Reducing Hospital Admissions

Learning and Action Network (LAN)

February 20, 2024

Facilitator: Sara Eve Schaeffer, MBA, MA, RD
ESRD National Coordinating Center

Meeting Logistics

Call is being recorded.

All participants are muted upon joining the call.

We want to hear from you.

Type questions and comments in the “Chat” section, located in the bottom-right hand corner of your screen.

Meeting materials will be posted to the ESRD NCC website.

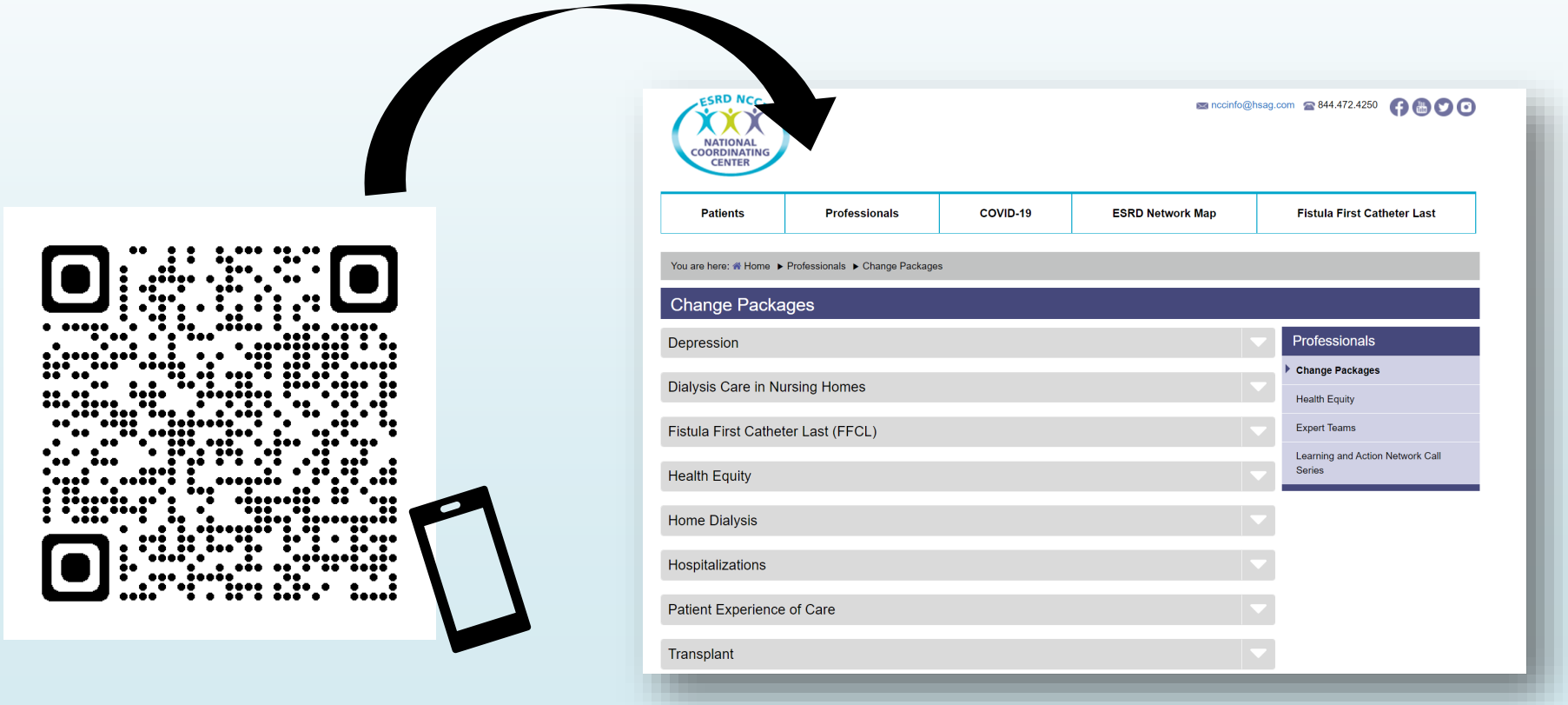
Ways to spread best practice from today's LAN

- Listen and share your approaches/experiences via Chat
- Identify how shared information could be used at your facility
- Apply at least one idea from today's LAN at your facility
- Commit to sharing your learnings with other colleagues

Learning and Action Networks (LANs) bring people together around a shared idea, opportunity, or challenge to offer and request information and experiences to improve the identified topic of discussion.

