2018
Increase Rates of Patients on a Transplant Waitlist
Quality Improvement Activity (QIA) Orientation Webinar

Bonnie Grasso, MSW
Manager, Patient Services
HSAG: ESRD Network 7
January 30, 2018
Orientation Webinar Attendance

To verify facility attendance, please send an email after the call with the name of the facility and attendees to Bonnie Grasso at: Bgrasso@nw7.esrd.net

Please note that this WebEx is being recorded.
Agenda

• Transplant QIA goals
• Timeline
• The 7-step waitlist process
• Transplant data reporting
• The Learning and Action Network (LAN)
• Incorporating patient and family engagement
• Health Disparities
• The 2014 changes to the National Kidney Allocation System
• Best practices—steps for success
• Questions
Goals

The 2018 Increase Rate of Patients on a Transplant Waitlist QIA goals are to:

• Improve the quality of life for ESRD patients by providing awareness and education on transplant as a modality option.
• Improve communication of information between transplant centers and dialysis centers caring for the same ESRD patients.
• Increase awareness of barriers and identify ways to support patients through the waitlist process.
• Demonstrate at least a 10% point increase in the rate of eligible patients placed on a waitlist for transplant.
Criteria

• For selection:
  – The Network identified 30% (123) of facilities within the service area for participation based on their percentage of patients on a transplant waitlist during the period of October 2016 to June 2017*.

• For successful completion:
  – Facilities must demonstrate a 10 percentage point increase in the rate of eligible patients placed on a waitlist for transplant from the baseline.

• For patient exclusion:
  – Patients will be excluded if they:
    • Are already on a waitlist
    • Are a transient patient
    • Have a medical exclusion documented in their patient record and reported to the Network.

• For facility credit:
  – Credit is given to the facility at which the patient was admitted as a non-transient as of the date the patient initiated on the UNOS transplant waitlist.

*Source: Centers for Medicare & Medicaid Services (CMS)
## QIA Timeline

Facilities participating in the 2018 Transplant QIA must adhere to the following timeline:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td><strong>January</strong></td>
<td>19</td>
<td>• Complete Initial Contact form and return to the Network via email to <a href="mailto:bgrasso@NW7.esrd.net">bgrasso@NW7.esrd.net</a></td>
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<tr>
<td>30</td>
<td>• Attend orientation webinar</td>
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<td>• Initiate use of an internal transplant tracking tool to identify where patients are in the 7-step process in January</td>
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<td>• Ask patients who refuse transplant education to complete the <em>Why Not Consider Transplant – Patient Refusal Form</em></td>
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<tr>
<td><strong>February</strong></td>
<td>5</td>
<td>• Complete initial self-reporting tool and root cause analysis via the Survey Monkey link provided by the Network</td>
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<td>12</td>
<td>• Identify a contact person at a local transplant center and request transplant information (if not already provided)</td>
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<td>23</td>
<td>• Provide education to all staff on transplant by utilizing information obtained from a transplant center</td>
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<td>• Attend the National Coordinating Center (NCC) transplant LAN, if offered</td>
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<tr>
<td><strong>March</strong></td>
<td>5</td>
<td>• Submit February self-reported data to the Network via the Network-provided Survey Monkey link</td>
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<td>12</td>
<td>• Distribute the “Patient Education” provided by the Network to all patients</td>
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<tr>
<td>19</td>
<td>• Ask patients refusing transplant education to complete the <em>Why Not Consider Transplant - Patient Refusal Form</em></td>
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<td><strong>April</strong></td>
<td>2</td>
<td>• Submit March self-reported data to the Network via the Network-provided Survey Monkey link</td>
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<td>16</td>
<td>• Host a transplant waitlist discussion (Lobby Day) to discuss the transplant waitlist process, and barriers</td>
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<td>• Have a subject matter expert (SME), such as a transplanted patient, patient already on the waitlist, or the</td>
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<td>• caregiver of a transplanted patient, participate</td>
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<td>• Attend the NCC Transplant LAN, if offered</td>
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<td><strong>May</strong></td>
<td>4</td>
<td>• Submit April self-reported data to the Network via the Network-provided Survey Monkey link</td>
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<tr>
<td>14</td>
<td>• Submit a list of best demonstrated practices to the Network</td>
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### QIA Timeline (cont.)

