



DRIVERS FOR HOME DIALYSIS

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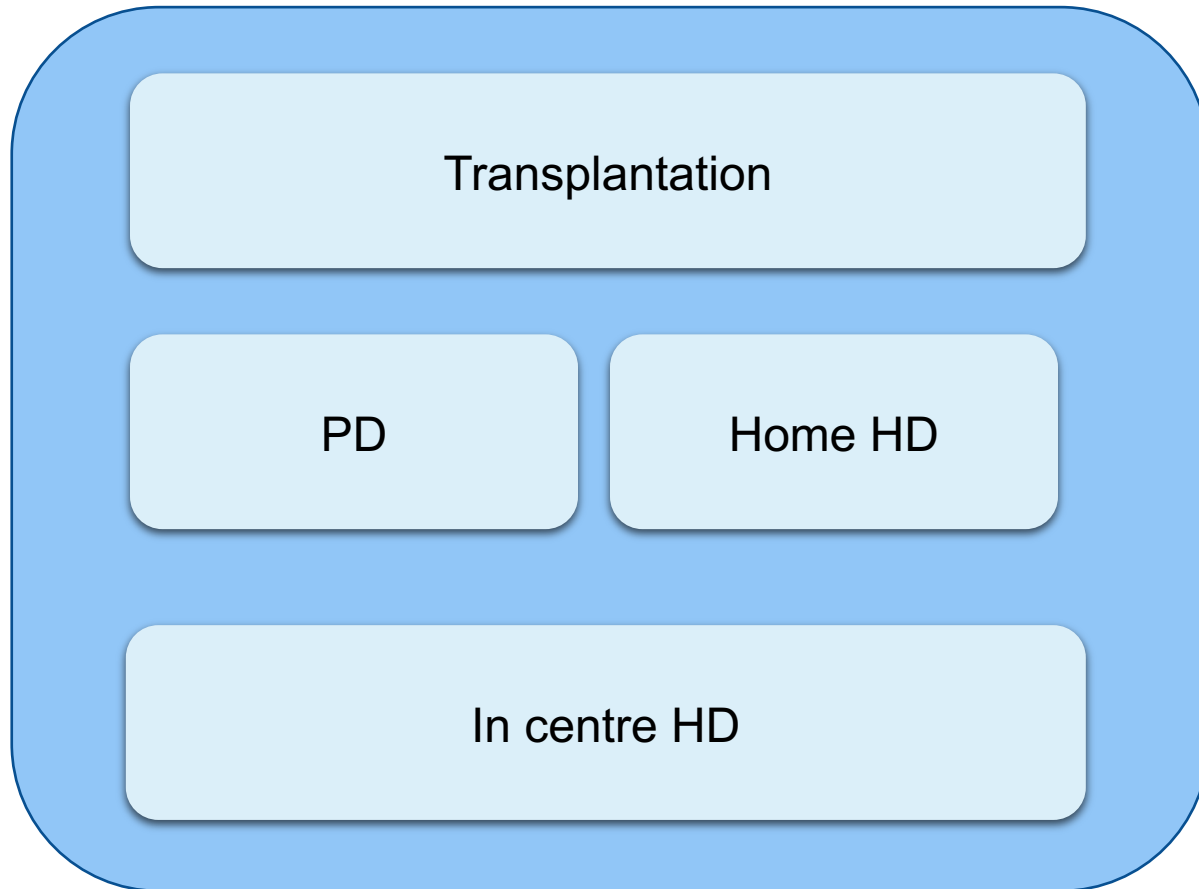
DISCLOSURES

- Fresenius Medical Care, Scientific Advisory Board, Speaker fees
- Baxter UK and Europe, Speaker fees
- FMC support to institution for research
- Clinical Director, Internal Medicine National Programme of Care, NHS England Improvement
- Clinical SRO, Renal Services Transformation Plan, NHSE/I

OUTLINE

- Drivers influencing home dialysis uptake
 - Strategic
 - Socioeconomic
 - National
 - Stakeholders – public, patients & professionals
 - Institutional
 - Individual – patient & professional
- The influence of ‘policy’ on home dialysis
- What is the ideal modality distribution?

AT WHAT LEVEL CAN WE INFLUENCE THIS DISTRIBUTION?



