

Reducing Hospital Admissions, Emergency Visits, and Readmissions

Learning and Action Network (LAN)

November 7, 2024

End Stage Renal Disease (ESRD) National Coordinating Center (NCC)



Meeting Logistics



**Please mute
your line when
not speaking.**



Participation

- Use the Chat feature.
- Share your thoughts.
- Participants can unmute themselves.

**This call is being recorded.*

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

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.

ESRD NCC Learning and Action Network Call

Creating Successful Transitions: Reducing Hospitalization, Readmissions and Emergency Department Visits

November 7, 2024

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THE NATIONAL
FORUM
OF ESRD NETWORKS

Goals for Today's Talk



- Define the adverse outcomes associated with emergency department (ED) utilization and opportunities to assist with safe diversion.
- Describe the varied opportunities for improving timely and safe transitions of care (ToC) through the hospital/rehabilitation setting with the goal of avoiding unnecessary readmissions.
- Personal experiences with local outpatient dialysis clinic, inpatient dialysis unit, acute rehabilitation dialysis unit transitions of care as well as comments regarding lessons learned from value-based care.
- Provide the dialysis facilities with some best practices that they can easily implement and provide resources.

ToC Case Study: Management of the ESRD Patient in the Emergency Room (ER)



It's Monday morning and a 62-year-old male dialysis patient presents to the emergency department complaining of shortness of breath.

History: Receiving in-center hemodialysis for over 3 months (End Stage Kidney Disease due to diabetic nephropathy) and has been coming to treatments regularly. Dialysis unit usually removes a lot of fluid (he doesn't urinate much anymore), however, his last dialysis treatment was Friday, he left about 1 kg above target weight due to low blood pressure and cramping, and "it was a hot weekend".

He hadn't had much pre-dialysis nephrology care and started treatments with a tunneled dialysis catheter and a maturing arteriovenous fistula.

ToC Case Study: Management of the ESRD Patient in the Emergency Department (ED)



ER evaluation: Afebrile with no signs of pneumonia. Viral testing negative. He has 2+ pitting leg edema and mild vascular congestion on chest x-ray. His oxygen sats are 99% on room air and he is in no acute distress.

Subsequent events (in specific order):

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

Missed Opportunities



Missed Opportunities



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

Missed Opportunities



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- Loss of residual kidney function (RKF) and lack of urine output when going into long periods without dialysis.

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- Education on notifying dialysis unit for changes in health.

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- Education on notifying dialysis unit for changes in health.
- Social Determinants of Health (SDoH) and culture of ED being source of medical care.

Missed Opportunities



- Lack of pre-dialysis education: diet/fluid intake, access.
- Loss of residual kidney function (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 ED and nephrology.

Let's Try a "Do Over"



ED evaluation: Afebrile with no signs of pneumonia. Viral testing negative. He has 2+ pitting leg edema and mild vascular congestion on chest x-ray. His oxygen sats are 99% on room air and he is in no acute distress.

Subsequent events (in specific order):

- ED 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 nurse: "His chair time is 11 am. Get him here as soon as you can!"
- ED case manager arranges ride share for patient to dialysis unit.
- ED/hospital wins, inpatient (and outpatient) dialysis unit wins, **PATIENT wins...**

ESRD Patient ED Utilization



Table 1: Characteristics for U.S. patients with ESRD and ED Use

Characteristic	2005-2011 Study Period (n=769,228)	Year of ESRD				
		First (n=769,228)	Second (n=502,632)	Third (n=348,222)	Fourth (n=232,274)	Fifth (n=146,038)
ED visits, Number (%) of patients	535,345 (69.6)	422,738 (55.0)	256,379 (51.0)	179,891 (51.7)	122,155 (52.6)	73,214 (50.1)
Total number 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 number of ED visits per- person year	2.68	2.89	2.48	2.54	2.70	2.64
Number of deaths	345,937	168,601	72,636	46,764	30,066	17,229
Number of ED visits						
Median (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)
90 th percentile	≤ 16	≤ 6	≤ 6	≤ 6	≤ 6	≤ 6
95 th percentile	≤ 23	≤ 10	≤ 9	≤ 9	≤ 9	≤ 9
99 th percentile	≤ 45	≤ 19	≤ 18	≤ 19	≤ 19	≤ 19
Hospital admissions from the ED Number (%) 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.

ED Use by Patients with ESRD in the United States



- Analysis of adult (age ≥ 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

*aOR=adjusted odds ratio

*CI=confidence interval

APP-Driven ED Interventions



- Part of inpatient rounding service.
- Embedded with local ED team. “First Call”
- Rapid assessments, communication with local dialysis unit(s).
- Ability to make high-level decisions.

