Expert Teams – Transitions of Care

Case-Based Learning & Mentorship

Friday, February 18, 2022

Facilitator: Kelly M. Mayo, ESRD National Coordinating Center

Meeting Logistics

- Call is being recorded and will be posted to www.esrdncc.org
- Lines will be open for all high performing organizations
  - 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 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

Introductions

- Meeting Focus – Transitions of Care
- Guest Expert – National Forum of ESRD Networks
  - David Henner, DO, Berkshire Medical Center (MA)
- Case Study Presenters – Kidney Patient Advisory Committee (KPAC)
  - Dawn Edwards, Patient Subject Matter Expert (NY)
  - Derek Forfang, Patient Subject Matter Expert (CA)
- High Performing Organizations
- ESRD Networks
- Centers for Medicare & Medicaid Services (CMS)

Questions to Run On

How Might We …

- Provide patients the knowledge and skills to prevent unplanned hospitalizations?
- Address health conditions that may contribute to hospitalizations, such as anemia or undiagnosed mental health?
- Assist patients with unstable support systems or financial issues that may impact hospitalizations?

Presentation by Guest Expert

David Henner, DO
President, National Forum of ESRD Networks
Division Chief of Nephrology
Medical Director of Dialysis
Berkshire Medical Center (MA)

Forum of ESRD Networks Transitions of Care Toolkit

David E. Henner, DO

Division Chief of Nephrology

Medical Director of Dialysis

Berkshire Medical Center, Pittsfield, MA

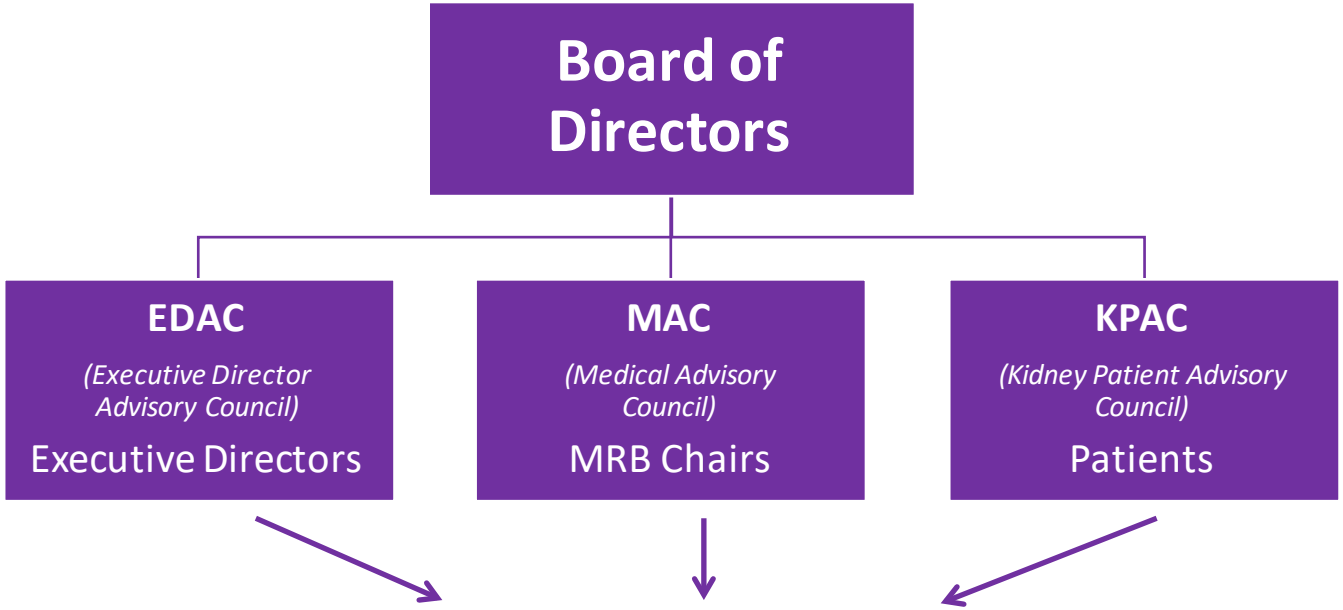
President- Forum of ESRD Networks

What is the Forum?

