

A Change Package To Reduce Hospitalizations

Key Change Ideas for Dialysis
Facilities to Drive Local Action

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I. Introduction

This change package is intended to support dialysis facilities and End Stage Renal Disease (ESRD) Networks in reducing hospitalizations, re-hospitalizations, and emergency department (ED) visits for patients receiving dialysis care. The change package includes actionable change ideas, collected from top-performing dialysis facilities. The change ideas presented are intended as a menu of interventions from which program leaders can choose to implement within their facilities.

How to Get Started

Change happens at the local level. Dialysis facility Quality Assessment & Performance Improvement (QAPI) meetings are the perfect place to start. Giving interdisciplinary team (IDT) members this change package for review will allow them to identify and prioritize change ideas that could be implemented to reduce hospitalizations.

The change ideas presented are not meant to serve as the entire universe of approaches to keep patients out of the hospital. They can, however, serve as “tests of change” that drive performance improvement and quality improvement programs.

About QAPI: QAPI merges quality assessment (QA) and performance improvement (PI) into a comprehensive approach to quality management. QA is the process of meeting standards and ensuring care reaches an acceptable level. PI is the proactive, continuous study of processes with the intent to identify opportunities and test new approaches to fix the underlying causes of persistent, systemic problems. Data-driven QAPI programs may be customized to facility needs. Key steps include:

- Identifying the problem and defining the goal
- Deciding on a measurement to monitor improvement
- Brainstorming solutions based on barriers and root causes
- Planning an intervention
- Using plan-do-study-act (PDSA) to implement the improvement project

Learn more about QAPI: <https://esrdnetworks.org/toolkits/professional-toolkits/qapi-toolkit/>

Dialysis facilities can contact their local ESRD Networks for assistance with PDSA principles and practices and questions about change strategies. A complete listing of ESRD Networks can be found at <https://esrdncc.org/en/ESRD-network-map/>.



II. Change Package Methodology

The ideas presented in this change package were identified through interviews with high-performing dialysis facilities. The facilities were selected based on an analysis of Medicare claims data. During the interviews, systemic themes emerged, which were organized into driver diagrams, visual displays of what drives and contributes to achieving an overall aim.¹ The diagrams include drivers and associated change ideas, which were reviewed by six experts from ESRD Networks to ensure relevance to a broad range of dialysis facilities. The input from these experts was incorporated into the document.

III. Drivers to Reduce Hospitalizations

Interviews with high-performing dialysis facilities revealed primary and secondary drivers being utilized to reduce hospitalizations (Table 1). “Primary drivers are the most important influencers” that “contribute directly to achieving the aim.” Secondary drivers are the actions and interventions that impact the primary drivers.²

The primary and secondary drivers (Tables 1–10), as well as the associated change ideas in the driver diagrams (Tables 2–10), are not in ranked order. They are numbered for easy reference.

Table 1. Primary and Secondary Drivers to Reduce Hospitalizations

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



IV. Key Change Ideas

The following driver diagrams (Tables 2–10) expand on the drivers to reduce hospitalizations (Table 1) and include specific change ideas for all the secondary drivers identified with high-performing dialysis facilities. The visualizations show the relationships between the primary and secondary drivers and the associated change ideas.

Table 2. Keep the Focus on Patients and Families

PRIMARY DRIVER #1: ADOPT A CULTURE THAT EMBRACES PATIENT-CENTEREDNESS AND HIGH-PERFORMANCE

Secondary Driver #1a: Keep the focus on patients and families

When patients see that they are at the center of everything that takes place in a facility, they feel safe to share concerns as they arise and ask for information. Staff can resolve concerns and issues early to prevent hospitalizations.