Answer using *Chat*
Make sure it's set *To: Everyone*

Have you previously applied best practices from the change packages to improve outcomes?



Network 7

HSAG HEALTH SERVICES ADVISORY GROUP

ESRD Networks 7, 13, 15, 17, 18

Community of Practice (CoP)

US Renal Care

Lehigh Acres

Lehigh Acres

- Involved in a Network Focus Group
  - Began targeted focus and intervention in October 2023
  - Specific focus on the Emergency Department use
  - Rate at time of inclusion was 4.26 visits per 100 patient months
  - Current rate (using January 2024 data) is 2.25 visits per 100 patient months

Identified Barriers

- Identified from the Change Package

AIM: REDUCE HOSPITALIZATIONS	
PRIMARY DRIVERS	**SECONDARY DRIVERS**
1. Adopt a culture that embraces patient-centeredness and high performance	1a: Keep the focus on patients and families 1b: Create a culture that contributes to low hospitalization rates 1c: Establish channels of communication to facilitate information sharing
2. Implement continuous quality improvement	2a: Track hospitalizations and related measures 2b: Review data in QAPI meetings and use data to drive QAPI processes
3. Implement processes to prevent hospitalizations and avoid readmissions	3a: Take proactive steps to prevent hospitalizations 3b: Give focused attention to patients who have been hospitalized
4. Educate patients and staff	4a. Provide patients with knowledge, so they can play an active role in staying out of the hospital 4b. Prepare staff to prevent hospitalizations

Primary Drivers

- Combined all drivers
  - Driver 1: Culture of patient-centeredness
    - Have been meeting with all patients individually instead of handing out education or speaking generally
  - Driver 2: Implement continuous quality improvement
    - Tracking and responding to all hospital and Emergency Department use with very timely patient discussion
    - Review trends
    - Review EDW's weekly with the team and the physician
  - Driver 3: Processes to prevent hospitalization
    - Meet with all patients individually
  - Driver 4: Educate patients and Staff
    - Use of calling the clinic and speaking to staff prior to deciding to go to the hospital
    - Reinforce reasons to go immediately to the hospital

Mitigation Strategies

- Mitigation for patients
  - Call the clinic for assistance
  - Use of tools like the hospitalization zone tool
  - Modified Sit Down and Round questions

- Mitigation for staff
  - Culturally competent education
  - Education and involvement of all disciplines

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Thank you!

Amy Carper

acarper@hsag.com

Network 8

LAN Hospitalization Review

University of Mississippi Medical Center

Outpatient Dialysis

Heidi Ferguson, RN, MSN, MHA

Evaluating Causes of Hospitalizations Among ESRD patient: A Quality Improvement Project

Carter Schwartz, Heidi Ferguson, Catherine Wells, Neville R. Dossabhoy
University of Mississippi Medical Center, Department of Medicine, Division of Nephrology

Background

- End-stage renal patient cost the healthcare system an enormous amount in terms of time and resources
- We evaluated CMS reported hospitalizations of our JMM dialysis patients to identify ways to conserve resources and streamline patient care

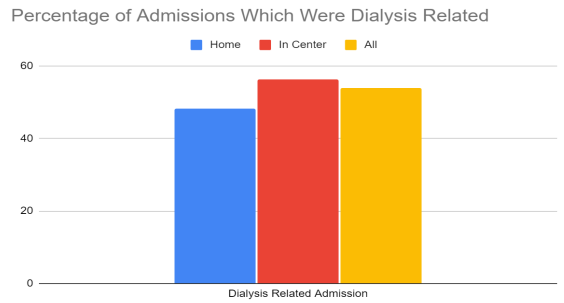
Methods

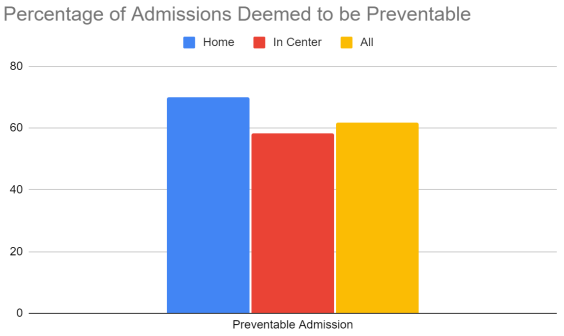
- A total of 202 hospitalizations were reviewed across both home and in-center JMM dialysis patients
- These charts were reviewed by nursing staff and a Nephrology fellow to determine if the cause of hospitalization was dialysis related and if it was felt

