

# Expert Teams – Hospitalization

*Case-Based Learning & Mentorship*

Tuesday, September 19, 2023

Facilitator: Julie A. Moss, 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  
SUCCESSSES 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

# Expert Team Call Objectives



Prepare for improvement using shared clinical cases



Test processes through the application of knowledge from the cases



Use inquiry-based learning to problem solve



Examine clinical reasoning, problem solving, and decision making through lived experience



Act as a consultancy for behavior change and improvement

# 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

**Daniel Landry, DO, FASN**

**Chair, Medical Advisory Council for the National Forum of ESRD Networks**

**Chief, Division of Nephrology**

**Medical Director, Inpatient Dialysis and Critical Care Nephrology**

**Baystate Medical Center**

**Associate Professor of Medicine, University of Massachusetts Chan Medical School-Baystate**





# ESRD NCC Transitions of Care Meeting

September 14, 2023

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**Daniel Landry, DO, FASN**

**Chair, Medical Advisory Council for the National Forum of ESRD Networks**

**Baystate Medical Center, Springfield, MA**

THE NATIONAL  
**FORUM**  
OF ESRD NETWORKS

## ToC Case Study: Management of the ESRD Patient in the Emergency Room



**Chief Complaint:** It's Monday morning and a 55-year-old male presents to the emergency department complaining of shortness of breath.

**History:** Receiving in-center hemodialysis for over 3 months (ESRD due to diabetic nephropathy) and has been coming to treatments regularly. Dialysis units usually removes a lot of fluid (he doesn't urinate much anymore), however, his last dialysis treatment was Friday and he left about 1 kg above target weight due to cramping. He hadn't had much pre-dialysis nephrology care and started treatments with a tunneled dialysis catheter and a maturing AV fistula.

# ToC Case Study: Management of the ESRD Patient in the Emergency Room



**ER evaluation:** Afebrile with no signs of pneumonia. COVID-19 testing negative. He has 2+ pitting leg edema and mild vascular congestion on CXR. His O2 sats are 99% on room air and he is in no acute distress.

## **Subsequent events (in specific order):**

- ER provider realizes today is patient's dialysis day and calls medicine for admission
- Nephrology then contacted to be made aware of the admission and to arrange for dialysis
- Dialysis unit is full (as is hospital) so patient waits 12 hours for 3h treatment
- He has an overnight stay ("24-hour observation") but ends up admitted for 2 more days due to med error with insulin and subsequent hypoglycemia

# Missed Opportunities



## Missed Opportunities



- Lack of pre-dialysis education: diet/fluid intake, access

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- SDoH and culture of ER being source of medical care



## Missed Opportunities



- Lack of pre-dialysis education: diet/fluid intake, access
- Loss of RKF and lack of urine output when going into long periods without dialysis
- Education on notifying dialysis unit for changes in health
- SDoH and culture of ER being source of medical care
- Better communication between ER and nephrology

## Groundhog Day, anyone?



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### **Subsequent events (in specific order):**

- ER provider realizes today is patient's dialysis day and **calls nephrology**
- Nephrology triage comes to assess patient. Determines safety of patient for ER discharge
- Nephrology contacts outpatient dialysis unit charge RN: "His chair time is 11 am. Get him here as soon as you can!"
- ER case manager arranges Uber for patient to dialysis unit
- ER/hospital wins, inpatient (and outpatient) dialysis units win, **PATIENT wins...**

