Expert Teams – Hospitalization

Case-Based Learning & Mentorship

Tuesday, June 20, 2023

Facilitator: Stephanie Hull, ESRD National Coordinating Center

Meeting Logistics

- Call is being recorded
- Participants can unmute themselves
  - Please stay on mute unless you are speaking
  - Do not place the call on “hold”
- Everyone is encouraged to use the video and chat features
- Meeting materials will be posted to the ESRD NCC website.

Meeting Guidelines

INTRODUCE YOURSELF BEFORE SPEAKING

KEEP PATIENT-SPECIFIC INFORMATION CONFIDENTIAL

BE WILLING TO SHARE SUCCESSES AND DIFFICULTIES

BE OPEN TO FEEDBACK

ASK THE DIFFICULT QUESTIONS

RESPECT OTHERS

USE "…AND" STATEMENTS

KEEP TO TIME LIMITS

Who Is On The Call?

- Clinician and Practitioner Subject Matter Experts
- Dialysis Facility and Transplant Professionals
- ESRD Network Staff
- Kidney Care Trade Association Members
- Centers for Medicare & Medicaid Services (CMS) Leadership

What are Expert Teams?

Participants from varying levels of organizational performance, each with lived experience and knowledge, come together to support continual learning and improvement

Help others learn faster by sharing what worked and what didn't work around a particular case, situation, or circumstance

Bring the best possible solutions to the table

What is Case Based Learning?

Describes an individual situation (case)

Identifies key issues around the problem, barrier, or missed opportunity

Analyzes the situation using relevant processes meant to mitigate the problem or situation

Recommends a course of action for the situation, including implementing PDSA cycles and process modifications

Questions to Run On. . . How Might We

- Provide patients the knowledge and skills to prevent unplanned hospitalizations?
- Improve communication between hospitals and dialysis facilities to reduce hospital readmissions?
- Assist patients with unstable support systems or financial issues that may impact hospitalizations and Emergency Department visits?

Guest Expert Presentation

Kam Kalantar-Zadeh, MD, MPH, PhD
Professor of Medicine, Pediatrics, Public Health, and Nursing Sciences, University of California

Transitions of Care in Chronic Kidney Disease

Kam Kalantar-Zadeh, MD, MPH, PhD

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Professor of Medicine & Chief, Division of Nephrology and Hypertension
Vice Chair for Research and Innovation, Dept. Medicine
Harbor-UCLA Medical Center
Chair, Kidney Health Workgroup, Los Angeles County Dept. Health Services

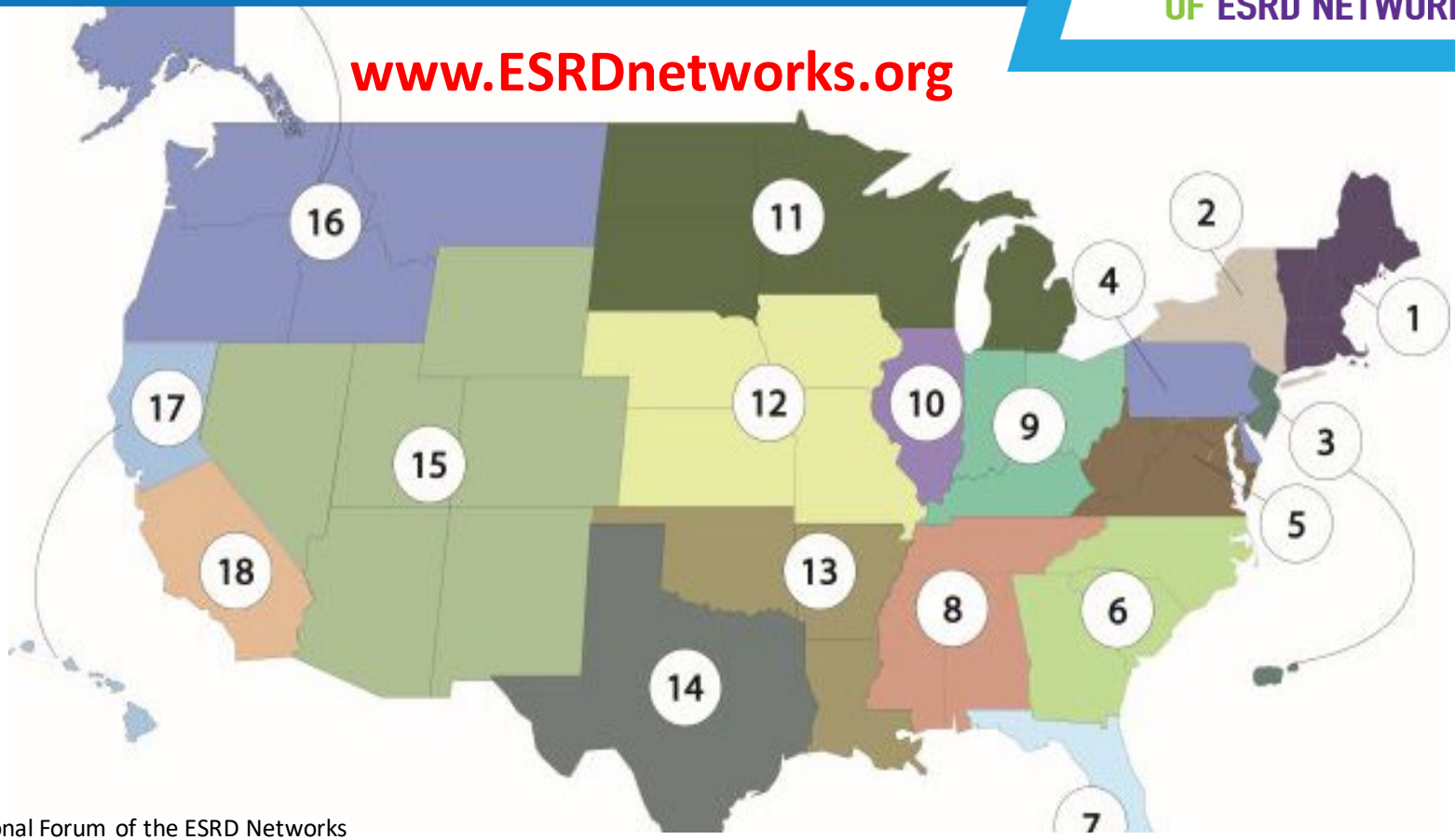
President-Elect
National Forum of the ESRD Networks

Editor-in-Chief
Journal of Renal Nutrition

ESRD Network Organizations

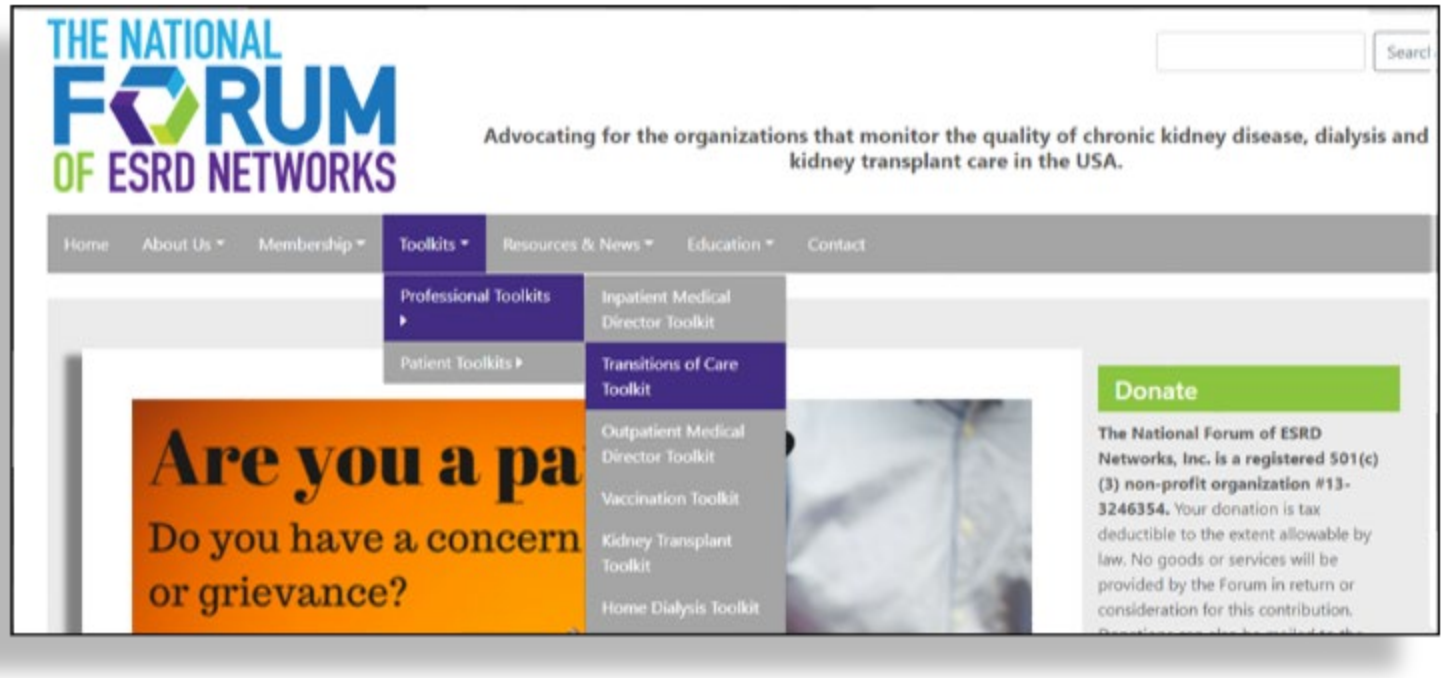
THE NATIONAL FORUM OF ESRD NETWORKS

www.ESRDnetworks.org



The Toolkits of the National Forum of ESRD Networks are available for free for all kidney care community members and stakeholders

https://esrdnetworks.org/toolkits



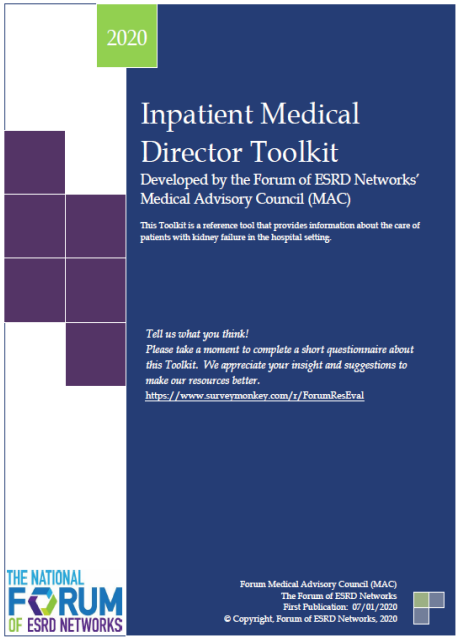
Forum's Toolkits

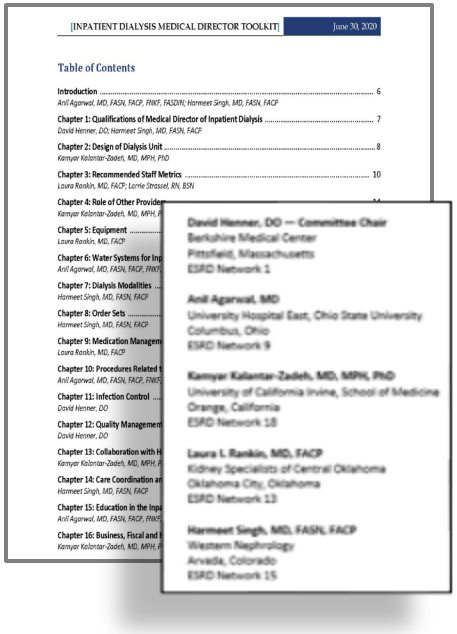
What are ESRD Forum's Toolkits?