National or regional

Facility

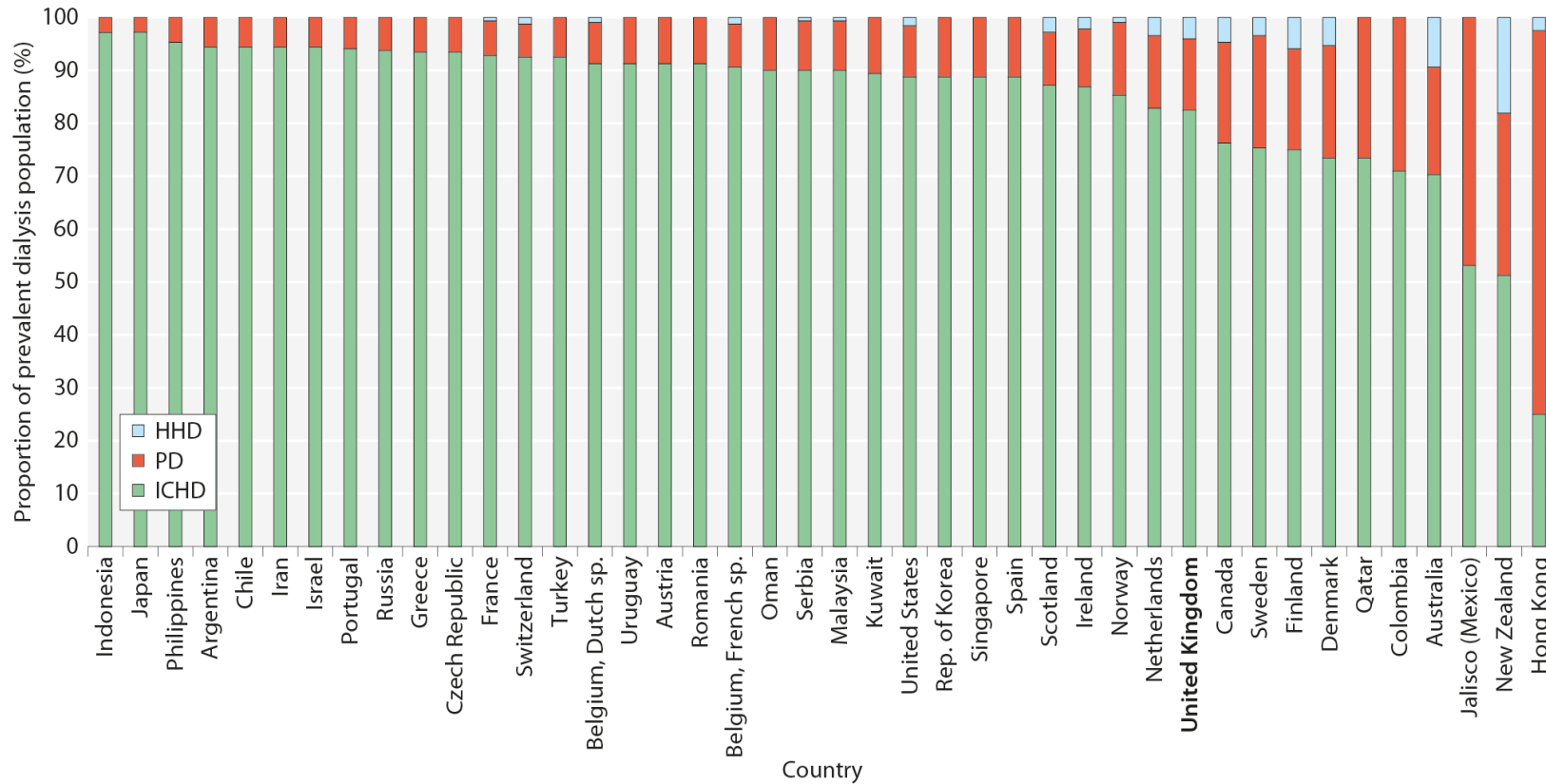
Individual

STRATEGIC (EXTERNAL NATIONAL) DRIVERS

- Availability
 - Water
 - Power
 - Infrastructure
 - Equipment
 - Consumables
- Affordability
 - The context of national health and well being priorities
 - Are there different challenges between high, medium and low income economies?
- Acceptability

VARIATION: BETWEEN NATIONS

Figure 13.16. Dialysis modality use by nation, 2014



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NATIONAL POLICY DRIVERS

- Health system
 - Targets
 - Financial incentives
- Professional
 - Guidelines
 - Improvement science
- Society
 - Equity
 - Demographics e.g. age
 - Comorbidity
 - Ethnicity
 - Health literacy
 - Technology