Change Ideas

1. Be empathetic to the challenges that patients on dialysis face. Treat patients with kindness.
2. Smile. Be welcoming. Be approachable, so that patients will ask questions and trust that staff will care about an issue and take care of it.
3. Recognize the unique culture of each community, e.g., community religious beliefs might not allow for the use of pork products (e.g., heparin) or cultures may not support that mental health issues may require medical intervention.
4. Engage families, especially in family-centered cultures. Ask for patient and family input.
5. Encourage the concept of “community” at the dialysis facility, so that patients help each other to be accountable for their treatments, e.g., not missing treatments.
6. Support patients with life and treatment goals. “If the patient has the will, the staff will find the way.”
7. Solve problems with the family and community, e.g., food assistance/delivery, assistance with housing or utilities or gas, getting supplies to patients who live in remote areas such as carrying boxes up a muddy road.



Table 3. Create a Culture That Contributes to Low Hospitalization Rates

PRIMARY DRIVER #1: ADOPT A CULTURE THAT EMBRACES PATIENT-CENTEREDNESS AND HIGH PERFORMANCE
Secondary Driver #1b: Create a culture that contributes to low hospitalization rates
<p>A positive environment in a dialysis facility incorporates a shared vision to provide high-quality care, teamwork, and involved leaders who are open to ideas. These elements form a solid framework that can support a facility’s strategies to reduce hospitalizations.</p> <p>Change Ideas</p> <ol style="list-style-type: none">1. Share the facility’s vision and quality outcomes via daily huddles, emails, staff meetings, and a communications book.2. Ask, “What are high-performing organizations doing and how can we implement their best practice strategies?”3. Continually evolve policies and processes.4. Emphasize safety. Report any problems or issues related to patients. “We don’t hide anything.”5. Work together as a team diligently and purposefully to keep patients out of the hospital.<ol style="list-style-type: none">a. Involve every team member (e.g., PCT, nurse, social worker, administrative assistant).b. Collaborate using a “how do we accomplish it?” approach.c. Educate, engage, and empower staff to make decisions and act as champions.6. Communicate goals in a way that is not stressful to the staff.7. As leaders, be approachable and listen to staff ideas and recommendations to improve care.8. To address issues promptly, encourage a high level of involvement by the medical director/nephrologist, including:<ol style="list-style-type: none">a. Reviewing critical elements, e.g., dry weights, during patient rounds.b. Being on-site at the facility two to three times a week and/or accessible at other times.c. Being approachable and open to talking with staff, e.g., patient care technician (PCT) talking with the nephrologist about a patient.



Table 4. Establish Channels of Communication to Facilitate Information Sharing

PRIMARY DRIVER #1: ADOPT A CULTURE THAT EMBRACES PATIENT-CENTEREDNESS AND HIGH PERFORMANCE
Secondary Driver #1c: Establish channels of communication to facilitate information sharing
<p>Facilities that figure out how to use informal as well as formal methods to communicate create pathways to share and gather vital information that can be used to prevent hospitalizations, readmissions, and ED visits.</p> <p>Change Ideas</p> <ol style="list-style-type: none">1. Foster open communication between management and staff, so staff feel comfortable coming to the charge nurse or manager with questions or concerns.2. Maintain frequent and timely communication among all staff. Do not wait for formal meetings, e.g., facility administrator and charge nurse check in with staff on the floor to hear what is going on and roll out information as needed.3. Create an environment where all staff members are approachable, regardless of position, e.g., PCT talks to manager or social worker and vice versa.4. Hold daily huddles to discuss patients, e.g., who was admitted/discharged and why were they admitted.5. Conduct weekly meetings with the IDT to discuss hospitalized patients.6. Give all staff the opportunity to communicate with physicians and ask questions, e.g., PCT with best knowledge of a patient issue speaking directly with the nephrologist on rounds.7. Utilize a liaison such as an administrative assistant to establish communications between the dialysis facility and the hospital, e.g., to obtain medical records.8. Develop a relationship with discharge planners in the hospitals, so they can serve as a point of contact when patients are being discharged.9. For organizations with multiple dialysis facilities, disseminate lessons learned and best practices across centers, e.g., improving handoff communications.



