Reducing Hospital Utilization 2017

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How Many Times Has This Happened in Your Facility?
Why are dialysis patients hospitalized so much?

- Underlying chronic conditions: diabetes, hypertension, CHF, bone disease, anemia, infection and malnutrition
- Take between 11-13 medications each day
- ESRD patients require several physicians to coordinate their complex health conditions
- Survival rate for most on hemodialysis after three years is 52%.
The ESRD population is admitted to a hospital nearly twice a year.

35% of the ESRD population have unplanned re-hospitalization within the 30 days following discharge and 2/3 of the readmissions were potentially avoidable.

Inpatient treatment accounts for approximately 40% of total Medicare expenditures for dialysis patients.

Patients with frequent hospitalizations experience adverse clinical outcomes. The rate of death (without re-hospitalization) within 30 days of a hospital discharge was as high as 7%.
CMS Required Quality Improvement (Designated Activity) - ESRD QIAs

1. Grievance – improve process & communication, reduce total
2. ICH CAHPS – improve survey results
3. Long Term Catheter – all facilities >10% LTC
4. Reduce Blood Stream Infections– reduce BSI and promote sepsis education
5. Increase Hep B and Pneumonia Vaccinations
6. Reduce Hospitalizations Project
7. ESRD QIP – Reduce hypercalcemia
8. NHSN Data Quality – improve reporting accuracy
Quality Improvement Activity Number 6 - Innovation

- Workgroup Focused on Reducing Hospital Utilization
- Joint project with Network 16 and 18 Teamed with three other Renal Networks
- 20-25 facilities with 5 to 7 medium sized hospitals that are associated
- Requirement - 2% reduction in unplanned hospitalizations
  - Make sure your hospitalizations are batching
  - Each admit should be listed
Project Details

- Improve Transitions of Care
- Gain EMR/HIE/EDIE access
- Rapid Cycle Improvement - Develop, Test and Adapt Interventions
- Population Specific
- Patient involvement is required!!!!
Baseline Data

• Hospitalizations from April through September 2016 from CROWNWeb

• Your Actual Hospitalization Rate
  – The rate reported in your letter multiplied by 2
  – 1.090 X 2 = 2.18
  – 0.733 X 2 = 1.46
Root Cause Analysis
Root Cause Analysis for New Facilities

- Fill in the data on your spreadsheet
- The Network will do the analysis for you
- RCAs will be done with:
  - Entire Cohort
  - By Network
  - By Facility
## Root Cause Analysis

<table>
<thead>
<tr>
<th>Living Status</th>
<th>Insure X. Medicare Primary</th>
<th>CoMorb top 4</th>
<th>Discharge DX</th>
<th>When Admit 1. Non Tx Day 2. Tx Day Pre 3. Tx Day During 4. Tx Day After</th>
<th>Planned X</th>
<th>Expired Date</th>
<th>BMI/EDW</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>X</td>
<td>Nephritis CVD Hep C</td>
<td>Aphasia Global Fatigue</td>
<td>4</td>
<td></td>
<td>12/19/2014</td>
<td>EDW 79kg</td>
<td>Non compliance with medications/dialysis prescription/lives rural village</td>
</tr>
</tbody>
</table>
Root Cause Analysis for 2016 (last years) Project Facilities

- Use Hospitalization report to target your root causes
- Start developing new interventions to deal with roots causes. Especially important if root cause did not change!!
- Reusing interventions that did not work before = ???
Any questions so far???????
Interventions

• Initial Interventions for everyone once RCA is done and submitted to Network-

No PHI!!

• Contact list for your primary hospital- Get access to their EMR!!
Interventions

• The Forum of ESRD Networks Medical Advisory Council (MAC) developed an excellent Transitions to Care toolkit just last year and there is some great information specific to hospitalizations in Chapter 8 along with some sample check lists/templates.

Toolkit

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.
Toolkit, cont.

**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.

The following list is a sample of transition problems between hospitals and dialysis clinics with causes and potential solutions. This list is based on surveys of dialysis staff, practitioners, and patients about the problems with transitions between hospitals and dialysis clinics. Also included is a section on SNF (or LTAC) and dialysis clinic transitions. Problems differ by clinic. Hospital systems, nephrology groups, and large medical providers all work differently. There will be different problems, and you will need to devise different solutions (processes) for each situation.