Technology as an enabler

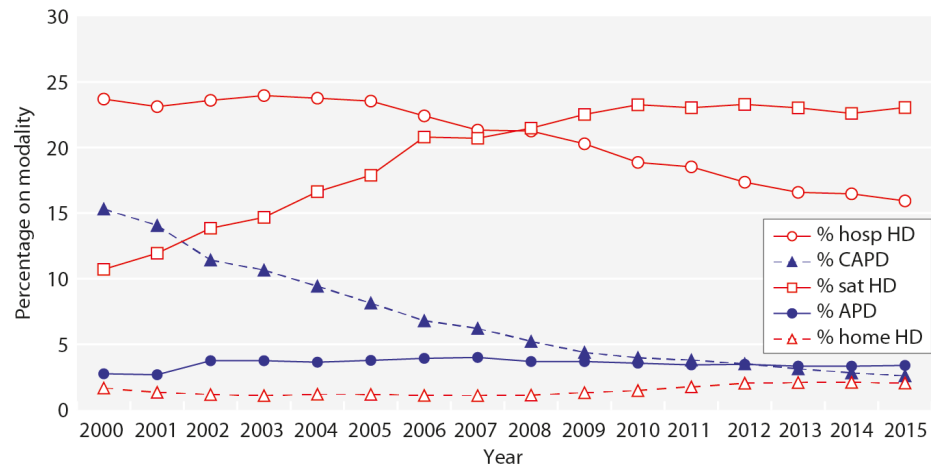
Improved outcomes
Change process
Sustainability – e.g. green
Communications
Knowledge transfer

VIRTUE OR NECESSITY?

- The overriding drivers affecting uptake and distribution of renal replacement therapy are national infrastructure investment and the role of private provision

Figure 2.10. Detailed dialysis modality changes in prevalent RRT patients from 2000–2015

*Scottish centres excluded as information on satellite HD was not available



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Yearly incidence and prevalence trend of renal replacement therapy patients in 2007-2013

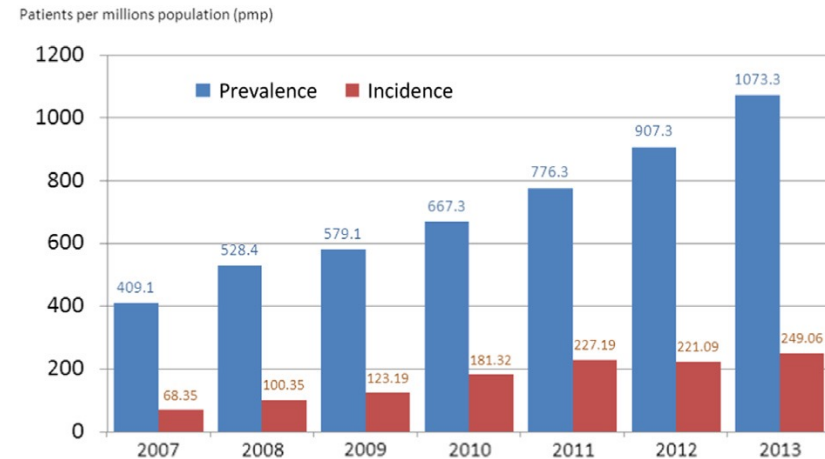


Figure 1. Yearly incidence and prevalence of patients starting renal replacement therapy in 2007 to 2013. Adapted from Thailand Renal Replacement Therapy Registry. Chuengsamarn et al Semin Nephro 2017

STAKEHOLDER POLICY INITIATIVES

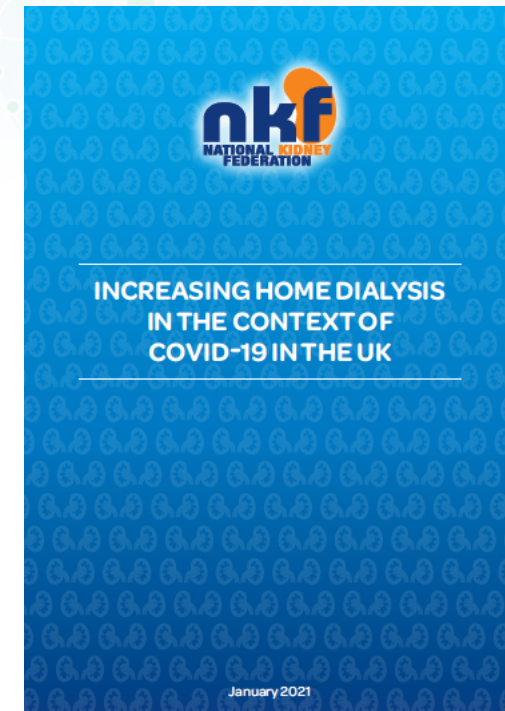
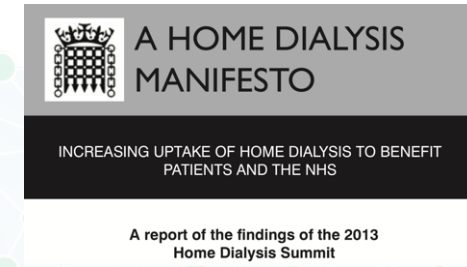
NICE guidance