Table 5. Track Hospitalizations and Related Measures

PRIMARY DRIVER #2: IMPLEMENT CONTINUOUS QUALITY IMPROVEMENT
Secondary Driver #2a: Track hospitalizations and related measures
<p>Facilities that improve rates for hospitalizations track data on a facility level to identify trends and issues that need to be addressed, e.g., increase in bloodstream infections (BSIs). “We need to know where we are to get where we are going.” Those facilities also track and trend data on an individual patient level, so they can determine patients who are at risk for hospitalization and then take focused actions to keep those patients out of the hospital.</p> <p>Change Ideas</p> <ol style="list-style-type: none">1. Document, track, and trend:<ol style="list-style-type: none">a. The number of hospitalizations, readmissions, and ED visits.b. The number of missed treatments.c. The reasons for the hospitalizations, readmissions, ED visits, and missed treatments to analyze at a facility level.d. Which patients have been hospitalized and missed treatments and why those patients were hospitalized or missed treatments, so individual care plans can be modified.2. At each treatment, ask patients, “Have you been in the hospital since your last visit?” Document hospitalizations or ED visits on the flowsheet. Review in QAPI meetings.3. Perform daily monitoring of absences/hospitalizations, e.g., have administrative assistants check hospital discharges every day and add to a list of patients being discharged.4. Assign a nurse to a set of patients, i.e., one nurse covers first shift on Monday-Wednesday-Friday to track hospitalizations, absences, and discharges and provides a report to the clinical manager.5. Complete post-hospitalization summary sheets to be incorporated into the medical record.6. Incorporate the social worker into monitoring missed treatments and reasons, including psychosocial or transportation issues.7. Track results of audits (e.g., hand hygiene) by staff and patients to identify breaks in infection control.



Table 6. Share Data in QAPI Meetings and Use Data to Drive QAPI Processes

PRIMARY DRIVER #2: IMPLEMENT CONTINUOUS QUALITY IMPROVEMENT
Secondary Driver #2b: Review data in QAPI meetings and use data to drive QAPI processes
<p>Effective QAPI meetings incorporate reviews of data regularly with the medical director and IDT to look into the “nooks and crannies of existing issues.” These root cause analyses determine facility-wide and patient-specific issues that contribute to hospitalizations. Facilities can address the causes and prevent hospitalizations.</p> <p>Change Ideas</p> <ol style="list-style-type: none">1. Assign a specific individual to the hospitalization area of QAPI.2. Hold monthly quality meetings with the medical director and the IDT.<ol style="list-style-type: none">a. Review hospitalization data for the month as well as trends for the past three months.b. Conduct root cause analyses for all patients who were hospitalized or visited the ED.c. Determine interventions for facility-wide issues, e.g., increase in BSIs.3. For each patient, take a deep dive into the data to identify the core issues using clinical data, e.g., outliers of lab results, missed treatments, anemia, fluid overload, mental health issues.4. Interview patients to support identification of root causes, e.g., if admitted for pneumococcal pneumonia, verify the patient has received a pneumococcal vaccine.5. Discuss hospitalizations for each patient admitted and discharged. Identify patients at risk for readmission.6. Be transparent. Review/share metrics monthly with the whole team.<ol style="list-style-type: none">a. Review data and discuss action plans in a staff meeting after each QAPI meeting.b. Share via secure email.c. Post data on a board in the conference room or breakroom, e.g., hospitalizations, missed treatments. Include trends and quarterly percentages.7. Repeatedly re-review data and patient status for opportunities to prevent hospitalizations, e.g., review all patients with a catheter >90 days and take action to get a permanent access placed.