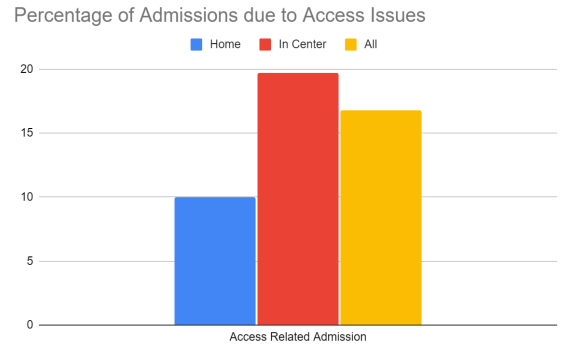
Results

- Among home dialysis patients 29/60 (48.3%) were found to have dialysis related complications leading to admission. Of the 60 admissions, 42 were deemed to have been preventable (70%)

- Among in-center hemodialysis patients 142 admissions were reviewed, revealing a total of 80 dialysis related admissions (56.3%). A total of 83/142 admissions were felt to be preventable (58.4%).







Conclusions

- Beyond the sheer volume of likely preventable occurrences, we were surprised with the high number of access issues. We have actively begun to collaborate with interventional radiology to arrange for more streamlined and seamless interdisciplinary care of our patients who require access interventions in an effort to facilitate a greater number of these on an outpatient basis.

- We also found that a degree of non-compliance with outpatient treatments led to many of the preventable hospitalizations, which led our JMM unit to begin incentivizing attendance at prescribed treatment with weekly raffles of small prizes for those with perfect attendance, which has been well received by patients

Future Plans

- Working diligently to reduce the utilization of inpatient admissions to remedy potentially preventable or manageable problems in the outpatient setting will continue to enable judicious allocation of healthcare resources and ensure that we are able to continue to provide high-quality care for our patients well into the future. We continue to actively review protocols and procedures to reduce unnecessary resource utilization.

Controllables

- Focus on those areas where we could focus
- We knew we could not take on all reasons for hospitalizations
- Focus Areas
  - Access Interventions
  - Missed Treatments

Access Interventions

- Labs prior to hospitalization
- Proactive when patient shows in ER
- Collaborated with IR and other disciplines to streamline intervention

Access Hospitalizations

2022

System		Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	% of Total Causes
Access	1	Access Interventions	1	5	2	1	4	3	2	2	6	1	1		28	14.9%
	2	Placement of Access	0	0	0	0	0	1	0	0	0	0	0		1	0.5%
		Access Total	1	5	2	1	4	4	2	2	6	1	1		29	15.4%

2023

System		Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	% of Total
Access	1	Access Interventions	1	3	2	2	2	0	1	1	5	2	0	1	20	9.8%
	2	Placement of Access	0	0	0	0	0	2	0	0	0	0	0	0	2	1.0%
		Access Total	1	3	2	2	2	2	1	1	5	2	0	1	22	10.7%