•Principal Goals:

- Reduce incidence of ESRD by **25%** by **2030**
- 80%** incident ESRD patients receive home dialysis or preemptive kidney transplant by **2025**
- Double** the number of kidneys available for transplant by **2030**

Secondary Goals:

- Encourage the development of the artificial kidney
- Restructure payment models to incentivize prevention, home dialysis, transplantation

Advancing American Kidney Health Models Overview – A. Howard

Model	ESRD Treatment Choices (ETC) 2021-2027	Kidney Care Choices (KCC) 2022-2026		Increasing Organ Transplant Access (IOTA) 2025-2030
		Kidney Care First (KCF)	Comprehensive Kidney Care Contracting (CKCC)	
Type	Mandatory	Voluntary		Mandatory (Proposed)
Participants	Nephrology Provider Dialysis Facilities	Nephrology Providers	Nephrology Providers Transplant Providers Dialysis Providers (Optional)	Transplant Centers Nephrology Providers (Optional)
Beneficiaries	Dialysis Patients (Medicare Primary & Medicare Secondary Payor)	Chronic Kidney Disease (CKD) 4/5 and Dialysis Patients (Medicare primary only)		Kidney Transplant Waitlist & Recipient Patients
Financial Incentives	High deductible plan(+), Performance Years 1-3 Preferred Provider Access Plan (+/-), Home Dialysis/Transplant Rates (Waitlist and Living Donor transplant)	Adjusted Monthly Capitation Payment with Home Dialysis True-Up, CKD Quarterly Capitated Payment (QCP), Kidney Transplant Bonus (KTB)		Achievement(Transplants) Efficiency(Offer Acceptance) Quality(Outcome/Quality)
		No Cost Sharing but Performance Based Adjustment	Shared Savings/Losses	
		Advanced Alternative Payment Model		
Kidney Transplant Bonus	No	Yes		N/A
Quality Measures	ESRD Quality Incentive Program	Optimal ESRD Starts, Patient Activation Measure (PAM), Depression Remission, Delay in CKD Progression, Standardized Mortality Rate CKD4/5 & ESRD, Health Equity Plan		Composite Graft Survival, Shared Decision Making, Colorectal Cancer Screening, Care Transition

Putting Health Equity into Practice



August 2024



Kidney Care Choices (KCC) Model

First Annual Evaluation Report,
Performance Year 2022

PREPARED FOR

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

PREPARED BY

The Lewin Group, Inc.
12018 Sunrise Valley Dr
Reston, VA 20191

Contract Number: 75FCMC19D0096
Task Order Number: 75FCMC22F0001

The Innovation Center contracted with The Lewin Group and our partners at the University of Michigan Kidney Epidemiology and Cost Center and Arbor Research to evaluate the KCC Model, with a focus on whether the model achieved its primary objectives. In this first annual evaluation report, we examine the impacts of KCC on important aspects of kidney care and patient outcomes during the first model performance year (Performance Year [PY] 2022).

Who Participated in Kidney Care Choice (KCC)?



Kidney Care First (KCF)

- Nephrology practices and their nephrologists and nephrology professionals can elect to participate in the KCF option.
- They receive capitated payments for managing the care of aligned patients, payment adjustments based on quality, and bonus payments for successful transplantation.

Comprehensive Kidney Care Contracting (CKCC)

- CKCC is available to nephrology practices that team with a transplant provider and optional partners such as dialysis facilities, vascular surgeons, care management companies, or home care providers to form Kidney Contracting Entities (KCEs).
- CKCC is a total cost of care model for all Medicare Parts A & B (hospital and medical) services and features varying levels of risk borne by the KCEs.

Delay
the progression
to dialysis

Increase
use of home
dialysis

Increase
access to
kidney
transplantation

Reduce
the cost of
care

Improve
quality of
Care

Impacts of KCC Model Year 1



Utilization

- **Use of home dialysis** in KCF grew by 2.1 percentage points (or 20%). **Use of peritoneal dialysis** increased by 2.3 percentage points (or 26%) in KCF and 0.74 percentage points (or 8%) in CKCC.
- We did not identify impacts on emergency department use or hospitalizations for either model option.

Payments

- The model did not affect **Total Medicare parts A & B payments**.
- We observed a small increase in evaluation and management payments (\$1 per patient per month, or 2%) and total dialysis payments (\$28 per patient month, or 1%) in CKCC.
- The model did not result in statistically significant net savings or losses to Medicare.

Impacts of KCC Model Year 1



Utilization

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Quality of Care

- **Most** quality metrics were unchanged in both model options, with two notable exceptions:
 - In KCF, we found a decline in arteriovenous fistulas of 5.3 percentage points (or 9%), which does not necessarily imply a decrease in quality without a corresponding increase in catheter use (to be examined in future reports).
 - In CKCC, we observed a 6.9 percentage point (or 16%) increase in **Optimal ESRD Starts**.

Transplantation

- We did not find a differential increase in **kidney transplant rates** between the model and comparison groups.
- We observed a 1.8 percentage point (or 15%) increase in patients with an active **waitlist status** in CKCC.

ToC Case Study: Transitions for the Hospitalized Patient on Dialysis



Chief Complaint: It's Monday morning and Mrs. Singh was admitted 2 weeks ago with pneumonia.

