Reducing Hospital Admissions and Emergency Department Visits

Learning and Action Network (LAN)

May 16, 2023

Facilitator: Gayla P. McClain, MSN, MBA, RN
ESRD National Coordinating Center

Meeting Logistics

Call is being recorded.

All participants are muted upon joining the call.

We want to hear from you.

Type questions and comments in the “Chat” section, located in the bottom-right hand corner of your screen.

Meeting materials will be posted to the ESRD NCC website.

Who Is On The Call?

- Dialysis Facility and Transplant Professionals
- ESRD Network Staff
- Centers for Medicare & Medicaid Services (CMS) Leadership
- Patients and Families

Key Objectives for Today

Provide an overview of QI strategies to help reduce hospitalizations.

Identify primary and secondary drivers from the hospitalization change package to reduce admissions and emergency room visits.

Identify strategies to empower patients to collaborate with their healthcare team in reducing avoidable hospital admissions and emergency room visits.

Ways to spread best practice from today's LAN

- Listen and share your approaches/experiences via Chat
- Identify how shared information could be used at your facility
- Apply at least one idea from today's LAN at your facility
- Commit to sharing your learnings with other colleagues

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.

Questions To Run On

- What “ah ha” concepts will I hear today that I can introduce to my organizations’ leadership team?
- How might my organization incorporate ideas from the hospitalization change package to reduce our admission rate?
- How might my organization adapt new approaches in empowering our patients to reduce avoidable ER visits and hospital admissions?

Polling Question #1

Are you familiar with the ESRD NCC hospitalization change package?

ESRD NCC Change Packages

A Change Package
To Increase
Home Dialysis Use

Key Change Ideas for Dialysis
Facilities to Drive Local Action

A Change Package
To Improve Patient
Experience of Care
(Grievances and Access to Care)

Key Change Ideas for Dialysis
Facilities to Drive Local Action

Released 2022

A Change Package To
Improve Health Equity

Key Change Ideas for Dialysis
Facilities to Drive Local Action

Released 2023

A Change Package
To Increase Kidney
Transplantation

Key Change Ideas for Dialysis
Facilities to Drive Local Action

A Change Package
To Increase
Vaccinations

Key Change Ideas for Dialysis
Facilities to Drive Local Action

Released 2022

Hospitalization Change Package

A Change Package To Reduce Hospitalizations

Key Change Ideas for Dialysis Facilities to Drive Local Action

Released 2022

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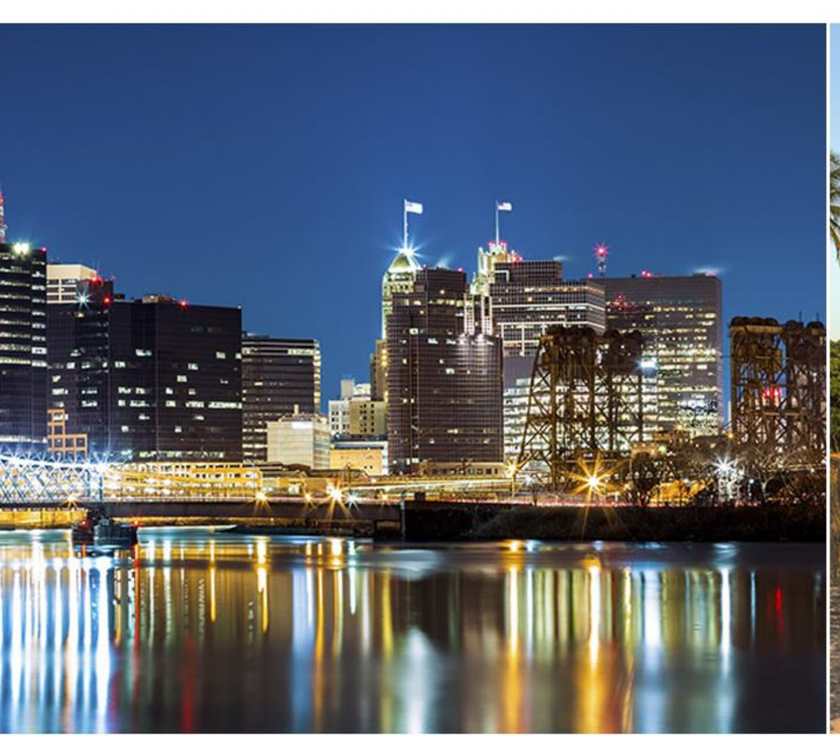

ESRD Network 3

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Quality Improvement Director

Reducing Hospitalizations

Fresenius Medical Care / Liberty Dialysis
Hammonton Clinic 7355

Tracey Santora RN BSN

PDSA Cycle

Plan

- Reduce hospitalizations by 4%.
- Improve team communication and involvement. Create a culture that contributes to low hospitalization rates.
- Track/trend/analyze data. Track hospitalizations and related measures.