# ESRD Patient ER Utilization



**Table 1. Characteristics for US Patients With ESRD and ED Use**

Characteristic	2005-2011 Study Period (n = 769 228)	Year of ESRD <sup>a</sup>				
		First (n = 769 228)	Second (n = 502 632)	Third (n = 348 222)	Fourth (n = 232 274)	Fifth (n = 146 038)
ED visits, No. (%) of patients	535 345 (69.6)	422 738 (55.0)	256 319 (51.0)	179 891 (51.7)	122 155 (52.6)	73 214 (50.1)
Total No. of ED visits	4 562 939	1 782 441	1 049 161	733 701	506 629	299 506
Collective person-years	1 704 212	617 569	422 652	288 432	187 983	113 317
Mean No. of ED visits per person-year	2.68	2.89	2.48	2.54	2.70	2.64
No. of deaths	345 937	168 601	72 636	46 764	30 066	17 229
No. of ED visits						
Median (IQR) [range]	2 (0-8) [0-528]	1 (0-3) [0-217]	1 (0-3) [0-139]	1 (0-3) [0-136]	1 (0-3) [0-165]	1 (0-2) [0-180]
90th percentile	≤16	≤6	≤6	≤6	≤6	≤6
95th percentile	≤23	≤10	≤9	≤9	≤9	≤9
99th percentile	≤45	≤19	≤18	≤19	≤19	≤19
Hospital admissions from the ED, No. (%) of ED visits	2 108 915 (46.2)	825 523 (46.3)	491 755 (46.9)	340 107 (46.4)	232 552 (45.9)	135 238 (45.2)

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## ESRD Patient ER Utilization



- Study based on national Medicare claims data
- The 3 most common admission diagnoses (during the first ESRD year) were:
  - 1) Hemodialysis access complication (107 609 [12.6%])
  - 2) Septicemia (66 554 [7.8%])
  - 3) Congestive heart failure (64 001 [7.5%])
- Patients with ESRD use the ED at 6-fold and 4-fold higher rates than the national mean rates for US adults and Medicare beneficiaries, respectively
- Several potentially preventable causes of ED use, including access to care
- Catheter hemodialysis access was strongest predictor of ED use

# Emergency department use by patients with end-stage renal disease in the United States



Ningyuan Wang<sup>1†</sup>, Jiao Pei<sup>2,3†</sup>, Hui Fan<sup>4</sup>, Yaseen Ali<sup>1</sup>, Anna Prushinskaya<sup>5</sup>, Jian Zhao<sup>6,7,8</sup> and Xingyu Zhan<sup>†</sup>

- Analysis of adult (age  $\geq 18$  years) ED patients with ESRD data from 2014 to 2016 ED visits provided by the National Hospital Ambulatory Medical Care Survey.
- Approximately 722,692 (7.78%) out of 92,899,685 annual ED visits represented ESRD patients.
- Males were more likely to be ESRD patients than females (aOR: 1.34; 95% CI: 1.09–1.66).
- Compared to whites, non-Hispanic Blacks were 2.55 times more likely to have ESRD (aOR: 2.55; 95% CI: 1.97–3.30), and Hispanics were 2.68 times more likely to have ESRD (95% CI: 1.95–3.69).
- ED patients with ESRD were more likely to be admitted to the hospital (aOR: 2.70; 95% CI: 2.13–3.41) and intensive care unit (ICU) (aOR: 2.21; 95% CI: 1.45–3.38) than patients without ESRD.
- ED patients with ESRD were more likely to receive blood tests and get radiology tests

Wang *et al. BMC Emergency Medicine* (2021) 21:25  
<https://doi.org/10.1186/s12873-021-00420-8>



2022

# Transitions of Care Toolkit

Developed by the Forum of ESRD  
Networks' Medical Advisory Council  
(MAC)

**This toolkit for health providers and practitioners is a reference tool that gives information about challenges in transitions of care and suggestions to help create solutions.**

*Tell us what you think!*

*Please take a moment to complete a short questionnaire about this Toolkit. We appreciate your insight and suggestions to make our resources better.*

<https://www.surveymonkey.com/r/ForumResEval>

# Transitions of Care Toolkit (2022)



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## CHAPTER 8. TRANSITIONS BETWEEN SETTINGS

**Problem:** Transitions of care between hospitals, skilled nursing facilities, long-term acute care hospitals, and dialysis clinics present major challenges and safety risks for patients.

**Goal:** Develop a seamless process for the transition of care between the dialysis clinic and other care settings so that patient care is safe, appropriate, and coordinated.

### Part 1: Introduction

Transition of care between settings is a critical part of care coordination and is particularly complex for kidney patients. Approximately 35% of hospitalized dialysis patients are re-hospitalized within one month, often for the same problem that caused the first hospitalization. Good discharge processes can decrease the risk of re-hospitalization, but many other processes are also important for safe transitions. Medical complications, including medication and dialysis treatment errors, occur when providers do not share information. If the dialysis team does not review information from the hospital in a timely manner, critical treatment changes can be missed. We need to consider what to do before, during, and after a hospitalization, as well as how to collaborate with an SNF or LTAC.

