2019
Transplant Coordination Quality Improvement Activity (QIA) Orientation Webinar

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*Quality Improvement Director*
Health Services Advisory Group (HSAG)
End Stage Renal Disease (ESRD) Networks 7 and 17
January 29, 2019
Orientation Webinar Attendance

If you were unable to join the WebEx and are only on the phone, verify facility attendance, by sending an email after the call with the name of the facility and attendees to Donna DeBello at: Ddebello@nw7.esrd.net

Please note that this WebEx is being recorded.
Agenda

• Transplant QIA scope and goals
• The 2014 changes to the National Kidney Allocation System
• The 6-step waitlist process
• Transplant data reporting
• Transplant tools, interventions, education and feedback
• Network Patient Representative (NPR) Program
• Timeline and expectations
• Health disparities
• Meeting the—steps for success
• Questions
QIA: Scope

The benefits of transplantation extend to ESRD patients regardless of:

• Age.
• Gender.
• Ethnicity.
• Common comorbid conditions, including:
  – Diabetes and hypertension.
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.

More information can be found here:
What the Conditions for Coverage (CFCs) Say About Transplant

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; patients 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
QIA: Goals

The goal of the Transplant Coordination QIA is to Increase the number of patients on the transplant waitlist by:

• Providing education to ESRD patients on transplant as a modality option.

• Improving the communication process and exchange of information between transplant centers, hospitals, nephrologists and dialysis centers caring for the same ESRD patients.

• Addressing barriers and identifying ways to support patients through the waitlist process.
QIA: Criteria for Selection/Completion/Credit

• For selection/inclusion in the QIA:
  – The Network identified 30 percent of facilities in the Network service area with the lowest rate of patients on the transplant waitlist.

• To successfully complete the QIA, facilities must:
  – Improve by two percentage points from the baseline.
  – Participate in the ESRD Transplant QIA Learning and Action Network (LAN) webinars.
  – Implement interventions identified from the LAN/distributed by the Network.
  – Demonstrate timely submission of all monthly reporting.

• To receive credit:
  – The facility must be the one at which the patient was admitted as a non-transient as of the date the patient initiated on the United Network for Organ Sharing (UNOS) transplant waitlist.
    • Only transient patients are excluded.

*Source: Centers for Medicare & Medicaid Services (CMS)
The 6-Steps in the Waitlist Process

• **Step 1—Patient interest in transplant**
  – Patient has expressed an interest in considering a deceased or living donor transplant.

• **Step 2—Referral call to transplant center**
  – Transplant center records indicate that a referral was made by the patient, nephrologist or dialysis center.

• **Step 3—First visit to transplant center**
  – Transplant center records indicate that the patient made an initial visit to the transplant center for evaluation and/or educational classes.
The 6-Steps in the Waitlist Process (cont.)

• **Step 4—Transplant center work-up**
  – Transplant center records indicate that the patient is in the work-up process.

• **Step 5—Successful transplant candidate**
  – Transplant center records indicate that the patient meets the requirements and is a successful transplant candidate.

• **Step 6—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.
Data Tracking

Use the *Monthly Internal Transplant Tracker* provided by the Network, or a facility specific tracking tool to:

- Track the number of patients in each of the six steps.
- Track the movement of patients across the steps each month.
- Track patients being added to the waitlist.
- Compile data to report the number of patients at each step to the Network monthly.