All ESRD Networks are members of the Forum of ESRD Networks, which is a not-for-profit organization that advocates on behalf of its membership and coordinates projects and activities of mutual interest to ESRD Networks. The Forum facilitates the flow of information and advances a national quality agenda with CMS and other renal organizations.

The **Mission** of the Forum is to support and advocate on behalf of the ESRD Networks in promoting methods to improve the quality of care to patients with renal disease.

Core values: volunteerism, collaboration, innovation and flexibility, spread of knowledge, integrity, autonomy of individual ESRD Networks, Person (Patient & Family) Centeredness



- Assisting the Networks
- Council Activities: MAC, EDAC KPAC
- Regular Communication with CMS
- Webinars & Toolkits
- Facilitate flow of information between the Forum and Network Staff/BOD/MRB/PAC
- Relationships with other Stakeholders (i.e. RHA, RPA, LDOs, NKF, AAKP, AHQA, CDC, ASN)

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(Effective 07/01/2021)

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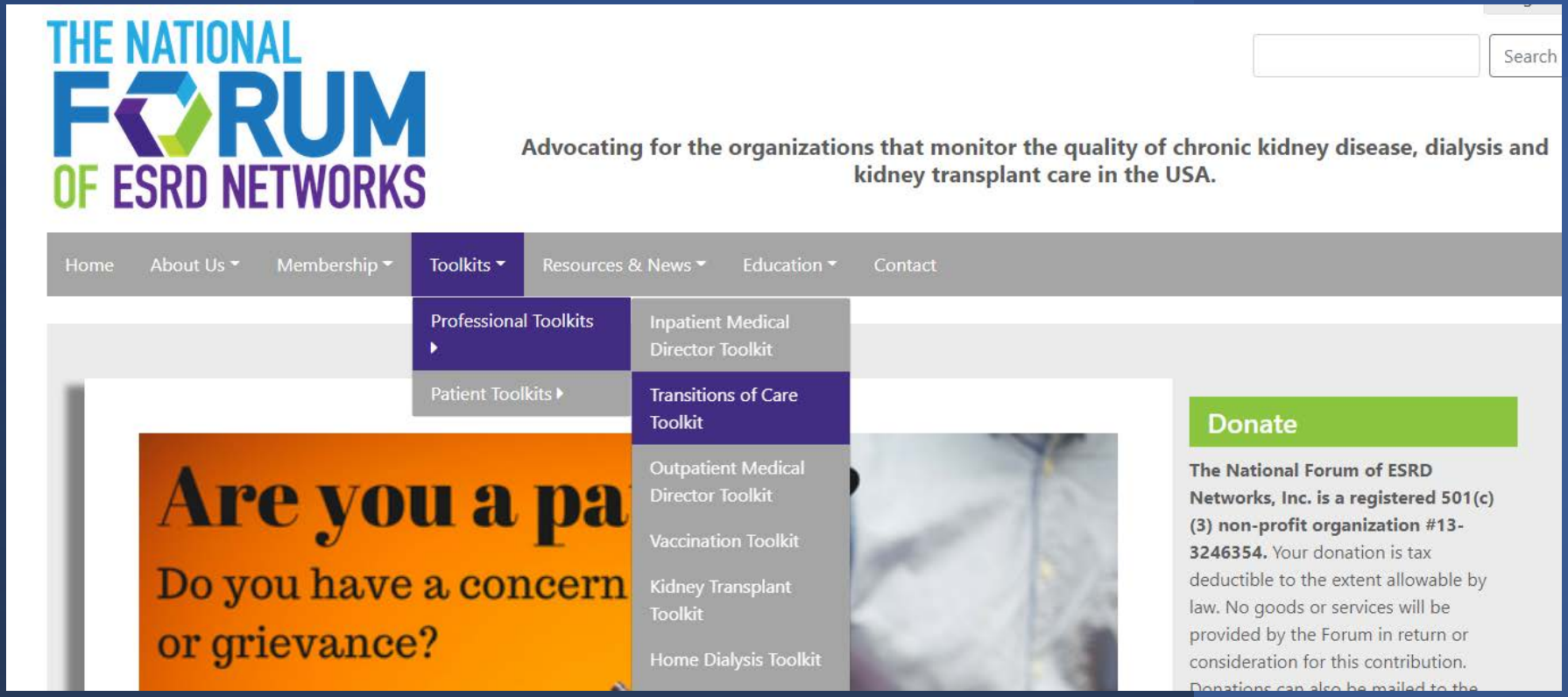
- https://esrdnetworks.org/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Transitions of Care Toolkit