Act
- What changes are to be made?
- Next cycle?

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

Study
- Analyse data
- Compare results to predictions
- Summarise what was learned

Do
- Carry out the plan
- Document observations
- Record data

Do

- Educate staff on action plan in place and goal for the clinic.
- Identify RN's responsible to complete post hospitalization checklist.
- Complete daily huddles with staff to inform them of any patient admissions or discharges. Identify any patient issues/concerns that could lead to a hospitalization.
- Obtain discharge summaries within 24 hours.
- Implemented action steps and monitor which included weekly rounding with MD while visualizing fluid management dashboard. Monthly MD rounds with the entire IDT to discuss patient centered care and address all patients concerns issues identified.

Change Package Elements

- Create a culture that contributes to low hospitalization rates.
- Establish channels of communication to facilitate information.
- Track hospitalizations and related measures.
- Provide patients with knowledge, so they can play an active role in staying out of the hospital.

A Change Package To Reduce Hospitalizations

Key Change Ideas for Dialysis Facilities to Drive Local Action

Released 2022

Create a post hospitalization culture

- Keep the focus on patient centeredness.
- Provide a culture that contributes to low hospitalization rates.
- Keep communication that facilitates information sharing.

Implement Continuous Quality Improvement

- Track/trend/analyze hospitalizations. Reviewed hospitalization trending workbook and hospitalization discharge analysis. Over the past 12 months we reviewed to identify the root cause of admissions. Focused on top 3 diagnosis.
- Engage MD, CM, CRN, RN, PCT, SW, RD and AA in review of the data and development of interventions . Complete post hospitalization checklist. Continue weekly rounding with focus on EDW, BP, any labs drawn and follow up appointments.
- Review admission and discharge with patients. Give out *Red Flag* education.

Continually Follow up on Hospitalization

- Document track/trend hospitalization, ER visit, and missed treatments. Put into a ***root cause analysis tool*** to identify driving admission diagnosis.
- At each treatment ask patients “Have you been in the hospital since last your treatment?”
- Perform daily monitoring of absences / hospitalizations.
- Complete post hospitalizations checklist and scan into doc manager.
- Incorporate the Social Worker to monitor missed treatments with reason- address psychosocial and transportation issues. Create a culture of zero missed treatment.

Educate patients and staff

- Ask key questions, “Do you know why you were in the hospital?”
- Provide education post hospitalization for causes of the hospitalization to take an active role in staying healthy and how to stay out of the hospital. Follow up with appointments.
- Complete medication reconciliation with patient within next two treatments.
- Use printed materials that are easy to read and in the patients primary language. Utilize language line.
- Weekly rounds discuss labs, BP and EDW.

Study

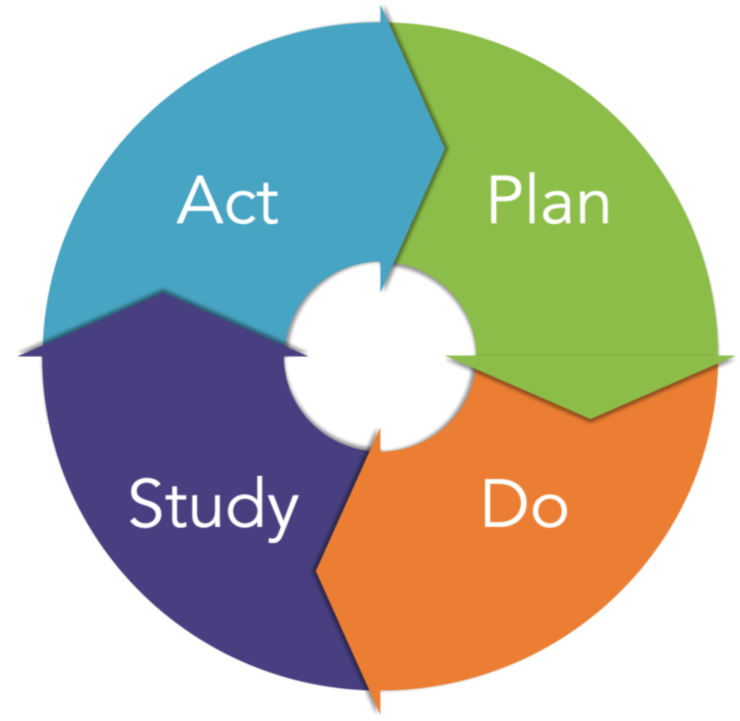
Reducing Hospitalizations

Measure	Baseline.Rate	Current. Rate	Goal.Rate	Goal.Met
ESRD Admissions	3.198	0.325	3.038	Yes
Unplanned Readmissions	0.100	0.000	0.095	Yes

Baseline Period: 01-Jun-2020 to 30-Apr-2021.
Current Period: 2022-05-01 to 2023-03-31.