When problems are encountered, **do not start by blaming any one person or group**. Collaborate with providers outside the dialysis clinic. Caregivers want to do the right thing but may not know what is necessary for continuity of care of kidney patients. **Engage patients, but they should not be your main source of information.** Remember that everyone is busy, and creating processes that work for your clinic are essential.
# Hospital to Dialysis Unit Transfer Summary

**Patient Information**

Name / ID: ____________________________ DOB: / / 
Primary Renal DX: ________________

**Hepatitis B**

Antigen: _______ Antibody: _______ 
Date: / / Other Instructions: ____________

**Allergies:** __________________________ 
Competent to Sign Consents: Yes / No

**Outpatient Dialysis Unit Accepting Transfer**

Facility: ____________________________ 
Phone: ____________________________ 
Contact: ____________________________

**Hospital Information**

Hospital: ____________________________ 
Unit: ____________________________ 
Phone: ____________________________ 
Admission Date: / / Inpatient Attending Nephrologist(s):

**Discharge Date:** / / 
Discharging Physician: ____________________________

**Current Vascular Access**

- Tunnelled catheter
- AVF
- AVG
- Other ____________________________

Any changes this admission:

- Clotting
- Declotting
- Revision
- New Placement - Please describe:

**Vascular access infection:**

- No
- Yes

Positive blood cultures: No / Yes - Name of antibiotic(s) given:

**Anemia Management**

- ESA’s given during the admission:
  - None
  - Epogen®
  - Aranesp®
  - Procrit®
  - Other ____________________________ 
Last Dose/Date Received: / / 

IV Therapy:

- Venofer®
- Ferrlecit®
- Feraheme®
- Infed®
- Dexcelrum®
- Other ____________________________

Last Dose/Date Received: / / 

**Miscellaneous**

Date of last HD prior to discharge: / / 
Changes to EDW: ____________________________ 
Treated for other infections (list): ____________________________

Other: ____________________________

**Co-morbid Conditions:** Did the patient receive treatment during this admission for the following conditions?

- Pericarditis
- Bacterial Pneumonia
- GI Bleeding

**Discharges Dialysis Prescription/Orders**

- TX per week: __________ 
- Duration: __________ 
- Schedule: __________ 
- Load: __________ 
- Hourly: __________ 
- Mid Tx bolus: __________ 
- DFR rate: __________ 
- BFR Rate: __________ 
- Dry Weight: __________

Heparin: ____________________________ 
Treatment tolerance: Well / Fair / Poor 

**Discharge Instructions**

- Telephone report to the Chronic HD unit
- Report any changes in access placement or function 
- Verify that transportation arrangements have been made through Social Service 
- Fax following Medical Records:
  - Last three HD treatment sheets
  - Medication list
  - Recent lab work - (Chemistries, CBC, Cultures) 
  - H&P, Nephrology consult, Radiology/Scan reports, Discharge Notes
Interventions

- Post Hospitalization Assessment
  - Medication Review - right away - involve nephrologist
  - EDW review
  - Anemia Management
  - Psychosocial Needs/Insurance needs - (Social Worker)
  - Discharge Dx Education/Intervention
Within 96 hours of hospital discharge a guided assessment is performed to prevent re-hospitalizations. The assessment consists of the following:

• The participant's hospital course will be reviewed and their clinical recovery and stability assessed.
• Determination of the participant's estimated dry weight (EDW).
• The participant's post discharge medications will be checked, compared to the prehospitalization medication, and discrepancies will be reviewed and corrected by Nurse Practitioner or Nephrologist.
• Blood tests will be ordered for the participant's first return dialysis treatment if medically appropriate after clinical assessment.
• Write new dialysis orders if needed.
• Dialysis Access- review access and determine any changes required in treatment.

Some Ideas
Interventions

• Select at least one patient to be a member of the team for this QIA
Monthly Reporting – “Machform”
Monthly Reporting – “Machform”
Hospitalization “Machform”

Facility Hospitalizations Tracking

CCN – Network and Facility Name

Reporting Month
February 2016 (January Data)

Facility Contact (Name)
First
Last
Phone
#
#
#
#
Email

Hospitalization Data Includes
- All Patients
- HD Only
- PD Only
- Patient Count

Discharge Diagnosis
Enter number of patients with corresponding unplanned discharge diagnosis (combined total will be displayed in number of unplanned hospitalizations).