# Summary



- ER visits by ESRD patients are very common and result in hospital admission nearly 50% of the time
- Patient education regarding awareness of dietary/fluid intake, dialysis access, efforts to preserve RKF, and communication with dialysis team is crucial
- Awareness of the social drivers of health for our patients and recognition of how these drivers affect access to care
- Communication between dialysis clinics and hospitals for ToC
- Education of our hospital/ER colleagues for early intervention/diversion strategies can yield improved outcomes

# Questions and Answer Discussion

# Case Presentations

# Reducing Hospitalization and Readmissions for Dialysis Patients

Becky Miller, Manager

Jannelle Stevens, Senior Quality Strategist

Jane Taber, Director

Maria Regnier, Senior Director



# The Tool

	0 Points	1 Point	2 Points	3 Points
BMI	$\geq 20$	18-19.99	16-17.99	<16
Functional Capacity	Normal	Occasional Difficulty in daily activities	Difficulty in independent activities	Bed/chair ridden
Number of Years on Dialysis	<1 year	1-3 years	3-4 years	>4 years
Serum Albumin	>3.5	3.2-3.5	2.8-3.1	<2.8
Serum Ferritin	<700	700-800	800-1000	>1000
Comorbidities	1	2	3	4

*Hashmi, M., Raza, H., et al, A Simple and Cheap Hospitalization Risk Assessment Tool for Use in Hemodialysis Patients, 2018*

# Identifying High Risk Patients

	Result	Score
BMI	22	0
Functional Capacity	Occasional difficulty in daily activities	1
Number of Years on	<1	0
Serum Albumin	2.8-3.2g/L	2
Serum Ferritin	>1000ug/L	3
CoMorbidity (to include: DB, HTN, IHD, CVD)	Two	1
	<b>Total Score</b>	<b>7</b>

PATIENT	Skip Dialysis	RISK SCORE	HOSPITALIZATIONS March 2022-March 2023			
	>3		2/23 Volume overload	1/23 Uremic pericarditis	11/22 Hyperkalemia	10/22 Hyperphosphatemia
	0	1				
	0	8	12/22 Rib Fx			
	1	5				
	0	10				
	0	9	2/23 hyperkalemia	12/22 Hyperkalemia	12/22 Chest Pain	11/22 Neuropraxia
	>3	4	3/23 Abdomen Pain	3/23 Pancreatitis	12/22 overload (x2)	11/22 Pulmonary Edema
	>3		1/23 Syncopy, HTN			

# Setting our Goal and Implementing a Plan

GOAL: Reduce number of admissions to the hospital by 15% and the number of readmissions to the hospital by 25% by November 2023

Evidence based Interventions	Steps to Accomplish	Staff responsible	Start Date	Measurement and Monitoring Plan (Describe how you will collect data to evaluate the results and monitor progress.)	Due Date & Date completed	Results, issues addressed (barriers)
Change current 'care conference meeting' with IDT to focus on only the high risk patients and potential interventions to reduce that risk.	Trial IDT rounding to complete monthly care conference	Becky Miller	May 1	Maria to score all current pts and align hospitalizations from past year to evaluate effectiveness		
	Develop patient risk rating tool	Maria Regnier	April 1			
Develop ER Deflection Tools and educate ER providers on this process	Hyperkalemia threshold Fluid overload thresholds	Dr. Pathak, Becky, Jane Maria	August			
Develop a post hospitalization assessment to determine dialysis rx changes, post hospitalization appts are set up and patient goes to it, med reconciliation, and any follow up needs	Define roles and assessment post hospitalization	Becky Miller, Janelle Stevens	May 15	Becky/Janelle define who and what will be reviewed post hospitalization to prevent readmit		
Increase the communication about high risk patients	Review risk patients in daily huddles	Becky Miller	May 1			
	Weekly, short IDT meeting to assess progress on tactics being implemented to reduce chance for admission or readmission	Becky Miller, Janelle Stevens	May 1			
	Evaluate where/how interventions will be documented.	Jane, Becky, Janelle	May 1			