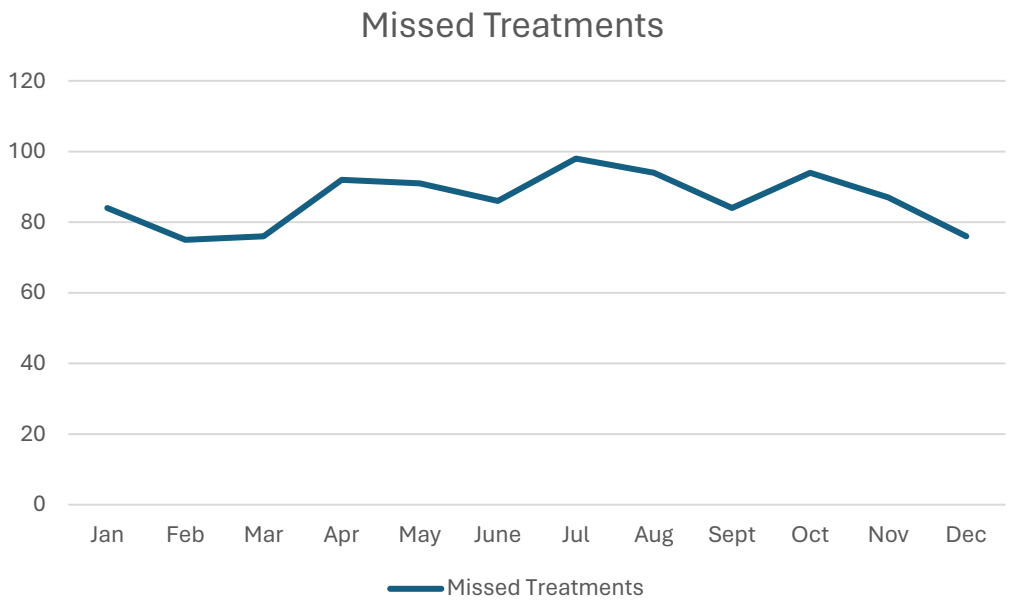
Decrease of 8 Patients requiring hospitalization due to access interventions

Missed Treatments

- Some patients missing 12 treatments a month
  - Worked with IDT team and Network 8 for resolution
  - Follow up with Well-Checks daily phone calls
- Patients missing Saturdays
  - Looked for schedule that better suited their needs
- Incentivize patients to show
  - Bi-weekly drawing
  - Patients would remind staff
- Incremental Program
- Slow but steady thinking

