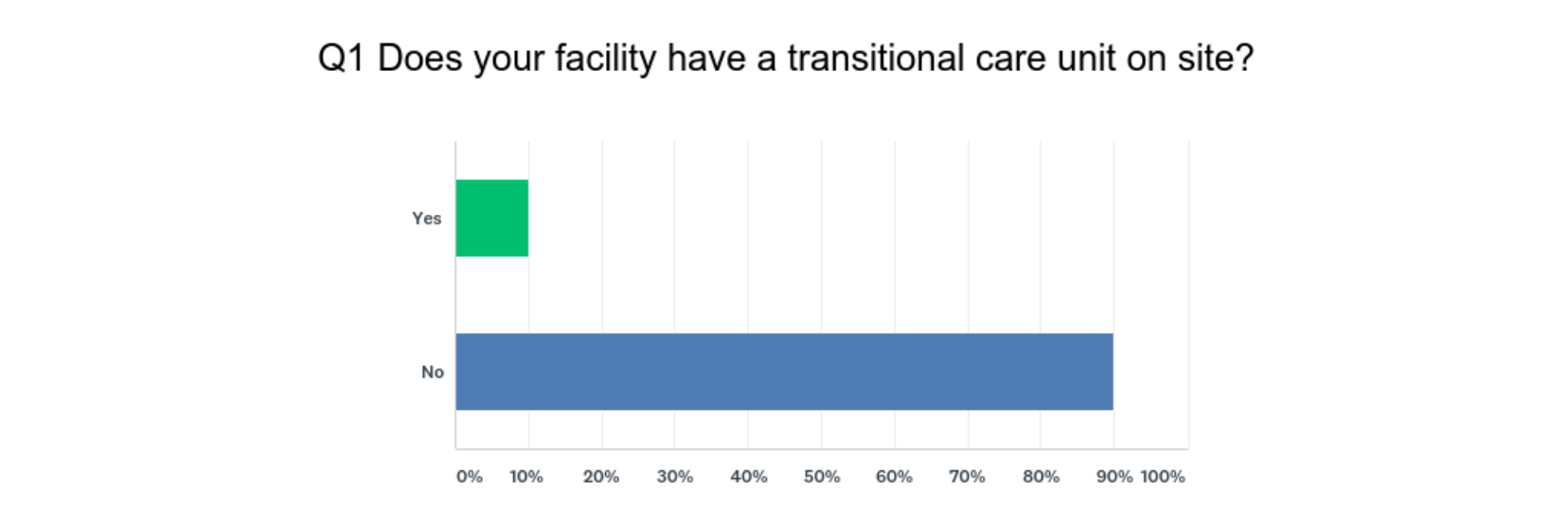
Welcome

Learning and Action Networks (LANs) bring people together around a shared idea, opportunity, or challenge to offer and request information and experiences to improve the identified topic of discussion.

As a participant in today's LAN activity we encourage you to:

- Engage in the chat box. Share your approaches and experiences related to the information being shared and ask questions.
- Apply the information and knowledge being shared to your own facilities and practices to help reduce bloodstream infections.

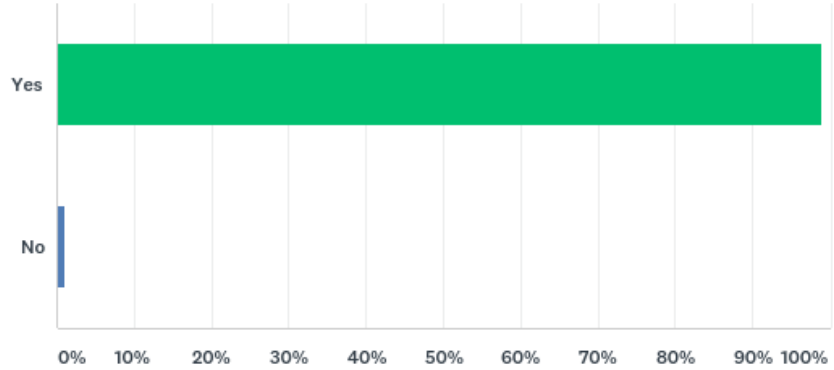
Pre-Work Feedback – Question 1



ANSWER CHOICES	RESPONSES
YES	44 (9.98%)
NO	397 (90.02%)
TOTAL	**441**

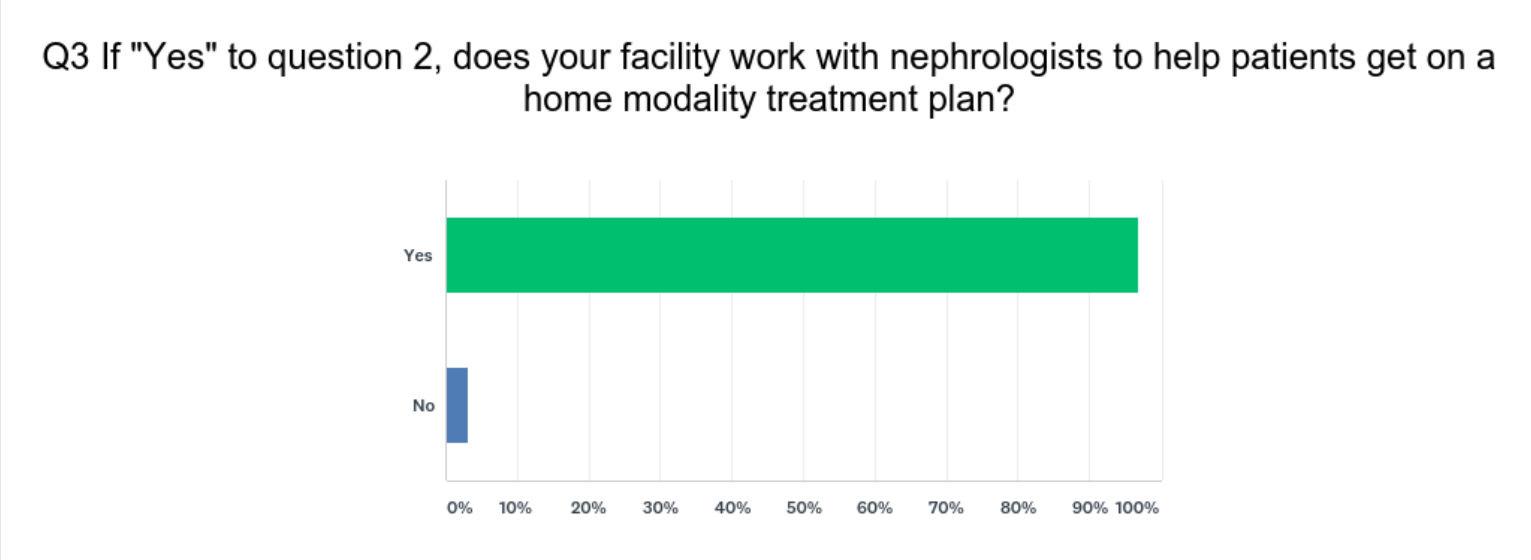
Pre-Work Feedback – Question 2

Q2 Does your facility provide patient education on home modality as a treatment option?



ANSWER CHOICES	RESPONSES
YES	437 (98.87%)
NO	5 (1.13%)
TOTAL	**442**

Pre-Work Feedback – Question 3



ANSWER CHOICES	RESPONSES
YES	428 (96.83%)
NO	14 (3.17%)
TOTAL	**442**

Pre-Work Feedback – Question 4

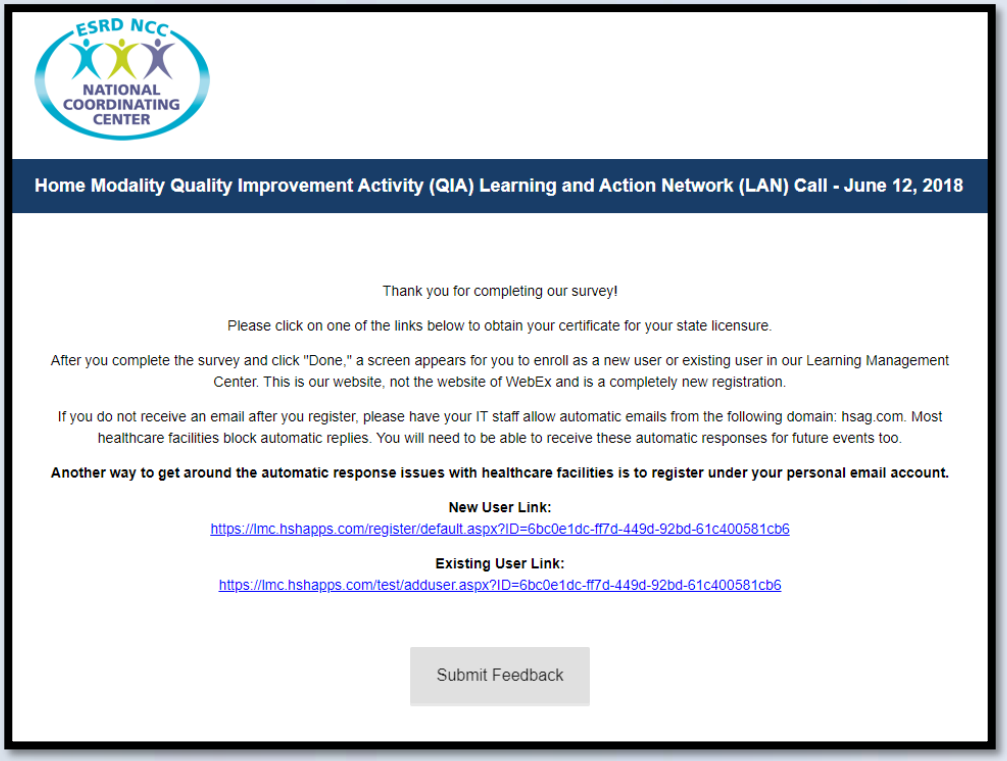
Q4 How do you manage patients who ask about home modality treatment options?

ANSWER CHOICES	RESPONSES
TOTAL	436

Questions to run on…

- What one idea to increase patients dialyzing at home are *you* excited to try at *your* facility?
- What steps will *you* take to implement a new idea to help patients move their dialysis to home in *your* patient population?
- What actions have *you and your facility* taken to help patients dialyze at home and how can *you* share that to help other patients?

CE Credit Process: Certificate



Home Modality Quality Improvement Activity (QIA) Learning and Action Network (LAN) Call - June 12, 2018

Thank you for completing our survey!

Please click on one of the links below to obtain your certificate for your state licensure.

After you complete the survey and click "Done," a screen appears for you to enroll as a new user or existing user in our Learning Management Center. This is our website, not the website of WebEx and is a completely new registration.

If you do not receive an email after you register, please have your IT staff allow automatic emails from the following domain: hsag.com. Most healthcare facilities block automatic replies. You will need to be able to receive these automatic responses for future events too.

Another way to get around the automatic response issues with healthcare facilities is to register under your personal email account.

New User Link:
https://lmc.hshapps.com/register/default.aspx?ID=6bc0e1dc-ff7d-449d-92bd-61c400581cb6

Existing User Link:
https://lmc.hshapps.com/test/adduser.aspx?ID=6bc0e1dc-ff7d-449d-92bd-61c400581cb6

Submit Feedback

Care Innovation "A Transitional Care Unit"

Webinar for National Home Dialysis Learning and Action Network

June 12, 2018

Robert S. Lockridge, Jr. M.D.

Retired Clinical Nephrologist Lynchburg Nephrology Physicians and Department of Nephrology at the University of Virginia

Medical Director of Home Therapies in Lynchburg 1982–2013

Goals of presentation

- What happens to our dialysis patients in the first year of in center hemodialysis?
- What is the concept of a “Transitional Care Unit?”
- The “Why, Who, Where, and How” of implementing a Transitional Care Unit
- Questions

What happens to our dialysis patients in the first year of in-center hemodialysis?

50% of patients “Crash” into dialysis.