Home HD Technology appraisal guidance
[TA48] Published date: 26 September 2002

PD Clinical guideline [CG125] Published date: 27 July
2011

All modalities NICE guideline [NG107] Published
date: 03 October 2018

COVID-19 rapid guideline: dialysis service delivery
NICE guideline [NG160] Published date: 20 March
2020 Last updated: 11 September 2020



NATIONAL POLICY INITIATIVES

US Advancing American Kidney Health

Principle driver – cost of ESRD programme in USA

Vision

Reduce incidence of ESRD

Double number of organs transplanted

Increase prevalence of home dialysis


Mechanism

AAKH payment model

Incentivisation

FMC Press release 23/02/2021

Reported 14% growth in home dialysis treatments and 37% increase in home HD




Executive Order on Advancing American Kidney Health

10 July 2019

[whitehouse.gov/presidential-actions/executive-order-advancing-american-kidney-health](https://www.whitehouse.gov/presidential-actions/executive-order-advancing-american-kidney-health)


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<https://twitter.com/i/moments/1057661851759230978>

Goals



- 80% of incident ESRD patients receive either home dialysis therapy or transplantation by CY 2025
- Standardize organ procurement reduce percentage of discarded organs
- Remove financial barriers for living kidney donors (up to \$5K for lost wages/child care)
- Encourage development of the artificial kidney
- Restructure payment models to incentivize prevention, home therapy/transplantation