# Weekly IDT Meetings

Weekly IDT 6/20/2023-6/26/2023

## Review of last week's interventions

- Elmer Fudd-uptrend of missed dialysis minutes due to pain
  - Nursing
    - Request Referral for PT, pain clinic, ortho (referrals obtained)
  - Social Services
    - Coordination of appts (appts made, transportation set up, appt reminder slips given to patient)
  - Dieticians
    - Re-enforce fluid and diet education (education completed)

## New Patients

- Bugs Bunny (AKI)
- Daffy Duck (ESRD)

## Hospitalizations

- Tweety Bird 6/21-6/24 for diabetic foot ulcer

## Missed Treatments

- Spiderman-no call no show
- Ironman- not feeling well
- Thunder Thor- arrived and left
- Hulk Hogan-transportation

## Goals:

1. Reduce Hospitalizations and Readmissions
2. Decrease Infections/BSIs

## Infections

- Miss Muffit-osteomyelitis of right index finger

## Out of Range Labs

1. Adequacy (1.2 or >) Week 2
  - a. Jane Doe KT/V at 1.0. Reviewed prescription and run flowsheets. Noted not at BFR due to high venous pressures
2. Phosphorus (2.3-5.5) Week 3
3. Albumin (depends on age) Week 3
4. Corrected Calcium (8.4-10.2) Week 2
  - a. Donald Duck-10.9.
5. Hemoglobin (>9) Weekly
  - a. Peter Pan Hemoglobin down trended from 10.5 to 7.2.
6. Potassium (3.5-5.5) Week 2
  - a. Spiderman potassium of 6.7

## At Risk for Hospitalization as deemed by IDT

Jane Doe-not adequate  
Hulk Hogan-missing dialysis

## New Interventions Assigned

- Nursing
    - Jane Doe-request order for fistulogram
    - Peter Pan-Nephrologist consulted, ordered occult stool test.
3. Decrease missed treatments

- Spiderman- encourage and educate on treatment compliance
- Pharm D
  - Donald Duck-ask MD about Sensipar
  - Peter Pan- review ESA.
  - Miss Muffit-review for renal friendly abx dose
- Dieticians
  - Donald Duck-review home meds that contain calcium and diet review
  - Spiderman-diet review
  - Miss Muffit-review albumin levels
- Social Services
  - Spiderman-review barriers to treatment compliance
  - Hulk Hogan-review transportation barriers
  - Tweety Bird- assist with post hospitalization follow-up appts

# Chair Side Rounding

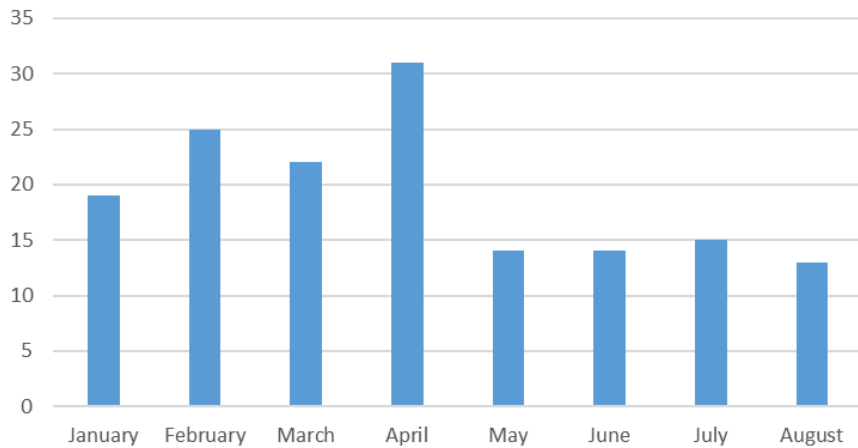
- Care conference meetings are completed chair-side with IDT on high risk patients and when the comprehensive assessments are due
- Discipline specific concerns, assessment findings and plan of care is presented to MD and patient for feedback

