Expert Teams – Transitions of Care

Case-Based Learning & Mentorship

Friday, May 20, 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
- ESRD NCC Change Package to Reduce Hospitalizations
  - Change Package Methodology
  - Primary and Secondary Drivers
- Case Study Presenter
  - Mary Chacon, ACSW, Dialysis Social Worker, Fresenius Kidney Care
- High Performing Organizations
- ESRD Networks
- Centers for Medicare & Medicaid Services (CMS)

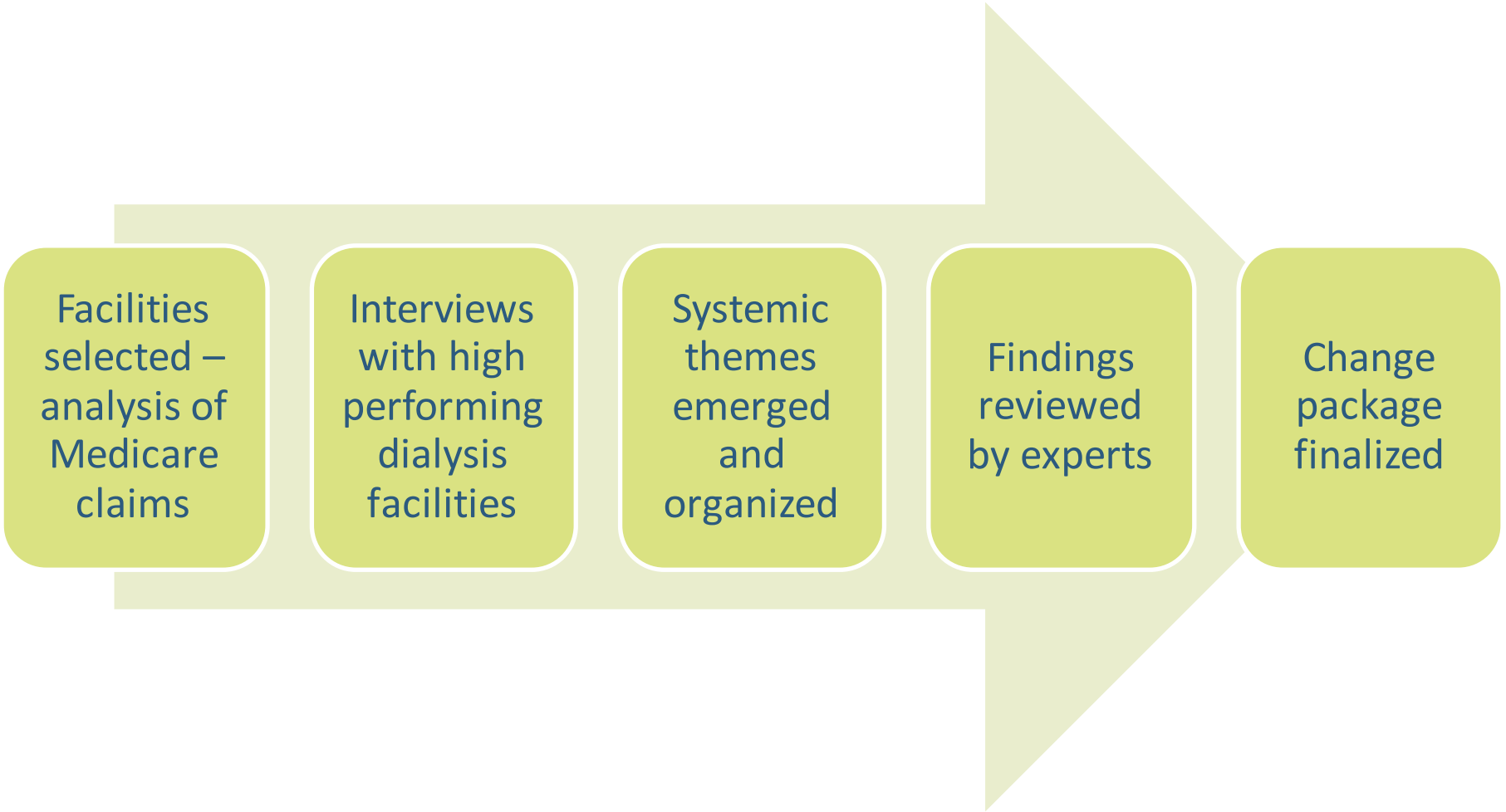
Questions to Run On

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?