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.

Updated 04/12/2019: Updates to this Toolkit include guidance for nephrologists in caring for transient dialysis patients. See pages 99-100 for a an explanation of the new Medication Conversion Guide and a sample Transient Dialysis Patient Form you can customize for your facility. These new tools were developed, in part, as a response to concerns expressed by kidney patients serving on the Forum's Board of Directors and Kidney Patient Advisory Council.

Transitions of Care Toolkit - [Updated April 2019]

Sample Transient Dialysis Patient Form v2.0 Excel - [03/12/2021]

Sample Transient Dialysis Patient Form v2.0 PDF - [03/12/2021]

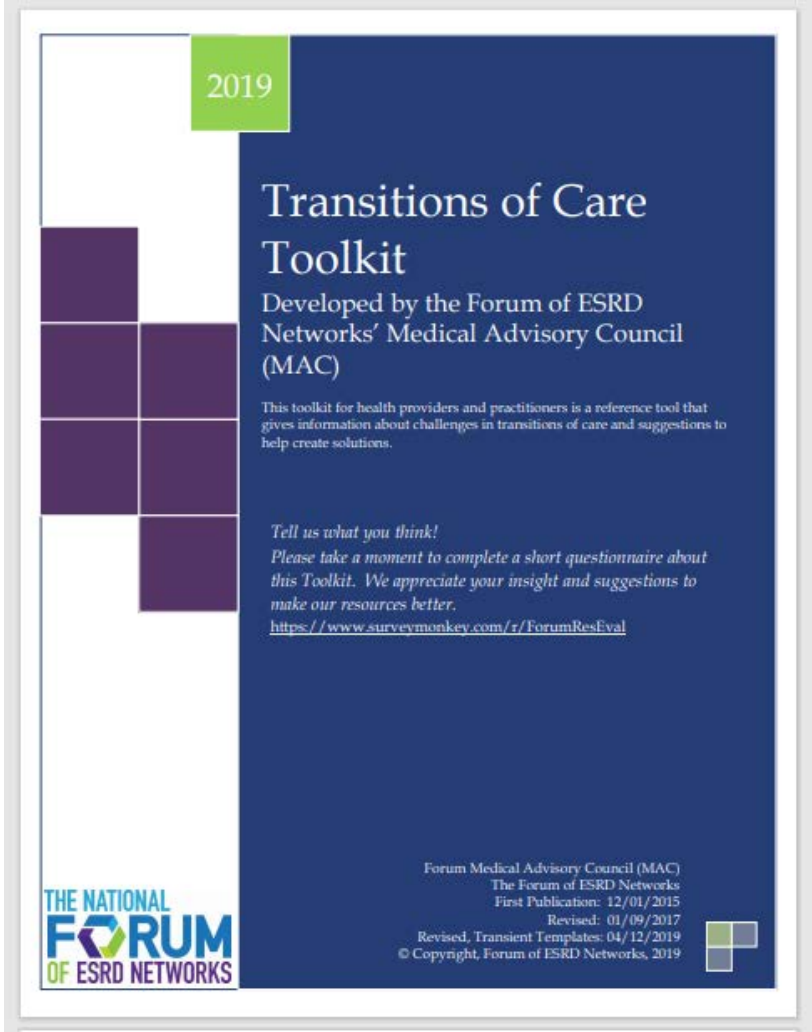
Medication Conversion Guide V1.2 - [02/11/2019]

Video & Slides: Updates to the Transitions of Care Toolkit [Nov 2019]

Included in the April 2019 updates are 2 new tools: the Medication Conversion Guide and a sample Transient Dialysis Patient Form. Learn about these updates and tools through this short video presentation by our Forum President, Ralph Atkinson, MD and MAC Chair, David Henner, DO.