Missed Treatments

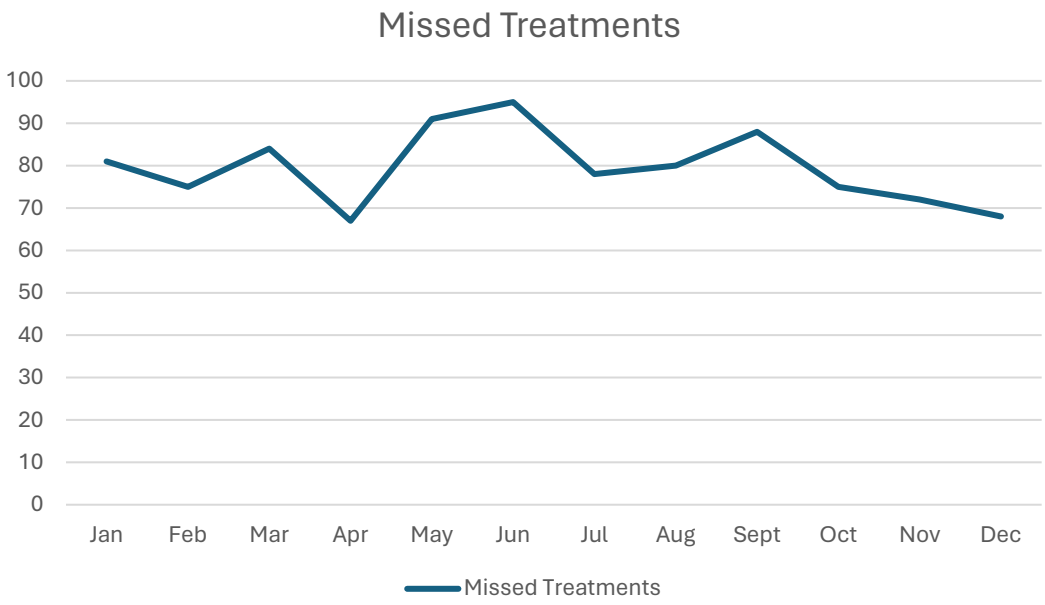
2022



1037 Missed Treatments

Missed Treatment Rate 2019 = 9.1%

2023

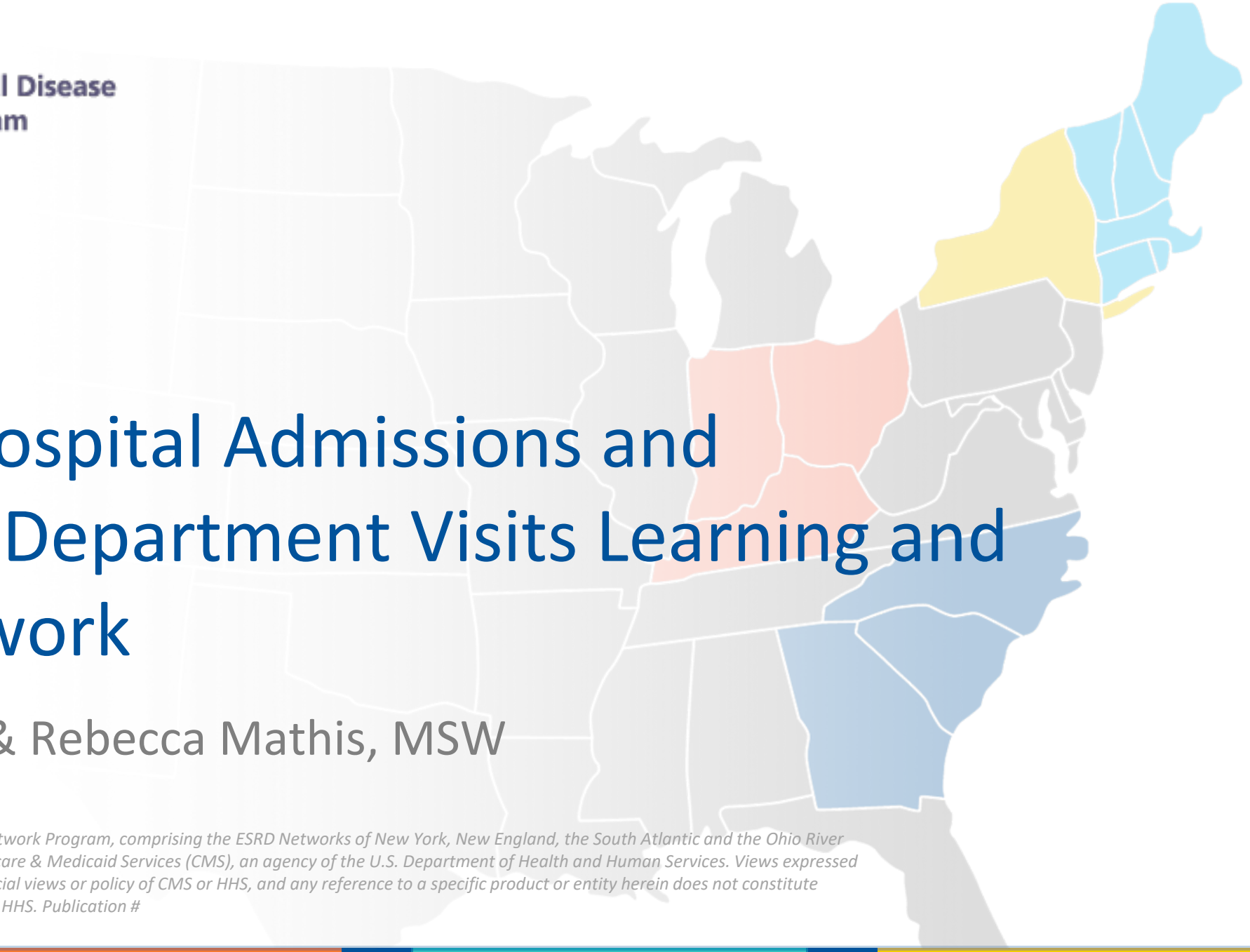


954 Missed Treatments

Missed Treatment Rate 2023 = 4.48%

Network 9

End-Stage Renal Disease Network Program



Reducing Hospital Admissions and Emergency Department Visits Learning and Action Network

Lynea Major RN & Rebecca Mathis, MSW

February 2024

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Network 9
Demographics

- Indiana, Kentucky, and Ohio

Total Dialysis Patients	In-center Patients	Dialysis Facilities
32,082	25,742	606
	Home Patients	
	5,541	
Total Transplant Patients		Transplant Centers
19,470		13