Table 7. Take Proactive Steps to Prevent Hospitalizations

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO PREVENT HOSPITALIZATIONS AND AVOID READMISSIONS
Secondary Driver #3a: Take proactive steps to prevent hospitalizations
<p>A proactive approach to preventing hospitalizations encompasses early identification of patients who are at risk for hospitalization; immediate review and communication of risk factors (e.g., abnormal lab results); and prompt implementation of interventions to address risk factors.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Identify patients who are at risk for hospitalizations. <ol style="list-style-type: none"> a. Use a software program that captures all labs, highlights outliers, and breaks the data into categories such as Kt/V or albumin. b. Meet weekly with the IDT to identify potential red flags per patient such as Kt/V (adequacy), anemia, fluid overload, signs of infection, psychosocial issues. Ask who has the potential for hospitalization or who has just been hospitalized. Review all quality indicators to determine anything out of range. 2. Involve the whole team with one person serving as the lead, e.g., if a patient is not getting enough protein, the dietitian would direct efforts but the whole team would reinforce the plan. 3. Follow up with patients about any issues that may cause hospitalization, e.g., making sure they are going to their PCP appointments or vascular surgeon appointments for catheter removal. Discuss in the plan of care meetings. 4. Monitor dry weights. Schedule for extra treatments or longer treatments as needed. 5. Securely email monthly lab results to the medical director, nephrologist, nurse manager, administrator, and all nurses, so they can review lab results early and immediately intervene. 6. Implement protocols (e.g., vascular access/AV fistula creation, anemia management, treating peritonitis) to decrease hospital admissions. 7. Adapt protocols based on current situations, e.g., protocol for COVID, requiring handwashing for all staff for all instances to enhance infection control versus using alcohol-based solutions. 8. Related to infections: <ol style="list-style-type: none"> a. Notify the medical director/nephrologist of lab results or early symptoms. b. Increase auditing of staff by staff and patients for hand hygiene, housekeeping, accessing the site (e.g., always scrub the hub). c. Implement CDC Core Interventions. d. Adopt a “report everything” culture, e.g., when monitoring infection rates, report contamination. e. Collaborate with an infection preventionist to address patients at risk for being hospitalized. 9. Engage nephrologists to refer patients to their PCPs if patients have not seen them in a while or other specialist as applicable. Let patients know they need their PCP involved, e.g., for blood pressure control.



PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO PREVENT HOSPITALIZATIONS AND AVOID READMISSIONS

Secondary Driver #3a: Take proactive steps to prevent hospitalizations

10. Monitor for missed treatments and reschedule as needed.
 - a. If a patient is a “no show,” call the patient to find out why. If it is a clinical issue, have the nurse explore in detail, as a treatment may resolve the issue.
 - b. Offer to re-schedule the treatment to avoid hospitalization. Instead of asking the patient, “When do you want to come in?” say, “We have a chair available at 2 p.m. tomorrow.” Give alternative times or days, so treatments are not missed.
 - c. Engage family members, especially the younger members of the family, to encourage their elders to follow treatment protocols.
 - d. Involve the social worker for missed treatments.
 - e. Implement an ED diversion team to address fluid-related issues. Work with the nephrologist to schedule extra treatments.
11. Hold daily huddles on the treatment floor to discuss patients or any topics, as needed, e.g., hospitalization of a specific patient or missed treatments.
12. Empower all staff to interact directly with nephrologists and ask questions, e.g., the PCT who may know the patient best speaks with the physician about a patient’s fear of getting a vaccine or the nurse asks the physician about ordering an extra treatment.
13. Have the social worker screen for mental health issues, such as depression, that could affect compliance with treatment protocols.
14. Discuss the option of offering a home therapy for patients who are missing treatments.
15. Advise patients to go to urgent care instead of the ED as appropriate, e.g., for skin rash.
16. Increase the frequency of clinicians being on the unit, e.g., nurse practitioner on the unit every day or the medical director at the facility two to three times per week to address issues quickly and make changes to the plan of care as needed.
17. Implement foot checks to avoid wound care issues that could result in hospitalization.
18. Work with the EDs to dialyze patients in the facility versus admitting the patient for fluid overload.
19. Distribute highly effective interventions to sister clinics for implementation and adaptation, e.g., anemia management protocol.
20. Implement interventions for facility-wide issues, e.g., increase in BSI rates.