Slides: Updates to the Transitions of Care Toolkit

Video: Updates to the Transitions of Care Toolkit



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Take Home Messages:

1. "Transitions of care" are not just about discharges from a hospital. Kidney patients and their families have many unique transitions—including a massive shift in what they expect for their futures.
2. Kidney failure does not go away, though its treatment may change. Both patients and providers must be ready for change, including different renal replacement therapy options.
3. Changes that seem routine for provider staff may be highly stressful for patients. Acknowledge and discuss the patient's fears with him or her. Do not minimize fear.
4. Communication is critical. Using easy to understand terms will reach the majority of the patients regardless of literacy or health literacy levels.
5. Respect is essential.
6. This is a complicated life journey. Many people interact with the patient. Clear, coordinated communication is key to success.

Help Engage Patients in Their Care:

1. Offer HOPE that patients can have a life that is worth living, even with their health problems. Share stories of other patients or find "buddies" to help them see that their lives are not over.
2. Seek out what motivates them so you can help them to achieve their life goals (e.g., being there for children or grandchildren, more education, pets?).
3. Show respect.
4. Support autonomy (self-directed choices).
5. Educate them to feel competent and equip them to take on self-management tasks, such as following a meal plan or taking medicines the right way.

Why are many transitions difficult for patients?

- Lack of understanding of the treatment plan
- Not being included in making the plan or goals in the first place
- Being overwhelmed and dazed
- Anger and/or depression
- Lack of resources (e.g., transportation)
- Discomfort and pain
- Getting conflicting advice from others
- Distrust of providers
- Other issues, such as work schedule or family needs
- Denial that the illness is even present
- Fear of the unknown—or even of the known—effects of following the treatment plan

Helping patients with transitions:

1. Speak with the patient about his or her values. What matters most?
   - Each person has different priorities. Here are a few:
     - A long life
     - A better quality of life
     - Spending more time with loved ones
     - Keeping a job
     - Having a child
2. Frame your communications in terms of how the desired behavior will help support the patient's values and goals.
   - For example, a patient who wants to keep his job may be motivated to choose a home dialysis option for schedule flexibility.

What Patients Say	Causes	Solutions
"I had a hard time transitioning into dialysis and being properly informed about treatment options available."	**2. Not knowing treatment options** • Education about treatment options may not have been done or may have been done at a difficult time. • The patient was too overwhelmed to understand the options. • Options may have been presented in a biased manner.	• Even if it was done pre-dialysis, repeat dialysis options education (if appropriate). Do not present modality options in terms of "pros or cons," since what is a "pro" for one patient may be a "con" for another. • Have a patient who is on a different modality speak with the patient about that modality. A patient who has used more than one modality may be very helpful. Patients often listen more to each other than they do to staff. • Provide written and online educational resources, like www.mydialysischoice.org. • Stress that there are options (if appropriate) and that the patient's choices may change over time. • Discuss all modalities, even those not offered by your clinic. This is a regulatory requirement. There may be another clinic available to the patient that does offer that modality.