**Note:** The tracker is not submitted to the Network. It is for internal use only.
Monthly Internal Transplant Tracker: To Record Progress Towards the 6-Steps

<table>
<thead>
<tr>
<th>Monthly Internal Transplant Tracker</th>
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<tbody>
<tr>
<td><strong>Goal:</strong> To achieve a <strong>two-percentage point increase</strong> in patients on a waitlist for transplant.</td>
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<tr>
<td><strong>Note:</strong> This is an internal facility tracking tool, to be used for internal facility purposes only.</td>
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<tr>
<td><strong>Instructions:</strong> 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. <strong>Please never email patient names or information to the Network.</strong></td>
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<table>
<thead>
<tr>
<th>Month</th>
<th>Step 1: Patient Interest</th>
<th>Step 2: Referral Call Made</th>
<th>Step 3: First Visit to Transplant Center</th>
<th>Step 4: Transplant Center Work-up</th>
<th>Step 5: Successful Transplant Candidate</th>
<th>Step 6: 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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Data Reporting

Report information and progress by completing and submitting the:

• Initial contact form:
  – The initial Transplant QIA introduction letter emailed to all facilities included a request for contact information to be completed through a Survey Monkey link.

• Initial reporting/root cause analysis (RCA) form:
  – Via a link sent following this webinar.
  – For provision of baseline information.
Data Reporting (cont.)

• Monthly Reporting Form:
  – Via a link provided by the Network monthly.
  – To be submitted monthly by the 10th of each month.
  – To report QIA progress.

• Intervention evaluations:
  – Used for patient/facility staff evaluation of interventions.
    ▪ Facility evaluations will be completed on the Monthly Reporting Form.
    ▪ Patient evaluations will be sent as PDFs or in hard copy for printing and distribution to patients.
For the 2019 Transplant QIA, please complete the contact information listed below to help us get start. Thank you

1. Please select your facility name and CCN# from the dropdown box

2. Please select your CMS Certification Number (CCN#) from the dropdown box

3. Please Provide your facility contact information

<table>
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<tr>
<th>Facility Name</th>
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4. Do Nephrologists at this facility support transplant?
   - Yes
   - No

5. Is there a communication process in place between the dialysis facility and Transplant Centers regarding patient referrals?
   - Yes
   - No

6. Is there a communication process in place between the dialysis facility and Nephrologists regarding patient referrals for transplant?
   - Yes
   - No
Interventions: Staff

• Educate staff using:
  – Internal facility-specific education.
  – The staff-specific [ASCENTTOTRANSPLANT.org](#) project video
  – Materials distributed by the Network
  – Project video, provided by the Network

• Attend the ESRD NCC Transplant QIA LAN webinars, which:
  – Are mandatory for all Transplant QIA facilities and will be tracked and reported to CMS.
  – Are held every other monthly and began in January.
  – Include national speakers who present best practices in an all-teach, all-learn environment.
Interventions: Patients

• Use the *Why Not Consider Transplant* patient refusal form with patients who refuse or indicate that they are not interested in transplantation

• Educate patients using:
  – The patient-/family-/caregiver-specific ASCENT Project video.
  – Materials provided by the Network.
  – Facility-specific patient education.
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)
Interventions: Patient Subject Matter Experts (SMEs)

Include Patient SMEs in all activities by:

• Hosting a Lobby Day:
  – To encourage patient engagement and interaction 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 to talk one-on-one with other patients.
Interventions:
Patient Subject Matter Experts (SMEs)

• Including family members and/or caregivers of transplant patients or who are waitlisted for transplant to talk to other family members.

• Recruiting a Network Patient Representative (NPR) to disseminate information to patients and support patient and family engagement (PFE) activities.
  – Additional details on the NPR program are forthcoming.
Tips for a Successful Lobby Day

Tips for Engaging Patients and Hosting a Successful Transplant Lobby Day

Communicate the Event in Advance
- Hand out flyers or invitations chairs and in the lobby.
- Hang posters in the lobby and the clinic announcing the event.
- Have staff talk about the event to patient, caregivers, and family members.

Invite Guests
- Invite a local transplant center to participate in the event.
  - Ask them to bring educational materials as handouts.
- Invite transplant recipients, caregivers, and/or family members of transplant recipients to participate.
- Invite patients who are currently waitlisted to be resources on navigating through the transplant waitlist process.
- Involve your facility social worker as a resource on how the facility can assist patients through the transplant process.