Patients are frightened because they are…

Overwhelmed, anxious, fear of dialysis

Fluid overload & decreased mental capacity

Poor health with lack of disease state awareness

and they need …

Time to adjust mentally

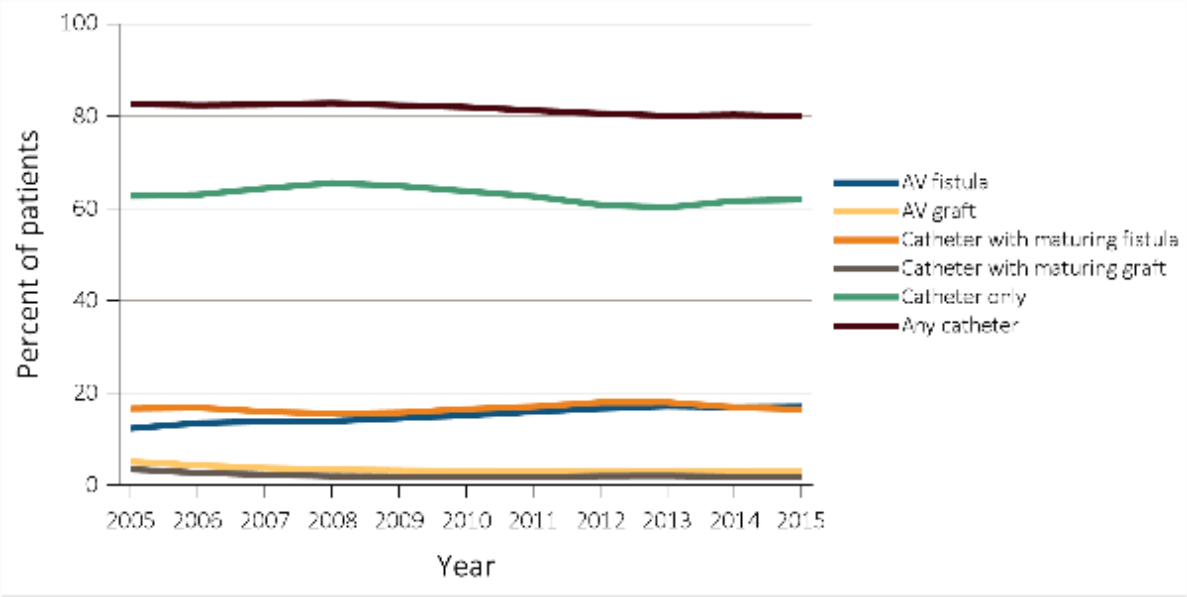
Therapy to address medical needs

Modality education with "Informed Choice"

What percentage of patients initiating in-center hemodialysis in the US in 2015 had a working AVF?

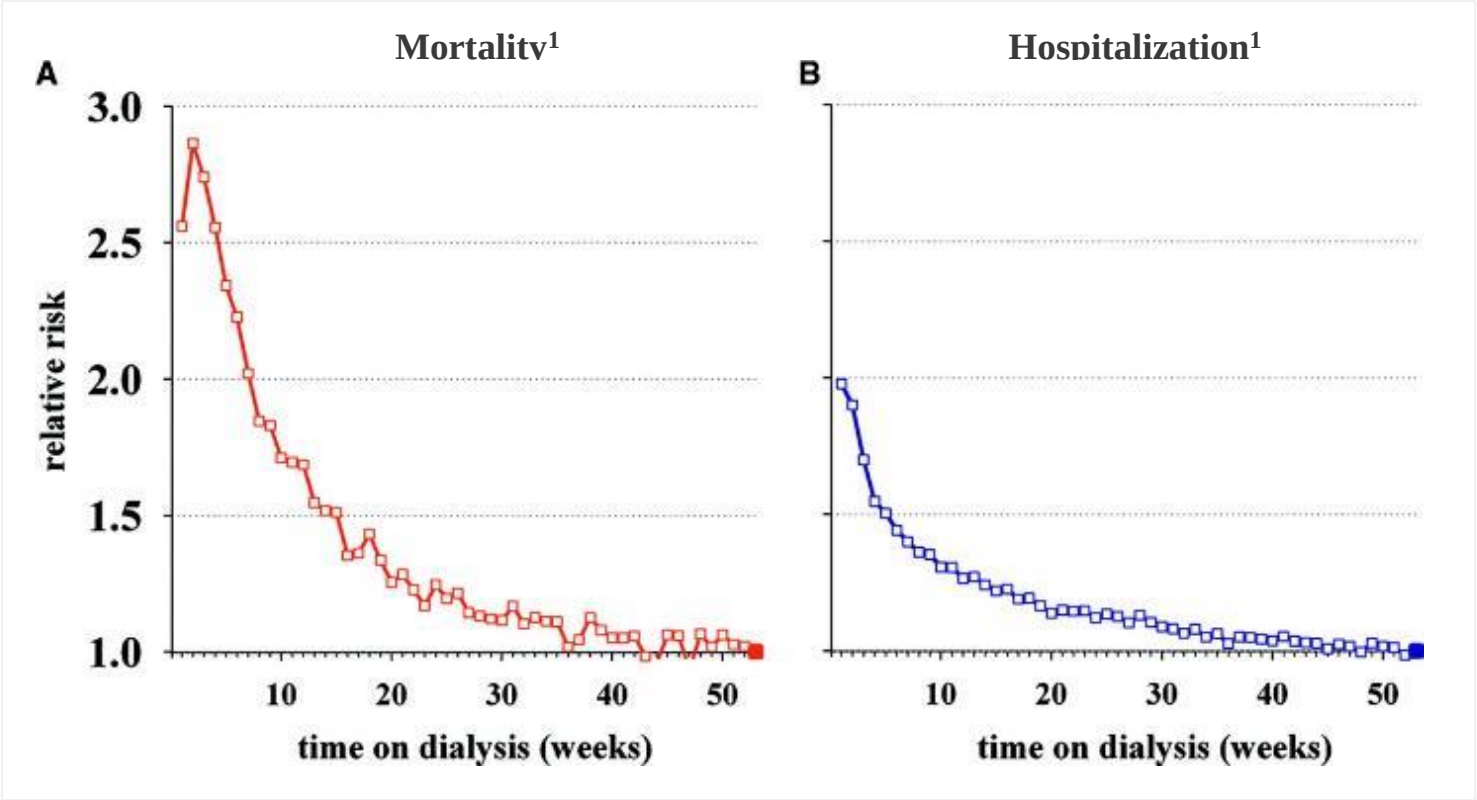
1. Less than 20%
2. 20 to 30%
3. 30 to 50%
4. 50 to 70%
5. Greater than 70%

vol 2 Figure 3.1 Vascular access use at hemodialysis initiation, from the ESRD Medical Evidence form (CMS 2728), 2005–2015



Data Source: Special analyses, USRDS ESRD Database. ESRD patients initiating hemodialysis in 2005-2015. Abbreviations: AV, arteriovenous; CMS, Centers for Medicare & Medicaid; ESRD, end-stage renal disease.

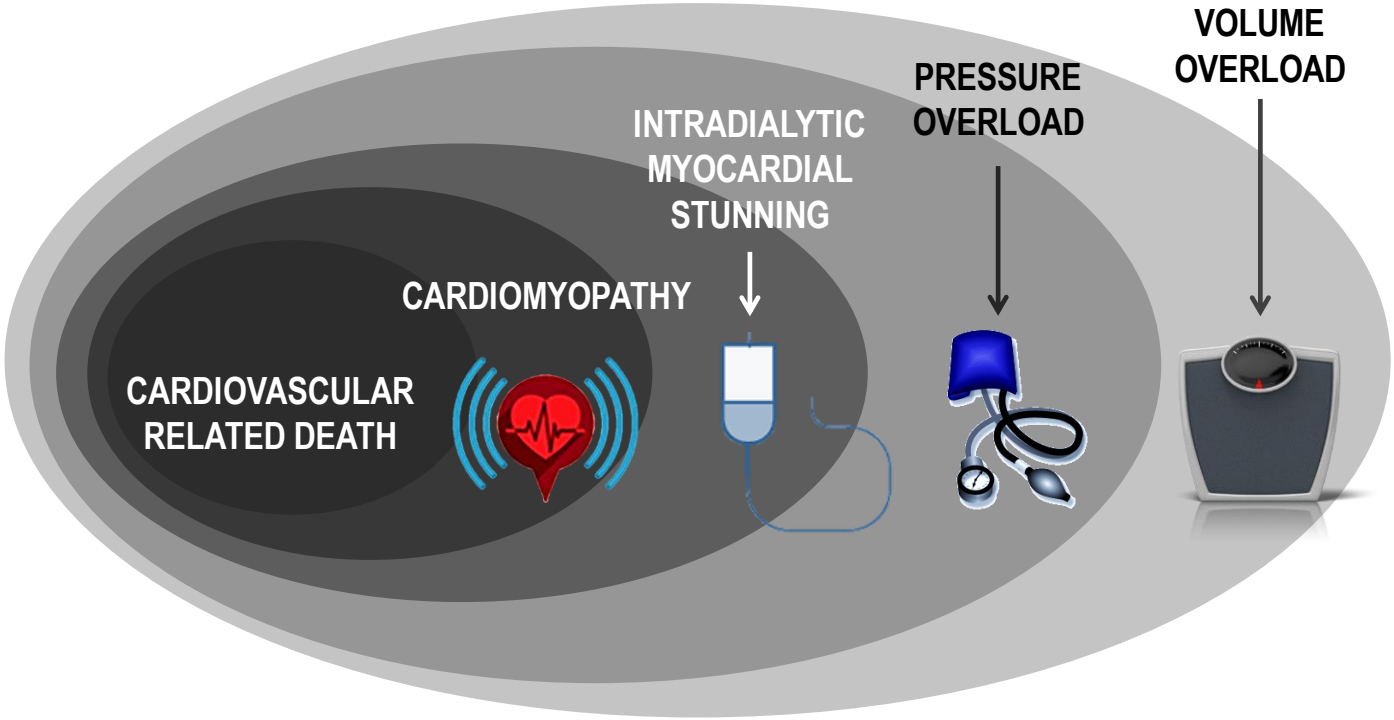
"Heightened Period of Risk"
The First 90 Days of Starting Dialysis



Reference: 1. Chan KE, Maddux FW, Tolkoff-Rubin N, Karumanchi SA, Thadhani R, Hakim RM. Early outcomes among those initiating chronic dialysis in the United States, Clin J Am Soc Nephrol 6: 2642-2649, 2011.

Cardiovascular Disease
#1 Cause of Death in Incident Patients

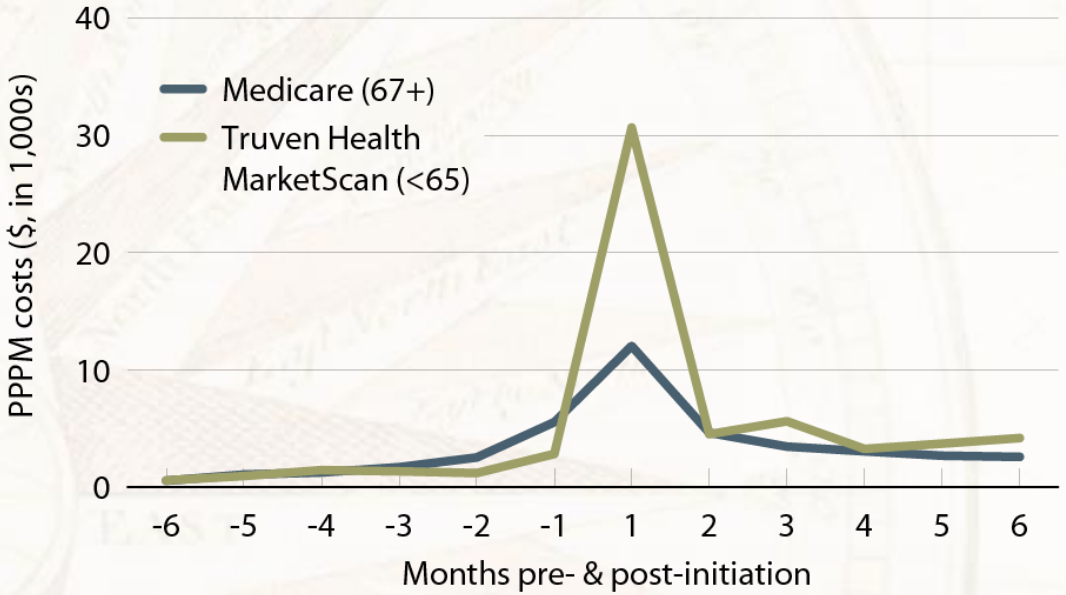
Effective fluid management is associated with better cardiovascular outcomes



Reference: 1. Lukowsky LR, Kheifets L, Arah OA, Nissenson AR, Kalantar-Zadeh H. Patterns and predictors of early mortality in incident haemodialysis patients: new insights. Am J Nephrol 2012;35:548-58

Per person per month (PPPM) expenditures for inpatient services during the transition to ESRD, by dataset, 2011

Figure 7.22 (Volume 1)



General Medicare patients with CKD age 65 & older, & Pre-ESRD patients age 67 or older at initiation of ESRD.

Does education of the patient about Renal Replacement Therapy Options work?

What percentage of DaVita and FMC patients initiating in-center hemodialysis in 2016 had received “Kidney Smart” or “Tops” education prior to starting dialysis?