- Data results hospitalization decreased
- Continue to implement process put in place

PDSA Cycle Cont'd



Act

- CM, CRN to continue to educate any new staff on clinic process
- Decrease # of hospitalizations.
- If initial PDSA cycle not successful reevaluate and repeat PDSA cycle for another 90 days.

Steps to sustain improvement

- Continue daily huddle, weekly rounds.
- Continue to complete post hospitalization checklist.
- Continue to provide educate to patients post hospitalization.
- Continue to foster open communication for staff and patients.
- Continue to track/ trend and analyze hospitalizations.

Post Hospitalization Checklist:

First treatment post- hospitalization

- Obtain hospital name and reason for admission
- Notify nephrologist of patient return and discuss plan for post hospitalization evaluation
- Draw HGB or any missed labs since last treatment.
- Confirm with MD if IV antibiotics are needed.
- Evaluate access and document in the patient's medical chart any infection, complication or procedures performed.
- Evaluate Fluid Management- complete fluid assessment, review EDW and consult nephrologist for new order if applicable
- Review with patient reason for hospitalization
- Verify Follow up appointments
- Document clinical note.

Post- Hospitalization Checklist:
Second treatment post-hospitalization

- Evaluate albumin/ nutritional status
- Evaluate HGB resume ESA per MD order update ESA order as necessary.
- Obtain discharge summary
- Confirm if patient was transfused.
- Obtain any cultures drawn within 24 hours of hospital admission.
- Complete a medication reconciliation and update medication list.
- Update the medical record with all diagnosis codes chronic and acute.
- Close absence and hospitalization record.

Questions?

ESRD Network 15

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Quality Improvement Director

Mor Kam, MSW, LCSW
DaVita Dialysis

Where we started

- Began working with the Network to examine our In-patient hospital use.
  - 24 patients in the denominator
  - One patient used was admitted to the hospital twice during the timeline
    - Once in October 2022
    - Once in January-February 2023

Patient Review

- Male
  - 56 years old
  - Began dialysis in August 2018
  - Went to the same hospital both times
    - One time for Sepsis (eight days in the hospital)
    - One time for Anemia (one day in the hospital)

What did we ask ourselves?

- Began by reviewing the Hospitalization Change Package
  - **Identified Primary Driver 4**: Educate Patients and Staff
  - **Identified Secondary Driver 4a**: Provide patients with knowledge, so that they can play an active role in staying out of the hospital.
    - Educate patients on key issues and related consequences that can result in hospitalization, e.g., missed treatment, fluid overload, pneumonia, infection related to vascular access.
    - Educate as opportunities arise, e.g., after an infection or a hospitalization.
    - Include the family in the education.
    - Following the patient’s hospitalization, ask key questions, such as, “Do you know why you were in the hospital?” Address specific reasons for the hospitalization with the IDT, e.g., dietitian to follow up with patients for fluid overload

What did we use?

UPI/MR#: ______________________________

Staff Name and Title: ___________________________

Date and Time: ________________________________

SIT DOWN – DON'T STAND

When your patient gets out of the hospital, pull up a chair.

Reducing Hospitalizations - Questions About You

Why were you in the hospital?

Based on the specific reason for your hospitalization, do you feel your health problem is resolved or stabilized?

What is the most overwhelming part of being out of the hospital (if any)?

Are you anxious or nervous about needing to go back to the hospital for the same reason? If so, what makes you think you might need to? What would make you feel less nervous or anxious (if anything)?

Did you receive any paperwork from the hospital when you were discharged? Is there anything in the paperwork that you don't understand?

What did we use?

ESRD Networks 7, 13, 15, 17, 18

We're Not Being Nosy – We Care!

In order to provide you with the best care we need to know certain things that are happening in your life.

Take note of the items below and be sure to alert your care team if:

- You have been in the **hospital**
- You have been to the **emergency room**
- You have been to a **specialty doctor**
- You have **started** a new **medication**(s) for any reason
- You have **stopped** a **medication**(s) for any reason
- You felt like going to the **emergency** room but didn't go
- You were seen by an **urgent care** center
- You experienced any **bleeding** for any longer than 10 minutes from anywhere (like a cut, nosebleed, or bleeding gums)
- You have any new access **pain**, **changes**, or **Problems**
- You need assistance with obtaining your medications or other health related equipment such as oxygen, walker, or a cane.