Provide Practical, Useful, and Up-to-Date Information
- Ensure educational materials are oriented to patients and their families.
  - Use easy-to-read, concise language.
- Consider using outside educational websites and materials to generate new interest, including:
  - The Ascent to transplant video www.ascenttotransplant.org, sent by the Network to the facility.
  - Educational materials from the transplant centers, including the transplant criteria.
  - The National Kidney Foundation (NKF) website.

Follow Up!
- Follow up with interested patients individually.
- Discuss patient interest and suitability with the medical director.
- Assist patients with the referral process.
Interventions: Facility-Other Provider Relations/Communications

Build relationships and communication processes by identifying and making contact with representatives at local:

• Transplant centers.
  – Request transplant Information to include:
    ▪ Required information to complete a referral.
    ▪ Admission criteria.
    ▪ The waitlist process.
    ▪ Appointment schedules.
    ▪ Other information as needed to assist patients. through the waitlist process.

• Nephrologists’ offices.

• Hospitals.
Interventions: Barrier Identification and Resolution

- Identify barriers to patients seeking to be waitlisted for transplantation.
- Develop processes to overcome barriers and assist patients through the waitlist process.
- Identify best practices that have proven effective in improving/accelerating the patient experience navigating the 6-step process toward getting on a transplant waitlist.
- Report barriers and successes/best practices to the Network on the Monthly Reporting Form.
  - Best practices will be distributed to all QIA facilities.
Interventions: QAPI Review

During monthly QAPI meetings facilities must discuss:

• Facility inclusion in the QIA to engage the support of the medical director and Interdisciplinary Team (IDT).

• Patient interest questionnaires to assess patients suitability for transplant and referral.

• Individual patients’ progress through each step, including:
  – Barriers encountered
  – Resolutions designed by your team that may be shared as best practices.
RCA and the 5 Whys

**Benefits of the 5 Whys**

- Help identify the root cause of a problem.
- Determine the relationship between different root causes of a problem.
- It is a simple tool; easy to complete without statistical analysis.

**When the 5 Whys is Most Useful**

- When problems involve human factors or interactions.
- To discover the root cause of a problem and affect change.
How to Complete the 5 Whys

Develop the problem statement. Be clear and specific.

Ask, “Why did the problem happen?”

To determine if the response is the root cause of the problem, consider “If the most recent response were corrected, is it likely the problem would recur?”

If the answer is yes, it is likely this is a contributing factor, not a root cause.

If the answer is a contributing factor to the problem, keep asking “Why?” until the root cause has been identified.

It often takes three to five whys, but it can take more than five!

Keep going until the team agrees the root cause has been identified.

Click [here](#) for more information and a Five Whys RCA template.
Plan-Do-Study-Act (PDSA) Cycle: How to Develop a Rapid Cycle Improvement (RCI) Plan
# QIA Timeline: Required Adherence