1. Less than 20%
2. 20 to 30%
3. 30 to 50%
4. 50 to 70%
5. Greater than 70%

DaVita “Kidney Smart” was seen on average by 25 to 30% of all new DaVita in-center starts in 2016

Fresenius “TOPs” was seen on average by 25 to 30% of all new FKC in-center starts in 2016

If patients are exposed to “Kidney Smart” or “TOPs,” they are 4x more likely to choose Home Dialysis

The concept of a “Transitional Care Unit”

Table 1. Summary of Transitional Programs for Incident Dialysis Patients

Relevant Publication	Center	Summary
Eschbach et al[27]	Northwest Kidney Centers	Hemodialysis Orientation Unit: • 2-mo education program for new-start patients to improve home modality uptake • 6-station dedicated unit • Improved home dialysis initiation over more than a decade of operation
Wingard et al[28]	Fresenius Medical Care of North America	Right Start Program: • Dedicated case manager delivering educational curriculum during 3×/wk in-center hemodialysis • Right Start educational handbook • Improved outcomes in anemia, mineral bone disorders, vascular access, and mortality
Rioux et al[31]	Toronto General	In-Hospital Education Program: • Dedicated nurse practitioner education program including 3-5 education sessions for unplanned urgent start patients • Education sessions occurred in hospital before discharge • In-program patients had ~35% uptake of home therapies
Reddy et al[29]	Renal Ventures Mgt LLC	RVCARE Program: • Dedicated CP assigned for the first 120 d from incident start • CP educates. coordinates care. and assists in modality choice • Improvements in mortality, access placement, and increased PD uptake
Wilson et al[32]	DaVita Inc	IMPACT Program: • 90-d patient management pathway and education intervention • Dialysis managers provided education and early interventions on various health variables • Improved mortality and preferred access placement rates versus propensity matched cohort at 180 d

Abbreviations: CP, Care Partner; IMPACT, Incident Management of Patients, Actions Centered on Treatment; PD, peritoneal dialysis; RVCARE, Renal Ventures Management LLC Coaching for Actions, Results, and Empowerment.

Am J Kidney Dis. Published online March 2018: Improving Incident ESRD Care Via a Transitional Care Unit

The "Transitional Dialysis Care Demonstration Initiative" December 2016 to December 2017

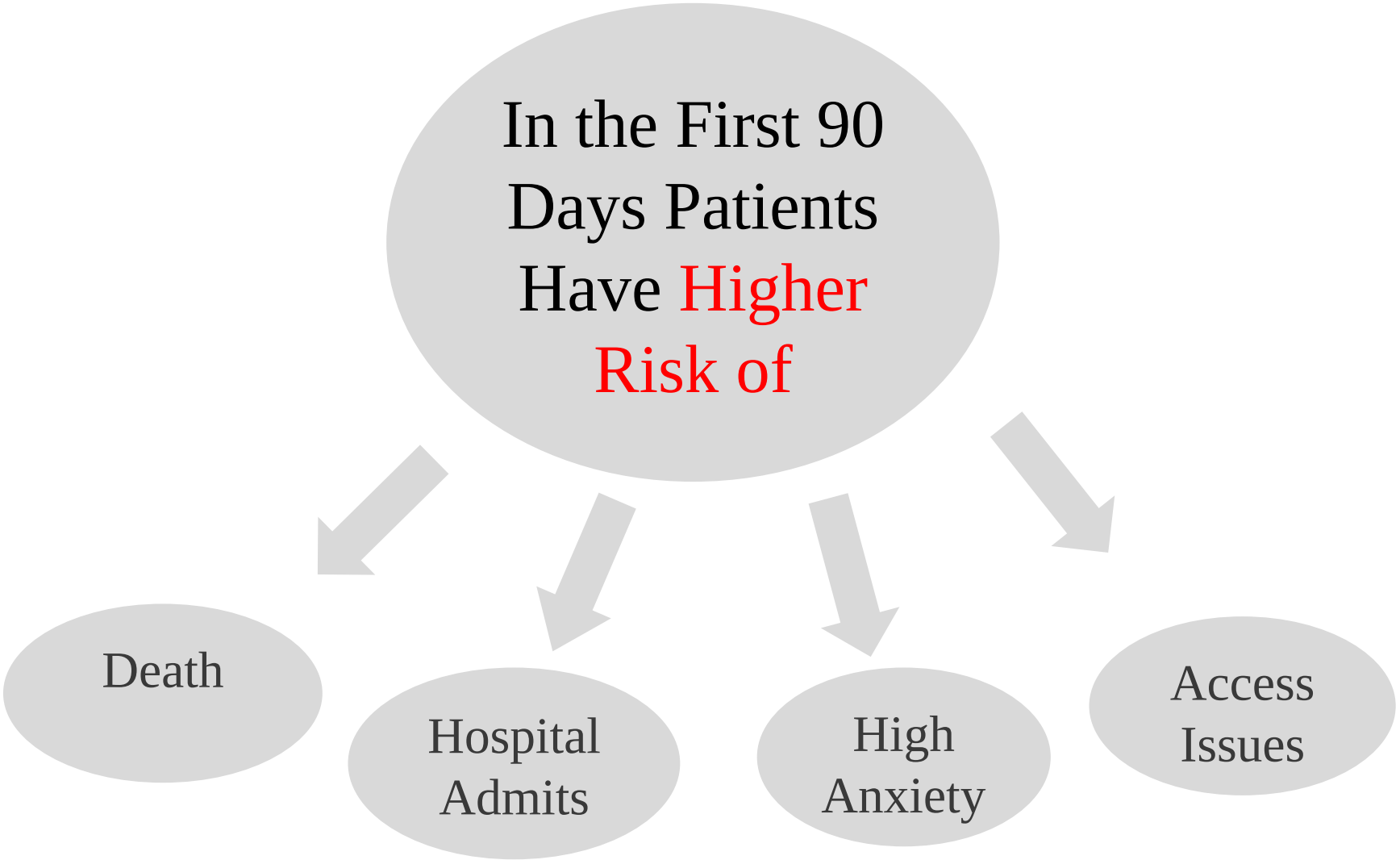
- Dr. Brendan Bowman, University of Virginia (VA)
- Debbie Cote, University of Virginia (VA)
- Dr. Jose Morfin, UC-Davis (CA)
- Rich Pandel, Agarwal Renal Center (NY)
- Dr. Melvin Seek, Ocala Kidney Group (FL)
- Deb Siler, NP FMC-Raleigh (NC)
- Dr. Gentiana Voinescu-Nephrologist Santa Fe, (NM)
- Stacy Cigliana, NxStage Kidney Care
- Marsha Dodd, Satellite Healthcare
- Marshall Moreland, Mayo Clinic (FL)
- Joan Arslanian, Trude Weishaupt Memoral (NY)
- Dr. Bob Lockridge, Advisor
- Michelle Carver, Sr. Director of Clinical Education for National Accounts, NxStage Medical
- Nick Castellano, Facilitator, NxStage Medical

The Definition of a “Transitional Care Unit”

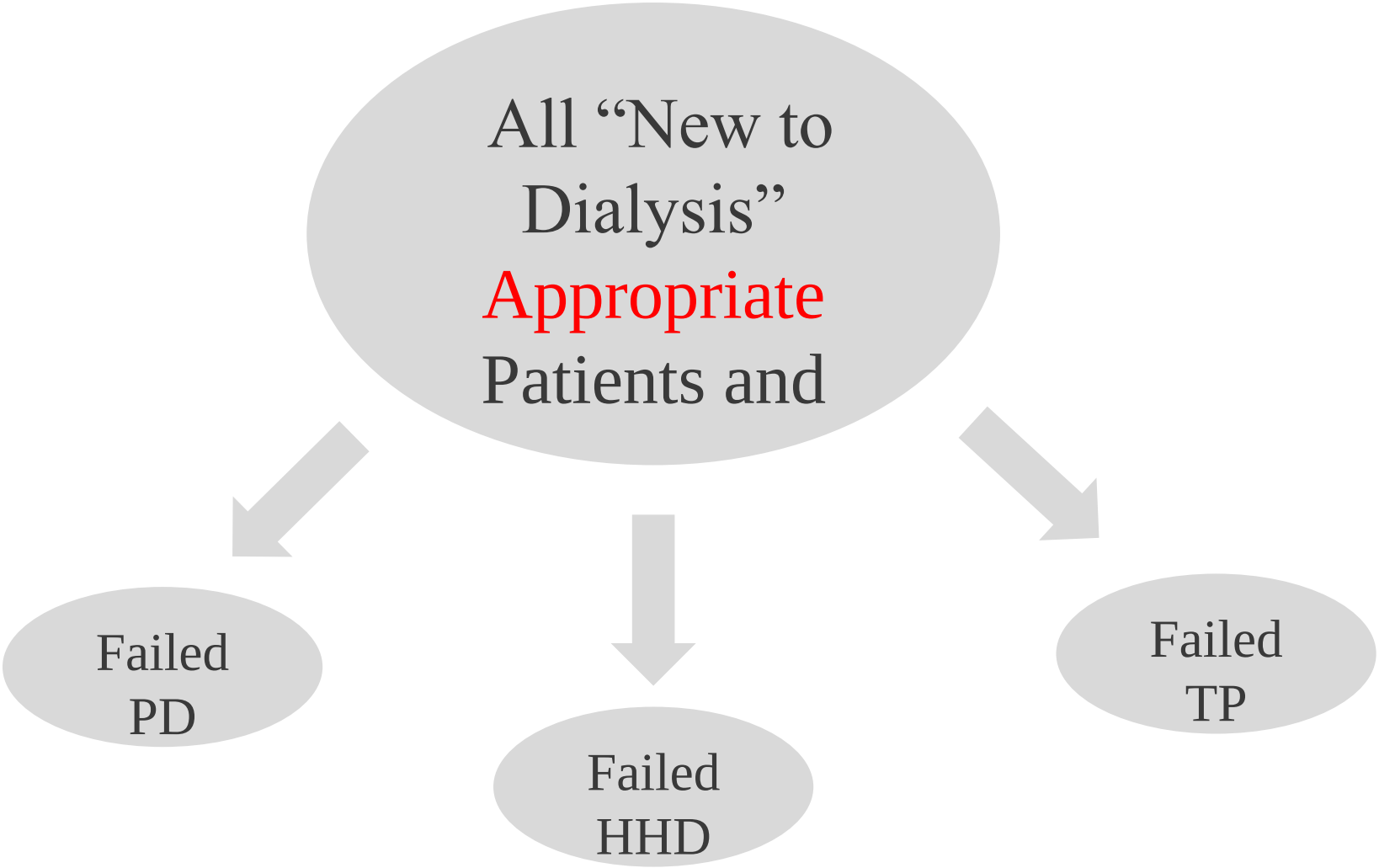
A Patient-Centered 4-week Educational Program for All Appropriate Patients Starting Dialysis

- Dialyze the patient with a gentler, slower and more frequent prescription using your home dialysis machine of choice, eliminating the two day killer gap
- First focus on fears and preconceived ideas about dialysis
- Find out about lifestyle and medical goals of the patient at initiation of dialysis
- Renal replacement education, including transplant education if appropriate, home dialysis education, both HHD and PD, and in-center education
- Access and economic education

Why should we have a transitional care unit?



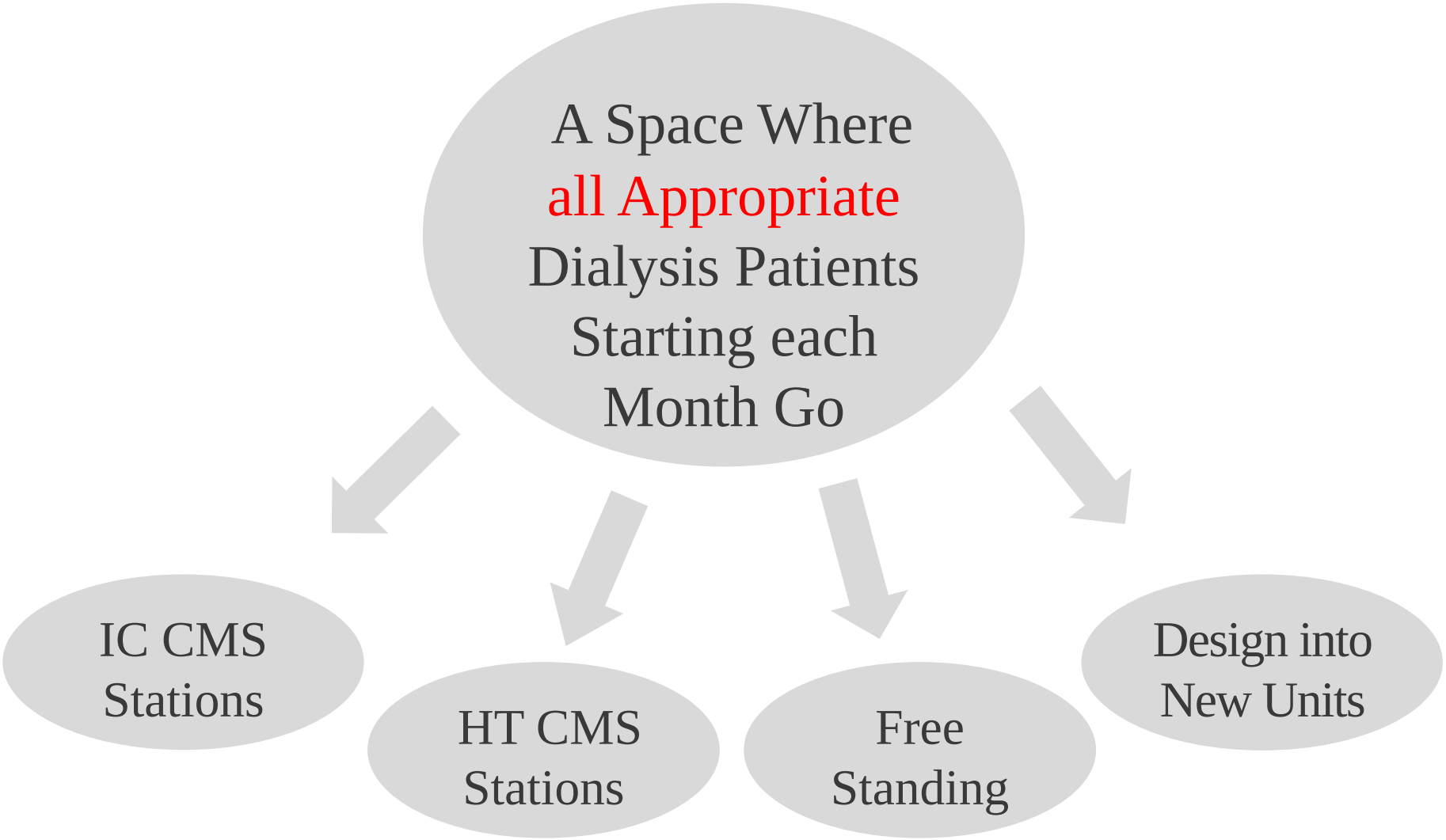
Who should be in a transitional care unit?



