Forming Communities of Practice to Reduce Hospitalizations/Readmissions and Emergency Room Visits in the ESRD Population

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Quality Improvement Director
IPRO ESRD Network Program
Goals for this project are:

<table>
<thead>
<tr>
<th>QIA</th>
<th>GOAL</th>
<th>Data source</th>
<th>May 2022- April 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Hospitalizations</td>
<td>20% Decrease</td>
<td>Medicare Claims Data</td>
<td>5% Decrease</td>
</tr>
<tr>
<td>30 Day Unplanned readmissions-following an admission</td>
<td>20% Decrease</td>
<td>Medicare Claims Data</td>
<td>5% Decrease</td>
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<td>National ED Visits</td>
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Primary Diagnosis Codes (not all inclusive):

- VA infections
- BSIs
- CHF
- Fluid Overload
- Sepsis
- Hyperkalemia
- Clotted Access
- Chest Pain
- Anemia
- Hypokalemia
- Hyperglycemia
To Reduce within Primary Diagnosis Codes

Which of these primary diagnoses codes your facility could chose to work on interventions to eliminate?

Primary Diagnosis Codes (not all inclusive)

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Improving Transitions of Care

Transitions of care refers to the movement of patients between health care practitioners, settings, and home as their condition and care needs change.

In the dialysis setting the most frequent transitions are between long term care facilities/ in-center hemodialysis units or in-center hemodialysis facilities and acute care hospitals.

Results of Poor Transitions in the ESRD community?
- 37% of ESRD patients are hospitalized
- ⅓ of those admitted will be readmitted in 30 days
- Patient Outcomes deteriorate with each hospital and ER visit
- Patients greater than 65 years readmitted for same diagnoses have a 10% chance of dying in the same year.
Why are many transitions difficult for patients?

Patients Report

- Lack of understanding of treatment plan
- Not included in plan or goals
- Overwhelmed by “one more thing”
- Anger and depression
- Lack of resources
  - Social Determinants of Health/Health Equity
- Receiving conflicting information
- Distrust
- Work and family needs
- Denial of condition
Helping Patient with Transitions
A Part of the Life Plan

Find the Patients **WHY** to Motivate Patients to Reduce Their Hospitalizations

Speak with Patient about his/her values.

**What Matters Most:**
- Longer life
- Better Quality of Life
- Spending more time with loved ones/keeping a job

Frame your Communication in terms of how the desired behavior will help support the patients values and goals

I would like to stay out of the hospital so that I can babysit my grandchildren

What can we work on to prevent you from going back to the hospital?
Transitions Champion Role Description
A Dedicated Person(s) who will manage transitions

Suggested Interventions

- Interview each patient after discharge from hospital or ER visit w/in 24 hours of d/c
- Assure medication reconciliation is complete post d/c
- Assist patient in understanding the importance of follow-up
  - Manage dialysis schedule to allow for visits
- Identify with patient the important S/S to report related to d/c diagnosis
- Lead QAPI discussion
- Mark patients unstable for 3 months post d/c
- Identify and work with patient facility representative to educate patients and integrate them into work

Transitions In Care: A Critical Review of Measurement
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5656252/
ESRD Forum Transitions of Care Toolkit
Assembled by Experts in Dialysis Transitions

- Review of common RCA of difficulties with Transitions between Hospitals and ICHD
- Presents many common root causes for increased hospital and emergency room visits, accompanied with strategies/interventions to correct
- Guide Book for the Transitions Champion
  - Chapter 8
  - Very readable

Performance Score Cards
New for 2022-2023!

Reducing Hospitalizations, 30 Day Unplanned Readmissions, and Emergency Room/Department Visits Report

- Only patients who have fee-for-service (FFS) Medicare coverage are counted in this report.
- Reducing hospitalizations and unplanned readmissions align with the Quality Incentive Payment Program (QIPP) goals for Standardized Hospitalization Rates (SHR) and Standardized Readmission Rates (SRR).

Reducing Emergency Room/Department Visits

- Baseline Emergency Dept Visits Jan - Dec 2022: 14
- Goal Not To Exceed Emergency Dept Visits April 2022: 13
- Current Total ER Visits to Date: 13

Reducing Inpatient Hospitalizations

- Baseline Inpatient Hosp Admits Jan - Dec: 40
- Goal Not To Exceed Inpatient Hosp Admis Jan-Apr: 20

Reducing Unplanned 30-Day Readmissions

- Baseline Unplanned Hosp Readmits Jan-Dec 2020:
- Goal: Not To Exceed Unplanned Readmits June 2021-April 2022:
- Current Unplanned Readmits to Date:

See Next Page for list of FFS UPIs counted as “Current” in this Report...
RCA Review:
What other CC facilities are saying?