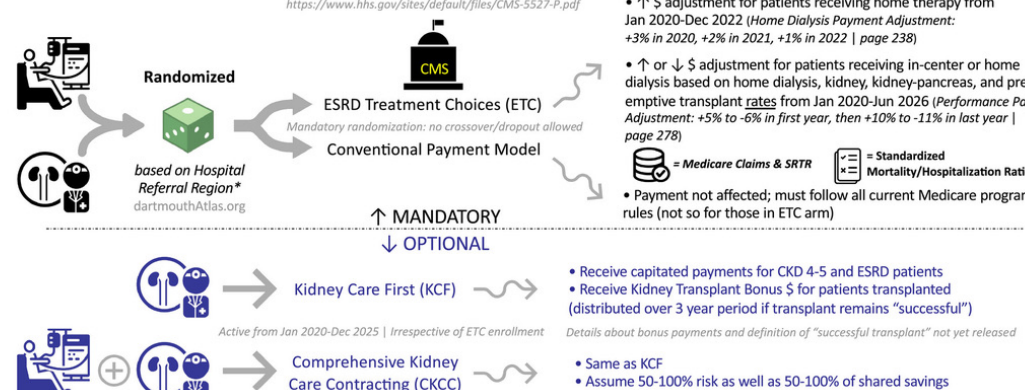
Payment Models



ETC | KCF
CKCC Graduated
CKCC Pro/Global

* Providers in the state of Maryland will be enrolled by a different method

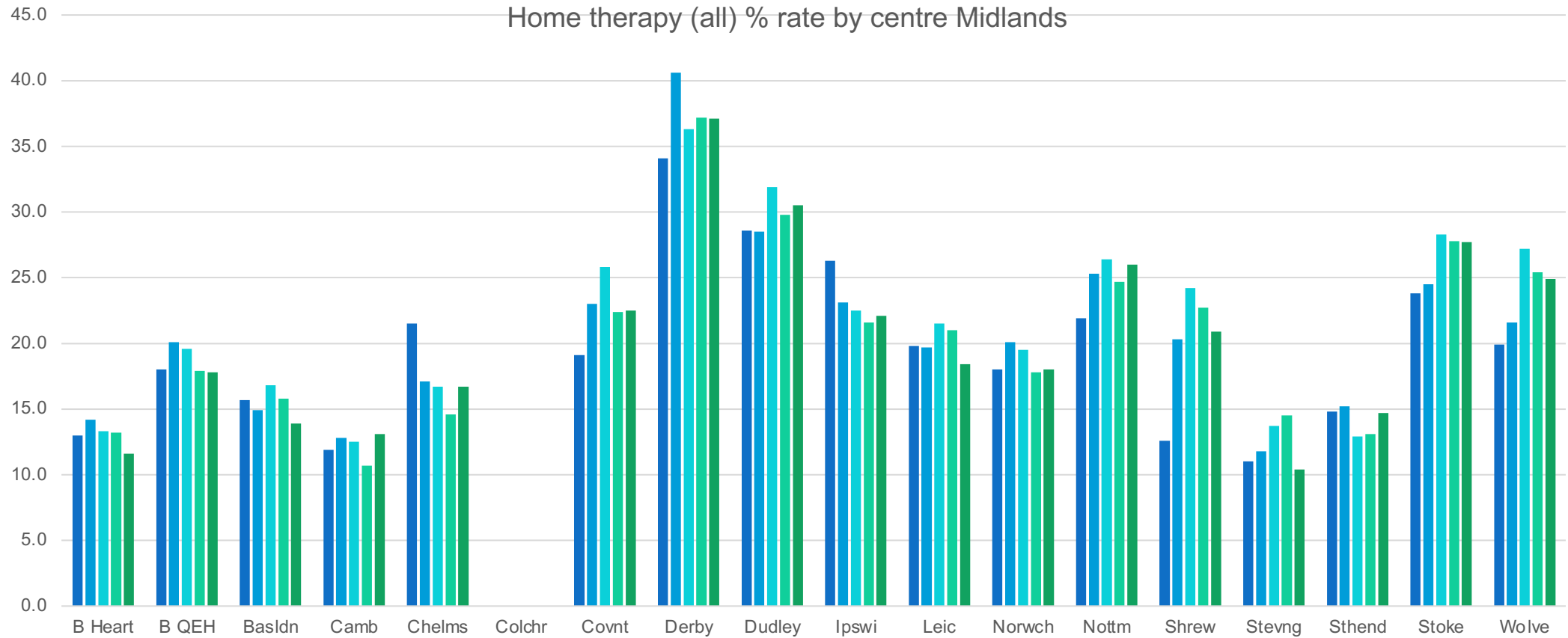
<https://www.hhs.gov/sites/default/files/CMS-5527-P.pdf>



The flowchart illustrates the randomization process for ESRD Treatment Choices (ETC) and Conventional Payment Model. It starts with a 'Randomized' box based on 'Hospital Referral Region' (source: dartmouthAtlas.org). This leads to two paths: 'ESRD Treatment Choices (ETC)' and 'Conventional Payment Model'. The transition to ETC is marked as 'MANDATORY' (upward arrow) and to the Conventional model as 'OPTIONAL' (downward arrow). The ETC path includes a CMS icon and a note: 'Mandatory randomization: no crossover/dropout allowed'. The Conventional path includes a note: 'Payment not affected; must follow all current Medicare program rules (not so for those in ETC arm)'. Below the flowchart, two additional paths are shown: 'Kidney Care First (KCF)' and 'Comprehensive Kidney Care Contracting (CKCC)'. KCF is noted as 'Active from Jan 2020-Dec 2025 | Irrespective of ETC enrollment' and includes a note: 'Receive capitated payments for CKD 4-5 and ESRD patients' and 'Receive Kidney Transplant Bonus \$ for patients transplanted (distributed over 3 year period if transplant remains "successful")'. CKCC includes a note: 'Same as KCF' and 'Assume 50-100% risk as well as 50-100% of shared savings'. A legend indicates that a stack of coins icon represents 'Medicare Claims & SRTTR' and a checkmark icon represents 'Standardized Mortality/Hospitalization Ratios'. A final note states: 'Details about bonus payments and definition of "successful transplant" not yet released'.



VARIATION: WITHIN NATIONS OR REGIONS



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PATIENT FLOWS HOME HD DERBY 2017