Introduction to the ESRD NCC Hospitalization Change Package

Change Package Methodology



AIM: REDUCE HOSPITALIZATIONS

Primary Driver #1: Adopt a culture that embraces patient-centeredness and high performance		
Keep the focus on patients and families	Create a culture that contributes to low hospitalization rates	Establish channels of communication to facilitate information sharing

AIM: REDUCE HOSPITALIZATIONS

Primary Driver #2: Implement continuous quality improvement

Track hospitalizations and related measures	Review data in QAPI meetings and use data to drive QAPI processes

AIM: REDUCE HOSPITALIZATIONS

Primary Driver #3: Implement processes to prevent hospitalizations and avoid readmissions

Take proactive steps to prevent hospitalizations	Give focused attention to patients who have been hospitalized

AIM: REDUCE HOSPITALIZATIONS

Primary Driver #4: Educate patients and staff

Provide patients with knowledge, so they can play an active role in staying out of the hospital	Prepare staff to prevent hospitalizations

Using the Change Package

- Change happens at the local level
- Change ideas serve as "tests of change"
- Quality Assessment & Performance Improvement (QAPI)
- Engage your ESRD Network

Q&As – 5 Minutes

Transitions of Care
Expert Team Case Studies

May 20, 2022

Mary Chacon, ACSW

Dialysis Social Worker

Fresenius Kidney Care

Dialysis Patient Hospital Discharges

- Vary in complexity and needs, especially related to caregiving
- Are addressed very differently based on hospital and community resources
- Often include balancing the patient's wishes with safety
- Don't always include dialysis staff notification but impact the patient's dialysis care
- Are insurance driven

Case 1

- 80-year-old male patient hospitalized for cardiac issues refuses Skilled Nursing Facility (SNF) placement and wants to go home with his wife who has a broken leg.
- Patient is told he was referred for home health, but they will not be available for two weeks.
- Patient was weak, could not walk and was using a wheelchair upon returning home with his wife.
- The patient's wife called the dialysis social worker (SW) upon the patient's return home with concerns about being able to care for him.

Case 1 Cont.

- The dialysis SW called the hospital case manager to advocate for getting home health for the patient sooner and tried to problem solve options for care assistance with the wife.
- The dialysis facility completed their post-hospitalization process including assessment of the dialysis prescription and patient follow-up needs.
- The hospital case manager later emailed the patient's wife a list of private duty agencies.
- The patient returned to the hospital after being at home for a week due to caregiving issues.

What processes or tools has your facility implemented to try and avoid or address readmissions like this one?

Case 2

- 77-year-old female patient began drinking heavily after the death of her husband, causing a decline in her health, including renal failure.
- As the patient's health continued to decline, she moved to an Assisted Living Facility (ALF).
- Upon her next hospitalization, the ALF reported that they did not feel she could return due to her needs and felt she should go to a SNF.

Case 2 Cont.

- Dialysis SW had access to the local hospital's electronic medical record.
  - Enabled SW to view discharge planning notes
  - Included contacts for hospital discharge planners
- Dialysis SW contacted the discharge planner and discussed referring the patient to a local palliative care program that offers supportive services.
- The patient was enrolled in the program before she left the hospital and was able to return to her ALF with palliative support services in place.

What community resources or programs has your facility worked with to help reduce patient readmissions?

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 from today's meeting
- Additional pathways for learning
  - Where will you share the information that you learned today?
  - Who could benefit from the information?
  - What one thing that you heard today could you start doing in your organization tomorrow?
- Change Package Posting to the ESRD NCC
- Event evaluation

Social Media

ESRD National Coordinating Center

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National Coordinating Center (NCC)

Thank You

Kelly M. Mayo
kmayo@hsag.com
813-865-3552

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