Who should not be in a transitional care unit?

- Patient that has chosen a home modality prior to starting dialysis
- Patient is a permanent resident of a long term care facility
- Patient is under hospice care per physician's recommendation
- Patient has a significant cognitive deficit that precludes meaningful participation
- Patient with no stable living arrangement

Where should transitional care unit be located?



TCU implementation depends on the location and the type of CMS station that are used

- In Center TCU has In-Center stations dedicated only to the TCU. In-Center stations result in In-Center billing for services provided.
- “Home Hemo First” TCU has patients usually going to the home training unit and the dialysis station could be designated as a Home Training station or In Center station. What the designation is will relate to how the service provided will be billed.
- In-Center stations and Home Training stations may have different state and CMS regulations dictating what services will need to be provided for billing purposes. You will need to evaluate prior to selecting your location.

Suggested Transitional Care Unit Hemodialysis Prescription

- Provide a more optimal, gentle dialysis with the home hemodialysis machine of choice
- Four-to-five dialysis sessions per week, eliminating the two-day killer gap
- Blood and dialysate flow rates consistent with typical home dialysis prescription and maximum UF of 10–13 mL/kg/hour
- No *less than* 12 hours of dialysis per week divided equally among four-to-five treatments
- Standard heparin, EPO, iron, VS, weight and laboratory protocols per unit

Four Week Educational Program for the "Transitional Care Unit"

Week One: Assure Patient

- Emotionally support patient during the transition period
- Elicit patient's fears concerning dialysis and address these fears
- Explain the cause of their renal failure
- Explain the costs of dialysis and how it is compensated from patient's perspective

Week Two: Overview RRTs

- General review of renal replacement therapies and access options by modality
- Review quality of life aspects of each modality
- Review clinical outcomes specific to each modality
- Collaboratively complete a patient-centered modality selection assessment tool like "My Life, My Dialysis Choice"

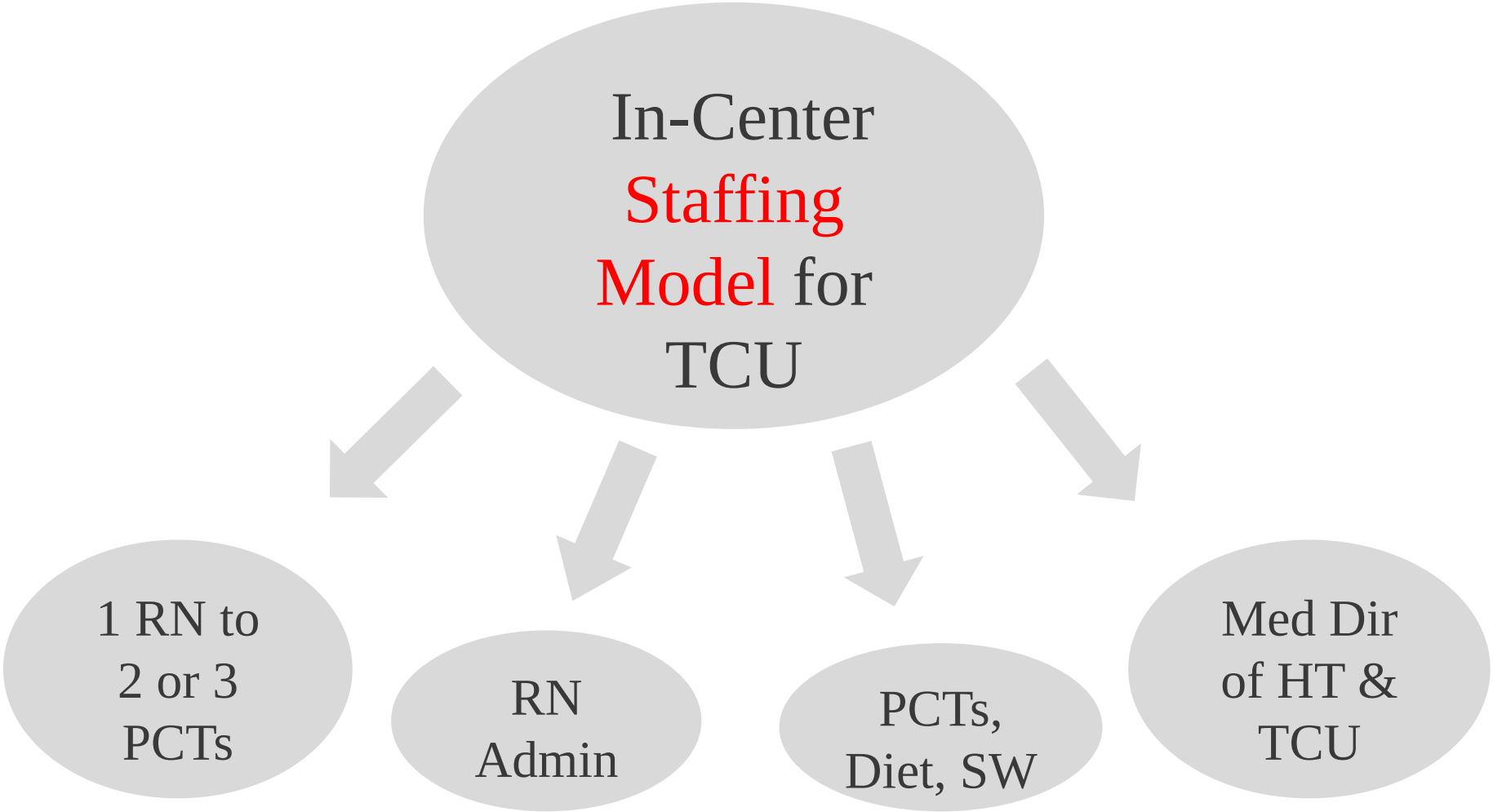
Week Three: In-depth Education Concerning RRTs

- Transplant and Access education
- Detailed peritoneal and home hemodialysis modality education by home training team
- In-center education by the TCU staff about transportation, schedule and vacation travel
- Patient on each modality meet with the TCU patient while in unit to discuss their modality

Week Four: Modality choice by Family, TCU Team & MD

- Final review of RRTs and access
- Refer patient to transplant center of choice
- If patient chooses a home modality, refer to the home training unit of choice
- Finalize the access plan for the patient when transitioning out of the TCU

What is the staffing of a "Transitional Care Unit?"



This is an exciting time for the "Renal Community"!

Questions?

Thanks!

boblockridge@gmail.com

Cell 434 660 7417

Appendix I:
Four-Week Education Program

Some “Operational Considerations”

- Goal Setting: What specifically do you want to achieve?
- Project Timeline: What and when do you need to accomplish?
- Physician Buy-In
- Home Nurse Buy-In
- Identify Program Champion
- Supply Management: If using HHD machine in center how do you maintain?
- EMR Integration
- Marketing Your Program

Week 1 Plan

Patient Education

Comfort & Assure Patient

- Provide emotional support and comfort patient
- Determine if patient would like a family member involved in the educational process
- Briefly introduce how dialysis works
- Address patient/family member initial questions, fears, and concerns
- Educate patient/family member on the cause of their ESRD
- Address pre-conceived ideas about dialysis and introduction to staff
- Assure patient that their insurance will pay (Medicare, commercial, etc.)

Patient Care Plan

Initiate & Optimize Therapy

- Initiate therapy with the transition team
- Stabilize the patient clinically
- Evaluate target weight and blood pressure medications
- Begin to establish vascular access plan (venous mapping & surgical appointment)

Week 1 Patient Education Plan:
Comfort & Assure Patient

Total Weekly Duration: **170 Minutes**

*No tactical daily session should last more than 30 minutes at a time *Patient should arrive 1 hour prior to their first treatment

GOAL	TACTICS	APPROX. TIME
Provide emotional support and comfort patient	• Briefly introduce patient to social worker (Social Worker)	10 Minutes
Determine if patient would like a family member involved in the educational process	• Conversation with patient regarding family/friend they may want involved (In-Center RN) • Encourage patient to include a family member or friend (In-Center RN)	5 Minutes
Briefly introduce how dialysis works	• As procedures are performed, such as obtaining vital signs, explain why procedures are being done (PCT)	30 Minutes
Address patient/family member initial questions, fears & concerns	• Review Kidney School Module 5 – *Coping with Kidney Disease* (In-Center RN) • Objectives: (1) Emotions, (2) Asking for Help, and (3) Recognizing and dealing with depression	30 Minutes
	• Allow patient/family to ask initial questions (economic, social, etc.) (In-Center RN)	30 Minutes
Educate patient/family member on the cause of their ESRD	• Review Kidney School Module 1 – *How They Work, How They Fail, and What You Can Do* (In-Center RN) • Objectives: (1) Normal Kidney Function, (2) Warning Signs of Chronic Kidney Disease, and (3) Slowing the Progression of Kidney Disease	20 Minutes
Address pre-conceived ideas about dialysis & introduction to staff	• Briefly introduce patient/family member to each relevant staff member (In-Center RN) • Review Kidney School Module 3 – Working With Your Healthcare Team (In-Center RN) • Objectives: (1) Care Team Members and Their Roles & Job Descriptions, (2) Role of the Dialysis Patient, (3) How to Talk To Your Doctor and Ask Questions, and (4) Understanding Professional Credentials	30 Minutes
Assure patient their insurance will pay (Medicare, commercial, etc.)	• Social Worker provides patient/family member with assurance for how insurance will cover patient's expenses (Social Worker)	15 Minutes

Week 2 Plan

Patient Education

Education About Key Topics

- Allow patient/family member to ask questions prior to week 2.
- Educate about fluid, infection, and medication management
- Discuss patient short & long-term lifestyle goals
- Provide basic modality and access education: PD, HHD; transplant and in-center
- Present outcomes data, quality of life data
- Review patient insurance benefits

Patient Care Plan

Begin Long-Term Care Plan

- Discuss vascular access options in detail
- Monitor blood pressure and adjust antihypertensive medications, as needed
- Prepare and present patient with potential benefit-related documentation

Week 2 Patient Education Plan:
Education about Key Topics

Total Weekly Duration: **270 Minutes**

*No tactical daily session should last more than 30 minutes at a time

GOAL	TACTICS	APPROX. TIME
Allow patient/family member to ask questions prior to week 2	• Address patient/family member questions based on week 1 (In-Center RN)	30 Minutes
Educate on fluid, infection, and medication management	• Review Kidney School Module 4 – *Following Your Treatment Plan* (In-Center RN) • Objectives: (1) Importance of following the treatment plan, (2) Elements of the treatment plan (dialysis prescription), (3) Getting all prescribed treatment time, (4) Managing medications, (5) Managing diet and fluids, (6) Fighting thirst, (7) CKD 3 & 4 diet, (8) Access care tips, (9) PD catheter care tips	90 Minutes
Discuss patient short & long-term lifestyle goals	• Have patient complete "My Life, My Dialysis Choice" via: https://mydialysischoice.org/ (PCT reviews with patient & prints report)	30 Minutes
Provide basic modality and access education: PD, HHD; transplant and in-center	• Review Kidney School Module 2 – *Treatment Options For Kidney Failure* (In-Center RN) • Objectives: (1) What does dialysis do?, (2) When to start dialysis, (3) Peritoneal dialysis—how it works, (4) Hemodialysis—how it works, (5) Transplant—how it works, (6) Pro & con table for 5 modalities, (7) Modality preference checklists, (8) Choosing no treatment, (9) 6 principles for living well with kidney disease, (10) Vascular access (brief discussion of types)	60 Minutes
Present outcomes data, quality of life data	• Read and present study to patient/family member (We will get study) (In-Center RN)	30 Minutes
Review Patient Insurance Benefits	• Social Worker provides patient/family member with a more thorough overview of insurance benefits (Social Worker) • Allow patient to ask questions regarding insurance coverage (Social Worker)	30 Minutes

Week 3 Plan

Patient Education

In-Depth Modality Education

- Allow patient/family member to ask questions prior to week 3
- In-depth education (including access) on:
  - PD
  - HHD
  - In-Center
  - Transplant
- Patient/family member discusses modalities with a PD, HHD, In-Center, and Transplant patient
- Financial education regarding dialysis therapy (water consumption, transportation to In-Center, etc.)