"ESRD Forum's toolkits are **useful** and **pragmatic resources** for colleagues and other stakeholders including those who work with or have topic related inquiries for the 18 congressionally mandated ESRD Networks and their affiliates and associates [are *not* meant to be guidelines or textbooks or ultimate/authoritative manifestos]"

Forum's toolkits are freely available the Forum website ESRDnetworks.org/toolkits

Inpatient Dialysis Medical Director (IMDT)





Released: 11/2020 → ***Peer-reviewed article published in AJKD in 2021***

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Medical Advisory Council (MAC)
The National Forum of the ESRD Networks
www.ESRDnetworks.org

Inpatient Dialysis Medical Director (IMDT)

THE NATIONAL FORUM OF ESRD NETWORKS

Released: 11/2020 → ***Peer-reviewed article published in AJKD in 2021***

Policy Forum Editorial — AJKD

Inpatient Dialysis Services: Nephrologist Leadership and Improving Quality and Safety

Kamyar Kalantar-Zadeh, David Henner, Ralph Atkinson III, Donald Molony, Anil Agarwal, Laura I. Rankin, Harmeet Singh, Robert J. Kenney, Louis H. Diamond, and Keith C. Norris, on behalf of the Medical Advisory Council of the National Forum of ESRD Networks

In contrast to outpatient dialysis facilities in the United States, which are required by the Centers for Medicare & Medicaid Services (CMS) under the Conditions for Coverage for ESRD Facilities to have a qualified medical director who oversees facility quality and operations,[1-3] inpatient dialysis programs have no such requirement. Despite the high level of complexity of inpatient dialysis therapies, currently there is no CMS or other governing body regulation that describes the qualifications and responsibilities for physician leadership oversight for kidney replacement therapy (KRT) performed in hospitalized patients. Unlike outpatient dialysis care, which is closely regulated and overseen by CMS, both operationally and fiscally, CMS does not have direct jurisdiction over hospital activities such as inpatient dialysis services. Instead, hospital accreditation overseeing entities including The Joint Commission (TJC) and state Departments of Health more commonly review the quality and safety of inpatient dialysis practices during periodic hospital surveys. However, TJC evaluated privileges and responsibilities to oversee the day-to-day clinical operation. This includes oversight of the dialysis and intensive care personnel performing dialysis, as well as the presence of practicing nephrologists who order dialysis and, in many instances, continuous KRT (CKRT) treatments for hospitalized patients if CKRT is managed by nephrologists.

Currently, there are several different models in place for how hospitals and medical centers provide dialysis in the inpatient setting. These include (1) contracted services between the hospital and a provider of acute dialysis services, which is the most common system at community hospitals and used at many larger medical centers; and (2) in-house dialysis services, which may also include a traditionally licensed outpatient hospital-based dialysis facility that also provides inpatient dialysis coverage or a dedicated inpatient-only facility that is not certified for ESRD care, staffed either by contracted staff or hospital employees. Inpatient provision of

Policy Forum highlights aspects of nephrology relating to payment and social policy, legislation, regulation, demographics, politics, and ethics, contextualizing these issues as they relate to the lives and practices of members of the kidney community, including providers, payers, and patients.

AJKD AMERICAN JOURNAL OF KIDNEY DISEASES

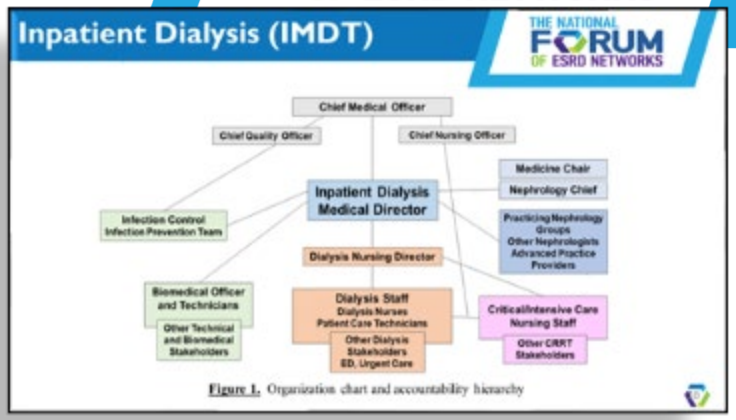


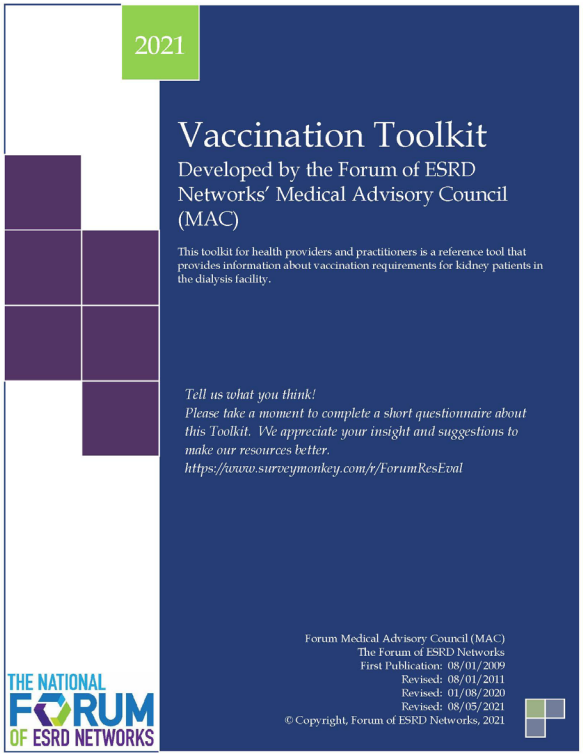
Figure 1. Organization chart and accountability hierarchy

Table 1. Comparison Between Inpatient and Outpatient Dialysis Medical Director Status

	Inpatient Dialysis Medical Director	Outpatient Dialysis Medical Director
Reporting status and accountability	Usually reports to CMO of the medical center	Reports to CMS with dotted reporting to the dialysis provider/owner
Immediate oversight	Medical center	ESRD networks, regional/county Department of Health, state Departments of Health
Ultimate oversight	TJC, via usually periodic surveillance (no a priori permission); state authorities in some states	CMS, via the Conditions for Coverage
Accreditation	Not defined	Across several areas: (1) CMS, (2) state licensing (as indicated), (3) certificate of need (as needed)
Biomedical and infection control	Infection Control Department of the hospital interacts with the biomedical staff (or may report to the engineering department)	Biomedical staff report to medical director
Financial compensation	Medical directorship fee based on contractual and administrative agreement with the medical center	Medical directorship fee according to contract with the dialysis provider
Administrative FTE	Equivalent of 0.1 to 0.25 FTE based on the volume (opinion)	Equivalent of 0.25 FTE or higher
Outsourced dialysis provider	If outsourced, the staff under the outsourcing entity also reports to the medical director	Hospital-owned or independent outpatient dialysis centers may have certain services outsourced, including management services
In-center vs home modalities	Usually a single medical director	There may be separate medical directors for different modalities
Dialysis payment model	Hospitals are not always reimbursed for dialysis treatments given that hospital reimbursement is DRG-based*	Facilities are reimbursed based on a per-treatment bundled payment model

Abbreviations: CMO, Chief Medical Officer; CMS, Centers for Medicare & Medicaid Services; DRG, diagnosis related group; ESRD, end-stage renal disease; FTE, full-time equivalent; TJC, The Joint Commission.
Adapted from the *Inpatient Dialysis Medical Director Toolkit*, ©2020 Forum of ESRD Networks, with permission of the copyright holder.
*There may be modifiers that can increase the DRG-based reimbursement.

