Improving Coordination of Care
Reducing Hospital Utilization 2018

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Quality Improvement Director
ESRD Networks 16 and 18
Participant Expectations

• Enter your name and facility CCN in the chat function
• Mute your line unless speaking/asking questions
• Be engaged
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%.
ESRD Hospitalization Statistics

- The ESRD population is admitted to a hospital nearly twice a year.
- 35% of the ESRD population has 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%.
Quality Improvement Activity
Number 4- Population Health Pilot

• Workgroup Focused on Reducing Hospital Utilization

• 10-15 facilities with 3 to 5 medium sized hospitals that are associated

• Requirement- 1% reduction in overall hospitalizations and 7% reduction in ESRD related 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 January through July 2017 from CROWNWeb

• Your Actual Hospitalization Rate
  – The rate reported in your letter

• National Average for ESRD patients is 1.5 hospitalizations per year
  – For this group it is 2.48 hospitalizations per year
Root Cause Analysis
Root Cause Analysis

• Fill in the ICD10 codes for your baseline period hospitalizations

• The Network will do the analysis for you

• RCAs will be done with:
  – Entire Cohort
  – By Facility

• Due Date is February 16th
### Root Cause Analysis

**Exhibit 3.7-6, RCA Template for Population Health Focused Pilot QIAs**

**PHFP Quality Improvement Activity RCA Report Form**

<table>
<thead>
<tr>
<th>Network Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESPD Network Number &amp; Name</td>
</tr>
<tr>
<td>Contract Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
</tr>
<tr>
<td>Facility CCN</td>
</tr>
<tr>
<td>QIA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Baseline Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Improvement Goal</td>
</tr>
<tr>
<td>Target (numeric)</td>
</tr>
</tbody>
</table>

### SECTION 1

**Root Cause Analysis**

<table>
<thead>
<tr>
<th>Name(s) of facility staff involved in RCA</th>
</tr>
</thead>
</table>

| Date RCA completed                        |

What are the top 3 underlying issues that facility staff identify as potential causes for poor performance on the identified measure(s) targeted for this PHFP QIA? Which root cause method did you use (e.g., Current Reality Tree, Failure Mode and Effect Analysis, Fault Tree Analysis, Fishbone Diagram, Five Whys Analysis, Pareto Analysis)?
### SECTION 2
PDSA CYCLE. Describe the intervention to address the root causes.

<table>
<thead>
<tr>
<th>PLAN:</th>
<th>DO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic: Name</td>
<td>What: What will implementation entail?</td>
</tr>
<tr>
<td>Goal: 0.0%</td>
<td>Specifically what will staff do?</td>
</tr>
<tr>
<td>Predictions: What are you trying to accomplish?</td>
<td>When: When will implementation of the intervention (the what), begin?</td>
</tr>
<tr>
<td>Data needed</td>
<td>Who: Who is the facility staff member that is responsible for overseeing the PDSA process?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STUDY:</th>
<th>ACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Reported</td>
<td>What changes can be made that will result in improvement?</td>
</tr>
<tr>
<td>CMS/NCC Reported</td>
<td></td>
</tr>
<tr>
<td>Jan: 0.00%</td>
<td>Jan: 0.00%</td>
</tr>
<tr>
<td>Feb: 0.0%</td>
<td>Feb: 0.00%</td>
</tr>
<tr>
<td>Mar: 0.0%</td>
<td>Mar: 0.00%</td>
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<tr>
<td>Apr: 0.0%</td>
<td>Apr: 0.00%</td>
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<td>May: 0.0%</td>
<td>May: 0.00%</td>
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<td>June: 0.0%</td>
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<td>July: 0.0%</td>
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<tr>
<td>Aug: 0.0%</td>
<td>Aug: 0.00%</td>
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<tr>
<td>Sept: 0.0%</td>
<td>Sept: 0.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention start date</th>
<th>On what date did the “Do” actions begin?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim performance targets and dates</td>
<td>How will the facility and the Network check process and how often?</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------</td>
</tr>
</tbody>
</table>
Any questions so far??????
Interventions

- Initial Interventions for everyone once RCA is done and submitted to Network- timing to be determined

No PHI!!

