

Expert Teams – Hospitalization

Case-Based Learning & Mentorship

Tuesday, December 19, 2023

Moderator: Julie A. Moss, MS



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.



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

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

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

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



ToC Case Study: Transitions for the Hospitalized Patient on Dialysis



Chief Complaint: It's Monday morning and a Mrs. Singh was admitted 2 weeks ago for worsening kidney transplant function and pneumonia.

History: She has advanced CKD at baseline (transplanted 12 years ago) and has had failing appetite for several months. By the time she went to the ER with a fever, her creatinine was up to 6.4 mg/dL and she wasn't responding well to diuretics. Her fistula had been evaluated as an outpatient earlier and was felt ok to use. She was preparing to start HHD training in another 1-2 months.

Now on dialysis for a week and feeling better, anxious to go to rehab. IV vancomycin for another week due to MRSA bacteremia.

ToC Case Study: Transitions for the Hospitalized Patient on Dialysis



Monday's hospital course: Mrs. Singh is felt to be “stable” from hospitalist perspective and patient is discharged to rehab late in the afternoon.

- Case manager (CM) works with rehab CM to transfer over
- Nephrologist contacted while in clinic
- In-center unit scrambles to get patient admitted and accommodated
- No conversation from provider to provider regarding discharge plan, meds, dialysis goals, etc...

Subsequent events (in specific order):

- Different EMRs and dialysis clinic never gets discharge paperwork
- Patient misses several vancomycin doses
- No conversation regarding HHD goals, management of immunosuppression plans...
- Patient is readmitted 2 weeks later with fever and septic arthritis

Missed Opportunities



- Poor weekend to weekday handoff from providers
- Failure to keep nephrologist in the loop for disposition planning
- Failed kidney transplant: immunosuppression planning?
- Did anyone listen to the patient? Goals of care for eventual home hemodialysis
- Patient has suffered a major “loss” – allograft function, independence, many emotions...
- The “other things” that people fail to address: social workers, dieticians, transportation, medication changes, dry weight/new dialysis prescription

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- We failed on multiple levels: modality transition, hospital to rehab transition, patient-centeredness...

Groundhog Day, anyone?



- Nephrologists communicate! Speak with outpatient transplant clinic and patient to understand “big picture” of patient goals and planning
- Inpatient MDT willing to keep nephrologist in the mix for d/c planning
- Nephrologist ability to give clear recommendations for immunosuppression planning, contact dialysis unit to orders, HHD goals (eventually), medication reconciliation and discharge summary
- Contact between hospital CM and dialysis SW and rehab team
- Patient education about this new transition...

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 question
this Toolkit. We appreciate your insight and suggestions
make our resources better.*

<https://survey.monkey.com/c/Forum-PacFi>

<https://esrdnetworks.org/toolkits/professional-toolkits/transitions-of-care-toolkit/>

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SAMPLE TEMPLATES

Post-hospitalization Checklist
Dialysis Unit to Hospital Transfer Summary
Hospital to Dialysis Unit Transfer Summary
Pediatric to Adult Care Coordination Letters ..
Medication Reconciliation Guide
Caring for Transient Dialysis Patients
Sample Transient Dialysis Patient Forum
Sample Confidentiality Agreement

ESRD Patient ER Utilization



There are not many publications about care transitions of patients with CKD or kidney failure.

We know that these patients are hospitalized more often and are more likely to be re-hospitalized, in that hospitalized dialysis patients upon discharge exhibit a 30-day readmission rate of up to 35% - almost double the readmission rate of the general Medicare population.

We know that they tend to have multiple health problems and are on multiple medications.

We also know that they see many providers needs of kidney patients.

<https://esrdnetworks.org/toolkits/professional-toolkits/transitions-of-care-toolkit/>

ESRD Patient ER Utilization

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

CHAPTER 5. THE TRANSITION TO DIALYSIS: THE FIRST DIALYSIS TREATMENTS

Problem: Patients do not know what to expect when they start dialysis. Starting dialysis may appear frightening.

Goal: Help patients understand what to expect during the initial dialysis treatments and plan for next steps. Assist patients by explaining their options, how to make their needs known, and how to engage in their own care.

Part 1: Introduction

Starting dialysis is a major life change for patients. What seems to be a smooth transition from the provider perspective may be frightening and confusing for patients.