Vaccination in Kidney Patients Toolkit



Updated and released 8/2021 →

Review article for peer-review submission under Dr Ramin Sam

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[VACCINATION TOOLKIT] August 5, 2021

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Outpatient Dialysis Medical Director Toolkit

THE NATIONAL FORUM OF ESRD NETWORKS

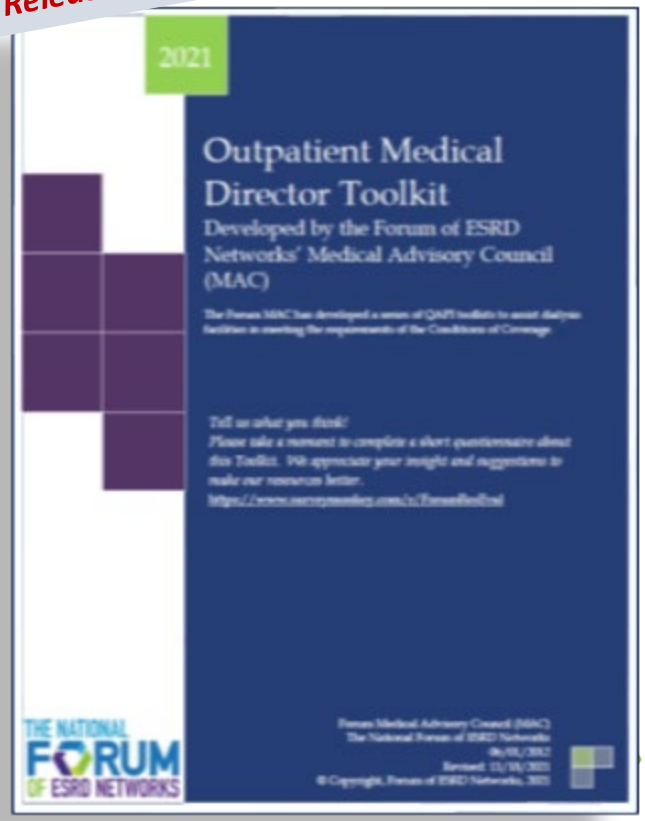
Volunteers: Drs. Henner, Kalantar, Molony, et al

Presented on *March 25, 2022*

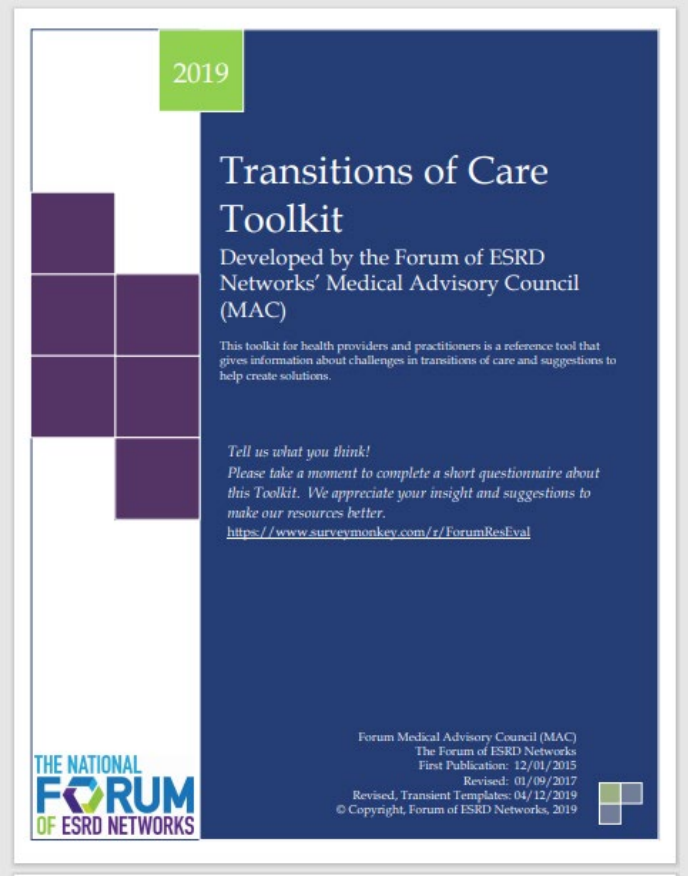
in Dallas, TX, during full-day Dialysis Medical Directorship Workshop

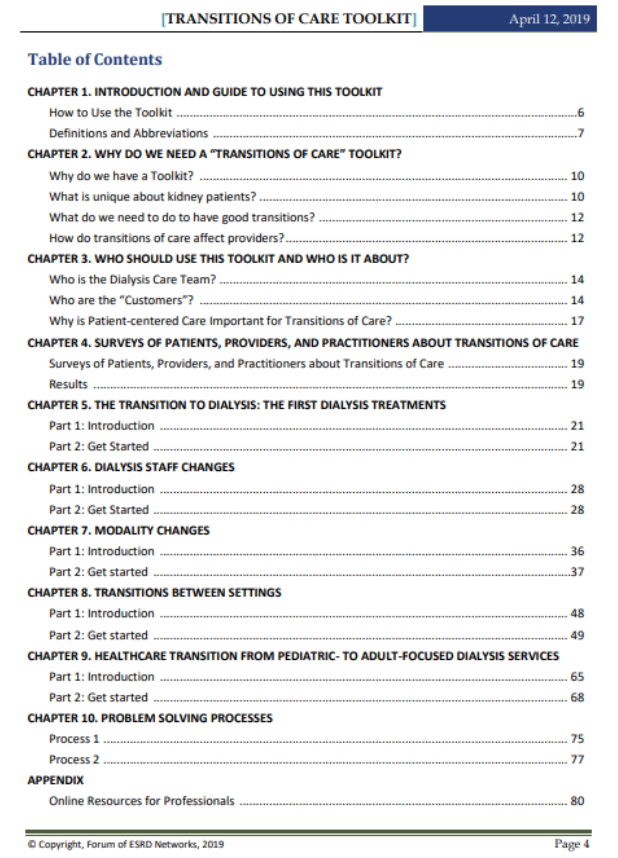
Renal Physician Association (RPA)

Released: 11/18/2021



Transitions of Care in Kidney Patients Toolkit





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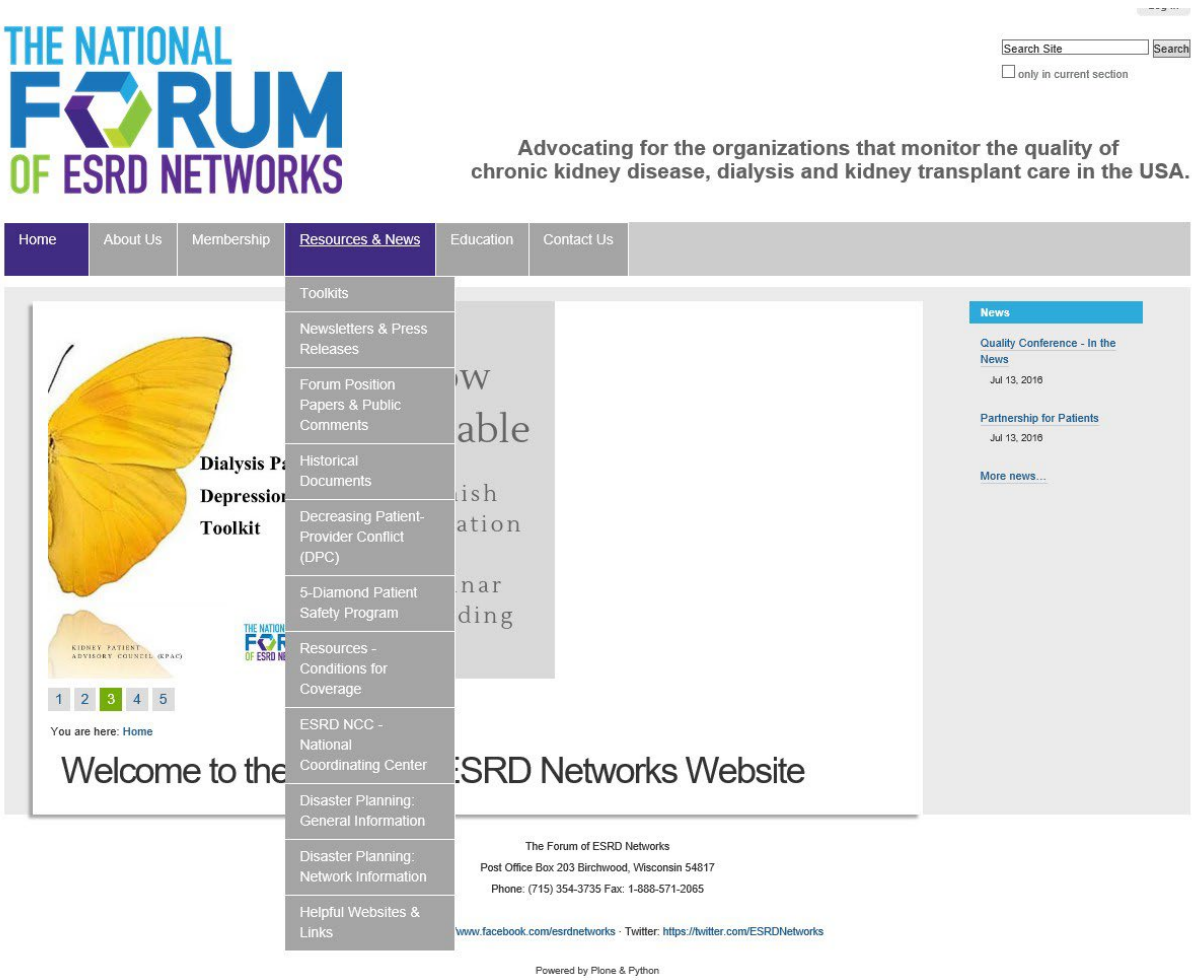
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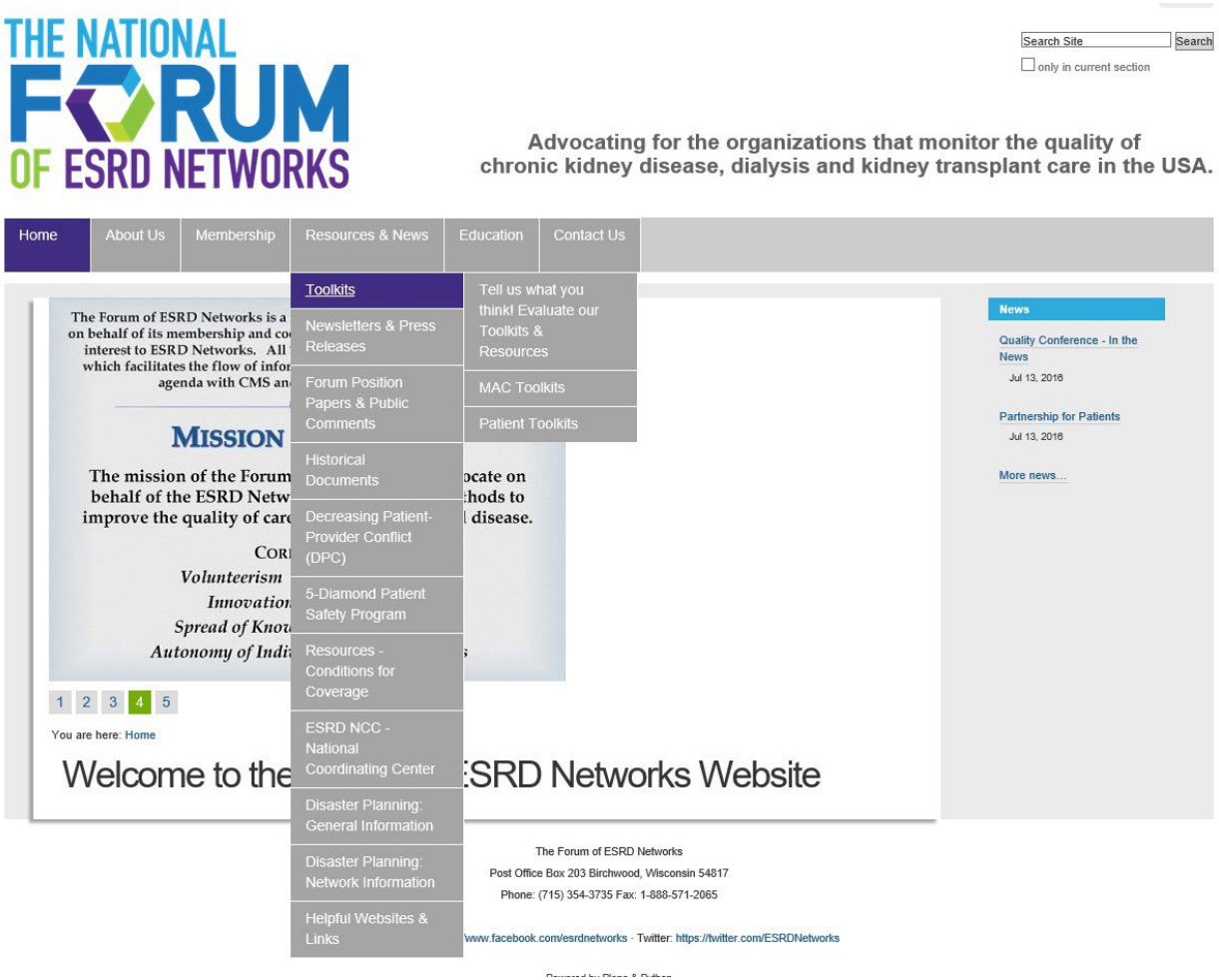
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Patient Toolkits
NEW! Medication Conversion Guide
Kidney Transplant Toolkit
Transitions of Care Toolkit (Updated 4/12/19)
Home Dialysis Toolkit
Medical Director Toolkit
QAPI Toolkit
Medication Reconciliation Toolkit
Catheter Reduction Toolkit
MAC Speaker's Bureau Brochure
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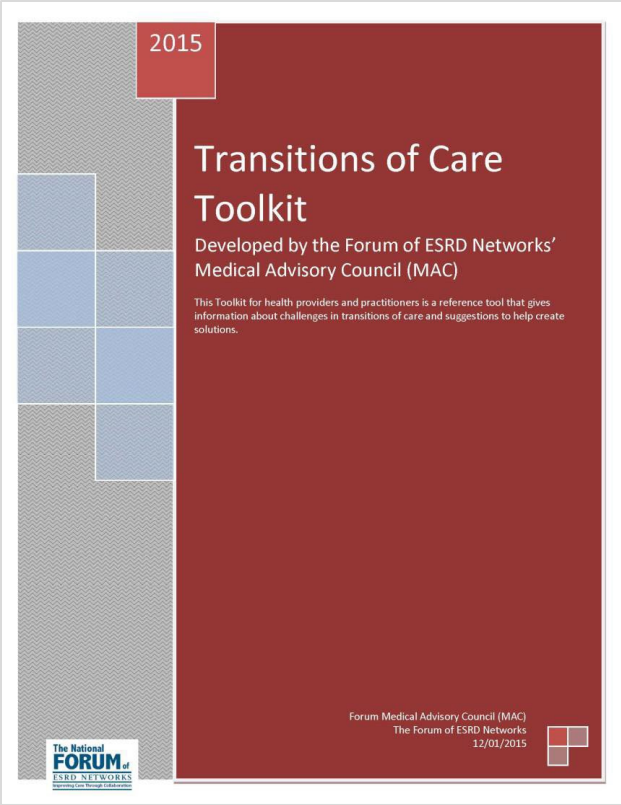
Transitions of Care Toolkit 2015