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
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<tbody>
<tr>
<td>June</td>
<td>4</td>
<td>• Submit May self-reported data to the Network via the Network-provided Survey Monkey link</td>
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<td>• Attend NCC Transplant LAN if offered</td>
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<td>July</td>
<td>2</td>
<td>• Submit June self-reported data to the Network via the Network-provided Survey Monkey link</td>
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<td>• Share best demonstrated practices</td>
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<td>August</td>
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<td>• Submit July self-reported data to the Network via the Network-provided Survey Monkey link</td>
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<tr>
<td>September</td>
<td>3</td>
<td>• Submit August self-reported data to the Network via the Network-provided Survey Monkey link</td>
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*Never use patient names or MPI numbers*
Interventions

- Complete a root cause analysis (RCA) to identify barriers in the process to move patients through the waitlist process.
- Educate staff using the staff-specific ASCENT Project video.
- Educate patients using the patient-/family-/caregiver-specific ASCENT Project video and other materials provided by the Network and transplant centers.
- Build Relationships by identifying and making contact with a representative at a local transplant center. Request transplant Information to include the admission criteria and the waitlist process, and other information as needed to move patients through the waitlist process.
Interventions (cont.)

• Include patient SMEs in all activities by:
  – Hosting a lobby day at the facility that encourages patient engagement among patients who are interested in the transplant process and patients who have been through or are going through the transplant process.
  – Identifying a patient and/or patients who have had a transplant or are on the waitlist for a transplant as subject matter experts (SME’s).
  – Including family members and/or caregivers of patients who have had a transplant or are waitlisted for transplant.
  – Facilitating the transfer of information and providing education and assistance as needed.

• Identify barriers and provide educational Interventions provided by the Network and/or Transplant Centers at each of the 7 steps to assist patients through the waitlist process.
Interventions (cont.)

• Track progress and Document results utilizing the Facility Internal Tracking Tool provided by the Network to track, document, and report monthly progress on the Self-Reported Report due to the Network each month.

• Use the Network reporting forms as required, including completion of the:
  – Initial Contact form
  – Initial Reporting Form to provide baseline information as requested
  – Monthly Transplant Self-Reporting Tracker to report on facility progress towards the 10% increase of eligible patients on a transplant waitlist and other information as requested.

Submitting all forms to the Network monthly via email. A link will be provided for both the initial and monthly reporting forms.
Interventions (cont.)

- Attend the ESRD NCC LAN per CMS guidelines. It is mandatory that each facility in the Transplant QIA attend the ESRD NCC LAN every other month. Attendance will be tracked by the Network and reported to CMS monthly.

- Implement patient and family engagement activities with technical assistance from the Network and report on the monthly reporting form.

- Provide Feedback to the Network on the effectiveness of the educational materials and interventions provided.

- Identify/report best practices to the Network that have proved effective in improving/accelerating the patient experience navigating the 7-step process toward getting on a transplant waitlist. Best Practices will be distributed to facilities who are facing challenges with the waitlist process.
The 7-Steps in the Waitlist Process

• **Patient Suitability**
  – Dialysis facility records or patient’s nephrologist indicates that the patient has no absolute contraindications* to kidney transplantation.

• **Patient Interest**
  – Patient expresses an interest in considering a deceased or living donor transplant.

• **Referral call to transplant center**
  – Transplant center records indicate that a referral was made by the patient, nephrologist, or dialysis center.

• **First visit to transplant center**
  – Transplant center records indicate that patient made an initial visit to transplant center.

• **Transplant center work-up**
  – Transplant center records indicate that the patient completed workup.

• **Successful transplant candidate**
  – Transplant center records indicate that the patient is a successful transplant candidate.

• **On waiting list or evaluate potential living donor**
  – Transplant center records indicate that patient is on a deceased-donor waiting list or a potential living donor is being evaluated.

*Absolute contraindications vary per transplantation center, check with the centers in your region for clarification.
## Transplant Monthly Internal Tracker: The 7-Steps

**Goal:** To achieve a 10 percentage point increase in patients on a waitlist for transplant

**Note:** This is an internal facility tracking tool, to be used for internal facility purposes only.

**Instructions:** Enter the total number of patients in each of the 7 steps on the last day of each month, and enter a check mark for activities completed within the reporting month. Keeping the tracker up-to-date will assist with reporting accurate information to the Network. **Please never email patient names or information to the Network.**

<table>
<thead>
<tr>
<th>Month</th>
<th>Step 1: Patient Suitability</th>
<th>Step 2: Patient Interest</th>
<th>Step 3: Referral Call Made</th>
<th>Step 4: First Visit to Transplant Center</th>
<th>Step 5: Transplant Center Work-up</th>
<th>Step 6: Successful Transplant Candidate</th>
<th>Step 7: On Wait List or Evaluate Potential Living Donor</th>
<th>Had Contact with a Transplant Center</th>
<th>Attended NCC Transplant LAN this Month</th>
<th>Returned Monthly Self – Reported Data this Month</th>
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### Initial Self-Reporting Form: Root Cause Analysis (RCA)