Most patients who responded to our surveys found starting dialysis to be challenging and overwhelming. Even patients who had education about their option the experience of dialysis would be like. They often f

CHAPTER 7. MODALITY CHANGES

Problem: Changes in treatment modality can be very difficult for a dialysis patient. These changes often occur during times of increased illness and can be associated with feelings of frustration, failure, and loss.

Goal: Help patients understand what to expect when changing modalities. They need to know how and who to ask for help and how to be engaged in the process.

Part 1: Introduction

Transitions between modalities include the change from in-center dialysis to home dialysis, change to a different type of dialysis, or even change from daytime to nocturnal dialysis. It also includes stopping dialysis following a successful transplant or starting dialysis after a failed transplant. For some patients, it includes stopping dialysis and starting supportive care. Supportive care is often hospice care, but not always. Some changes are voluntary, such as when a hemodialysis patient wishes to try peritoneal dialysis. Often the transition is involuntary, such as when a transplant fails. In our surveys, most patients reported that a modality change is challenging an transition from transplant to dialysis. Most provide not a threat to patient safety.

Transitions of Care Post- Hospitalization Checklist

Patient Name: _____

Date/Initial when checklist is completed: _____

Complete prior to first post-hospitalization treatment:

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

Complete during first post-hospitalization treatment:

Contact physician to discuss treatment orders/protocols and medication prescription changes, and enter all changes/new orders in EMR.

- Treatment order changes (e.g. vascular access plan, target weight, dialysate bath, treatment time, etc.)

- In-center or Home administered medications (new, discontinued, change in dose)

- IV/IP antibiotics/blood cultures

- Labs to be drawn on return from hospital (i.e. Hb, Fer, TSAT, Alb, etc.)

Initiate home medication review.

- Ask patient to bring in all new medication bottles.

- Update any changes in the medication list in the EMR.

- Coordinate with patient's prescriber/pharmacy to fill any updated prescriptions.

Follow your facility's Fluid Management Pathway.

Conduct physical assessment to identify any new issues or complications (e.g., vascular access, foot check)

Complete during first week post-hospitalization:

Follow up to obtain discharge summary if not received.

Follow up to complete home medication review once patient brings in any new medication bottles.

Support and reinforce any patient/caregiver education that is specific to the patient's reason for admission.

Ensure patient has been educated on and received an advance directive form to complete at dialysis center, and that patient updates the form as needed.

Support patient with any post-hospitalization follow-up.

- Provider/specialist appointment(s).

- Durable medical equipment

- Home health referral(s)

https://www.midwestkidneynetwork.org/sites/default/files/transitions_of_care_checklist.pdf

CHAPTER 10. PROBLEM SOLVING PROCESSES

There are many ways to approach problem solving. The first process described here differs slightly from the usual PDSA (Plan-Do-Study-Act) format of defining the problem, gathering a team, defining barriers and root causes, devising solutions, then acting and assessing and planning again. It may be a little more straightforward for some teams.

The second process presented here is the familiar PDSA cycle referenced in the Transitions Between Settings chapter of this toolkit. The Forum of ESRD Networks' 2010 QAPI toolkit (<https://esrdnetworks.org/toolkits/professional-toolkits/qapi-toolkit/>) is another resource for designing a problem-solving process. See an example of a problem-solving process at the end of this chapter.

Start taking steps

The dialysis and hospital (or SNF/LTAC) transition team will need to:

1. Identify what processes, if any, are already in use when patients transition between another setting and the dialysis clinic. It is vital to know details so that you can identify flaws. Be as concrete and specific as possible.
2. Track the problem until understood. Do not rely on anecdotal reports. Real data are necessary to find out what processes to improve.
3. Start asking “why” the process in place did not work. List the causes and the causes of the causes—and keep asking why. Note: There may not be a standardized process in place. Use that as an opportunity to create a process that works.
4. Think of solutions. Solutions must be things over which the dialysis team has control and that will improve the outcome. These include processes for two-way communication and patient/family education. Think about the details that are often overlooked (such as the voice mail being full or that the patient cannot remember the name of the dialysis clinic).