Table 8. Give Focused Attention to Patients Who Have Been Hospitalized

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO PREVENT HOSPITALIZATIONS AND AVOID READMISSIONS
Secondary Driver #3b: Give focused attention to patients who have been hospitalized
<p>A patient leaving the hospital is in a state of transition and vulnerable to readmission. Dialysis facilities can safeguard against a patient’s return to the hospital by orchestrating a secure handoff from the hospital, adjusting the plan of care, conducting medication reconciliation, and assisting patients to complete follow-up activities such as going to physician appointments and getting prescriptions filled.</p>
<p>Change Ideas</p> <ol style="list-style-type: none">1. Appoint a dialysis staff member to serve as the hospital liaison to communicate with the hospitals regarding hospitalized patients and the transition back to the dialysis facility.2. Build good relationships with hospitals to obtain copies of flowsheets and to get updates on the patients like dry weights and treatment order changes post-hospitalization.3. Offer to meet with hospital discharge planners to have a face-to-face meeting and introduction. Share the facility’s goals and expectations.4. Develop a robust and collaborative relationship with the staff at the hospital’s inpatient dialysis unit to ensure continuity of care.5. Obtain medical records.<ol style="list-style-type: none">a. Call the nurse at the hospital for information while the patient is hospitalized or ask the medical director to reach out to the facility.b. Request access to the electronic medical record (EMR) at the local hospital to follow the patient and obtain the discharge summary and other medical records post-hospitalization. Assign the administrative assistant to pull reports from the system.c. Ask the medical director to facilitate gaining access to the hospital’s EMR and/or to directly access the history and physical.d. Obtain medical records post-hospitalization by connecting with the hospital discharge planner or PCP.e. Ask the patient to bring in the discharge summary and the discharge instructions with the physician’s name.6. Collaborate with the hospital, nephrologist, and PCP while the patient is in the hospital and prepare for the patient’s care and return to dialysis, e.g., revised orders for treatment, new medications, new dry weight.7. Review the discharge summary, lab results, medication changes, etc. and contact the nephrologist for updates to the treatment plan.8. Evaluate the patient’s dry weight; adjust as needed and monitor.9. Draw blood for labs the first day back from the hospital if the patient missed lab day or if medically indicated.10. Update the patient’s status using a nursing summary sheet after hospitalization and add to the EMR. Updates may include:<ol style="list-style-type: none">a. Transfusionsb. EKGc. Medication changes



PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO PREVENT HOSPITALIZATIONS AND AVOID READMISSIONS

Secondary Driver #3b: Give focused attention to patients who have been hospitalized

- d. Information from the discharge summary
 - e. Follow-up cultures
 - f. Referrals
 - g. Follow-up appointments
 - h. Steps to prevent readmission
11. Implement a Transition of Care Checklist to be completed on the first day the patient returns from the hospital.
 12. Conduct medication reconciliation monthly and with changes in care, including hospitalizations.
 - a. Partner with pharmacists for medication reconciliation post-hospitalization.
 - b. Identify a medication reconciliation champion and use a checklist to review medications that includes collaboration with the hospital.
 - c. Engage the facility administrative assistant to send reminders for patients that need medication reconciliation to bring in their medications.
 13. Engage the social worker to assist patients with post-hospitalization follow-ups, e.g., filling prescriptions, scheduling appointments with referral physicians, transportation to appointments.
 14. Explore the option of having a delivery service bring new medications to the dialysis facility.
 15. Hold daily huddles to discuss each patient that is planned for release in the next 24 hours, patients that have been released, and patients at risk for readmission.
 16. Work hand-in-hand with other key providers, e.g., Indian Health Service.