**11. Why do you think less than 40% of eligible patients at your facility are on the waitlist for transplant?**

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<tr>
<th>Reason</th>
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<th>3</th>
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<th>6</th>
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<th>N/A</th>
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<td>Patients are unable to meet the criteria for transplant</td>
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<td>Patients are not completing the follow-up requirements of the transplant center</td>
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<td>Patients do not have access to transportation</td>
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<td>Patients do not have appropriate funding</td>
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<td>Patients do not have appropriate social support systems in place</td>
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<td>Patients think the wait time is too long for a transplant</td>
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<td>The facility lacks a process for assisting and coordinating patients through the transplant process</td>
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Other (please specify)
15. How many patients at your facility are at Step #1 "Patient Suitability for Transplant" (defined as the absence of absolute contraindications identified in the medical record) at the end of January?

16. How many patients at your facility are at Step #2 "Patient Interest in Transplant" at the end of January?

17. How many patients at your facility are at Step #3 "Referral call to transplant center" at the end of January?

18. How many patients at your facility are at Step #4 "First visit to transplant center" at the end of January?

19. How many patients at your facility are at Step #5 "Transplant Center work up" at the end of January?

20. How many patients at your facility are at Step #6 "Successful transplant candidate" at the end of January?

21. How many patients at your facility are at Step #7 "On waiting list or evaluate potential living donor." at the end of January?
“Why Not Consider A Transplant”
Patient Refusal Form

Why not consider a Transplant?

Did you know that more than 10,000 kidney transplants are performed every year, and that 95% of people who have a kidney transplant are still alive after one year?

You have indicated that you do not want to be considered for a transplant. We would like to understand why.

Please tell us why you would rather not be considered for a transplant. We have provided a checklist of possible reasons below. Your feedback will help us to develop new educational materials to address patient concerns.

Please check all concerns with transplant below that apply.

☐ I do not think that I would qualify for a transplant
☐ Transplants do not work
☐ A transplant has too much risk
☐ Transplants do not last
☐ I do not have insurance to cover the cost of a transplant
☐ I do not have enough funds to cover the cost of the medications after the transplant
☐ I do not know enough about it to make a decision
☐ I am too old to have a transplant
☐ I am too sick to have a transplant
☐ Other Reason(s)

[Text box for additional reasons]
NCC Transplant LAN

• Each facility must participate in the Transplant LAN calls.
  – LAN calls will start in February and will then be held every other month.

• LANs are:
  – A forum for patients, family members, caregivers, providers, and other stakeholders to share ideas around a shared goal.
  – Mechanisms by which large scale improvement toward the achievement of a person-centered outcome based goal is fostered, studied, adapted, rapidly spread, and sustained.
  – Regardless of the change methodology, tools, or time-bound initiative used.
Patient and Family Engagement at the Facility Level: CMS Requirement

CMS requires that the Network:

• Ensure the implementation of interventions at the dialysis facility level that foster patient and family involvement

• Assist facilities in adjusting to the heightened focus on patient and family centered care by providing technical assistance on:
  – Establishing a patient and family council support group and/or new patient adjustment group
  – Incorporating patient, family, and caregiver participation into the quality assurance performance improvement (QAI) program and governing body of the facility.
  – Developing policy and procedures related to patient, family and caregiver participation in the patient’s care.
Health disparities are the differences in health outcomes closely linked with social, economic and environmental disadvantage – are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic locations, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families and communities. To learn more, contact:

• HealthEquityTA@cms.hhs.gov.
• www.ascenttotransplant.org.
Plan-Do-Study-Act (PDSA) Cycle

**ACT**
- What changes are to be made?
- Next cycle?

**PLAN**
- Objective
- Predictions
- Plan to carry out the cycle (who, what, where, when)
- Plan for data collection

**STUDY**
- Analyze data
- Compare results to predictions
- Summarize what was learned

**DO**
- Carry out the plan
- Document observations
- Record data
2014 Change to the National Kidney Allocation System

• *All* dialysis time is counted.
• Time is dated back to the day a patient began dialysis.
  – If a patient began dialysis before they were listed for a transplant, their transplant waiting time will be backdated to their first dialysis date.
  – Patients who have been on dialysis for a long time are now given priority for a deceased donor kidney transplant.
Meeting the Requirements: Steps For Success

• Build a relationship with a contact person at a local transplant center.
• Attend all ESRD NCC LAN meetings.
• Identify eligible/suitable transplant patients and identify interest.
• Utilize an internal transplant tracker.
• Complete and return the contact form to the Network.
• Complete and submit the initial reporting form provided by the Network.
• Submit the monthly reporting form to the Network.
• Share the monthly activities and educational materials that are provided by the Network with patients, family members, staff and caregivers.
• Identify barriers early and assist patients through the 7-step process.
• Host a Lobby Day
• Developing and implementing successful processes will increase the opportunity for future sustainability.
Best practices will be used by the Network to assist facilities and patients who are having challenges with moving through the waitlist process.