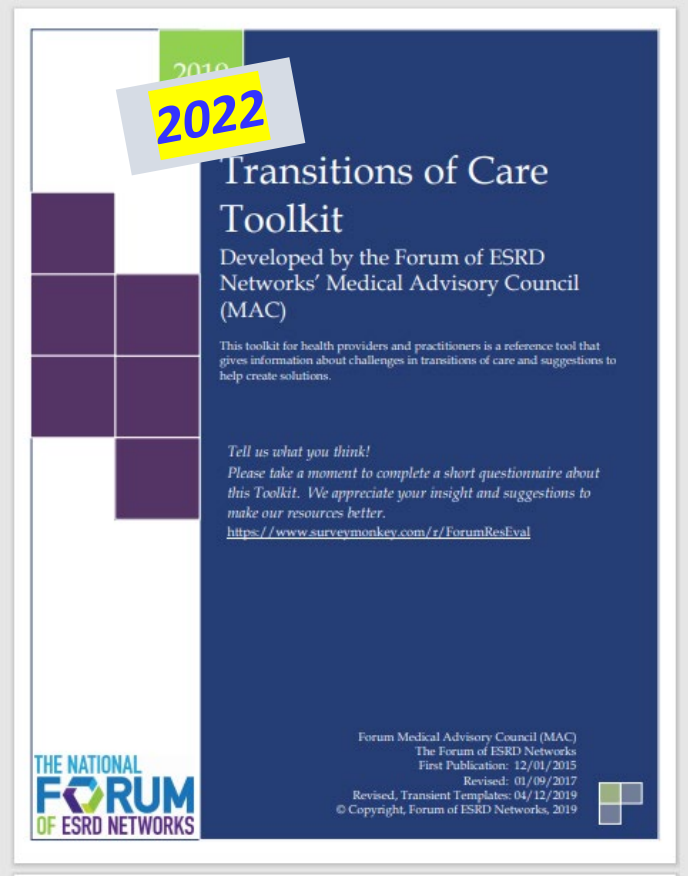


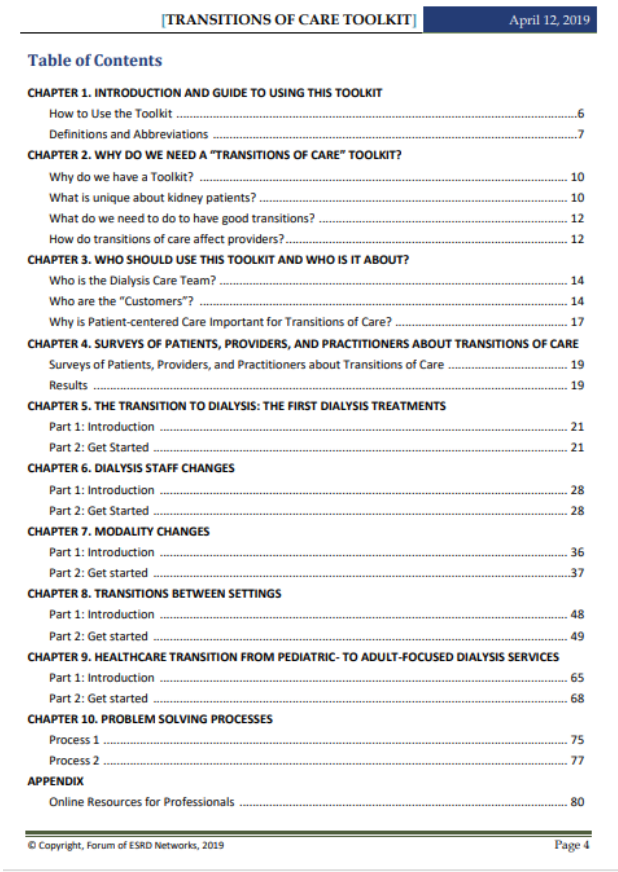
First published in 2015 – Why?

- Transitions of care are frequent in CKD and ESRD
- Error-prone and cause anxiety, morbidity and excessive costs
- Complex interactions between multiple providers and patients
- ESRD patients have unique transitions and challenges
- Dialysis providers are often "out of the loop" of communication
- Electronic medical records do not fix the problems
- Patients and providers have difference perspectives on transitions
- CMS holds providers responsible for hospitalizations and re-hospitalizations

Transitions of Care in Kidney Patients Toolkit

THE NATIONAL FORUM OF ESRD NETWORKS





[TRANSITIONS OF CARE TOOLKIT] April 12, 2019

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Released: Mar 3, 2022

Transitions of Care in CKD

Transition from CKD to ESRD

- In patients with very late stage (ADVANCED) non-dialysis dependent (NDD) CKD (eGFR <25 ml/min /1.73 m^2) the optimal transition of care to renal replacement therapy (RRT, i.e., dialysis or transplantation) is not known.

RRT: kidney replacement therapy

Kalantar-Zadeh et al. NDT 2017 [Blueprint of TC-CKD]

transition

- *[tran-zish-uh n, -sish-]*
- noun 1. *movement, passage, or change from one position, state, stage, subject, concept, etc., to another;*
- **"the transition from adolescence to adulthood."**