History: She is a 46-year-old peritoneal dialysis patient (for 4 years) and had been doing well prior to admission. Her hospital course was complicated by acute respiratory failure, brief mechanical ventilation. She became physically deconditioned and now isn't strong enough to go home.

ToC Case Study: Transitions for the Hospitalized Patient on Dialysis



- 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 (or provider to patient!) regarding discharge plan, meds, dialysis goals, etc...

Subsequent events (in specific order):

- Different Electronic Medical Records and dialysis clinic never gets discharge paperwork.
- Patient misses several vancomycin doses.
- No conversation regarding modality goals.
- Patient is readmitted 2 weeks later with fever and septic arthritis.

Missed Opportunities



- COMMUNICATION: provider to provider, provider to patient.
- Failure to keep nephrologist updated regarding disposition planning.
- Did anyone listen to the patient? Involuntary loss of modality.
- Patient has suffered a major “loss” – modality, independence, control...
- The “other things” that people fail to address: social workers, dieticians, transportation, medication changes, dry weight/new dialysis prescription.
- Lack of peritoneal dialysis (PD) support in rehabilitation settings.

Taking Another “Do Over”



- Patient communication! Understand “big picture” of patient goals while educating patient about next steps in transition.
- Inpatient multidisciplinary team willing to keep nephrologist in the mix for discharge planning.
- Nephrology provider gives clear instructions to dialysis unit for orders, PD goals, medication reconciliation, and discharge summary.
- Contact between hospital CM and dialysis social worker and rehab team
- Dialysis team “readmission huddles” to discuss patient support.
- Nephrology integration with local rehab facility to stand up dialysis support.

ESRD Patient Hospital 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 who may not know about the unique needs of kidney patients.

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

ESRD Patient Challenges

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 advise 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 the known-effects of following the treatment plan

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>

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

Forum Toolkits

Available at: <https://esrdnetworks.org/toolkits>



Professional Toolkits

- Inpatient Medical Director Toolkit (2020)
- Kidney Transplant Toolkit (2019)
- Transitions of Care Toolkit (2022)
- Vaccination Toolkit (2021)
- Outpatient Medical Director Toolkit (2021)
- Home Dialysis Toolkit (2nd edition) (2023)
- Catheter Reduction Toolkit (2011)
- QAPI Toolkit (2010)
- Health Equity Toolkit (in progress)

Patient Toolkits:

- Dialysis Patient Depression Toolkit
- Dialysis Patient Grievance Toolkit
- Financial Help Resources
- Kidney Patient Transplant Toolkit
 - *Patient video providing an overview of the toolkit available at https://media.esrdnetworks.org/documents/Is_A_Kidney_Transplant_Right_For_Me.mp4; consider sharing with your patients!*

Transitions of Care Toolkit (2022)



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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 even unsafe. Even patients who had education about their options before they started treatment did not know what the experience of dialysis would be like. They often found that no one told them what was happening at

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 and/or a safety threat. This was especially true for the transition from transplant to dialysis. Most providers also found modality changes to be challenging, but 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 for use in the 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)

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).

PDSA Cycles for Problem Solving/Process Improvement



Broad Concepts:

1. Embed new processes (“hardwire”) into the routine admission and discharge activities of the hospital, skilled nursing facility (SNF) or long-term acute care (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 how the dialysis clinic works or what it needs from them unless told.
3. Having 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 setting 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 to 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 fear 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 levels.
5. Respect is essential.
6. This is a complicated journey. Many people interact with the patients. Clear, coordinated communication is key to success.

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



- ED visits by ESRD patients are very common and result in hospital admission nearly 50% of the time.
- Education of our hospital/ED colleagues for early intervention/diversion strategies can yield improved outcomes.
- Patient education regarding awareness of dietary/fluid intake, dialysis access, efforts to preserve RKF, and communication with dialysis team is crucial.
- Communication between dialysis clinics and hospitals for ToC.
- There is a need to increase awareness of the social drivers of health for our patients and improve efforts to increase patient activation.
- Nephrology community needs to establish better rehab care strategies.

Personal Takeaways



Investment for quality outcomes:

- Cost savings won't come until we get the quality efforts right.
- Nurses and APPs should be a major part of our staffing infrastructure:
 - CKD education
 - Continuous dialysis access support
 - PAM and depression measurements and interventions
 - Embedded ER and inpatient services

Where are we lacking?

- Education of nephrologists (and nephrologists in training)
- More effort behind ToC in all aspects
- Making patient activation more than just a metric (health literacy)
- Better post-acute support to maintain modality
- Ongoing push to help patients perform dialysis modalities that are best for them (assisted home dialysis)

Questions and Answers



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Thank you!

- Upon conclusion of this webinar, all attendees will receive an email.
- It will include a link to the post-event survey and to the continuing education units (CEUs).

Please email the ESRD NCC with any questions at
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