What Patients Say	Causes	Solutions
"Not knowing what I don't know yet." "I passed out because my blood pressure fell too low." "No one explained what they were doing or why." "There was no consideration that this was my first treatment."	**3. Not knowing what to expect** • The patient did not visit a dialysis clinic before starting treatment. • No one took the time to explain each step of before or during the treatment. • The patient has language or other barriers to understanding what has been discussed. • The patient did not want to know anything before starting (denial?). • The patient is very scared.	• Whenever possible, have the patient and/or family visit the clinic and meet with the nurse or other staff before starting treatment. Discuss what will happen at each step starting when the patient enters the clinic. • Have a nurse and/or PCT explain each step of the treatment before, during, and after. If you can, arrange for extra staffing when a new patient starts dialysis. Have a designated "trainer" or at least a standard process for staff to follow. • Include family in the clinic orientation and teaching processes as much as possible, depending on the patient's wishes. • Think about having an orientation area for new patients. You can also ask a current patient to be a buddy for a new patient—speak with him or her

What Patients Say	Causes	Solutions
"Where is my usual nurse?"	**Why is it hard for patients to adapt to new or different staff members?** *(Note that the causes and possible solutions shown here do not line up. It will be your job to line up causes and solutions for your own clinic.)*	**What can we do now and in the future to make the transitions in staffing a better experience for patients?**

Author's Note: Access issues are covered first, since access cannulation is a major concern when patients were asked about staffing changes in our surveys. Pain was noted more often than loss of the access.

What Patients Say	Causes	Solutions
"New techs do not have a good understanding of my access, depth, curves, narrowing, etc., causing the new staff member to fish around the access to cannulate, causing pain and infiltration."	**1. Fear of painful cannulation or access damage by new staff** • There is no common place to share access details, which is especially vital for the patient with a difficult or unusual access. • Orientation for new staff members, especially PCTs, is often too short. • Staff may not have been thoroughly educated about how to assess an access prior to cannulation. • Senior staff do not mentor newer staff. New staff are allowed to cannulate without a	• Make sure there is a section in each patient's chart (or EMR or clipboard) with a detailed access drawing if a fistula or graft is present, with information about cannulation. Require all RNs and PCTs to view the drawing before cannulating if they have not worked with the patient before. • Insist on in-depth staff education that includes access assessment and prolonged mentoring by senior staff. Do not pretend that a new staff person has extensive experience. • Make sure that there is always a PCT or RN with good cannulation skills in the clinic to help other staff who need it. Enforce policies that limit the number of cannulation attempts, and tell patients about those policies. • Staff floating within one company's clinics should have the same skills.

New Tools

Sample Transient Dialysis Patient Form:

Developed by the Forum MAC, this form can be customized to fit your facility needs but includes some of the information felt to be most important for the receiving dialysis facility to know how to deliver the best care to the visiting patient while at the facility away from home.

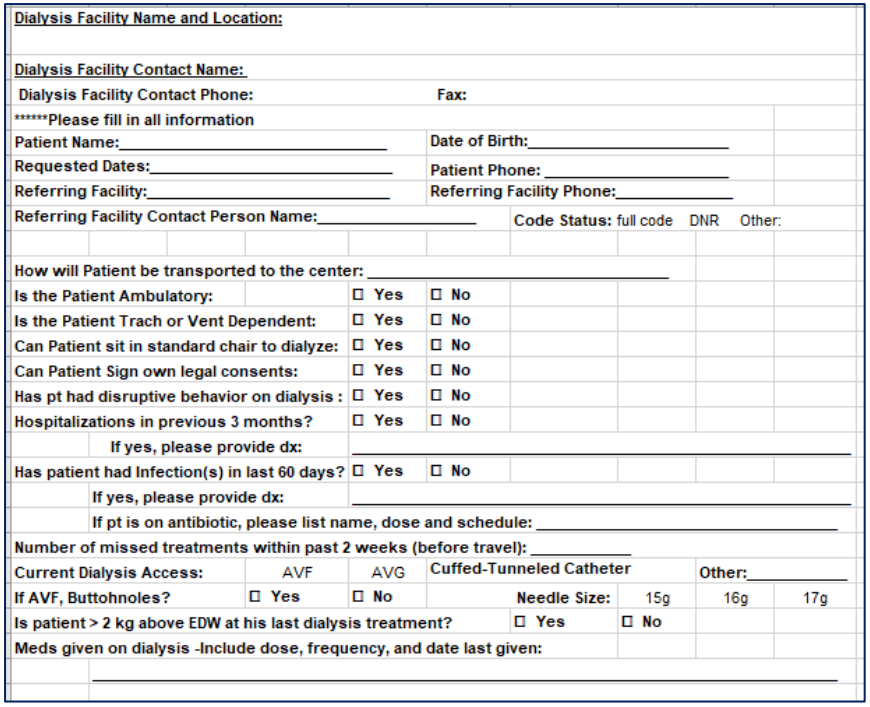
https://esrdnetworks.org/resources/toolkits/mac-toolkits-1/new-toolkit-transitions-of-care-toolkit