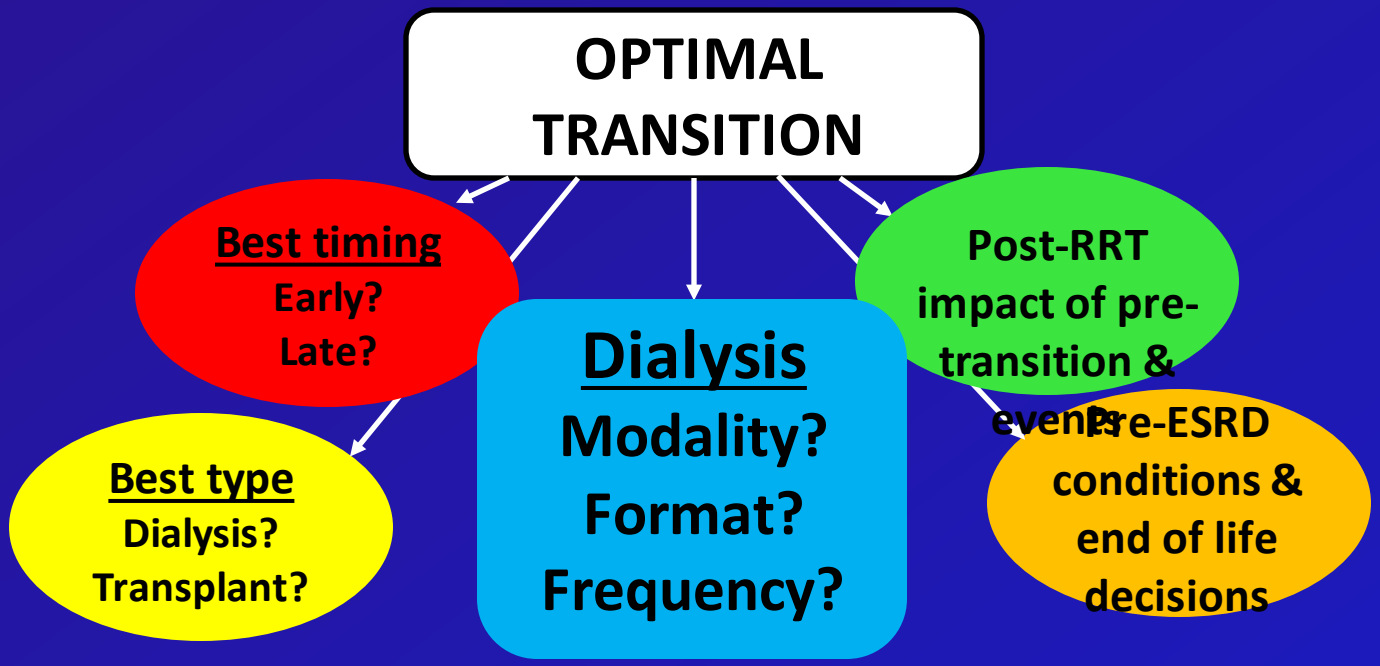
– **Dictionary.com**

start

- *[stahrt]*
- 1. to begin or set out, as on a journey or activity.
- 2. to appear or come suddenly into action, life, view, etc.; rise or issue suddenly forth.
- 3. to spring, move, or dart suddenly from a position or place: The rabbit started from the bush.
- 4. to be among the entrants in a race or the initial participants in a game or contest.
- 5. to give a sudden, involuntary jerk, jump, or twitch, as from a shock of surprise, alarm, or pain: The sudden clap of thunder caused everyone to start.

Kalantar-Zadeh et al. NDT 2017 [Blueprint of TC-CKD]

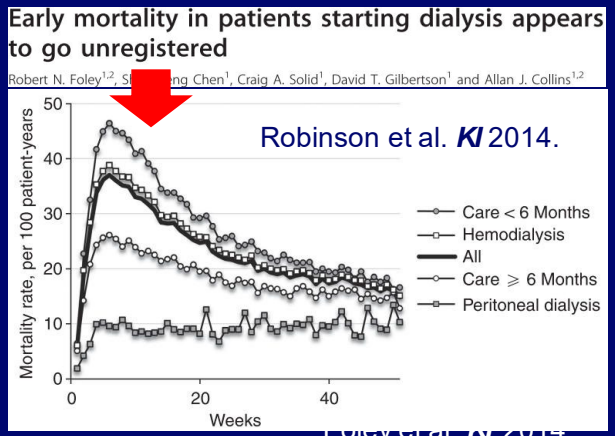
Questions regarding transition :
Impact of pre-transition conditions?

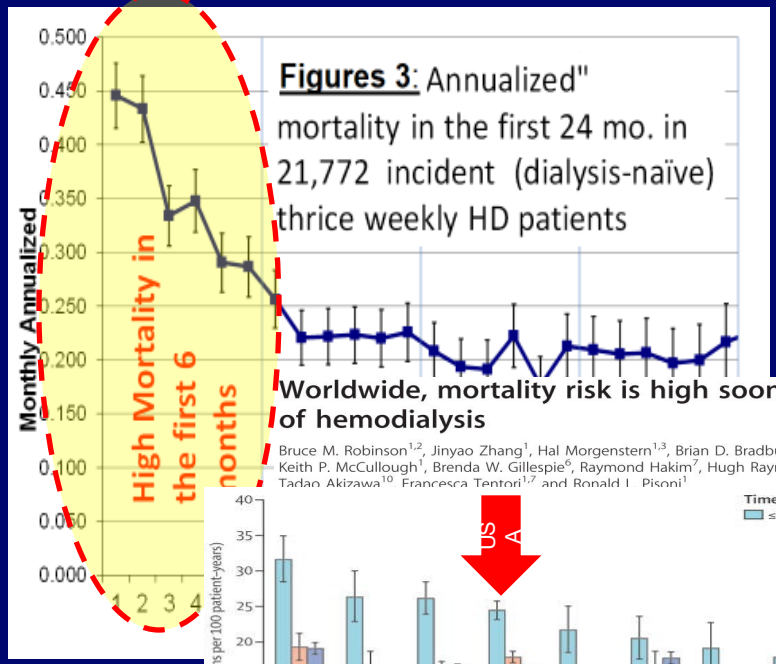


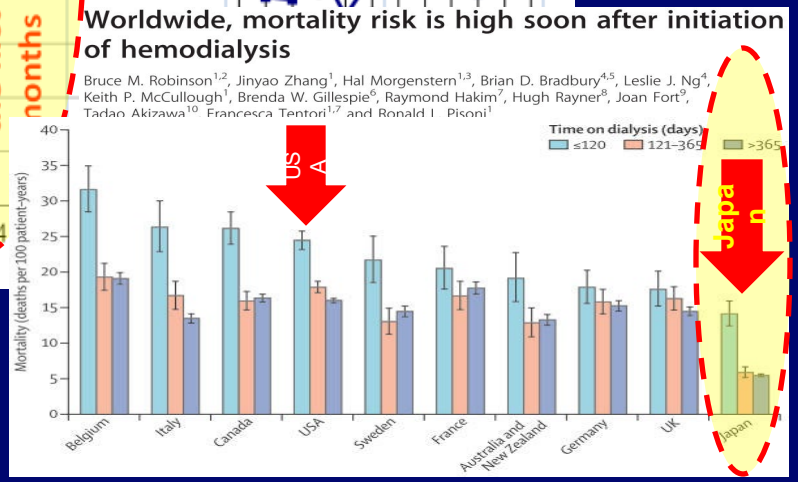
Challenges of Transition to Dialysis:
Very High Early Mortality after Transition

The first 3-6 months of dialysis is associated with an even higher risk of death compared to

prevalent dialysis patients.







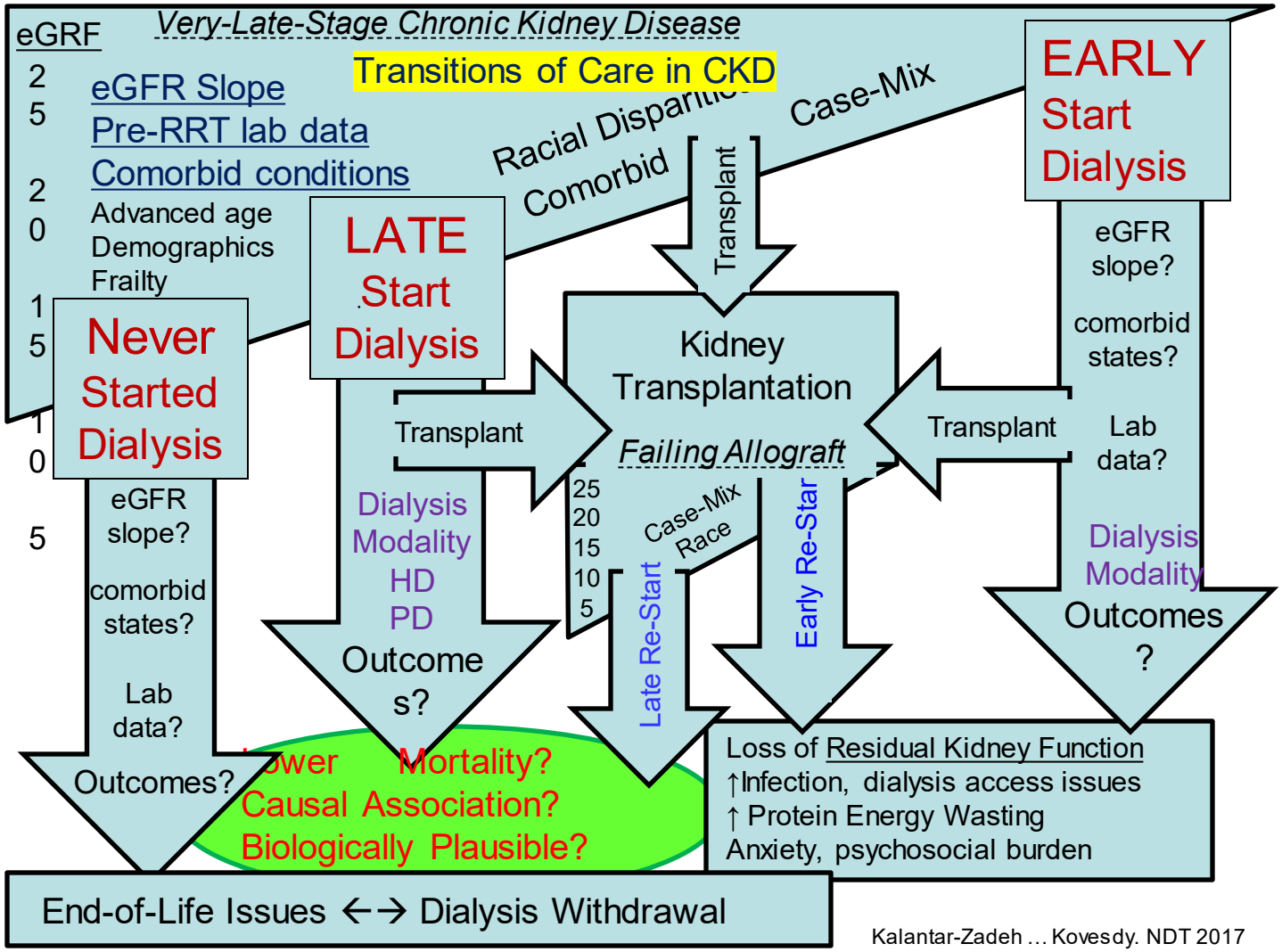
Lukowsky … Kalantar-Zadeh, *Am J Nephrol* 2012

Transition of Care in ELDERLY and Multi-Morbid CKD Patients

It is not clear whether the poor outcomes of RRT justify these expensive therapies in the elderly esp. if mortality remains essentially unchanged

CONSRVATIVE MANAGEMENT of CKD
Extending Dialysis Free Interval

RRT: kidney replacement therapy



Kalantar-Zadeh … Kovesdy. NDT 2017

Other Types of Transitions of Care in CKD

1. Transition from CKD to Dialysis
2. Transition from Dialysis to Transp
3. Transition from Dialysis C
4. Transition from t
5. Transiti
   (
6. Tr ities (iHD, PD, HHD
   (Tr sis units)
7. Tra Dialysis to Hospice

- Changes that seem routine to providers (dialysis initiation, transplantation, hospitalization, hospice) may be highly stressful to patients and their care-partners.