Broad Concepts:

1. Embed new processes (“hardwire”) into the routine admission and discharge activities of the hospital, SNF or LTAC, and the dialysis clinic. Work with the hospital or other setting to create the processes. Redesign the processes if they do not work.
2. Remember that communication is a two-way street. The hospital, SNF, and LTAC need information from the clinic. They do not know as much about kidney patients as you do, and they rely on your expertise. They do not know how the dialysis clinic works or what it needs from them unless told.
3. Have a system in place to track and trend transitions. Know if the processes in place are working. Designate a person to maintain a log of transitions and any problems that arise. Transitions between settings are high-risk events. The dialysis team, including the clinic’s medical director, should review them regularly to evaluate improvement possibilities. Anticipate the need to “tweak” the processes in collaboration with the hospital.
4. Caregivers must share information for care coordination. Work with the hospital during a hospitalization so the hospital staff can share information during admission and before discharge.
5. Engage and educate patients and families. Ask for their feedback. However, do not make them the primary source of communication between settings.
6. Do not get into the “blame game.” Cooperation and collaboration are necessary to make transitions safe and efficient.

Summary

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.**

Questions and Answer Discussion

Case Presentations

Barbara Dommert Breckler
Comagine Health ESRD Network 16
and
Travis Wood
Facility Administrator
DaVita

Katy Robertson
Facility Administrator
FMC Eucalyptus Clinic



Reducing Hospitalization- PCPs and Diet.

Barbara Dommert Breckler

Comagine Health ESRD Network 16

Travis Wood

DaVita

It all started with a live site visit.

Comagine
Health

Site Visit- July 2023

- Facility was on the priority zip list

- At OY2 Baseline

Facility Rates

- Admissions Baseline 1.299
- ER Usage 1.732

- Network Rates

- Admissions 1.685
- ER Usage 0.94

Health Care Environment

- PCPs/Extenders left the local area
- 1 Urgent Care
 - If patient arrived after 8:30am they were sent to the hospital
- Transportation
 - Lacking community transportation
 - High gas prices (almost \$5 a gallon)

Getting Primary Care Providers- Start the Conversation

- Collaboration is key for overcoming barriers.
- Schedule monthly meetings with hospital and nephrology directors.
- What can you do for them?
- What can they do for you?
- Make those calls.
- Look for nurse practitioners and extend your radius for PCPs.

Make a Meaningful Impact on Diet and Nutrition- Go Beyond Patient Education

- Focus on dialysis friendly foods and include diabetes.
- Educate food banks and local churches within your county.
- Educate skilled nursing facilities and nursing home communities.
- Patient caregivers can have the greatest impact.
- Don't do it alone.
- Include your medical director, social worker, dietitian & AA.

Results

- No hospital admission since August
- One ER visit since August



Phosphorus and Fluid

How can you help?

Bone Disease

- High phosphorus levels
 - Bone strength
 - Vascular calcification or calcium put into the vessels --> heart attack and death.
- Patients have trouble with taking their medications and managing their diet for phosphorus because high phosphorus “doesn’t hurt”.



Phosphorus levels 3.0 - 5.5



Patients considered for transplant need tight control of phosphorus for two reasons:



1. Managing phosphorus and taking their medications as ordered indicates the patient would be able to handle a more complex medication schedule after transplant.




2. Lower calcification of the vascular system reduces the risk of attempting a transplant and finding the connecting veins/arteries to the new kidney can't be attached.

Controlling phosphorus is necessary but challenges patients – WHY?




- 1 - They have to remember to take binders every time they start to put something in their mouth that isn't water.
- 2 - It is a social interruption. Sitting around a table with family, going out to eat—we are all on the go and the distractions of others and the desire to not be different will weigh in on their decision.
- 3 - Taking a lot of medication is hard. Patients have a difficult schedule to keep track of. Lots of pills also means more fluid they need.

Helping Patients Make Better Diet Choices to Lower Phosphorus intake

- Phosphorus is found in all food but some foods have more absorbable phosphorus than others.
 - phosphorus from plants are less absorbed than animal phosphorus and even less than additives or preservatives in food.
- Helping a patient realize that they may be eating foods from snack machines, convenience stores, fast food restaurants and foods that are ready to go in the grocery store increases intake of very absorbable phosphorus.
 - This includes most processed drinks except for Root Beer, 7-UP/Sprite, and Ginger Ale.