Medication Conversion Guide:

Intended to assist physicians to convert the does of a medication a patient is currently receiving, to a substitute medication that is available, or less costly. Medications converted using this tool must be approved or ordered by the patient's Nephrologist, however, we encourage all care providers and patients to share this guide with their care teams.

https://esrdnetworks.org/resources/toolkits/mac-toolkits-1

Update to Transfer Summary Form- updated to include COVID-19 status and Vaccine



Dialysis Facility Name and Location:

Dialysis Facility Contact Name:

Dialysis Facility Contact Phone: Fax:

******Please fill in all information

Patient Name:_____ Date of Birth:_____

Requested Dates:_____ Patient Phone: _____

Referring Facility:_____ Referring Facility Phone:_____

Referring Facility Contact Person Name:_____ Code Status: full code DNR Other:

How will Patient be transported to the center: _____

Is the Patient Ambulatory:	☐ Yes	☐ No
Is the Patient Trach or Vent Dependent:	☐ Yes	☐ No
Can Patient sit in standard chair to dialyze:	☐ Yes	☐ No
Can Patient Sign own legal consents:	☐ Yes	☐ No
Has pt had disruptive behavior on dialysis :	☐ Yes	☐ No
Hospitalizations in previous 3 months?	☐ Yes	☐ No
If yes, please provide dx:	_____	
Has patient had Infection(s) in last 60 days?	☐ Yes	☐ No
If yes, please provide dx:	_____	

If pt is on antibiotic, please list name, dose and schedule: _____

Number of missed treatments within past 2 weeks (before travel): _____

Current Dialysis Access:	AVF	AVG	Cuffed-Tunneled Catheter			Other:_____	
If AVF, Buttohnoles?	☐ Yes	☐ No	Needle Size:	15g	16g	17g	
Is patient > 2 kg above EDW at his last dialysis treatment?			☐ Yes	☐ No			

Meds given on dialysis -Include dose, frequency, and date last given:

_____

Any Symptoms of possible COVID-19? _____

Name of patient's Primary Nephrologist to contact for any questions:_____

Phone number/pager of Primary Nephrologist to contact if any questions:_____

** Please fax copy of the following (required):

- ☐ Current Dialysis Prescription Orders
- ☐ Updated Medication List and Allergies. * *Please include medications given on dialysis**
- ☐ Current Month and previous month's Labs (including URR), electrolytes, Calcium, Phos, and Hgb
- ☐ Problem List/Comorbiditis or H+P within 1 year
- ☐ EKG within 1 year
- ☐ Hepatitis (Hep) B Surface Ag results within 1 month, Hep B S Antibody and Hep C Antibody within 1 year
- ☐ Demographic information
- ☐ Completed 2728 Form
- ☐ Copies of all active insurance cards (front and back)
- ☐ MSP Questionnaire
- ☐ Authorization to Treat & Financial Consent Forms
- ☐ Involvement of Care Form
- ☐ Confidentiality Form (demographic information and Privacy Practices)
- ☐ PPD results within 1 yr, if + PPD please send CXR results within 1 yr
- ☐ Patients transferring for ≥30 days, also need up-to-date comprehensive assessment(s) and plan of care
- ☐ Documentation of COVID-19 Vaccine(s) OR documentation of most recent neg COVID-19 PCR test(s)