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| January  | • Complete Initial Contact form via the SurveyMonkey link.  
  • Attend orientation webinar.  
  • Initiate use of an Internal Transplant Tracker to identify where patients are in the 6-step process.  
  • Review Transplant Coordination QIA in QAPI. |
| February | • Identify a contact person at a local transplant center, nephrologist office, and local hospital, to develop a communication plan for exchanging information including direct email, address, direct phone numbers, etc.  
  • Recruit a transplanted patient or waitlisted patient to assist with QIA and/or an NPR.  
  • Submit initial self-reporting tool/root cause analysis via the SurveyMonkey link provided by the Network  
  • Implement Network-identified interventions from the Transplant LAN.  
  • Review Transplant Coordination QIA in QAPI. |
| March    | • Update the Internal Transplant Tracker to identify where patients are in the 6-step process.  
  • Submit the February Monthly Reporting Form to the Network via the provided SurveyMonkey link.  
  • Provide transplant education to all staff using the staff-specific [ASCENTTOTRANSPLANT.org](http://ASCENTTOTRANSPLANT.org) project video.  
  • Ask patients who are refusing transplant to complete the Why Not Consider Transplant—Patient Refusal Form.  
  • Provide transplant education to all patients.  
  • Identify a transplanted patient or waitlisted patient to assist with QIA and/or an NPR.  
  • Attend the NCC Transplant LAN on March 19.  
  • Review Transplant Coordination QIA in QAPI. |
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| April | • Update the *Internal Transplant Tracker* to identify where patients are in the 6-step process.  
• Submit March Monthly Reporting Form to the Network via the provided Survey Monkey link.  
• Host a transplant waitlist Lobby Day and include a transplanted patient, a patient already on the waitlist, or the caregiver of a transplanted patient to participate.  
• Continue providing patient education.  
• Implement Network identified interventions from the Transplant LAN.  
• Initiate NPR activities.  
• Review Transplant Coordination QIA in QAPI. |
| May   | • Update the *Internal Transplant Tracker* to identify where patients are in the 6-step process.  
• Submit April *Monthly Reporting Form* to the Network via the provided Survey Monkey link.  
• Continue providing patient education.  
• Host Lobby Day if not completed in previous month.  
• Attend the NCC Transplant LAN on May 21. |
| June  | • Update the *Internal Transplant Tracker* to identify where patients are in the 6-step process.  
• Submit May *Monthly Reporting Form* to the Network via the provided Survey Monkey link.  
• Continue providing patient education.  
• Host Lobby Day if not completed in previous month.  
• Implement Network identified interventions from the Transplant LAN.  
• Review Transplant Coordination QIA in QAPI.
## QIA Timeline: Required Adherence (cont.)

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| July    | • Update the *Internal Transplant Tracker* to identify where patients are in the 6-step process.  
• Submit June *Monthly Reporting Form* to the Network via the provided SurveyMonkey link.  
• Share best demonstrated practices with the Network via monthly self-reporting.  
• Continue providing patient education.  
• Host Lobby Day if not completed in previous months.  
• Attend the NCC Transplant LAN on July 16.  
• Review Transplant Coordination QIA in QAPI. |
| August  | • Update the *Internal Transplant Tracker* to identify where patients are in the 6-step process.  
• Submit *July Monthly Reporting Form* to the Network via the provided SurveyMonkey link.  
• Implement Network identified interventions from the Transplant LAN.  
• Continue providing patient education.  
• Host Lobby Day if not completed in previous months.  
• Review Transplant Coordination QIA in QAPI. |
| September | • Update the *Internal Transplant Tracker* to identify where patients are in the 6-step process.  
• Submit August *Monthly Reporting Form* to the Network via the provided SurveyMonkey link.  
• Attend the NCC Transplant LAN on September 17.  
• Review Transplant Coordination QIA in QAPI. |

*Never use patient names or MPI numbers*
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 identify, 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
Meeting the Requirements: Steps For Success

- Utilize an internal transplant tracker.
- Complete and return the contact form to the Network.
- Attend all ESRD NCC LAN meetings and implement interventions.
- Complete and submit the initial reporting form provided by the Network.
- Submit the monthly reporting form to the Network by the 10th of each month.
- Build a relationship with a contact person at a local transplant center, nephrologist office, and local hospital.
Meeting the Requirements: Steps For Success

• Identify suitable transplant patients, identify interest, and refer.
• Share the monthly activities and educational materials that are provided by the Network with patients, family members, staff and caregivers.
• Host a Lobby/educational Transplant Day.
• Identify barriers early and assist patients through the 6-step process.
• Develop and implement successful processes to increase the opportunity for future sustainability.
Resources

• Link to a disparity resource from CMS—Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries.
  – HealthEquityTA@cms.hhs.gov.
  – www.ascenttotransplant.org

• Link to the CMS Conditions for Coverage
Questions
Thank you!

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