Blood Pressure
Broken Bones

[HealthInsight ESRD Alliance]
Hospitalization “Machform”

Discharge Diagnosis
Enter number of patients with corresponding unplanned discharge diagnosis (combined total will be displayed in number of unplanned hospitalizations).

- Blood Pressure *
- Cardiovascular *
- DM Complications *
- Gastrointestinal *
- Infection Control *
- Mineral (incl Anemia) *
- Not Reported *
- Broken Bones *
- Dialysis Access *
- Fluid Control *
- Infection Airborne *
- Infection Urinary Tract *
- Pulmonary *
- Other (not listed)** *

Total Hospitalizations (Unplanned Hospitalizations Only)
0

***
WARNING: DO NOT ENTER RH/HB ON THIS FORM
Hospitalization “Machform”

WARNING: DO NOT ENTER PHI/PII ON THIS FORM.
No PHI/PII in the fields below. Examples of PHI include patient name or initials, birthdate, SSN, etc.

Enter RCI (Rapid Cycle Improvement)

Enter Patient Involvement

Enter CAPA (Corrective and Preventative Action) Progress

REMINDER: No PHI/PII in any fields.
Please review your data and check this box to verify that no PHI/PII is included

Check here to verify *
☐ I agree that no PHI/PII is included in this form
Hospitalization “Machform”

WARNING: DO NOT ENTER PHI/PII ON THIS FORM.
No PHI/PII in the fields below. Examples of PHI include patient name or initials, birthdate, SSN, etc.

Enter RCI (Rapid Cycle Improvement)
Our Facility will improve hospitalization rates to 6% by August 2016
Hospitalizations will be reduced by reviewing and adjusting EDW on timely basis.
Cardiovascular Hospitalizations will be decreased by reinforcing patients the importance of continuing follow up with their cardiologist

Enter Patient Involvement
1. Pt. were pro active, most of the patients that are hospitalized d/t Cardiovascular are able to determine and decide on calling emergency service or going to hospital immediately if they have chest pain.
2. Pt. and family are educated on importance of fluid/sodium restrictions to avoid fluid overload

Enter CAPA (Corrective and Preventative Action) Progress
Cardiovascular
1. Educate patients to continue follow up with cardiologist
2. Educate patients to take medications prescribed by their cardiologist and to continue to have their follow up check up with their doctors
3. Reinforced on patients to continue being pro active and vigilant on monitoring any s/sx related to cardiovascular for prompt diagnosis and intervention
4. Reinforce dietary restrictions and lifestyle modifications on patients
Fluid
1. Continue educating patient on fluid restriction and dietary restrictions (sodium restrictions) on patients
2. Offer patients on extra treatment or UF only for pts. that can not tolerate treatments with their high fluid gains
3. Doctors and RNs will continue to monitor and evaluate the correct DW of patients
4. Utilize Fluid wise Report b weekly
5. Utilize BP monitoring tool to monitor trends to help on DW adjustments

REMINDER: No PHI/PII in any fields.
Please review your data and check this box to verify that no PHI/PII is included

Check here to verify

Entry Info
Date Created 9 Aug 2016 - 07:01:18 PM
Date Updated
IP Address 71.31.128.218
Initial Expectations

- Everyone – sign project acknowledgement via link sent in email
- New facilities- send requested data No PHI!!!
- Last years facilities- Submit RCA and initial Interventions for everyone No PHI!!!
  2 Intervention Plans (discharge dx and comorbidities)
- Everyone- Contact list for your primary hospital- Get access to their EMR!!
Ongoing Expectations

• Use Rapid Cycle Improvement to add or modify interventions

• MACHFORM completion – due on the 10th of month beginning in February
  – Monthly updates on your Intervention Plans, PDSA, Hospitalization Rates, Discharge Dx, Progress Toward EMR Access, Hospital Rate and Census
  – Include how you will use your Patient’s Perspective

• Webinars- Email will be sent for mandatory webinars to help reduce hospitalizations
“Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has.”

Margaret Mead
Questions?

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HealthInsight

HealthInsight is a private, non-profit, community-based organization dedicated to improving health and health care, operating in nine western states: California, Alaska, Idaho, Montana, Oregon Washington, Nevada, New Mexico and Utah. The HealthInsight ESRD Alliance was formed in 2015 to bring together the strengths of all partners to further integrate quality efforts across the care continuum for patients at risk for kidney disease, those with chronic kidney disease, those on dialysis or receiving kidney transplant care.