What did we use?

Date/Initial when checklist is completed: ______________________

Complete prior to first post-hospitalization treatment:

- ☐ Request all medical records for the hospital
- ☐ Enter any additional co-morbidities in Electronical Medical Record (EMR)

Complete during first post-hospitalization treatment:

- ☐ Contact physician to discuss treatment orders/protocols and medication prescription changes, and enter all changes/new orders in EMR.
  - ☐ Treatment order changes (e.g. vascular access plan, target weight, dialysate bath, treatment time, etc.)
  - ☐ In-center or Home administered medications (new, discontinued, change in dose)
  - ☐ IV/IP antibiotics/blood cultures
  - ☐ Labs to be drawn on return from hospital (i.e. Hb, Fer, TSAT, Alb, etc.)
- ☐ Initiate home medication review.
  - ☐ Ask patient to bring in all new medication bottles.
  - ☐ Update any changes in the medication list in the EMR.
  - ☐ Coordinate with patient's prescriber/pharmacy to fill any updated prescriptions.
- ☐ Follow your facility's Fluid Management Pathway.
- ☐ Conduct physical assessment to identify any new issues or complications (e.g., vascular access, foot check)

Complete during first week post-hospitalization:

- ☐ Follow up to obtain discharge summary if not received.

What did we learn?

- We met in TQM to review patient and other patients to discuss.

HSAG

ESRD Networks 7, 13, 15, 17, 18

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)
QUALITY IMPROVEMENT ACTIVITY (QIA) MONITORING FORM
Improving Transitions of Care

Facility Name: ______________________________

Date of QAPI/QA Meeting: ____________________

Attendees: ____

QIA Monitoring Metrics for Month	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.
Number of patient hospitalizations							
Number of patients discharged from the hospital that were readmitted in 30 days for same reason							
Number of patient Emergency Room (ER) Visits (not resulting in a hospitalization)							

1. **Which QIA metric(s) did the facility work on this month:**
   - ☐ **Reducing Hospitalizations**
   - ☐ **Reducing Readmissions**
   - ☐ **Reducing ER visits**
   - ☐ **Other:** ____
2. **What activities did the facility implement during the last month? (ex: created and started using new tracker)**
3. **What barriers still remain? What new barriers were identified?**
4. **Provide feedback from the QAPI/QA attendees:**
5. **What is the facility's plan to address the identified barriers during the next month?**

What are we doing differently?

- Began:
  - Asking patients about cough
  - Reviewing fluid status with patients
    - Education from the ESRD Network
    - Education from DaVita
    - All team approach
    - Motivational discussions about reducing fluid intake
    - Offer additional treatments now that staffing is stable
    - Continue ongoing communication with family
      - Follow recommended restrictions
      - Report symptoms early

Questions, Answers, and Discussion

Polling Question #2

Now that you have heard this presentation, what is the likelihood that you will use ideas from the hospitalization change package?

Moving from Learning to Action…

- Share best practices from this presentation with your colleagues.
- Consider using the hospitalization changes package as a supplementary resource to improve your patient outcomes and overall patient experience of care.
- Empower your patients to be active participants in helping your facility reduce avoidable hospital admissions and emergency room visits.

Reminder: May 25th Home Dialysis LAN Call

Register Today!

In partnership with the Centers for Medicare & Medicaid Services (CMS), the End Stage Renal Disease National Coordinating Center invites you to join us for a:

Home Dialysis

Learning and Action Network Call

By the end of this call, attendees will identify:

1. Barriers to patients transitioning to home dialysis
2. Strategies to mitigate barriers to improving home dialysis transition rates

Who should attend?

This presentation is appropriate for all facility administration, and staff, including directors of operations, facility administrators, clinic managers, clinical coordinators, nurses, social workers, dietitians, transplant professionals, patients and families.

Meeting Date:

May 25, 2023
2:00-3:00 PM ET
This is a FREE WebEx event

Register today!
Click the link below:
https://tinyurl.com/5n7rzst7

1.844.472.4250 | NCCInfo@hsag.com | www.esrdncc.org | Facebook: ESRD.NCC | Twitter: @ESRDNCC

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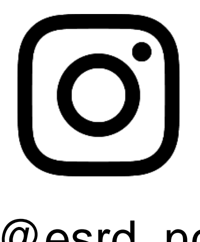

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Thank you!

Please take a few minutes to respond to the post-call survey.

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