Table 9. Provide Patients with Knowledge

PRIMARY DRIVER #4: EDUCATE PATIENTS AND STAFF
Secondary Driver #4a: Provide patients with knowledge, so they can play an active role in staying out of the hospital
<p>When patients understand potential causes of hospitalization, they take an active part in staying healthy and out of the hospital and ED. They see the connections between adherence to treatment protocols, lifestyle choices such as fluid restriction, and hospitalization. They also recognize concerns that should be brought to healthcare professionals, such as early signs of infection and psychosocial issues that cause them to miss treatments.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Educate patients on key issues and related consequences that can result in hospitalization, e.g., missed treatment, fluid overload, pneumonia, infection related to vascular access. 2. Discuss issues that could lead to hospitalization (e.g., abnormal lab values) during rounds. 3. Conduct patient education monthly. For patients that have issues related to adherence, provide extra education. 4. Discuss eating foods with high fluid content in moderation, like limiting the amounts of salads and fruit that have a lot of water, e.g., watermelon. <ol style="list-style-type: none"> a. For patients who like to eat ice, show them how much liquid it is when it melts. Describe alternatives such as eating frozen grapes. b. Don't tell patients "No." Reframe and say, "We understand you like this, but how can we make it work within moderation?" 5. Use printed materials, corporate intranet, verbal 1:1 instruction, self-paced education on site, posters, company or Network flyers, and You Tube videos. 6. Make information easy to read and succinct, use bullets and color, and keep to one page. 7. Educate as opportunities arise, e.g., after an infection or a hospitalization. 8. Ensure all team members present the same message per topic (e.g., potassium or fluids) with the level of detail depending on the staff member's role. 9. Provide a nutritional report card. Point patients to resources for kidney-friendly recipes. 10. Include the family in the education. 11. Provide education in the language in which patients are most comfortable. Engage family, if possible, to support translation and education for languages that are less common (e.g., Zuni). 12. Educate on the importance of a primary care physician for continuity of care. <ol style="list-style-type: none"> a. Share a list of PCPs, so patients can call for their own appointments. b. Enlist social worker to help patients find a PCP. 13. Ask patients to call the on call nurse 24/7 for questions or issues instead of going to the ED. 14. Following the patient's hospitalization, ask key questions, such as, "Do you know why you were in the hospital?" Address specific reasons for the hospitalization with the IDT, e.g., dietitian to follow up with patients for fluid overload . 15. Track patient education in the EMR. 16. Explain why dialysis facilities need the discharge summary, instructions, changes in medications. Ask patients to request the paperwork and bring it to the facility.



Table 10. Prepare Staff to Prevent Hospitalizations

PRIMARY DRIVER #4: EDUCATE PATIENTS AND STAFF
Secondary Driver #4b: Prepare staff to prevent hospitalizations
<p>Educating staff about causes of hospitalization and ED visits increases their ability to act early and help patients stay healthy and out of the hospital.</p> <p>Change Ideas</p> <ol style="list-style-type: none">1. Provide education for staff on all topics related to hospitalization to include fluid overload, infections, missed treatments, and anemia.2. Discuss the root causes of hospitalization, so staff can act early to implement interventions and protocols.3. Incorporate education into daily staff huddles.4. Provide opportunities for staff to improve clinical assessment skills, which will help them identify early risk factors for hospitalization.5. Assign everyone a role in educating patients. Coordinate efforts for consistent messaging.



V. Conclusion and Next Steps

The ideas presented in this change package are being implemented in high-performing dialysis facilities across the United States. These ideas can be tailored and adapted to fit the needs of dialysis facilities and the patients with ESRD that they serve across the country.

As with any change, a best practice is to start small and build improvement toward systemic change. Facilities can start with one test of change and do it well. This will relieve the burden on staff and encourage buy-in when change begins. Measuring and monitoring performance improvement will ensure the facility stays on track with goals. Celebrating every success with staff, patients, families, and community partners at every change will be contagious. Above all, the best time to start performance improvement is now. With this change package in hand, program leaders, administrators, and staff should ask themselves, “What can I do by next Tuesday to get this started?”

VI. References

1. Institute for Healthcare Improvement. *QI Essential Toolkit* [ebook]. 2017; pp. 7–8. Available at: http://www.ihl.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=Whiteboard-Video&utm_source=ihl. Accessed February 5, 2020.
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