DCI - DANVILLE

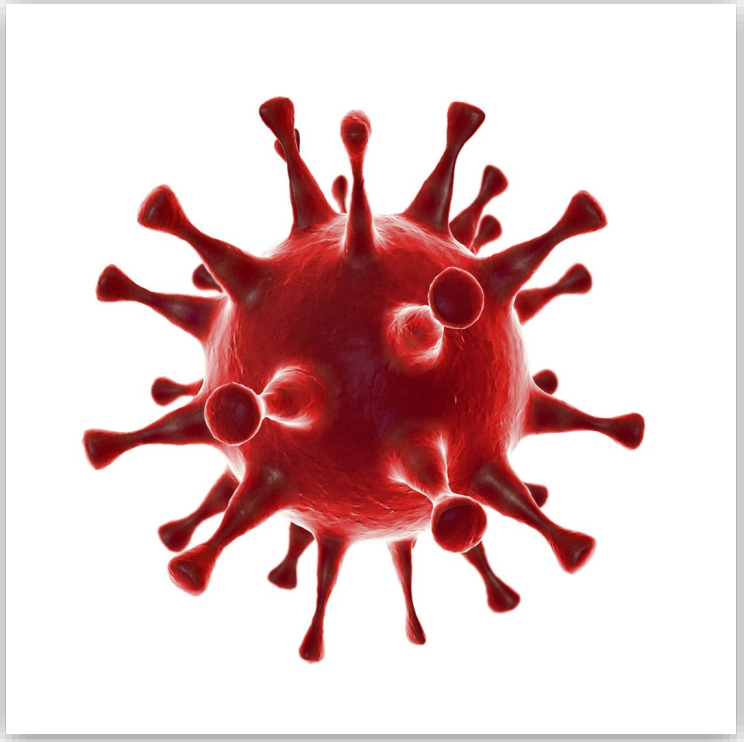
Demographics

- Danville, Kentucky

- ICHD
  - Census of 52
  - Open 6 days a week

RCA/PDSA Cycle

Reducing Hospitalizations/Readmissions/ER Visits



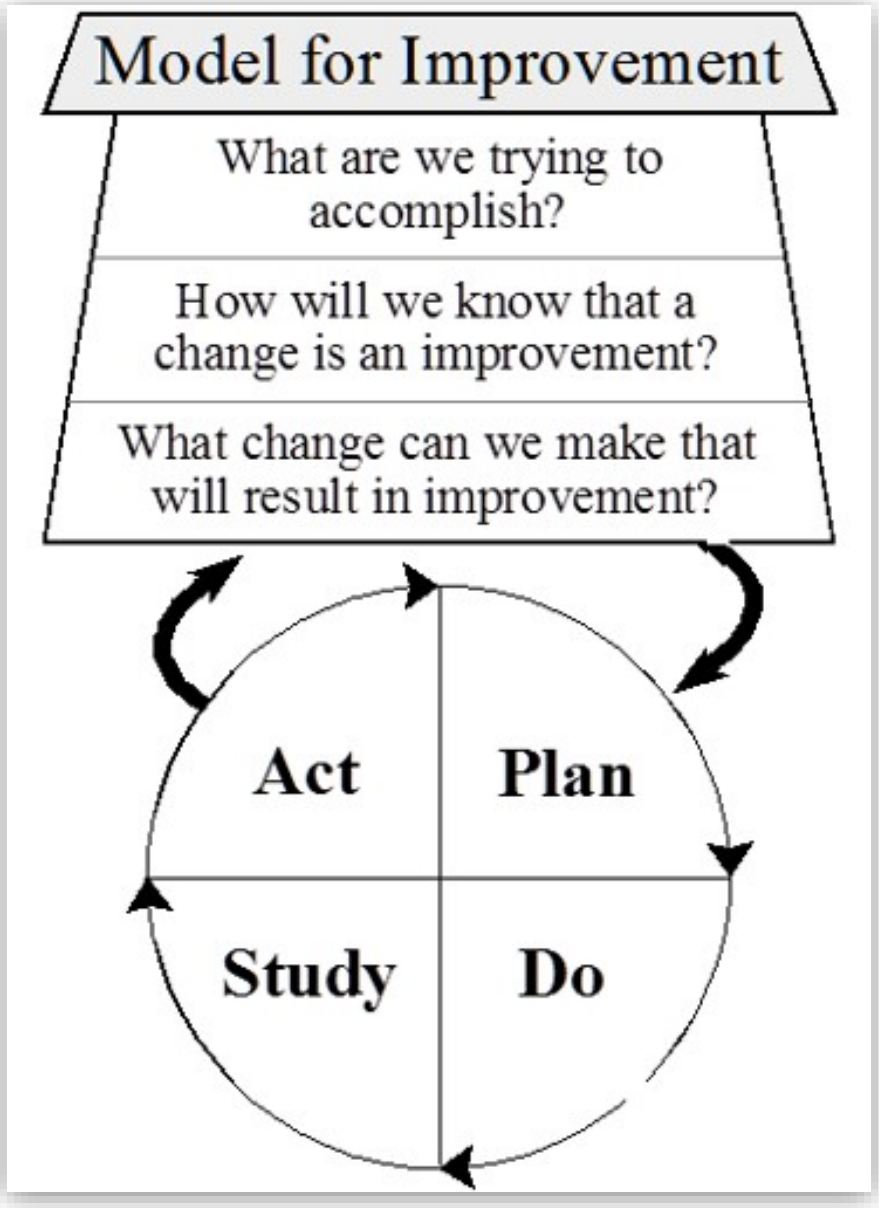
DCI Danville Focus

Fluid Overload

Access Infections

Plan

- Reduce hospitalizations
  - Fluid overload
  - Access infections
- Patient engagement and involvement
  - Creative
  - Reward System
  - Positive reinforcement



Do/Study

Implementation- Tip Cards

- Facility to create cards with catchy slogan
  - Each card will have 12 squares
  - 12 opportunities for patient to monitor fluid or access care
    - If patient has 2.7kg or less weight gain between treatments