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

• We will be scheduling meeting with your primary hospitals

• By January 31 send me your contacts at your local hospitals
  – Nephrology Nurses
  – Discharge Planners
Identifying Patients

Dialysis Patient Identification Card

If this patient is treated in the ED or is hospitalized, please include the dialysis facility contact information below in the patient’s medical record:

Name: ________________________
DOB: ________________________
Dialysis Facility: ________________________
Phone: ___________ Fax: ___________
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.

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

• Please read and work into your interventions Chapters 1, 5, and 8-10.
# Hospital to Dialysis Unit Transfer Summary

## Patient Information
- **Name / ID:**
- **DOB:** / / 
- **Primary Renal DX:**
- **Hepatitis B**
  - Antigen: ________________  
  - Antibody: ________________  
  - **Code Status:**
    - □ Full
    - □ DNR
  - **Date:** / / 
  - **Allergies:**
    - □ Competent to Sign Consents
    - □ Yes
    - □ No

## Hospital Information
- **Hospital:**
- **Unit:**
- **Phone:**
- **Admission Date:** / / 
- **Inpatient Attending Nephrologist(s):**
- **Discharge Date:** / / 
- **Discharging Physician:**

## Outpatient Dialysis
- **Facility:**
- **Phone:**
- **Contact:**

## Current Vascular Access
- □ Tunneled 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:**
- **Organism Type:**

## Anemia Management
- **ESA’s given during the admission:**
  - □ None
  - □ Epogen®
  - □ Aranesp®
  - □ Procrit®
  - **Last Dose/Date Received:** / / 
- **IV Ferrotherapy:**
  - □ Venofer®
  - □ Ferrlecit®
  - □ Feraheme®
  - □ Infed®
  - □ Dextran®
  - □ Other: ________________
  - **Last Dose/Date Received:** / / 

## Any RBC transfusions:
- □ NO
- □ YES
- **Date(s):**
- **HGB prior to transfusion(s):** ___________ gm/dL 
- **Most recent:**
  - **Hgb:** ___________  
  - **Date:** / / 
  - **Hct:** ___________  
  - **Date:** / / 

## Miscellaneous
- **Date of last HD prior to discharge:** / / 
- **Changes to EDW:**
- **Treated for other infections:**
  - (list): ________________
  - **Other:**

## Co-morbid Conditions
- □ Pericarditis
- □ Bacterial Pneumonia
- □ GI Bleeding

## Discharges Dialysis Prescription/Orders
- **TX per week:** ___________  
  - **Duration:** ___________
  - **Schedule:** ___________
- **Dialysate Na:** ___________ K: ___________ Ca: ___________
- **Bicarb setting:**
- **DRF rate:** ___________  
  - **BFR Rate:** ___________  
  - **Dry Weight:** ___________

## Medication changes:

## Co-morbid Conditions
- Did the patient receive treatment during this admission for the following conditions?
  - □ Pericarditis
  - □ Bacterial Pneumonia
  - □ GI Bleeding

## 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- involve nephrologist
  – EDW review
  – Mobility Changes
  – Anemia Management/Transfusions
  – Psychosocial Needs/Insurance needs-(Social Worker)
  – Discharge Dx Education/Intervention
  – Pending Blood Test
  – Status Changes
Interventions

• Post-Hospitalization Assessment
  – Must be completed on every hospitalization discharged between January 1st and August 30th
  – Send your initial plan for implementation by January 19th
Interventions

• Select at least one patient to be a member of the team for this QIA
Initial Expectations

- Everyone – sign project acknowledgement via link sent in email by the 19th
- Everyone- Contact list for your primary hospital- Get access to their EMR!!
- Send Post Hospitalization Assessment plan by January 31
- Patient identification cards printed and distributed January 31
- Read MAC Toolkit (minimally chapters 1,5 and 8-10)
- RCA is due by February 15th
Ongoing Expectations

- Use Rapid Cycle Improvement to add or modify interventions
- Webinars - email will be sent for mandatory webinars to help reduce hospitalizations
  - Required to participate in the ESRD NCC Pilot Project LAN
  - Project webinar schedule to be decided after LAN schedule is posted
“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
Attendance

Please enter your name and CCN in the chat to get credit for attendance
Contact Information

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