Enforce Hope!

What is Hope and why Hope is important in CKD care and Patient Empowerment?

- Hope is feeling of expectation and desire for a certain outcome to happen to makes your life better
- Hope is a feeling of trust.
- Hope involves "*planning and motivation and determination*" to get what one hopes for.
- **Hope makes patients feel more powerful.**

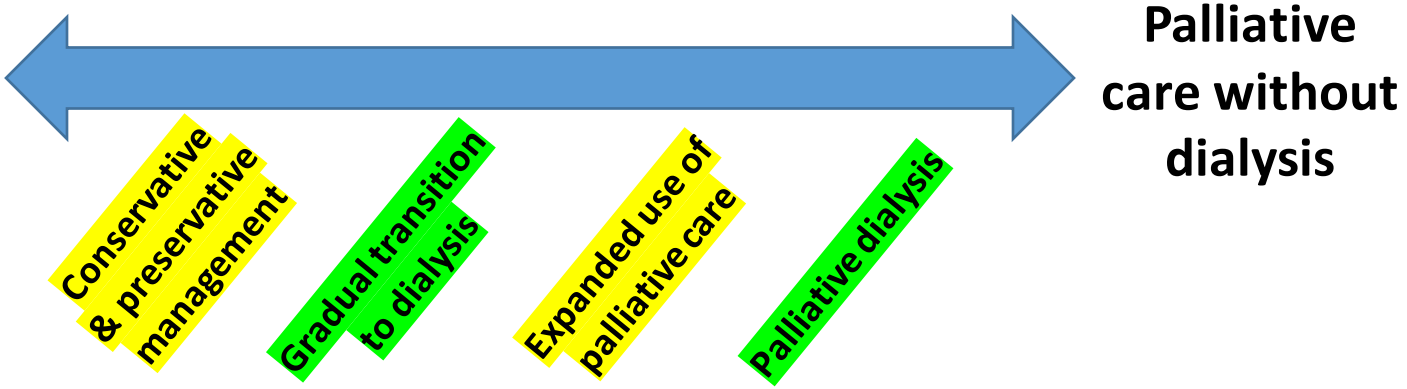
Kalantar-Zadeh K, Li PKT, Tantisattamo E…Tong A. ***Kidney Int***. 2021;99:278-284

Olsman, Willems, and Leget. ***Med Health Care Philos***. 2016;19(1):11-20

Kalantar-Zadeh, Wightman and Liao. ***N Engl J Med*** 2020;383:99-101.

Dichotomy

Dialysis therapy versus palliative care without dialysis



- *To overcome the perceived dichotomy, especially for hospitalized patients, and to mitigate the pressure to reduce hospital lengths of stay and prevent readmissions, alternative treatment options can be used.*

Kalantar-Zadeh, Wightman and Liao. ***N Engl J Med*** 2020;383:99-101.

What is CHOICE?

And why choice is important to empower patients and care-partners?

Kalantar-Zadeh K, Li PKT, Tantisattamo E…Tong A. ***Kidney Int***. 2021;99:278-284

Access to Dialysis for All: Hope

- The process of reviewing goals of care should give patients and their care partners the opportunity to reconsider the fundamental reasons why they chose dialysis in the first place.
- *The 1973 Medicare expansion allowed nearly all Americans with terminal kidney failure access to life-sustaining dialysis.*

- The 1973 ESRD Legislation permitted patients to choose dialysis not just to survive, but also to maintain HOPE:
  - Hope of continuing valued relationships
  - Hope for rehabilitation
  - Hope of achieving life goals and pursuits

Kalantar-Zadeh, Wightman and Liao. *N Engl J Med* 2020;383:99-101.

- **Target audience**: CKD and Transplant Clinic and Dialysis Facility affiliates and practitioners, as well as all CKD and ESRD stakeholders
- The **Kidney Care Team** include CKD clinic and dialysis staff and practitioners but most importantly the **patient** and his/her/their **care-partners.**
- **The dialysis team needs to "own" the transitions** – the team cannot wait for hospitals and primary care providers to reach out.
- Patient and care-partner perspectives are critical in evaluating processes and outcomes.
- In the Value-Based Model era: Expanded CKD care beyond ESRD including CKD 4 and 5 not on dialysis.

Dialysis Means Life

Allen Henry Nelson

Glen Mills, Pennsylvania

Aug 14, 1940 – May 4, 2020 (Age 79)

2017 Patient Representative Logo

- Patient Inspired – Dialysis Means Life
- Patient Representative Moto – Encourage patients to be engaged in their Health Care

DML

Dialysis Means Life

Patient Representative

Network 4

Our thoughts with Allen, the amazing hero. "I'm here today, because of dialysis, and that's what I tell people," said Allen - whose kidneys failed in 2012 as a result of type 2 diabetes. "Dialysis means life." Allen H. Nelson, Aug 14, 1940 – May 4, 2020 (Age 79) "had pins made that are emblazoned with the words "dialysis means life," which he has given to at least 100 fellow patients in his unit. It's just one of the many ways that Allen shows his gratitude for the treatment."

A Dialysis Patient Helped Others as a Peer Mentor

Happy 100th Birthday
Hemodialysis Patient

Hemodialysis patient turned 100 years old in March 2022

- **FKC University of Irvine (UCI) Dialysis Clinic**

- The practice of "Transitions of Care in CKD" is not just about admissions to or discharges from a hospital, it has a broader mandate.
- CKD does not go away and has no cure, but its management changes throughout the CKD progression journey, and many types of transition will happen.
- Changes that seem routine to providers (dialysis initiation, transplantation, hospitalization, hospice) may be highly stressful to patients and their care-partners.
- Enforce hope, offer choice, show respect, support autonomy, and ensure "Living Well with Kidney Disease"

Questions? Contact the Forum Office

Website: https://esrdnetworks.org/

https://www.facebook.com/esrdnetworks/

@ESRDNetworks

Your local ESRD Network is also a resource:
http://esrdnetworks.org/membership/esrd-networks

THE NATIONAL FORUM OF ESRD NETWORKS

Acknowledgement

The Harold Simmons Center for Kidney Disease Research & Epidemiology

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The Forum is committed to supporting the activities of the ESRD Networks and improving care for all kidney patients.
We have a variety of free educational materials on our website and more under development.
We are a non-profit organization and do all this through volunteer members and limited financial resources.
Consider a donation today to support this work.
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https://esrdnetworks.org

THE NATIONAL FORUM OF ESRD NETWORKS

Forum of ESRD Networks PO Box 203, Birchwood, WI 54817

Transition to Dialysis, Choice and Hope

Ensuring Choice for People with Kidney Failure — Dialysis, Supportive Care, and Hope - CASE

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THE NATIONAL FORUM OF ESRD NETWORKS

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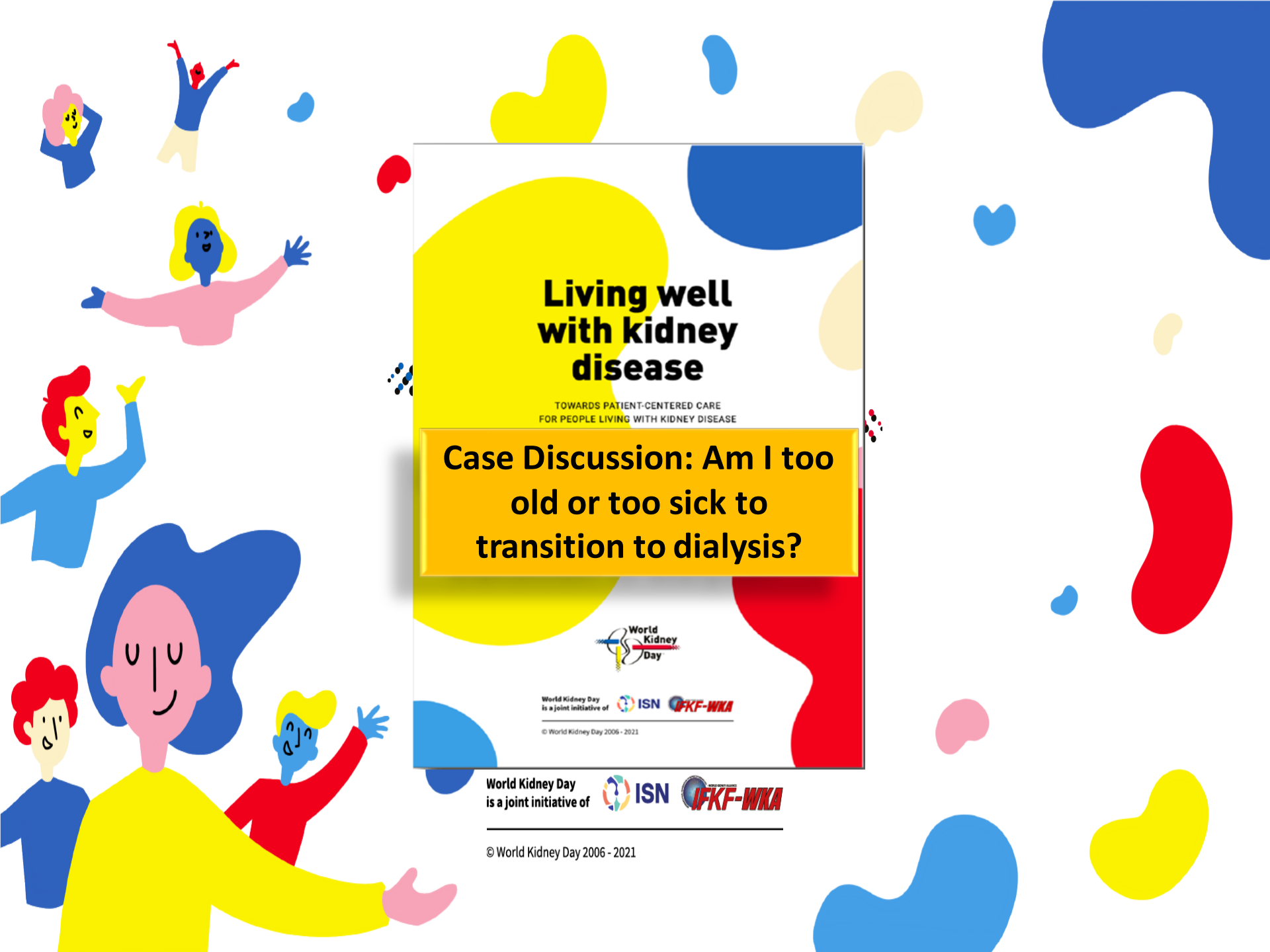
THE HAROLD SIMMONS CENTER for Kidney Disease Research and Epidemiology
Committed to Improving Patient Survival in Kidney Disease, Dialysis and Transplantation