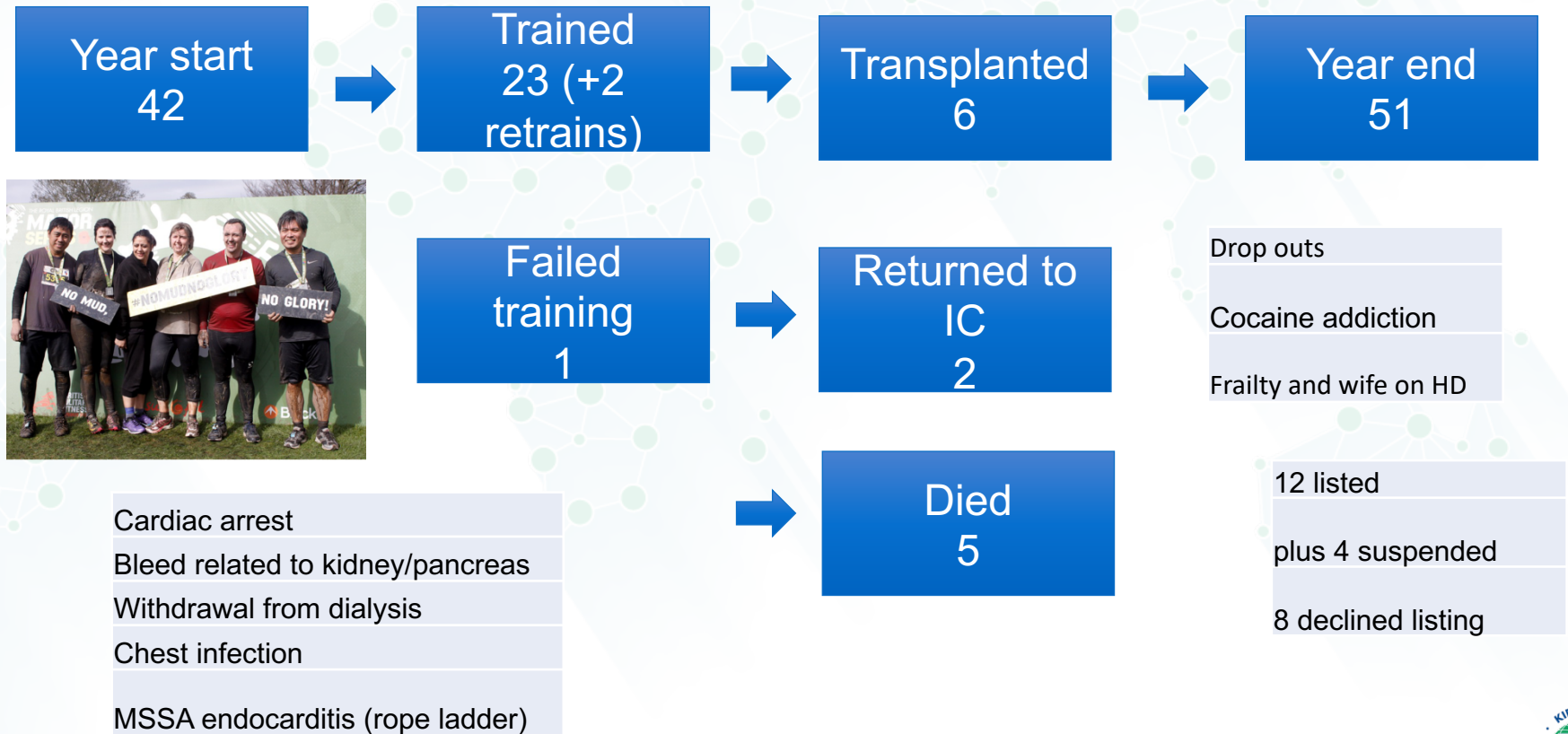


- Thinking about process
 - Recruit – Train - Retain

Current programme

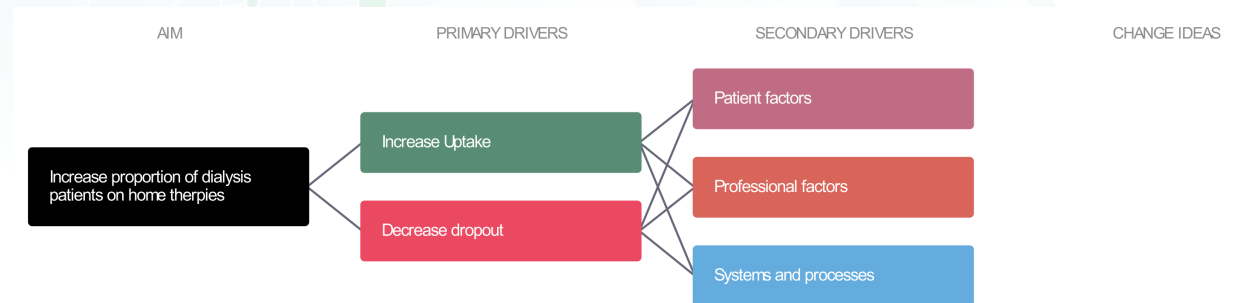
65 on HHD 69 on PD
206 IC HD 39 Satellite
HD

- Leadership
- Engagement
- Technology
- Process
- Agility
- Flexibility
- Integration
- DIKAR



DO WE UNDERSTAND VARIATION WITHIN 'SYSTEMS'?