Patient Care Plan

Ensure Clinical and Emotional Stability of Patient

- Finalize vascular access plan
- Assess target weight, RRT, and medication regimen
- Evaluate delivered dose of dialysis

Week 3 Patient Education Plan:

In-depth Modality Education

Total Weekly Duration: **320 Minutes**

*No tactical daily session should last more than 30 minutes at a time

GOAL	TACTICS	APPROX. TIME
▪ **Allow patient/family member to ask questions prior to week 3**	• Address patient questions based on week 2 (In-Center RN)	30 Minutes
▪ **In-depth education (including access) on:** ▪ **PD** ▪ **HHD** ▪ **In-Center** ▪ **Transplant**	• Provide and review Home Dialysis Comparison Chart (Home RN) (http://www.homedialysis.org/documents/ModalityComparison.pdf)	20 Minutes
	• Show patient a PD cycler, catheter, etc… (Home RN)	15 Minutes
	• Further show and explain NxStage HHD (system, bags, Pureflow, etc..) (PCT)	15 Minutes
	• Discuss travel opportunities using various modality options (Home RN)	30 Minutes
	• Discuss various forms of HHD (nocturnal, short-daily, in-center etc.) (Home RN)	30 Minutes
	• Discuss various forms of PD (CAPD and CCPD) (Home RN)	30 Minutes
	• Review results of "My Life, My Dialysis Choice" with the patient (Home RN)	15 Minutes
	• Review Kidney School Module 8 – *Vascular Access: A Lifeline for Dialysis* (In-Center RN) • Objectives: (1) Types of vascular access for hemodialysis, (2) Catheters—access for PD, (3) Deciding about an access, (9) Self-cannulation and the buttonhole technique	30 Minutes
Patient/family member discusses modalities with a PD, HHD, In-Center, & Transplant patient	• Introduce patient/family member to other patients on all dialysis modalities (in-person), even if patient is leaning towards a specific modality (Patient) • Patient advocates must be enthusiastic and factual about their modalities (Patient)	90 Minutes
Financial education regarding dialysis therapy (water consumption, transportation, etc.)	• Social Worker provides patient/family member with an overview (Social Worker)	45 Minutes

Week 4 Plan

Patient Education

Patient Modality Choice

- Allow patient/family member to ask questions prior to week 4
- Determine patient's modality preference
- Reassure patient that all options remain available
- Teach patient dietary restrictions
- If patient is interested in transplant, refer to appropriate transplant centers
- If patient chooses a home modality, refer them to helpful resources

Patient Care Plan

Complete Patient Care Planning

- Ensure patient comprehends their vascular access plan
- Refer to PD or HHD training program or In-Center facility closest to home and schedule visit
- Schedule home visit, if appropriate
- Re-evaluate transportation needs, if In-Center
- Ensure necessary insurance documentation is completed by patient (2728 FORM)

Week 4 Patient Education Plan:

Patient Modality Choice

Total Weekly Duration: **175 Minutes**

*No tactical daily session should last more than 30 minutes at a time

GOAL	TACTICS	APPROX. TIME
Allow patient/family member to ask questions prior to week 4	• Address patient/family member questions based on week 3 (In-Center RN)	30 Minutes
Determine patient's modality preference	• Conversation with patient/family member to select modality (Physician)	10 Minutes
Reassure patient/family member that all options remain available	• Conversation explaining patient can change choice, if desired (Physician)	10 Minutes
Teach patient/family member dietary restrictions (Customized based on modality choice)	• Review Kidney School Module 9 – *Nutrition and Fluids For People On Dialysis* (Dietitian) • Objectives: (1) Calories and calorie requirements, (2) Food value chart and food groups, (3) Getting the right amounts of nutrients (protein, fats, and carbohydrates), (4) Meal planning & estimating portion size, (5) Meal-planning grid, (6) Protein and vitamin supplements, (7) Eating out, (8) Tips for vegetarians, (9) Renal bone disease, (10) Binders and antacids	90 Minutes
If patient is interested in transplant, refer to appropriate transplant centers	• Provide patient with transplant center information (Physician)	30 Minutes (If Needed)

If patient chooses a home modality, refer them to helpful resources	▪ Share at least the 2 below references: (Home RN)
	  ▪ http://homedialyzorsunited.org/
	  ▪ http://www.homedialysis.org/
		5 Minutes (If Needed)

Educational & Dialysis Staffing requirements

Staff Member	Week 1	Week 2	Week 3	Week 4	Total
PCT	30 Minutes		15 Minutes		45 Minutes
In Center RN	115 Minutes	210 Minutes	60 Minutes	30 Minutes	415 Minutes
Dietitian				90 Minutes	90 Minutes
Social Worker	25 Minutes	30 Minutes	45 Minutes		100 Minutes
Home RN			140 Minutes	5 Minutes	145 Minutes
Physician				50 Minutes	50 Minutes
TOTAL	170 Minutes	240 Minutes	260 Minutes	175 Minutes	845 Minutes

*If a Financial Advisor is on staff, they may assume some responsibilities of the social worker

Staffing model to provide dialysis care is 1 RN to 2 or 3 PCTs

Appendix II:
Suggested TCU Hemodialysis Prescription

Suggested Hemodialysis Prescription for a Patient Starting in a TCU

Can be modified by treating nephrologist

- Emphasis is on eliminating the 2-day “killer gap”
  - 4 treatments per week (M, W, F & Sat) or (M, Tue, Thu & Sat)
  - 5 Treatments per week (ex. M, Tue, Thu, Fri, Sat)
- If home machine of choice is NxStage, use System One S, if Fresenius, use 2008K@Home
- Goal Blood Flow: 350cc/min
- Time: Minimum of three hours per treatment
- Access: AVF, AVG, or CVC
- Heparin per unit protocol at the beginning of treatment

Suggested prescription for TCU Hemodialysis orders

Suggested Hemodialysis Prescription for a Patient Starting in a TCU (cont.)

Can be modified by treating nephrologist

- Max fluid removal 10-13 mL/kg per hour.
  - Do not exceed Max ultrafiltration per hour if patient has gained too much fluid between treatments.
- Check VS (BP, temp) pre and post checking BP setting and standing.
  - During treatment check BP every 30 minutes on dialysis.
- Obtain weight pre & post treatment.
- Baseline Monthly lab at beginning of the TCU.

Suggested prescription for TCU Hemodialysis orders

Suggested Hemodialysis Prescription for a Patient Starting in a TCU (cont.)

Can be modified by treating nephrologist

- Dose EPO and iron based on monthly lab and in center EPO and iron protocols.
- Monitor BP medications and target weight closely adjusting to prevent hypotension during and after treatments.
- Check Std Weekly Kt/V at beginning of third week in the TCU.
- If home training machine of choice is the Fresenius 2008K@Home, set dialysis flow at 300cc/min.

Suggested prescription for TCU Hemodialysis orders

Suggested Hemodialysis Prescription for a Patient Starting in a TCU (cont.)

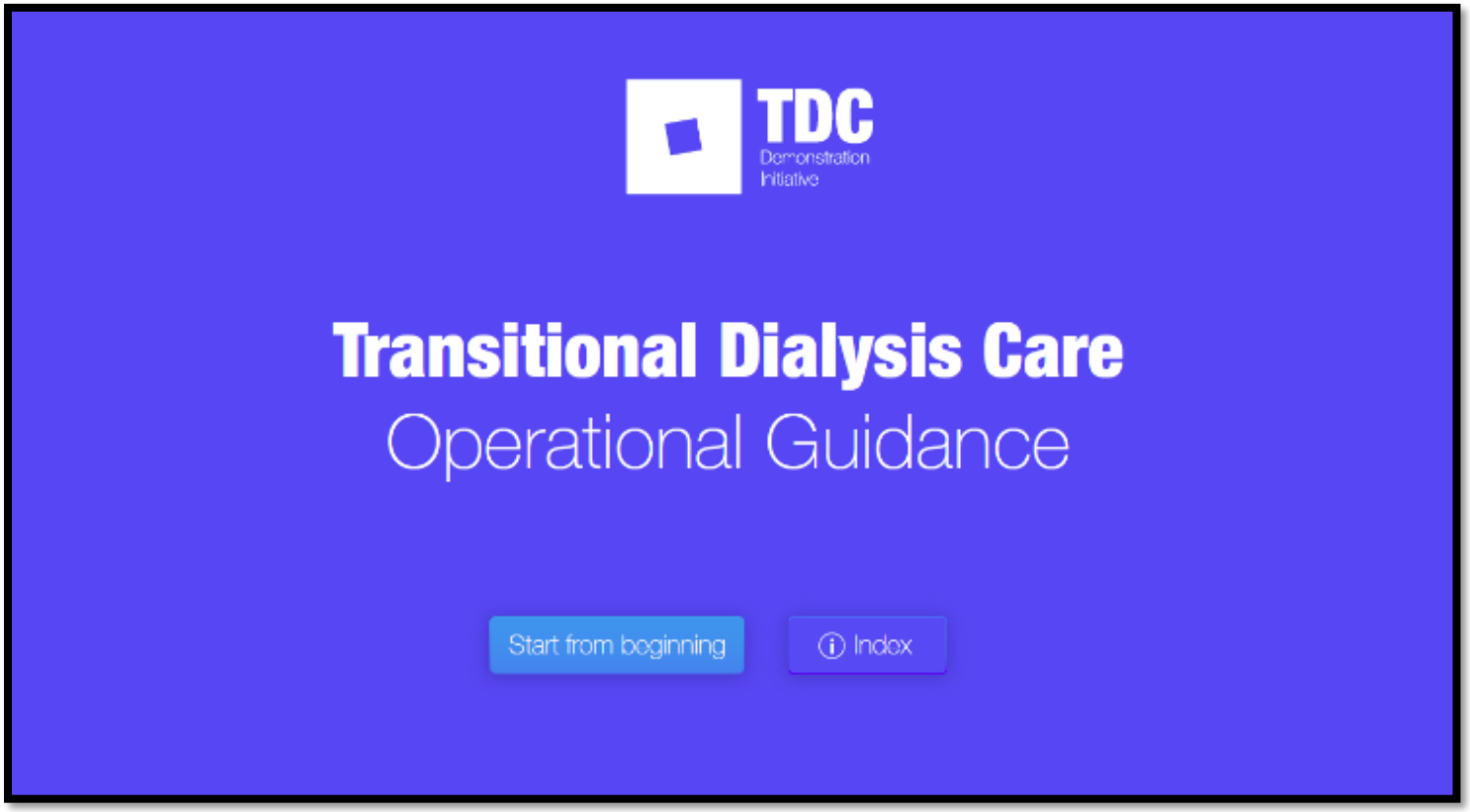
Can be modified by treating nephrologist

- If home training machine of choice is the NxStage System One S, use the following dialysate volume per treatment:
  - Patient weight <60 kg use 30 liters
  - Patient weight 60 kg to 80 kg use 40 liters
  - Patient weight 80 kg to 100 kg use 50 liters
  - Patient weight >100 kg use 60 liters
  - Set dialysate flow rate as fixed amount with the NxStage System One S