VA LONG BEACH HEALTHCARE SYSTEM
A Division of VA Desert Pacific Healthcare Network

UCLA School of Public Health

Journal of Renal Nutrition


Living well with kidney disease
TOWARDS PATIENT-CENTERED CARE
FOR PEOPLE LIVING WITH KIDNEY DISEASE
Case Discussion: Am I too old or too sick to transition to dialysis?
World Kidney Day
World Kidney Day is a joint initiative of ISN IFKF-WKA
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World Kidney Day is a joint initiative of ISN IFKF-WKA
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Case 1 – 89-year-old man with eGFR 9 ml/min/1.73

- **89-year-old male Veteran with CKD Stage 4 progressed to CKD 5 (eGFR 9) and history of hypertension and MGUS attend his monthly CKD clinic.**
- Social history: Retired, owns a house in a nice location of Los Angeles County with ocean view. Lives by himself, went to Europe (Italy) for fun with his college student grandson last summer.
- Medications: metoprolol, sertraline, NaHCO3, erythropoietin, iron, calcitriol (lisinopril was d/c'ed a year ago)
- Physical exam: Weight 166 lbs, BMI 23 kg/m^2 , BP 128/65, HR 71, makes 0.7-1.2 Lit of urine/day. mild crackles in lung bases, ankle edema, asterixis.
- **Patient reports that he has decided to die at home without dialysis. His family members (a daughter, a son and 2 grand children) are supportive of his decision. Family members have helped him to finalize his will and to evaluate the status of his life insurance and real estates.**
- **What do you recommend?**

Case 1 – 89-year-old man with eGFR 9 ml/min/1.73

- 89-year-old male Veterans with CKD Stage 5 not-on dialysis and history of hypertension and MGUS attend his monthly to quarterly CKD clinic.

- **He has decided to die at home without dialysis.**
- **His family members are supportive of his decision.**
- **His will and life insurance are well prepared.**

- *He was under Dr Kalantar's care for 3 years, since he was 86, the team managed to delay his dialysis by 3+ years using a plant-dominant low protein (**PLADO**) diet, which he followed and enjoyed.*

- **He was seen by Dr Kalantar's younger nephrologist colleagues, who invariably encouraged the patient to avoid dialysis and eat more protein and meat. Similarly, his primary care physician, his cardiologist and his hematologist were supportive of no dialysis. Most physicians (other than Dr Kalantar) told him that dialysis may cause more suffering at this advanced age and that it is better for him to avoid dialysis.**

- **What do you recommend?**

Case 1: 89-year-old man with eGFR 9 ml/min/1.73 and worsening uremic sign and symptoms, who has decided to die without dialysis.

- What do you (nephrologist) recommend to do?

A. Support patient's decision to die without dialysis and do nothing else, discharge him from your CKD clinic.

B. Support patient's decision to die without dialysis. Refer him to Palliative and Hospice Medicine Clinic for home Hospice.

C. Continue low protein diet (e.g. PLADO 0.6-0.8 g/kg/day) or offer very low protein diet (0.3 -0.4 g/lg/day) supplemented with keto-analogues to lower burden of nitrogenous end-product and alleviate uremia without dialysis.

D. Recommend immediate initiation of outright full dose (thrice-weekly) hemodialysis in a near dialysis unit, 3 times a week 3 to 4 hrs, while arraigning for AVF and concurrent tunneled dialysis catheter placement via vascular surgery.

E. Recommend incremental transition to hemodialysis, e.g. twice a week in-center HD, or thrice-weekly home hemodialysis at home, or gradual transition to PD at home with less PD exchanges initially.

NEJM, July 9, 2020, Perspective

Ensuring Choice for People with Kidney Failure — Dialysis, Supportive Care, and Hope

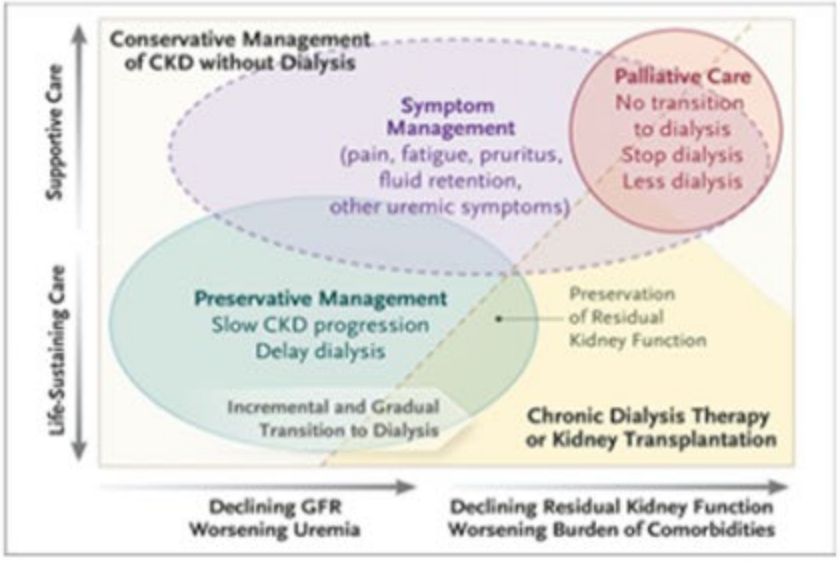
The NEW ENGLAND JOURNAL of MEDICINE

Kamyar Kalantar-Zadeh, M.D., M.P.H., Ph.D., Aaron Wightman, M.D., and Solomon Liao, M.D.

"The 1973 Medicare expansion allowed nearly all Americans with terminal kidney failure access to life-sustaining dialysis. It permitted patients to choose dialysis not just to survive, but also to maintain ***hope***:

hope of continuing valued relationships, hope for rehabilitation, and hope of achieving life goals and pursuits."

"Despite its flaws and burdens, dialysis prolongs life for many people — people who ***choose*** to start or continue this therapy to maintain hope in the face of organ failure."



Conceptual Model of the Conservative Management of Advanced CKD

World Kidney Day
is a joint initiative of ISN IFKF-WKA

Questions and Answer Discussion

Case Presentations

MARY ALBIN, BS, CPHQ
Executive Director
Alliant Health Solutions | ESRD Network's 8 & 14

Amy Carper, LCSW, CCM, NSW-C
Quality Improvement Director
HSAG | ESRD Network's 13 & 15

ALLIANT
ESRD NETWORK 14

Network 14 Hospitalization
June 20, 2023

Option Period 1 PDSA

Network 14 exceeded all three hospitalization measures in OP1

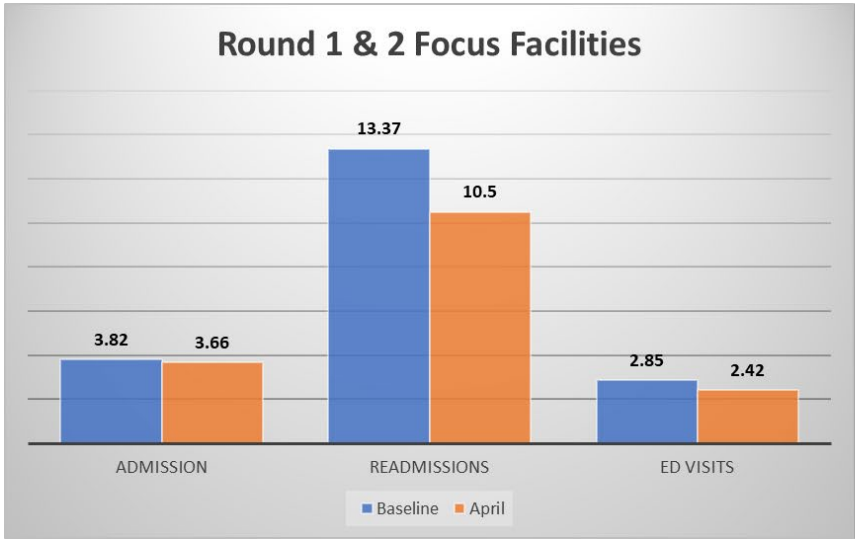
- 260 facilities participated in three PDSA Cycles
  - 154 reduced ED Visits
    - 1.36% average reduction
  - 105 reduced Admissions
    - 1.30% average reduction
  - 85 reduced Readmissions
    - 11.65% average reduction
- 37 facilities reduced in all three categories
- 73 facilities reduced in two categories
- 94 facilities reduced in one category

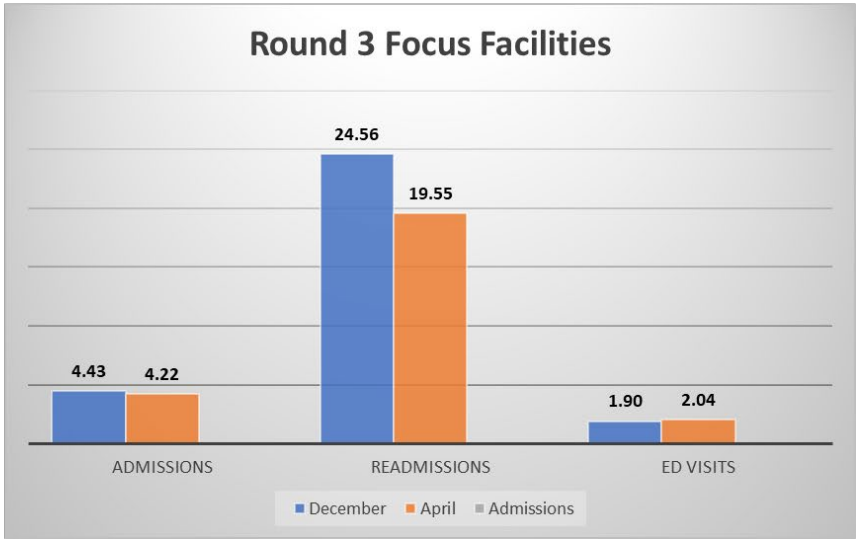
Option Period 1 PDSA Interventions

Sustainable interventions and practices implemented by facilities in the three four-month PDSA resulted in successfully reducing hospitalizations by:

- Accessing a reviewing hospital's medical reports to adjust prescription and medication reconciliation
- Entire IDT addressed and educated regarding treatment adherence
- Rescheduling treatments to accommodate patient conflicts
- Assisting patients with obtaining a PCP
- Utilizing post-hospitalization checklist and tracking tools

Option Year 1 PDSA Group Results





Contact Information

4099 McEwen Rd, Suite 820
Dallas, Texas 75244
Patient Toll Free number:
1-877-886-4435
Email: nw14info@allianthealth.org
Website: https://quality.allianthealth.org/nqiic/esrd/esrd-network-14/

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ESRD NETWORK 14

@ESRD8AND14

ESRD Network of Texas

@ESRDNetworkofTX

ESRD Networks 8 and 14

Produced under CMS Contract number 75FCMC19D005-75FCMC21F0002.