**We may transfer transient patient to another of our facilities if chair needed for new patient start

Form updated by ESRD Forum of Networks MAC, V2.0- Lauren Schutz and David Henner, DO 3/12/2021

Medication Conversion Guide

THE NATIONAL FORUM OF ESRD NETWORKS

Conversion Guide for Hemodialysis Patients Visiting Dialysis Facilities

This is a Guide to be used to help convert dose of medication patient currently on, to one that is available or less costly

****This is only a guide- any medication changes must be ordered by/approved by Nephrologist covering patient**

*****This guide is being used to help better serve patients on dialyis, and therefore includes both Brand Names and generic names of medications. The use of brand names is to facilitate use of the tool.**

Instructions on Use:

1. Look for current medication that you wish to convert in Column B and medication you wish to convert to in Column G and chose appropriate row that includes both.
2. Enter dose of current medication in column C (shaded green), and equivalent dose of medication you wish to convert to will be listed in column H (shaded red).
3. See column L for dose forms, and round dose in column H off to closest dose that can be used, using available dose forms in column L (check dialysis facility for dosage forms available)
4. Do not exceed maximum recommended dose of medication listed in column M, without specific written or electronic order entered by Nephrologist.

Current Medication	Enter Current Dose Here:	Units	Route	Frequency	Substitute Medication	Equivalent Dose	Units2	Route3	Frequency4	Substitute Med Dosage Form	Maximum Recommended Dose
Aranesp (Darbepoetin)		mcg	IV	Weekly	Epogen (Epoetin Alpha)	0	units	IV	q Tx	2,3, 4, 10, or 20,000 units/ml	175 units/kg
Aranesp (Darbepoetin)		mcg	IV	Weekly	Mircera (Methoxy polyethylene glycol-epoetin beta)	0	mcg	IV	q 2 Weeks	30, 50, 75, 100, 150, 200 mcg/0.3 ml	180 mcg q 2 weeks
Calcitriol		mcg	PO/IV	q Tx	Hectorol (Doxercalciferol)	0	mcg	PO	q Tx	2.5 mcg PO Capsule	20 mcg
Calcitriol		mcg	PO/IV	q Tx	Hectorol (Doxercalciferol)	0	mcg	IV	q Tx	2 mcg/ml, 4 mcg/ml IV vials	18 mcg
Calcitriol		mcg	PO/IV	q Tx	Zemplar (Paricalcitol)	0	mcg	PO/IV	q Tx	2 mcg PO caps, 2 mcg/ml IV	16 mcg
Epogen (Epoetin Alpha)		Units	IV	q Tx	Aranesp (Darbepoetin)	0	mcg	IV	Weekly	10, 25, 40, 60, 100, 200 mcg/ml	200 mcg IV Weekly
Epogen (Epoetin Alpha)		Units	IV	q Tx	Mircera (Methoxy polyethylene glycol-epoetin beta)	0	mcg	IV	q 2 Weeks	30, 50, 75, 100, 150, 200 mcg/0.3 ml	180 mcg q 2 weeks
Ferrlecit (Ferric gluconate)		mg	IV	Weekly	Venofer (Iron Sucrose)	0	mg	IV	Weekly	20 mg/ml (2.5, 5, 10 ml)	100 mg IV q tx
Ferrlecit (Ferric gluconate)		mg	IV	q Tx	Venofer (Iron Sucrose)	0	mg	IV	q Tx	20 mg/ml (2.5, 5, 10 ml)	100 mg IV q tx
Hectorol (Doxercalciferol)		mcg	IV	q Tx	Calcitriol	0.00	mcg	IV/PO	q Tx	0.25, 0.5 mcg PO, 1mcg IV	4 mcg
Hectorol (Doxercalciferol)		mcg	PO	q Tx	Calcitriol	0.00	mcg	IV/PO	q Tx	0.25, 0.5 mcg PO, 1mcg IV	4 mcg
Hectorol (Doxercalciferol)		mcg	PO	q Tx	Hectorol (Doxercalciferol)	0	mcg	IV	q Tx	2 mcg/ml, 4 mcg/ml IV vials	18 mcg
Hectorol (Doxercalciferol)		mcg	IV	q Tx	Hectorol (Doxercalciferol)	0.00	mcg	PO	q Tx	2.5 mcg PO Capsule	20 mcg
Hectorol (Doxercalciferol)		mcg	PO	q Tx	Zemplar (Paracalcitriol)	0	mcg	PO/IV	q Tx	2 mcg PO caps, 2 mcg/ml IV	18 mcg
Mircera (Methoxy polyethylene glycol-epoetin beta)		mcg	IV	q 2 Weeks	Aranesp (Darbepoetin)	0	mcg	IV	Weekly	10, 25, 40, 60, 100, 200 mcg/ml	200 mcg IV Weekly
Mircera (Methoxy polyethylene glycol-epoetin beta)		mcg	IV	q 2 Weeks	Epogen (Epoetin Alpha)	0	units	IV	q Tx	2,3, 4, 10, or 20,000 units/ml	175 units/kg
Venofer (Iron Sucrose)		mg	IV	Weekly	Ferrlecit (Ferric gluconate)	0	mg	IV	Weekly	12.5 mg/ml (5 ml)	250 mg
Venofer (Iron Sucrose)		mg	IV	q Tx	Ferrlecit (Ferric gluconate)	0	mg	IV	q Tx	12.5 mg/ml (5 ml)	250 mg