# Future Work

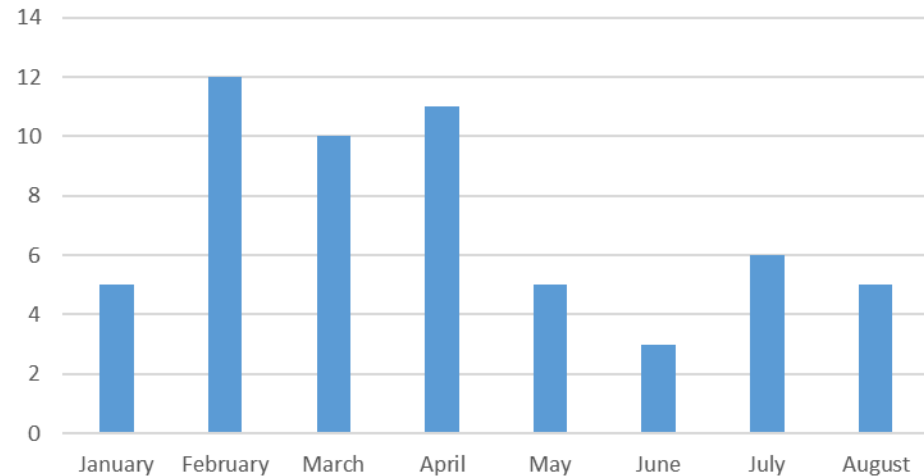
- ER Deflection Tool
  - Work with ER physicians on hyperkalemia and fluid overload thresholds
  - IDT to develop patient education on how to avoid ER visits
  - IDT to develop post ER assessment tool to determine reasons for ER visit

# Tracking our Rates

Number of Hospitalizations



Number of Readmissions



# Opportunities to Reduce Hospitalizations

September 19, 2023

Audrey Broaddus  
Qsource ESRD Network 10



## Facility Demographics

- Dialysis facility located in Urban Area: Central Illinois
- Payor mix includes Medicare and Commercial
- In-center census fluctuates between 80 – 90
- M-W-F = 3 shifts: T-T-S = 2 shifts



# Challenge

17.6% rate of 30-Day  
unplanned hospital  
readmissions

Opportunity for Improvement

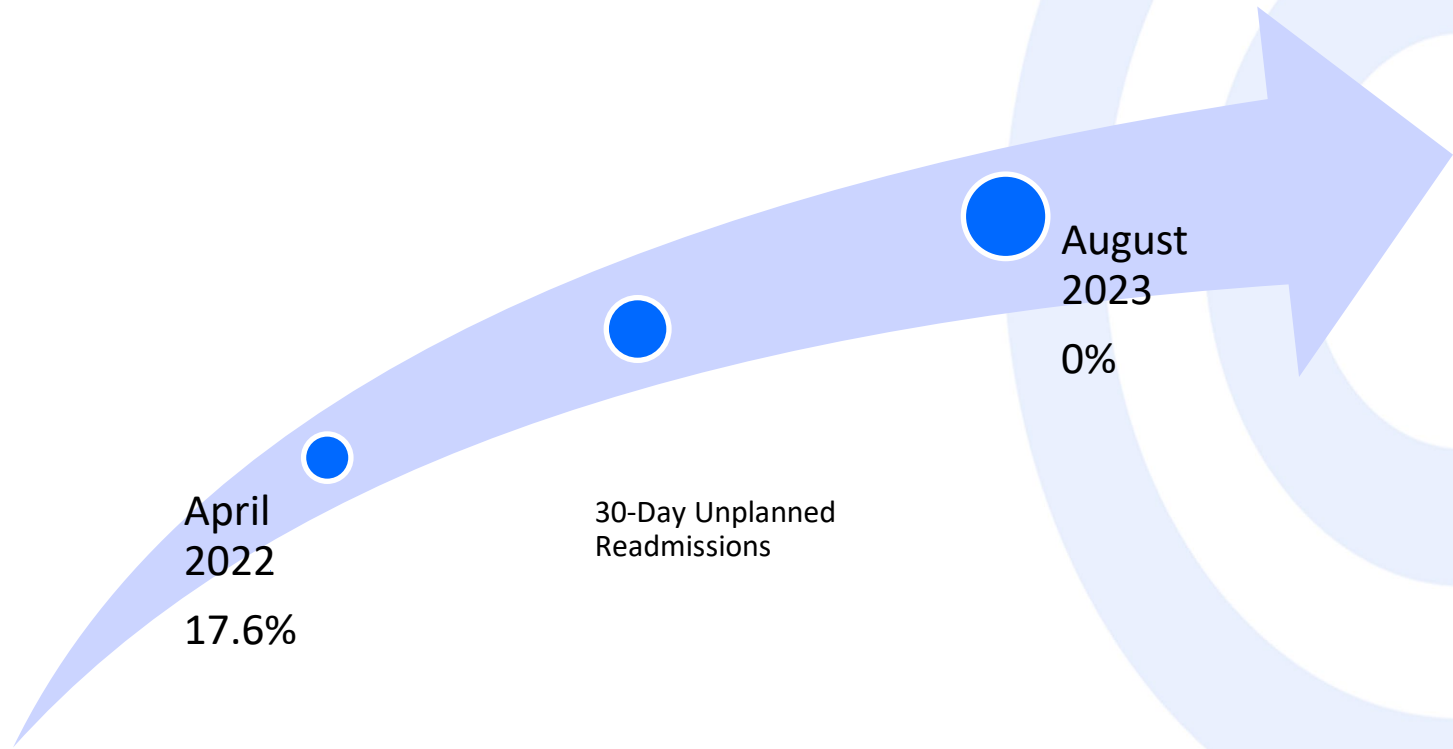
Poor communication  
pathways between the  
dialysis facility and hospital  
  