Questions and Answer Discussion

Case Presentation
ESRD Network 13

Amy Carper, LCSW
Quality Improvement Director

Case Study

- 45 year old female
- Currently working
- Has a family including a spouse and two school-age children
- Currently on a first shift dialysis schedule
- Has not been to treatment 3x's weekly consistently for three months
- Goes to the Emergency Department for care when not adherent to tx
- Does not communicate regularly with the dialysis staff or answer calls
- When available to discuss treatment states she will come starting soon
- Wants to be on the transplant list

Options for mitigation

- Reinforce benefits of home treatment with regard to time away from family
- Consider nocturnal dialysis as an option so not unavailable for family
- Reinforce commitment to family includes staying alive and home
- Schedule time to discuss goals where treatment isn't tied to coming
- Involve spouse in education about effects of not getting routine dialysis since wife doesn't look "sick"
- Discuss requirements for transplant and how it can be short-term commitment for long-term benefit
- Attempt to have discussion while she treats in the ED or via Zoom when home if not able to come to clinic

Case Presentation
ESRD Network 15

Amy Carper, LCSW
Quality Improvement Director

Case Study

- 68 year old male
- Lives alone
- In the hospital for COPD exacerbation resulting in missed scheduled treatments
- Has trouble making it through treatment without being short of breath
- ED visits result in:
  - treatment for breathing issues (nebulizer)
  - Recommendation to follow-up with primary doctor and pulmonary specialist
  - No change in prescription
- Calls 911 from home when symptomatic
- Has not been able to get to out-patient physician follow-up appointments

Options for mitigation

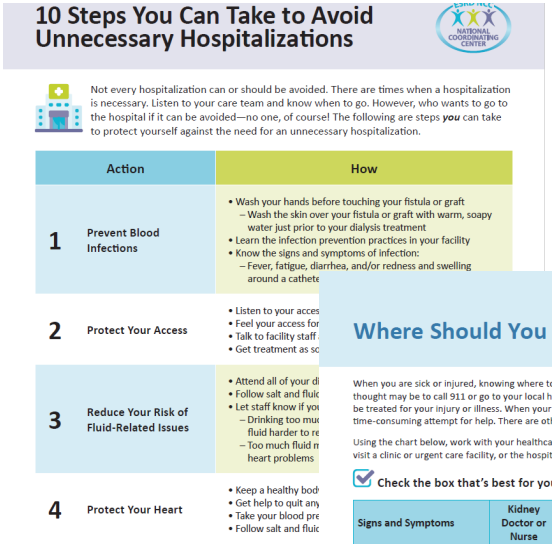
- Assess patient understanding of disease process and treatment
- Interview patient about highest quality of life environment (home vs clinic)
- Review ongoing referral to pulmonologist
- Communicate with primary doctor and pulmonologist urgency of appointment
- Ensure clinic receives and reviews the recommendations of the physician visits
- Build in plan for symptom management which may involve palliative care and review goals of care (life plan) to increase commitment

Thank You

Amy Carper
Network 13

Patient and Professional Resources

Patient



10 Steps You Can Take to Avoid Unnecessary Hospitalizations

Not every hospitalization can or should be avoided. There are times when a hospitalization is necessary. Listen to your care team and know when to go. However, who wants to go to the hospital if it can be avoided—no one, of course! The following are steps ***you*** can take to protect yourself against the need for an unnecessary hospitalization.

	Action	How
1	Prevent Blood Infections	• Wash your hands before touching your fistula or graft – Wash the skin over your fistula or graft with warm, soapy water just prior to your dialysis treatment • Learn the infection prevention practices in your facility • Know the signs and symptoms of infection: – Fever, fatigue, diarrhea, and/or redness and swelling around a cathete
2	Protect Your Access	• Listen to your acces • Feel your access for • Talk to facility staff • Get treatment as sc
3	Reduce Your Risk of Fluid-Related Issues	• Attend all of your di • Follow salt and fluic • Let staff know if yo – Drinking too mu fluid harder to re – Too much fluid heart problems
4	Protect Your Heart	• Keep a healthy bod • Get help to quit an • Take your blood pre • Follow salt and fluic

Where Should You Go for Medical Care?

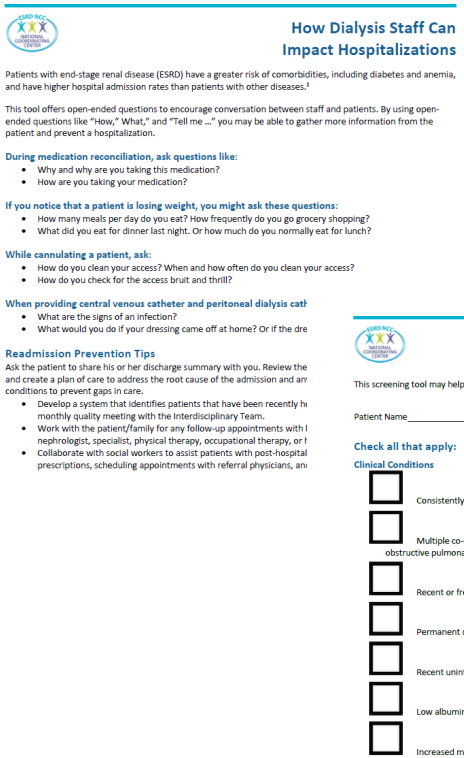
When you are sick or injured, knowing where to go to get good care can save you valuable time and frustration. Your first thought may be to call 911 or go to your local hospital's emergency room (ER). But the ER may not be the best place to be treated for your injury or illness. When your injury or illness isn't life threatening, the ER is an expensive, time-consuming attempt for help. There are other options that can be faster and less expensive.

Using the chart below, work with your healthcare team to identify what conditions you should see a doctor or nurse, or visit a clinic or urgent care facility, or the hospital ER.

☑ Check the box that's best for you.

Signs and Symptoms	Kidney Doctor or Nurse	Clinic or Urgent Care Facility	Hospital ER	Notes
Feeling confused or cannot think clearly				
Dizzy or light-headed or feel like you may faint				
Increase in blood pressure				
Exposed to someone with COVID-19				
Cough, cold, or sore throat				
Rashes or skin irritations				

Professional



How Dialysis Staff Can Impact Hospitalizations

Patients with end-stage renal disease (ESRD) have a greater risk of comorbidities, including diabetes and anemia, and have higher hospital admission rates than patients with other diseases.[1]

This tool offers open-ended questions to encourage conversation between staff and patients. By using open-ended questions like "How," What," and "Tell me ..." you may be able to gather more information from the patient and prevent a hospitalization.

During medication reconciliation, ask questions like:
- Why and why are you taking this medication?
- How are you taking your medication?

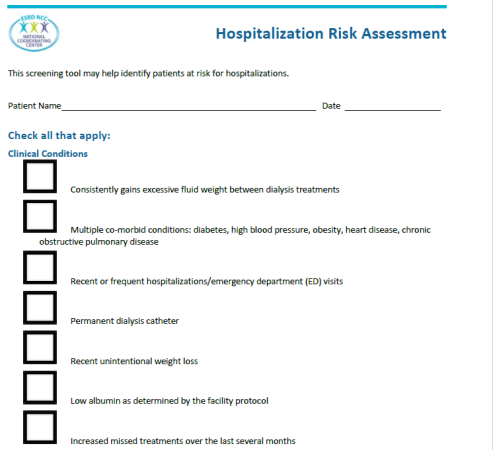
If you notice that a patient is losing weight, you might ask these questions:
- How many meals per day do you eat? How frequently do you go grocery shopping?
- What did you eat for dinner last night. Or how much do you normally eat for lunch?

While cannulating a patient, ask:
- How do you clean your access? When and how often do you clean your access?
- How do you check for the access bruit and thrill?

When providing central venous catheter and peritoneal dialysis cath
- What are the signs of an infection?
- What would you do if your dressing came off at home? Or if the dre

Readmission Prevention Tips

Ask the patient to share his or her discharge summary with you. Review the and create a plan of care to address the root cause of the admission and arr conditions to prevent gaps in care.
- Develop a system that identifies patients that have been recently h monthly quality meeting with the Interdisciplinary Team.
- Work with the patient/family for any follow-up appointments with nephrologist, specialist, physical therapy, occupational therapy, or
- Collaborate with social workers to assist patients with post-hospital prescriptions, scheduling appointments with referral physicians, an



Hospitalization Risk Assessment

This screening tool may help identify patients at risk for hospitalizations.

Patient Name_____ Date _____

Check all that apply:

Clinical Conditions

- ☐ Consistently gains excessive fluid weight between dialysis treatments
- ☐ Multiple co-morbid conditions: diabetes, high blood pressure, obesity, heart disease, chronic obstructive pulmonary disease
- ☐ Recent or frequent hospitalizations/emergency department (ED) visits
- ☐ Permanent dialysis catheter
- ☐ Recent unintentional weight loss
- ☐ Low albumin as determined by the facility protocol
- ☐ Increased missed treatments over the last several months

Top Take-Aways – Putting Knowledge Into Action

What is one thing you learned today that you could start doing immediately?

How will this action improve your current way of doing the practice/process?

Who is involved and how can they support the action to make it sustainable?

Recap & Next Steps

- Additional pathways for learning
  - Sharing Best Practices to a greater community through coalition meetings
  - Using Case Study examples to identify new ways of doing something or missed opportunities

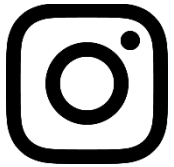
- Next meeting – Tuesday, September 19, 2023

Visit the ESRD NCC website to find materials and share

https://esrdncc.org/en/professionals/expert-teams/

Social Media

ESRD National Coordinating Center



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National Coordinating Center (NCC)

Thank You

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