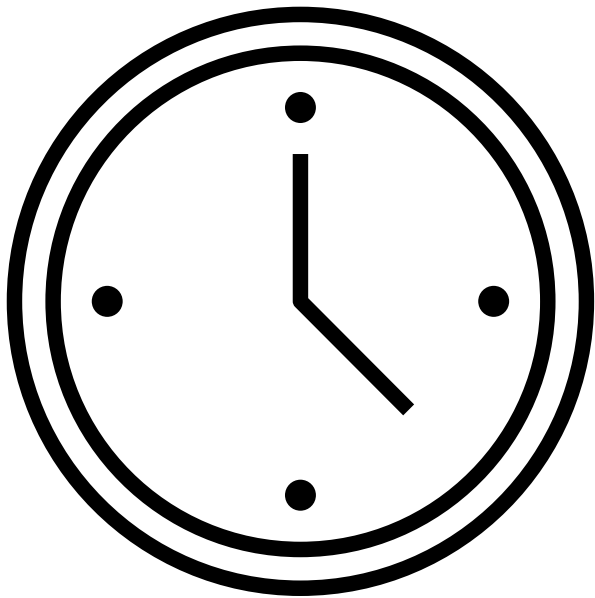
Helping patients realize that staying their entire treatment time can lower their phosphorus

- **Goal: to reinforce that time helps the removal of phosphorus.**
 - Time on dialysis matters to our patients to remove toxins and fluids.
 - Phosphorus is a molecule that can be removed during treatment. Molecules are removed at different times during the treatment.
 - Phosphorus is removed later in the treatment because it is a bigger molecule than potassium and other toxins thus, there is a benefit for the patient to stay their entire time.
 - There are many reasons that patients need to stay for their ordered treatment and phosphorus removal is another benefit for the patient to complete their time.
- 
- 
- 



Missed Treatments

Fluid management



Stay for your full dialysis session—every time. Your doctor will prescribe the treatment time that’s right for you.

Completing every treatment will help maximize the effectiveness of your dialysis.

Reducing your prescribed treatment time by even 10–15 minutes will allow toxins and fluid to build up in your body—which will impact your health and how you feel.

Missing Dialysis Treatment is Dangerous

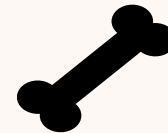
High potassium

- can lead to heart problems including arrhythmia, heart attack, and death.



High phosphorus

- can weaken your bones over time and increase your risk for heart disease.

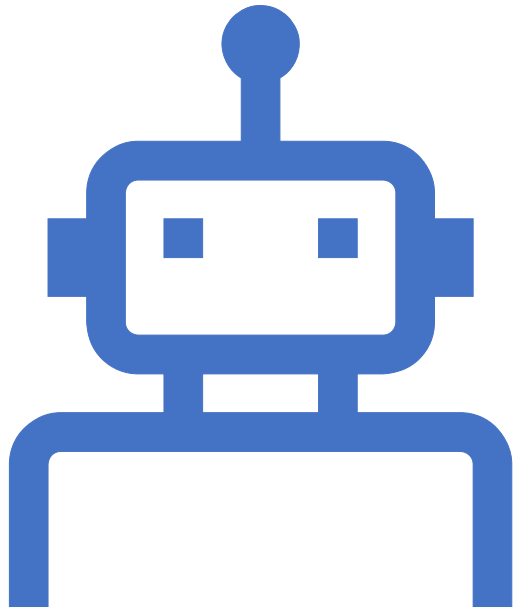




“Give me a reason to stay for my full treatment”