- If a 'national' system was perfect it would expect to see
 - Minimal variation between providers
 - Evidence of continuous improvement
- What characterises 'high performing' facilities?
 - What is high performance?
 - Balancing measures
 - Leadership – patients & HCP
 - Culture
 - Shared vision, SDM
 - Internal systems
 - An improvement, rather than target, mindset

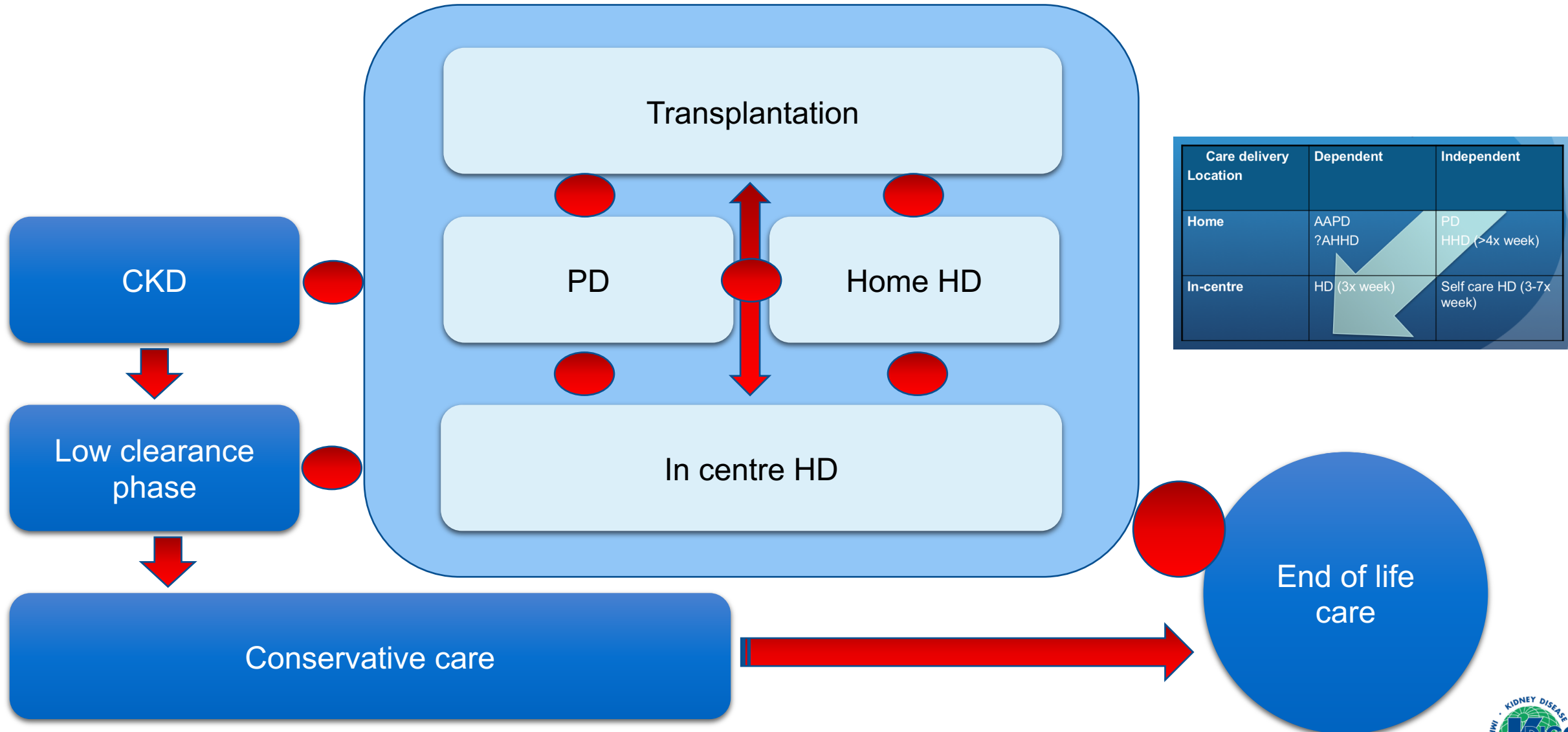


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WHAT IS THE OPTIMAL DISTRIBUTION OF THERAPY?