• Identify and report best practices at each step of the 7-step process.
• A list of the best practices will be shared with all of the facilities for future reference and sustainment of outcomes.
The patient has the right to be informed about all treatment modalities

V458 (7) Be informed about all treatment modalities and settings, including but not limited to, transplantation, home dialysis modalities (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), and in-facility hemodialysis. The patient has the right to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients; Documentation in patient records must demonstrate that facility staff provide unbiased education to patients/designees about transplantation and all dialysis treatment options (modalities and settings) offered for kidney failure, whether or not those options are offered at the current dialysis facility. This includes alternate scheduling options for in-center hemodialysis patients who attend school or are working. Patients who work or attend school should be encouraged to continue doing so and facilities should recommend the most appropriate modality and setting for their dialysis. Examples of how facilities may meet this requirement include developing a resource information packet for patients or providing patients an existing resource list of facilities that offer alternate schedules or home dialysis treatment options can be found at Medicare’s Dialysis Facility Compare, and Home Dialysis Central.

The requirements for assessment of patients for home dialysis and transplantation are addressed at V512 and V513 and at V553 and V554 respectively under the Condition for Patient plan of care.

Evaluation of Suitability for a transplantation referral

V513 (10) Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for non-referral must be documented in the patient’s medical record. The IDT comprehensive assessment must demonstrate that each patient is evaluated for suitability for transplantation referral, using selection/exclusion criteria provided by the transplant center.

The regulations for transplant programs require written selection criteria to be developed and provided upon request to patients and dialysis facilities. Selection criteria vary among transplant centers; if the dialysis facility refers patients to multiple transplant centers, the dialysis facility should have the selection criteria for each center on file and available to patients; patient are also free to select a transplant center other than the ones normally utilized by the dialysis facility for referrals.

If the assessment finds a patient is not suitable for transplantation, the reason for the non-referral should be documented as part of the Comprehensive assessment.

The requirements for plan of care for transplant status are at V554.
Referral Plan for Transplant and Documentation of Reasons for Nonreferral

V554 (ii) Transplantation status. When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient’s plan of care must include documentation of the—

(A) Plan for transplantation, if the patient accepts the transplantation referral;

(B) Patient’s decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or

(C) Reason(s) for the patient’s non-referral as a transplantation candidate as documented in accordance with § 494.80(a)(10). The patient’s plan of care must reflect the information from the interdisciplinary team’s evaluation of the patient's suitability for transplantation referral, required under the Condition for Patient assessment at V513.

The patient record must show evidence that the patient was informed about transplantation as an option, living and deceased kidney donation, area transplant center(s) and each transplant facility’s selection criteria. Each patient's record must reflect the IDT's determination about the patient's suitability and whether the patient accepted or declined referral for transplantation and reason for non-referral.

If a patient was determined as suitable for transplantation referral, the IDT must document making the referral and providing applicable information to the transplant center as appropriate or when requested.

Documentation in patient records should agree with the patient’s understanding of their status as a transplant candidate. Patients may independently contact a transplant center for an appointment for more information and evaluation. If this is the case, the IDT should be aware of the self-referral. A patient’s insurance coverage and a transplant center’s selection criteria may dictate which transplant center(s) the patient can access.

For more information contact: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/esrdpgmguidance.pdf
The Role of the Quality Assessment and Performance Improvement (QAPI) in the QIA

Review all Transplant QIA efforts/accomplishments during facility QAPI Meetings including:

• Facility inclusion in the Transplant QIA.
• An overview of the QIA.
• The Transplant QIA goals.
• Monthly Interventions.
• Monthly internal tracking forms.
• Patient status in the 7-step waitlist process.
Resources

• CMS disparity resources:
  – Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries.
  – Building an Organizational Response to Health Disparities.

• Information regarding changes in the allocation system information:
  – www.ascenttotransplant.org

• CMS CfCs:
Questions
Thank you!

Bonnie Grasso, MSW
813.865.3415 | bgrasso@hsag.com