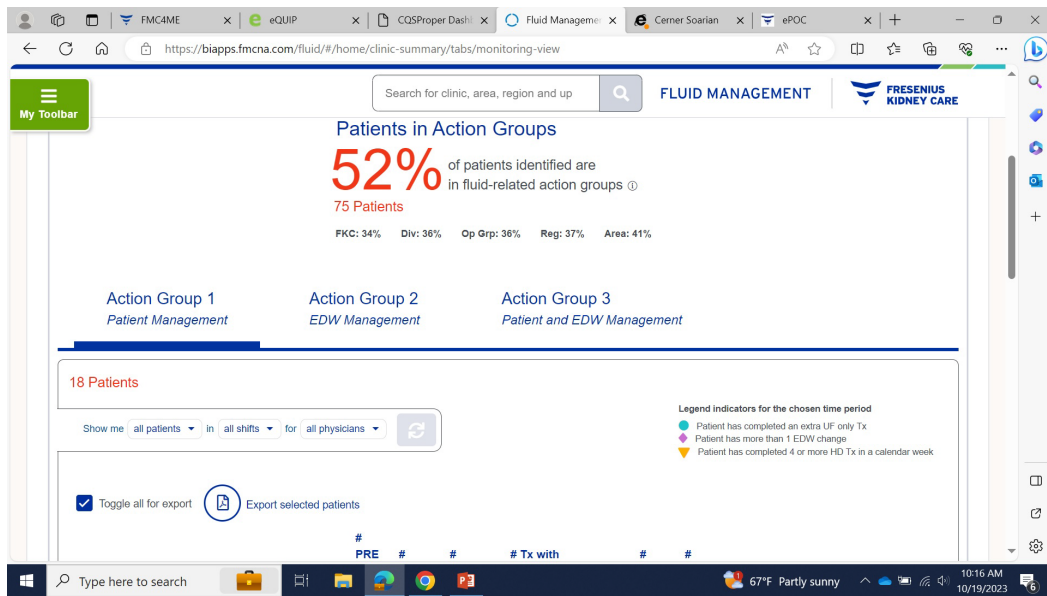
“I’ll give you two”

- Shortening 3 or more sessions per month can result in a 20% higher risk of death
- Skipping 30 minutes of dialysis per treatment equal 2 months worth of dialysis



Set	Set expectation with patients that missed treatments are unacceptable.
Provide	When discussing reschedules with the patient, provide the information to the secretary or ward clerk.
Follow	Follow a script for patient discussion
	Always reschedule and make up the treatment ASAP
Celebrate	Celebrate when the patient makes up treatment

Fluid Dashboard



18 Patients

Show me all patients in all shifts for all physicians

Legend Indicators for the chosen time period
 ● Patient has completed an extra UF only Tx
 ◆ Patient has more than 1 EDW change
 ▼ Patient has completed 4 or more HD Tx in a calendar week

Toggle all for export Export selected patients

Patient Name ^	MRN	# PRE SBP > 160	# POST SBP > 140	# Current BP Meds	# Tx with Intradialytic Hypotensive Episodes	# EDW	# PWV > +/- 1kg	# IDWG > 4%	Rx Time	Missed Tx	Shortened Tx
<input checked="" type="checkbox"/> + [Redacted]	[Redacted]	5	8	2	0	59.5	0	5	3Hr 30Min	1	1
<input checked="" type="checkbox"/> + [Redacted]	[Redacted]	0	6	2	0	60	2	1	3Hr 45Min	0	8
<input checked="" type="checkbox"/> + [Redacted]	[Redacted]	7	6	1	0	81	1	0	3Hr 45Min	3	4
<input checked="" type="checkbox"/> + [Redacted]	[Redacted]	4	7	3	0	65.5	3	1	3Hr 0Min	2	1

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
1 Prevent Blood Infections	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Fever, fatigue, diarrhea, and/or redness and swelling around a catheter
2 Protect Your Access	<ul style="list-style-type: none"> Listen to your access Feel your access for Talk to facility staff Get treatment as sc
3 Reduce Your Risk of Fluid-Related Issues	<ul style="list-style-type: none"> Attend all of your d Follow salt and fluid Let staff know if you <ul style="list-style-type: none"> Drinking too muu fluid harder to re Too much fluid n heart problems
4 Protect Your Heart	<ul style="list-style-type: none"> Keep a healthy bod Get help to quit am Take your blood pre Follow salt and fluid

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 cat:

- 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, 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



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, March 19, 2024

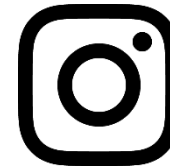
Visit the ESRD NCC website to find materials and share <https://esrdncc.org/en/professionals/expert-teams/>



Social Media



ESRD National Coordinating Center



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National Coordinating Center (NCC)



Expert Teams – Case-Based Learning & Mentorship

Thank You

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