    - Patient washes access when coming into treatment

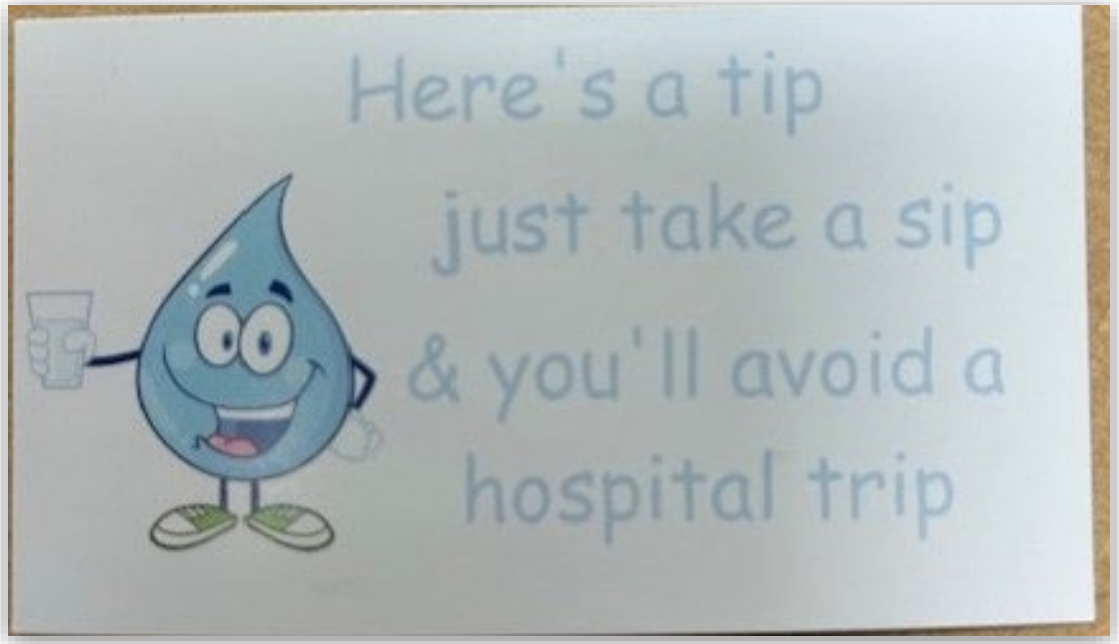
- Staff will will sign and date the card when patient accomplish either of these
  - Once the card is full the patient will turn it into the manger to receive a treat bag
  - Patient will then get another card to start filling in

- Increased Patient engagement
- Decreased Hospitalizations for infections and Fluid overload

Do/Study

TIP CARD

"Here's a tip, just take a sip and you'll avoid a hospital trip."



Do/Study

TIP CARD

"Wash your access and remove the grime and it will save your lifeline"

Results

Option Period Two

Hospitalizations	2
Readmissions	0
Emergency Room Visits	1

Patient Experience

Questions?