Physician enters dosage of current/regular medication in the left column, conversion to alternative medication and dosage is automatically calculated in the left columns.

Current Medication	Enter Current Dose Here:	Units	Route	Frequency	Substitute Medication	Equivalent Dose	Units2	Route3	Frequency4	Substitute Med Dosage Form	M Re
Aranesp (Darbepoetin)		mcg	IV	Weekly	Epogen (Epoetin Alpha)	0	units	IV	q Tx	2,3, 4, 10, or 20,000 units/ml	17
Aranesp (Darbepoetin)	60	mcg	IV	Weekly	Mircera (Methoxy polyethylene glycol-epoetin beta)	96	mcg	IV	q 2 Weeks	30, 50, 75, 100, 150, 200 mcg/0.3 ml	18
Calcitriol		mcg	PO/IV	q Tx	Hectorol (Doxercalciferol)	0	mcg	PO	q Tx	2.5 mcg PO Capsule	20
Calcitriol		mcg	PO/IV	q Tx	Hectorol (Doxercalciferol)	0	mcg	IV	q Tx	2 mcg/ml, 4 mcg/ml IV vials	18
Calcitriol		mcg	PO/IV	q Tx	Zemplar (Paricalcitol)	0	mcg	PO/IV	q Tx	2 mcg PO caps, 2 mcg/ml IV	16
Epogen (Epoetin Alpha)		Units	IV	q Tx	Aranesp (Darbepoetin)	0	mcg	IV	Weekly	10, 25, 40, 60, 100, 200 mcg/ml	20
					Mircera (Methoxy polyethylene					30, 50, 75, 100, 150, 200	

Questions / Comments:

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Sharing something about the KPAC? Use #KPACPatientVoice

THE NATIONAL FORUM OF ESRD NETWORKS

Q&As – 5 Minutes

Case Study Presentation

Dawn Edwards
KPAC Co-Chair

Derek Forfang
KPAC Co-Chair

Q&As – 5 Minutes

Questions to Run On -- Revisited

How Might We …

- Help patients to adjust behaviors that may contribute to hospitalizations, such as not taking medications, smoking, or missing appointments?
- Address health conditions that may contribute to hospitalizations, such as anemia or undiagnosed mental health?
- Support patients with unstable support systems or financial issues that may impact hospitalizations?

Recap & Next Steps

- Top take-aways
- Additional pathways for learning

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National Coordinating Center (NCC)

Thank You

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