Appendix III:
TDC Operational Guidance
Interactive PDF

TDC Operational Guidance Interactive PDF

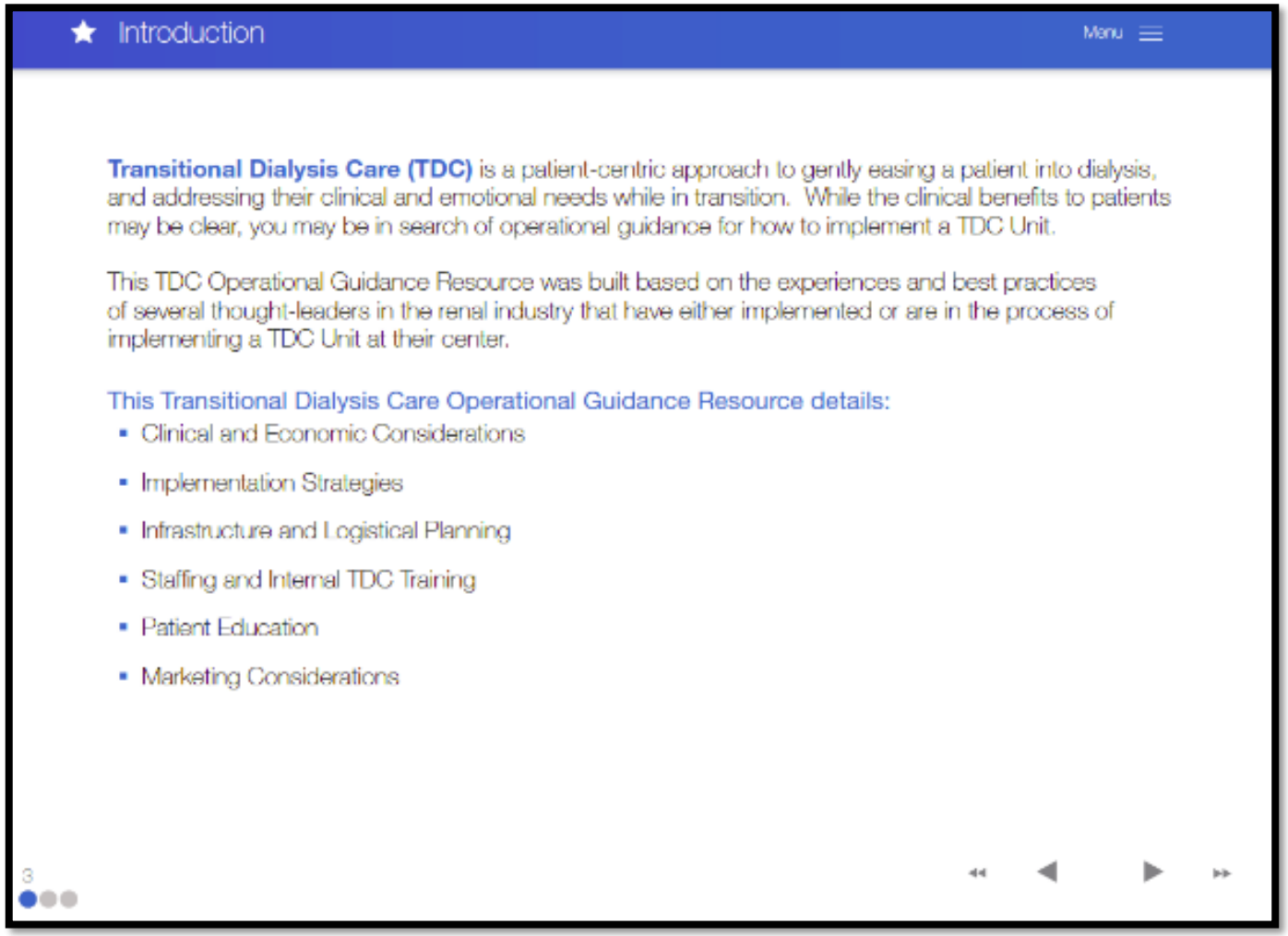
https://drive.google.com/file/d/1er6bTvv5OPQAfCUk2d_2fYRjQhGH9jOO/view?usp=sharing



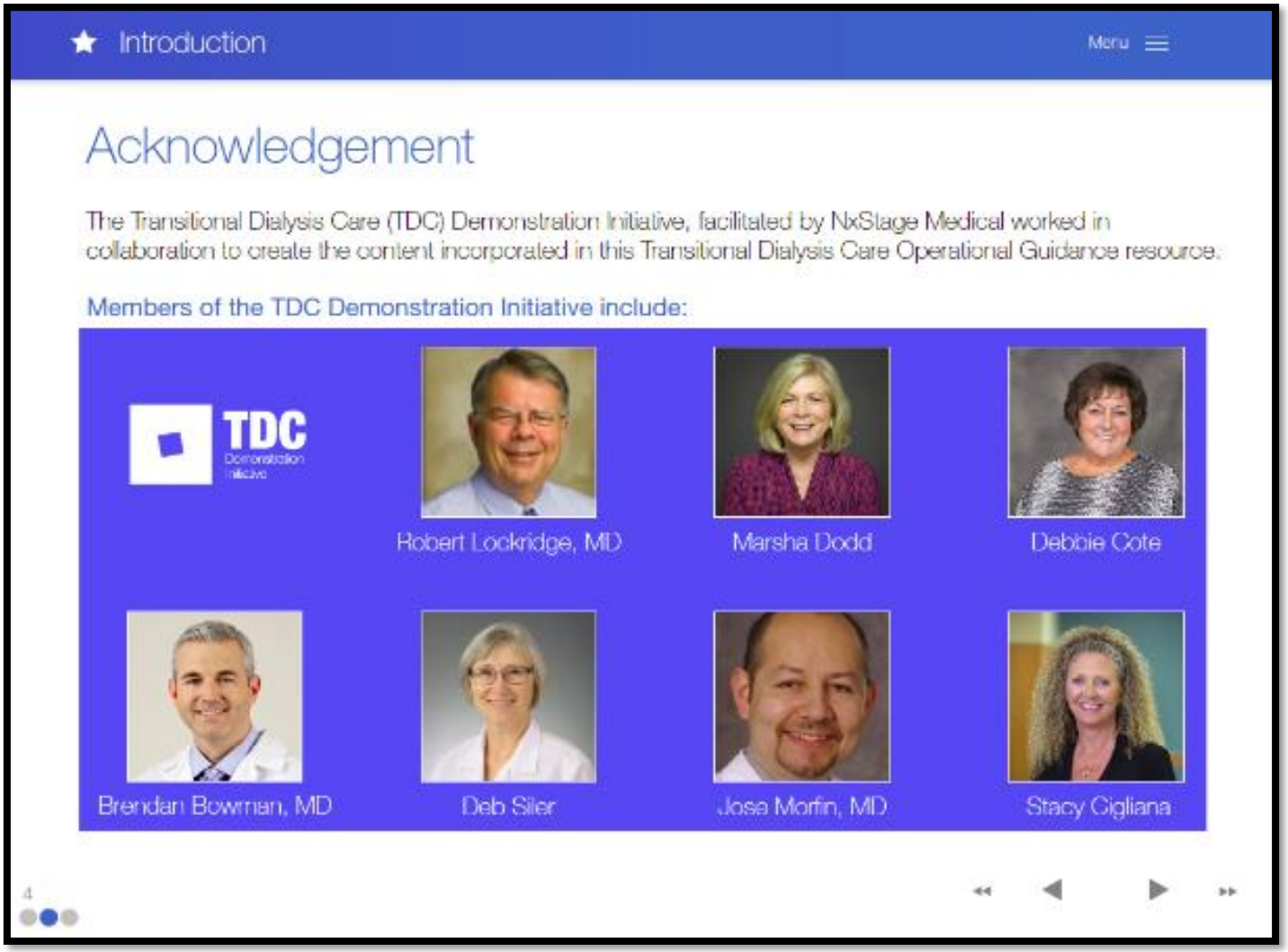
Viewing on Desktop or Laptop

- No special applications are required to be downloaded when viewing via a desktop or laptop.
- Having access to internet will enable viewers to utilize the Transitional Dialysis Care Operational Guidance Resource Webpage
- The Transitional Dialysis Care Operational Guidance Resource Webpage allows viewers to download helpful tools for implementing a program including:
  - Policies & Procedures
  - Implementation Timeline Template
  - Patient Education Curriculum Guide

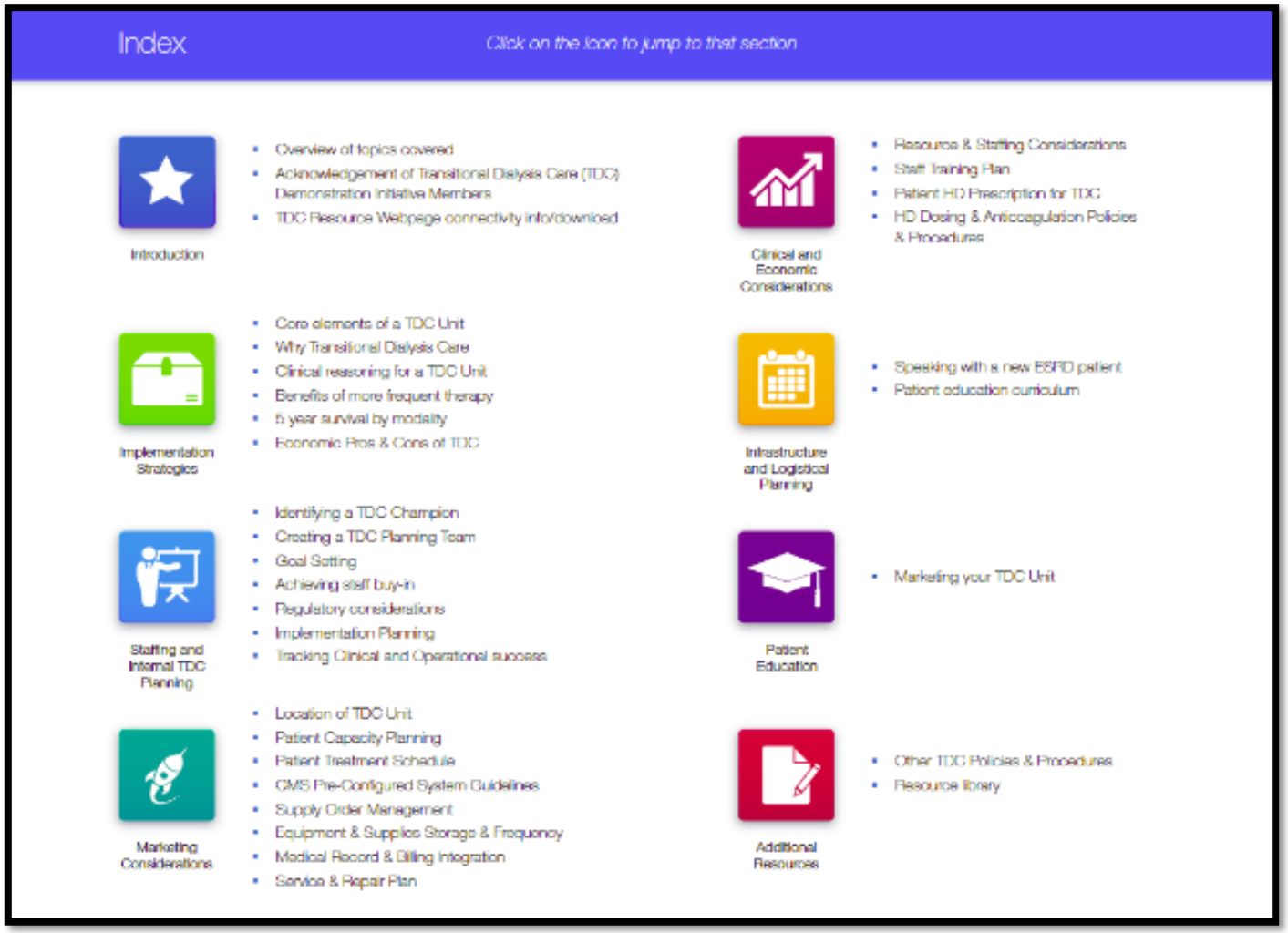
Purpose of TDC Operational Guidance Resource