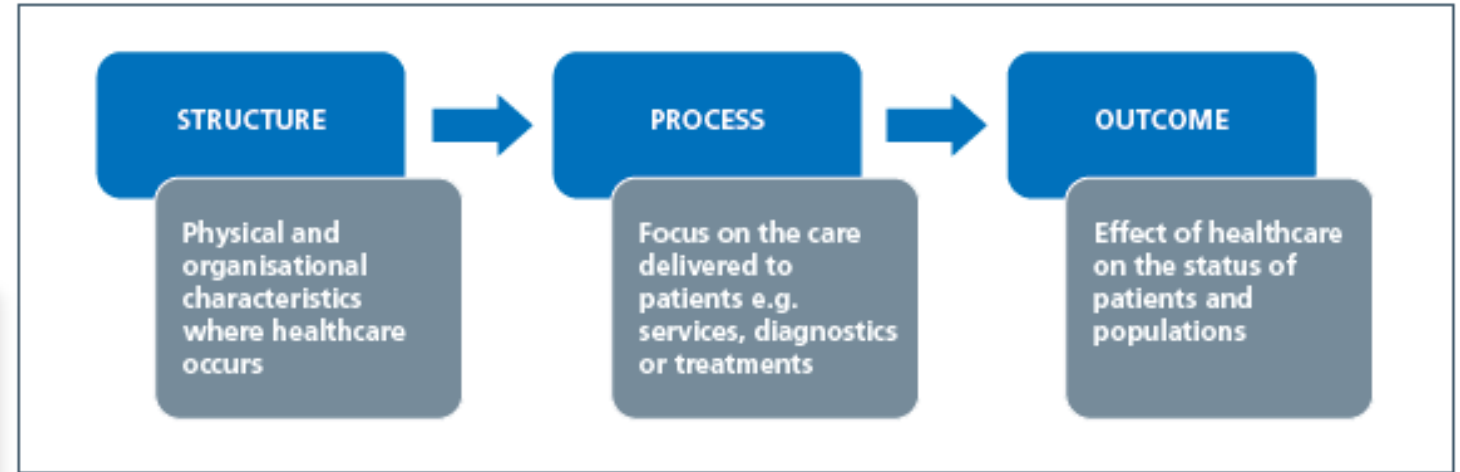
- The impossible question
 - Home dialysis should be used in between 0 and 100% of people on dialysis
- Principles
 - What should be included in the metrics?
 - Transplant – Home HD – PD – Shared/self care HD – Assisted PD – In centre HD
 - Competition or synergy?
 - Measure on a population basis not by facility
 - Measure to improve, not judge
 - Measure to improve 'value' – patient, clinical and resource outcomes/process plus balancing measures
- Should the focus be on the transition points?

THE PATHWAY: A FOCUS ON TRANSITION NOT DESTINATION

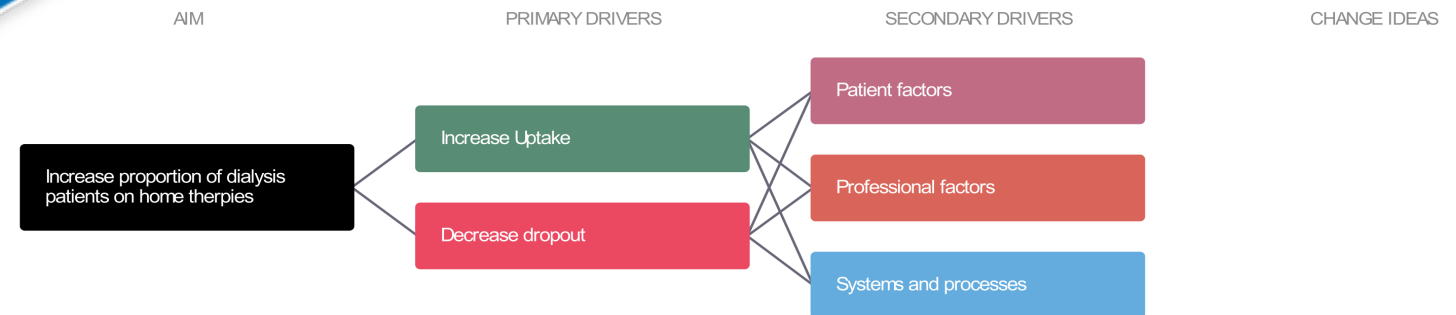


How? TOP DOWN VISION, BOTTOM UP IMPLEMENTATION

Figure 1: The Donabedian model for quality of care



Balancing measures



CONCLUSION: WHERE TO NOW?

Transplantation 50-60%

PD 10-12.5%

Home HD 10-12.5%

In centre HD 20-25%

Develop National VALUE agenda

Focus on Facility/Population QI

Improve uptake and retention for individuals



Thank you for listening

Questions, comments and
challenge always welcome