Thank you

End-Stage Renal Disease Network Program

Katie Chorba MSN, RN

Quality Improvement Assistant Director

IPRO ESRD Network Program/ Better Healthcare realized

Direct: 216-755-3055 / https:esrd.ipro.org/

Office Hours: Monday-Thursday 7:30 am-4:30 pm Friday 7:30 am-01:30 pm

Schedule a meeting (Please Click the Link)
https://calendly.com/kchorbaiproesrd/30min

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Social Media and Website

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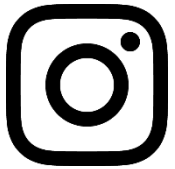

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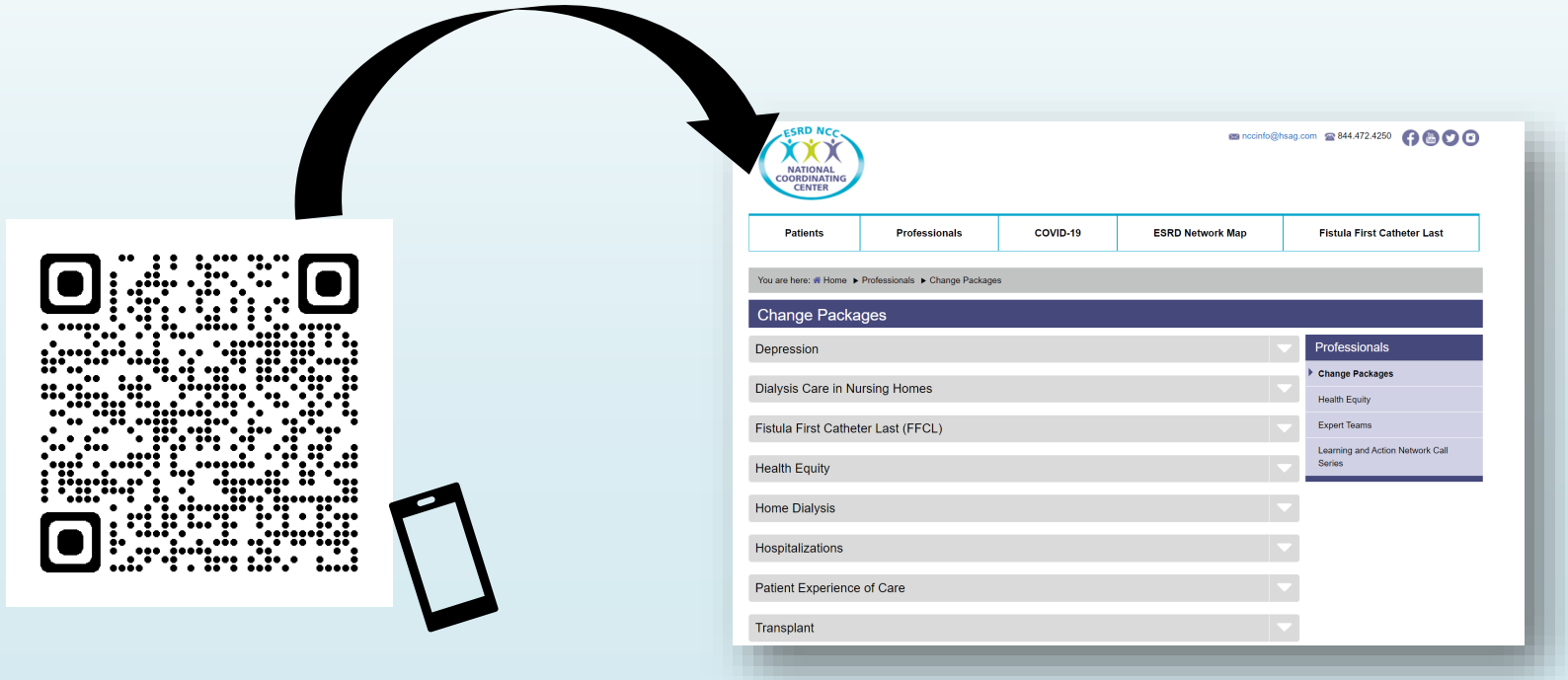
Moving from Learning to Action

Share best practices from this presentation with your colleagues.

Use the ESRD NCC Changes Packages to improve patient outcomes and overall patient experience of care.

Please complete the post-event survey.



Thank you!

Please take a few minutes to respond to the post-call survey.