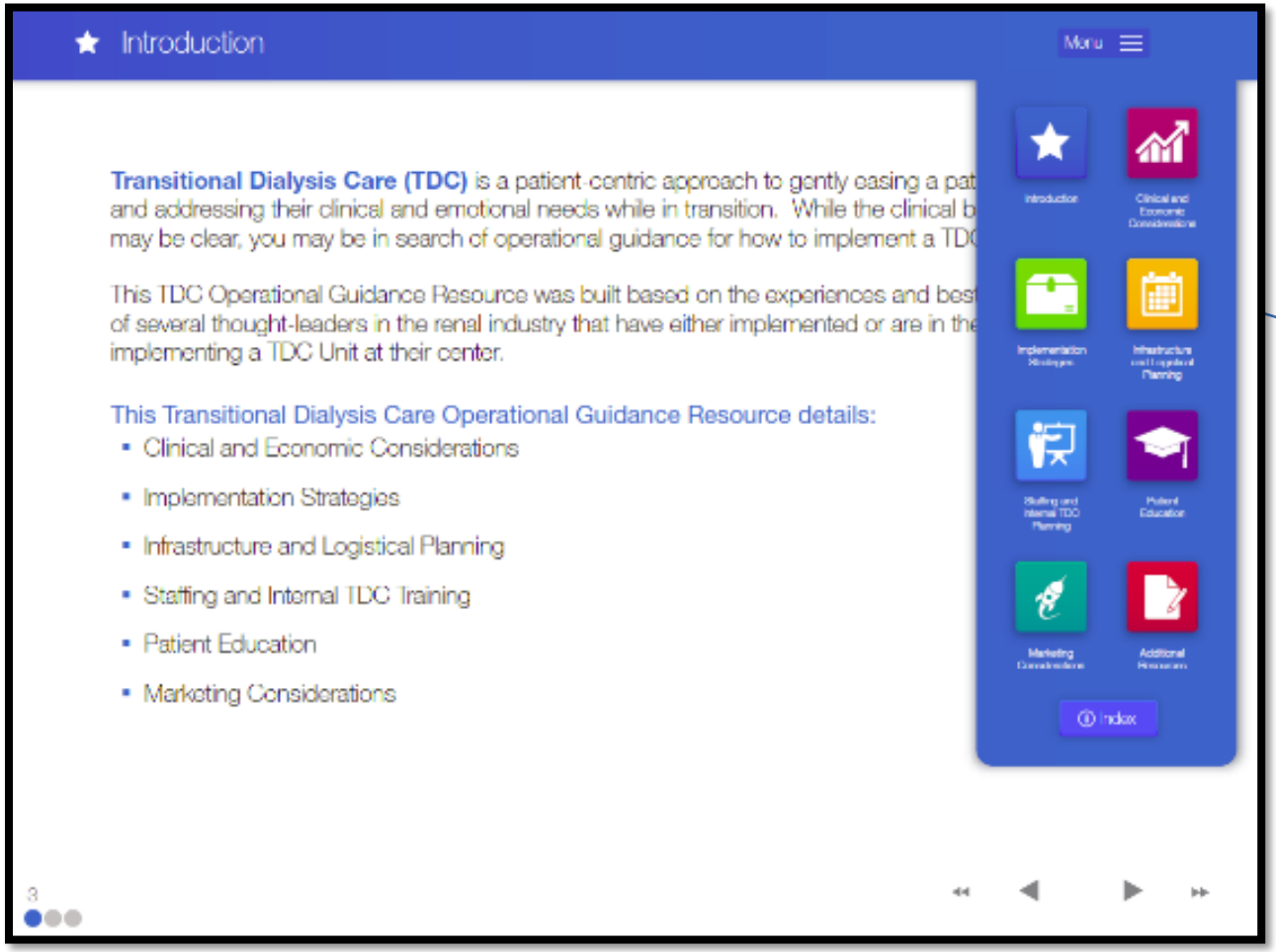
Acknowledgement



Index Page for Easy Navigation



Navigational Drop-Down Menu



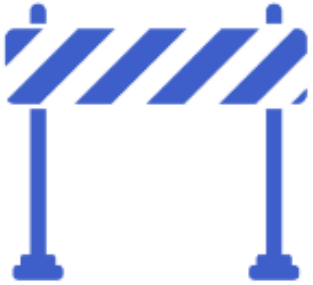
An easy to use menu allows users to quickly and efficiently toggle between sections

Example of Content Included

Staffing & Internal TDC Planning

Menu

Labor Considerations for Delivering TDC Treatments

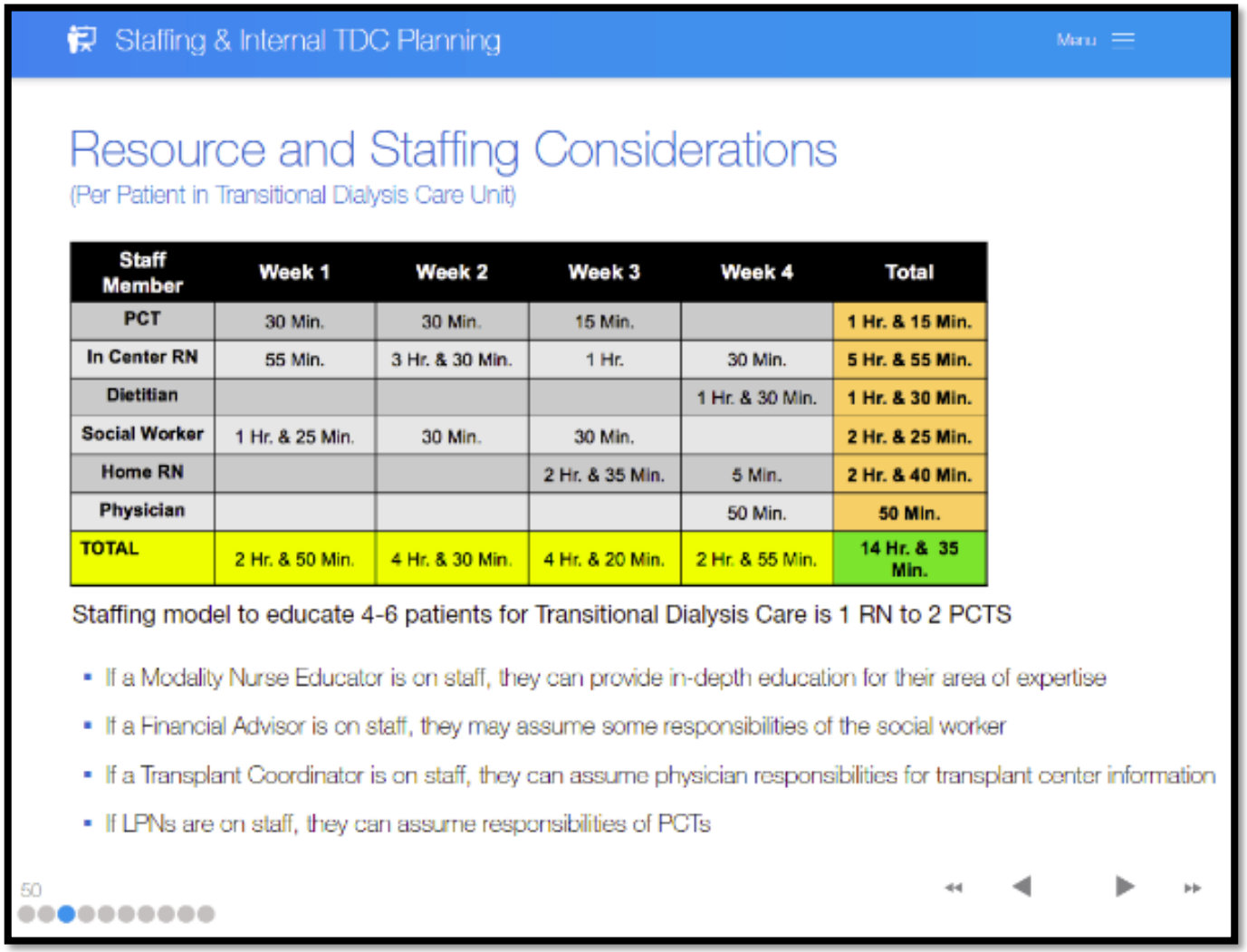


It is recommended that…

- The PCT or LPN perform treatments at a 1 to 3 patient ratio (maximum)
- A RN should oversee all TDC treatments and should be staffed at a 1 to 6 patient ratio (maximum) so that additional patient education can be accommodated
- Other members of the Interdisciplinary Team (IDT) may assist in patient education as deemed appropriate (see next page for further detail)

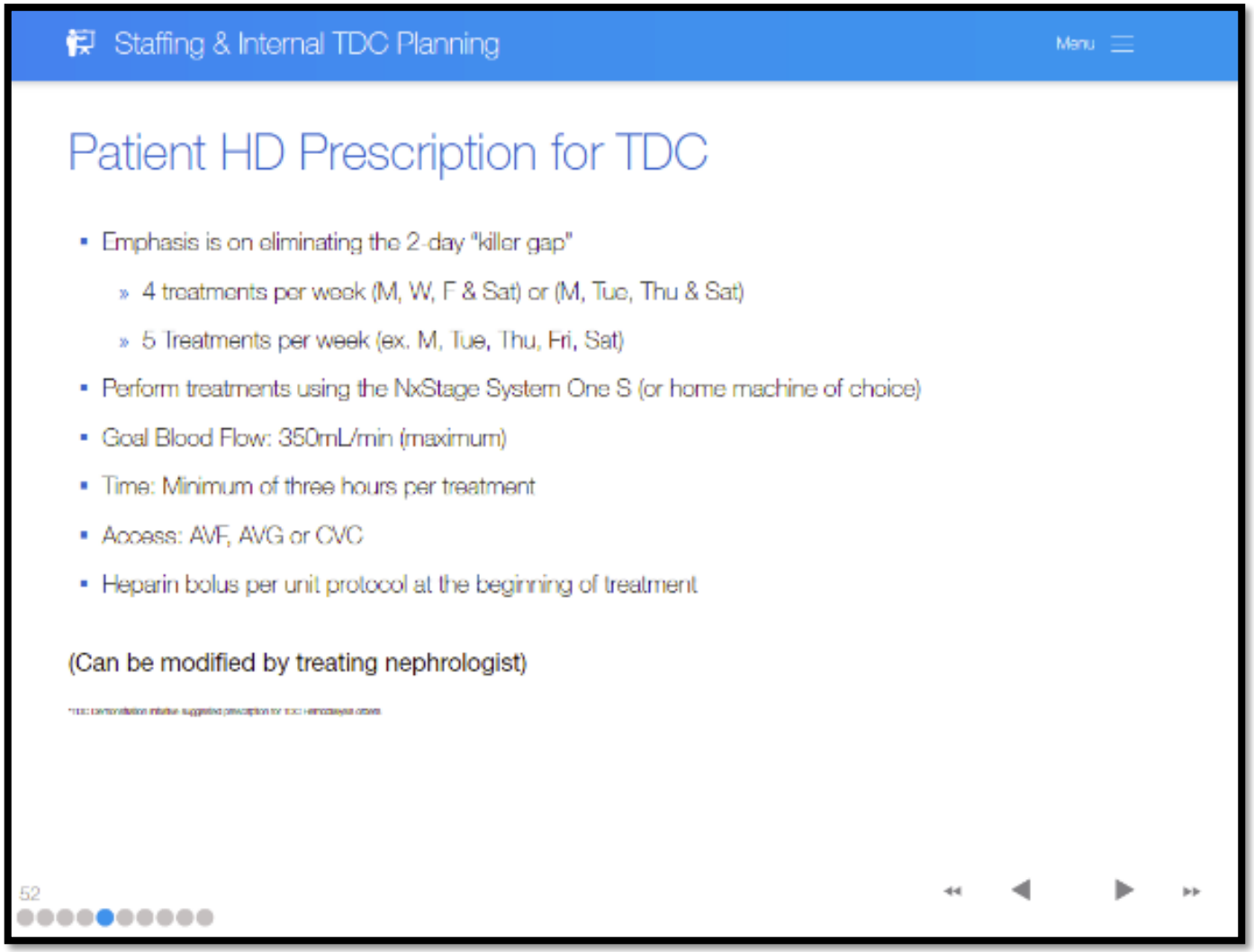
49

Example of Content Included (cont.)

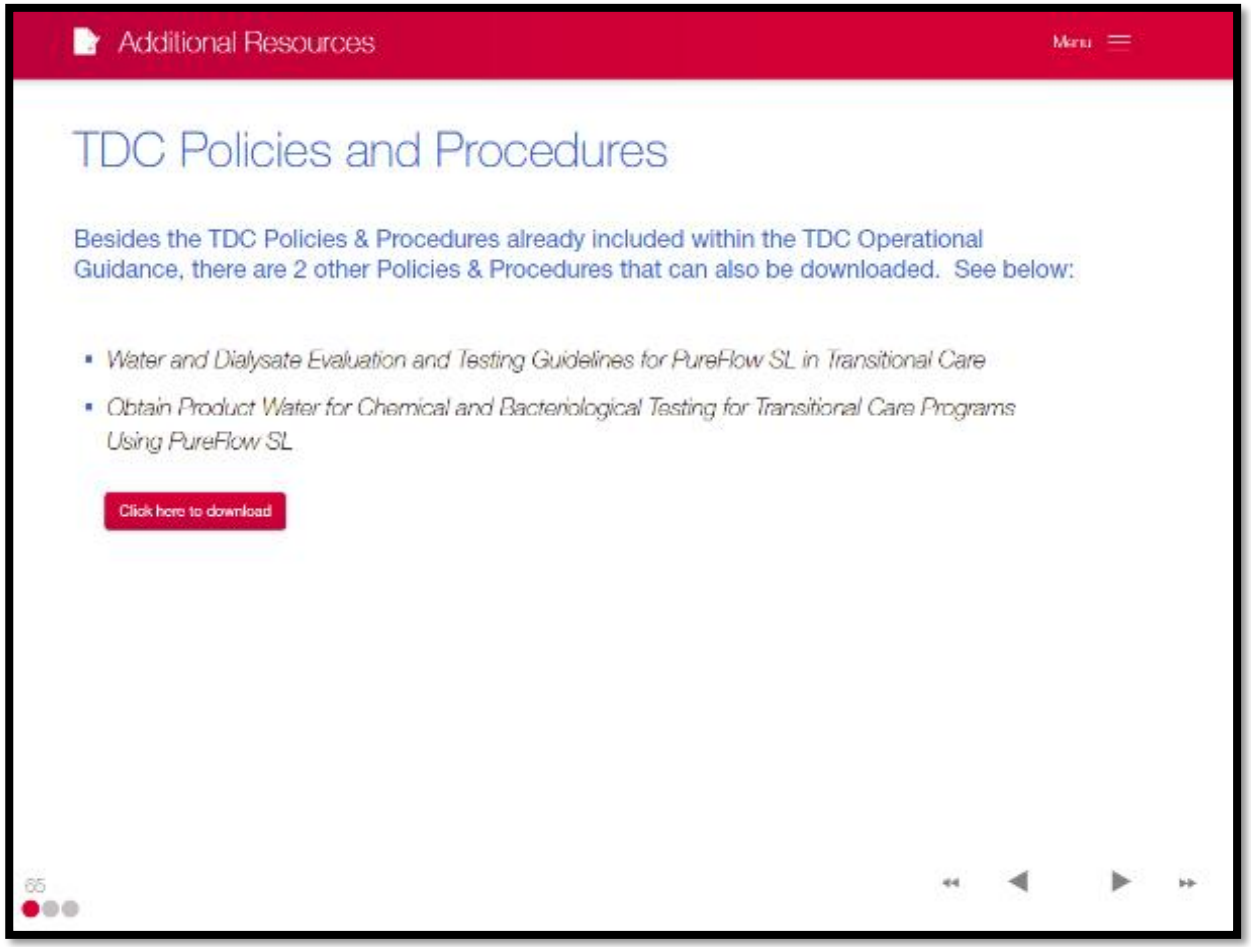


Staff Member	Week 1	Week 2	Week 3	Week 4	Total
PCT	30 Min.	30 Min.	15 Min.		1 Hr. & 15 Min.
In Center RN	55 Min.	3 Hr. & 30 Min.	1 Hr.	30 Min.	5 Hr. & 55 Min.
Dietitian				1 Hr. & 30 Min.	1 Hr. & 30 Min.
Social Worker	1 Hr. & 25 Min.	30 Min.	30 Min.		2 Hr. & 25 Min.
Home RN			2 Hr. & 35 Min.	5 Min.	2 Hr. & 40 Min.
Physician				50 Min.	50 Min.
TOTAL	2 Hr. & 50 Min.	4 Hr. & 30 Min.	4 Hr. & 20 Min.	2 Hr. & 55 Min.	14 Hr. & 35 Min.