Patient non-compliance with  
discharge instructions

Identified Root Cause

Daily huddles to inform dialysis  
staff of hospitalizations  
Access to EMR at local hospitals  
Discharge Checklist (via EMR or  
calling hospital)  
Engage patient in review of  
Discharge Checklist

Interventions

# Facility Efforts Realized



# Questions and Answer Discussion

# 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?

# 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
<b>1 Prevent Blood Infections</b>	<ul style="list-style-type: none"> <li>Wash your hands before touching your fistula or graft                             <ul style="list-style-type: none"> <li>Wash the skin over your fistula or graft with warm, soapy water just prior to your dialysis treatment</li> </ul> </li> <li>Learn the infection prevention practices in your facility</li> <li>Know the signs and symptoms of infection:                             <ul style="list-style-type: none"> <li>Fever, fatigue, diarrhea, and/or redness and swelling around a catheter</li> </ul> </li> </ul>
<b>2 Protect Your Access</b>	<ul style="list-style-type: none"> <li>Listen to your access</li> <li>Feel your access for</li> <li>Talk to facility staff</li> <li>Get treatment as sc</li> </ul>
<b>3 Reduce Your Risk of Fluid-Related Issues</b>	<ul style="list-style-type: none"> <li>Attend all of your d</li> <li>Follow salt and fluid</li> <li>Let staff know if you                             <ul style="list-style-type: none"> <li>Drinking too mu fluid harder to r</li> <li>Too much fluid n heart problems</li> </ul> </li> </ul>
<b>4 Protect Your Heart</b>	<ul style="list-style-type: none"> <li>Keep a healthy bod</li> <li>Get help to quit an</li> <li>Take your blood pr</li> <li>Follow salt and fluid</li> </ul>

### 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.<sup>1</sup>

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 drc

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 an 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 I nephrologist, specialist, physical therapy, occupational therapy, or I
- Collaborate with social workers to assist patients with post-hospital prescriptions, scheduling appointments with referral physicians, and



### 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

# Recap & Next Steps

- Additional pathways for learning
  - Sharing Best Practices to a greater community through coalition meetings
  - Using case studies to identify new ways of doing something or missed opportunities
- Next meeting – Tuesday, December 19, 2023

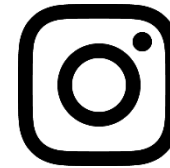
Visit the ESRD NCC website to find materials and share <https://esrdncc.org/en/professionals/expert-teams/>



# Social Media



ESRD National Coordinating Center



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National Coordinating Center (NCC)



Expert Teams – Case-Based Learning & Mentorship



# Thank You

Julie Moss

[jmoss@hsag.com](mailto:jmoss@hsag.com)

813-300-6145

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