Example of Content Included (cont.)

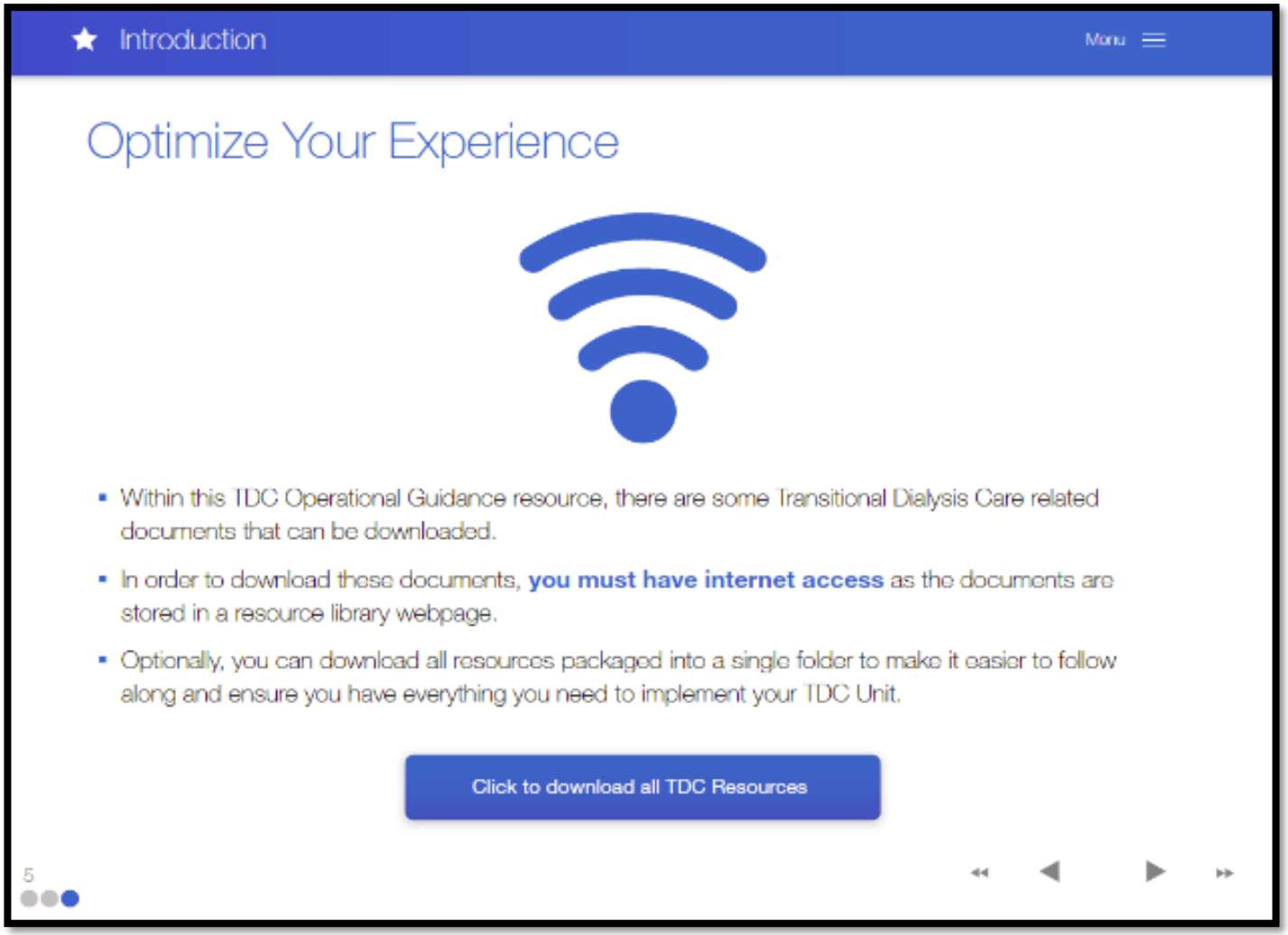


Additional Resources Section



Other important TDC resources such as Policies & Procedures, Staff Training Plans, and examples of Patient Education Curriculum can all be downloaded via the TDC Operational Guidance webpage

Optimize Your Experience



Transitional care can be done incenter or in the home program. If incenter with no training, it is simply incenter care. If incenter, with some aspects of training, it is incenter self care training, and does not need additional certification. If done in the home unit, it is home dialysis and patients must be consented as home patients.

This is the Interpretive Guidance for the ESRD Conditions for Coverage https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/esrdpgmguidance.pdf.

V582	*(a) Standard: Training.* The interdisciplinary team must oversee training of the home dialysis patient, the designated caregiver, or self-dialysis patient before the initiation of home dialysis or self-dialysis (as defined in § 494.10) and when the home dialysis caregiver or home dialysis modality changes.	As defined at § 494.10 Definitions, "Home dialysis" means dialysis performed at home by an ESRD patient or "caregiver" (also called a "helper") who has completed an appropriate course of training as described in § 494.100(a) of this part; "Self-dialysis" means dialysis performed with little or no professional assistance by an ESRD patient or helper who has completed an appropriate course of training as specified in § 494.100(a) of this part. A certified dialysis facility approved for outpatient maintenance dialysis services needs no additional certification or approval to provide in-center self-dialysis or to teach an in-center patient to perform all or part of their dialysis treatment (e.g., self-cannulate, monitor blood pressure). If a patient expresses the desire to perform self-dialysis in-center, the facility interdisciplinary team's response should incorporate assessment of that patient for self-care training and planning for the goal of self-care as appropriate. Refer to V512 under Patient assessment. Any patient who performs aspects of self-dialysis

Essential Components of A Transition Program

Lisa Hart, MSN, CNN

Satellite Dialysis

Choosing a Location

- Dedicated space in an in-center clinic is ideal due to visibility and access for current in-center patients
- Ideally in semi-separate area for noise control to promote education
- Can certainly be done within a home dialysis training center if space allows

Staff Selection

- Dedicated RN with experience in all modalities and strong desire to educate and provide support and exploration of patient lifestyle, resources and preferences. Needs to be independent, self-directed, committed to program and non-biased as well as serving as patient advocate.
- Experienced CCHT with excellent cannulation and people skills as well as flexibility with schedules and a great deal of patience for demonstration and reinforcement of learning.
- Vital that RN and CCHT are well bonded and communicate freely—
  It gets stressful sometimes!

Program Design

- Thoughtful consideration of desired program content and timelines
- Inclusion or exclusion of self-care, cannulation, plan for progression to training
- Period of stabilization, getting comfortable, exploration of patient and family goals, lifestyle, needs, abilities, potential barriers

Organization and Implementation

- Hours of operation
- Acceptance criteria: new to RRT, existing patients, trials, interest in home therapies
- Supplies and ordering (start-up and beyond)
- Educational materials: handouts or manual
- Promotion of program: brochures, flyers, lobby days
- Coordination with ICD: EDUCATE EXISTING STAFF !!!

Technical Issues

- Phone and computer access
- Forms and handouts
- Use of technology: video, iPad, CD, etc.
- Charting: flow-sheets, integration with EMR (no "chairside" entry to date)
- May require manual charting in some situations with plan to scan/fax to EMR
- Billing (ICD) but if include training as continuation of program will change to HHDT or PDT

Patient Outcomes: Win-Win

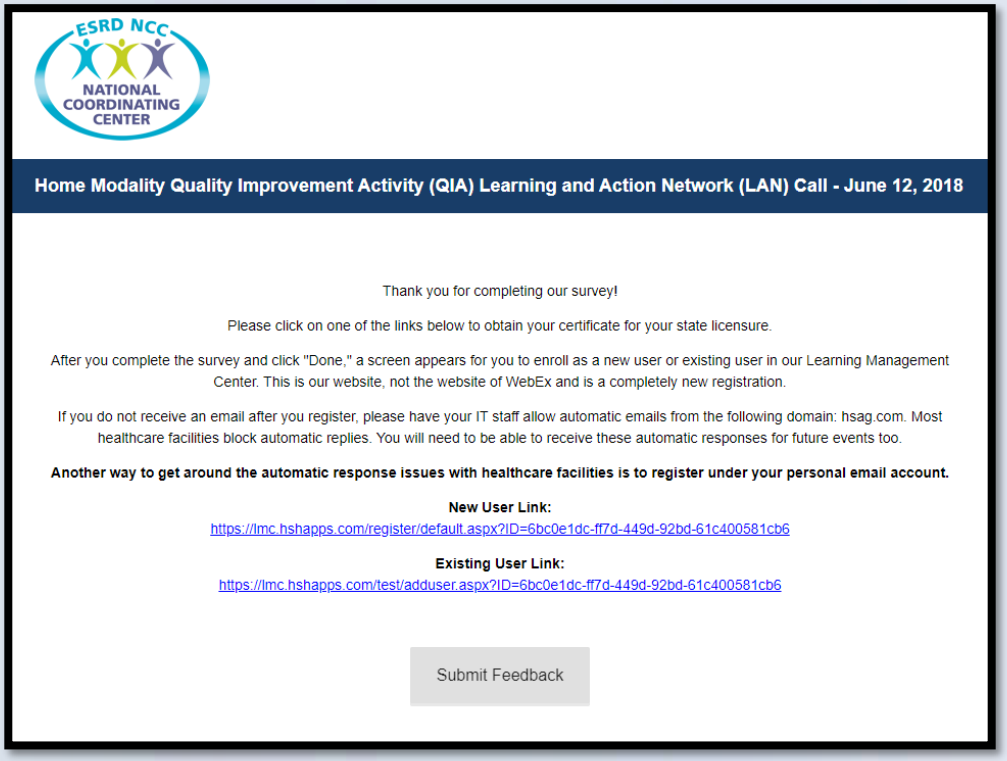
- We are seeing more than 50% of our patients choose a home modality with no patient drop-out due to treatment burden
- For those not choosing a home therapy, the seed is planted
- Of those patients not choosing home, most of the patients who have been through the program request 4 treatments a week, run full treatments, advocate for themselves and appear to be more adherent to medication, fluid and dietary restrictions.

Questions

ESRD NCC NATIONAL COORDINATING CENTER

Questions?

CE Credit Process: Certificate



Home Modality Quality Improvement Activity (QIA) Learning and Action Network (LAN) Call - June 12, 2018

Thank you for completing our survey!

Please click on one of the links below to obtain your certificate for your state licensure.

After you complete the survey and click "Done," a screen appears for you to enroll as a new user or existing user in our Learning Management Center. This is our website, not the website of WebEx and is a completely new registration.

If you do not receive an email after you register, please have your IT staff allow automatic emails from the following domain: hsag.com. Most healthcare facilities block automatic replies. You will need to be able to receive these automatic responses for future events too.

Another way to get around the automatic response issues with healthcare facilities is to register under your personal email account.

New User Link:
https://lmc.hshapps.com/register/default.aspx?ID=6bc0e1dc-ff7d-449d-92bd-61c400581cb6

Existing User Link:
https://lmc.hshapps.com/test/adduser.aspx?ID=6bc0e1dc-ff7d-449d-92bd-61c400581cb6

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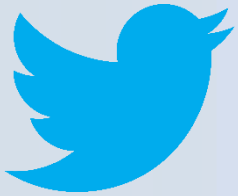

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