- Frequent Flyers (super-utilizers) 56%
- Missed treatments 29%
- Poor communication between acute care hospitals and dialysis facilities 6%
- Non-dialysis related comorbidities that lead to admissions 6%
- Physicians routinely send all patients to ER for assessment 3%
Review Your Complete RCA to Create a PDSA

**PLAN**- Create a Plan to implement your change
**DO**- Begin to work your change
**Study**- What part of the change plan is working? If not working reroute your plan
**ACT**- How will you incorporate the change in doing business as usual: incorporate in staff training, patient education, create a policy or standard of care?
**Test the Change**

**PDSA Cycle**

**PDSA Cycle** is a model to test change by planning it, trying it, observing the results and acting on what is learned.

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<tr>
<td>Identify 4 “Frequent Flyers” in Facility and work with them to determine root cause of misuse of hospital for primary care</td>
<td>IDT Root Cause Analysis for frequent trips to hospital for each patient and work to mitigate cause</td>
<td>Continue this for 5 months every month selecting X new patients each month to complete the “DO”</td>
<td>If hospitalizations and ER visits decrease in the study population, institute practice with all patients discharged from ER and hospital</td>
</tr>
<tr>
<td>Focus on health equity: PCP Transportation Homeless Food resources</td>
<td>Mark patient’s care plan as unstable and review patient monthly</td>
<td></td>
<td>If intervention planned or steps of the DO are not successful, apply what you learned to update PDSA</td>
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**Test the Change**

**PDSA Cycle**

PDSA Cycle is a model to test change by planning it, trying it, observing the results and acting on what is learned.

### EXAMPLE

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<td>Select a Transitions Champion</td>
<td>Utilize Transitions Champion Interview Tool</td>
<td>Continue this for 5 months every month selecting new patients each month from performance scorecard admissions to complete the “DO”</td>
<td>If hospitalizations decrease in the selected population, institute practice with all patients discharged from ER and hospital</td>
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Consider the patients that are your super-utilizers:

- Do they have access to a primary care physician?
- When do their admissions occur?
- Is their primary language English?
- Transportation issues that prevent them getting to follow up appointments?
- Are they homeless?
- Do they have a Medicaid spend down that prevents them from utilizing outpatient services or refilling prescriptions until a certain amount of medical expenses have accrued?
- Are they accessing the hospital, at the end of the month when their food has run out
- Are they socially isolated, or have no support from family, family or faith based groups?

Consider the Patient Whys to Instances of Admissions, Readmissions and ER Visits? Is it related to health equity?
Share Your Work with the Team

Goals that are shared are the ones that are made!

Use a Huddle Board or Bulletin Board to share progress to goal, new resources, strategies that are working or need to be revise

- Have patient(s) facility representative help you create a visual display
- You will be asked to upload to IPRO Learn as an activity
Share you work!

Include:
- Resources
- Interventions
- Performance Score Cards

**PRO TIP** Include the patients concerns about increased hospitalization and emergency room visit.
Discussion Board

- Each facility will be asked to share their huddle/bulletin board
- Post one best practice that they found that works in their facility
- Comment on another individual's post
- Share how they are using their Patient Facility Representative in the work
Where Do I Start?

1. Gain Access to IPRO Learn
   a. If you are unsure of the LOGIN please complete a Help Desk Ticket
   b. https://help.esrd.ipro.org/support/tickets/new

2. As a community Coalition you will be required to complete activities each month to assist you make a change

3. If you have not done so, complete RCA (this is in IPRO Learn)
   a. Consider using your last Hospitalization Performance Scorecard to guide you to what measures you are not doing well in
   b. Discuss with your QAPI team what action you will take

4. Select a Patient Facility Representative and complete required paperwork
Transplant Interventions/Resources
IPRO Learn

ESRD Facility Quality Improvement Collaborative 2021-2022
Dashboard / My Courses / ESRD Facility QI Collaborative 2021-2022

What's New / Recent Announcements
- SURVEY PARTICIPANTS NEEDED: Reducing Disparities in Access to Kidney Transplantation Study
- Educational Events: Living It Up: New York Style 2022
  - Restricted: Not available unless you belong to NW2 (hidden otherwise)
- Regulatory Update: 4/13/2022: Health secretary extends the U.S. public health emergency
- Celebrate Home modalities Top-Performing Facilities!
  - Restricted: Not available unless you belong to NW6 (hidden otherwise)
- Upcoming Event: 6/12/2022: NF Kidney Walk in Northwest Ohio
  - Restricted: Not available unless you belong to OH (hidden otherwise)

Welcome! Please watch the 5-Minute IPRO Learn Onboarding Tutorial that will help you get started.

QIA Best Practices
Now able to upload attachments!

To Do / Required Activities for April - Due April 30, 2022
## Project Outline

<table>
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<tr>
<th>Month</th>
<th>Staff Focused Activities</th>
<th>Patient Focused Activities</th>
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| Pre-Work Month 1 | □ Identify your project lead. This person will be receiving all project communications from the Network. Once you’ve selected your project lead. Login to **ESRD Contact Management System** to update the project lead contact information AND any other contacts at your site. Please add, remove, and edit personnel as needed.  
□ Complete the **Root Cause Analysis (RCA)** Activity in IPRO Learn and review with your interdisciplinary team  
□ Login to **IPRO Learn** and review the transplant toolkit as this may assist you in completing your RCA. Your facility should be receiving a facility performance report card monthly. Review the report card information on how your facility is progressing in Transplant. Use this information to aid in the completion of your **Root Cause Analysis (RCA)**.  
• Please put in a **help desk ticket** if you do not know your IPRO Learn login information  
□ Complete all assigned activities in IPRO Learn by the end of each month | □ Watch and share the PFR Recruitment Video with patients at your facility.  
□ Nominate a patient facility representative (PFR) to engage in quality improvement work. The goal of the patient representative program is to promote patient, family, and caregiver engagement in ESRD care. To nominate a patient facility representative (PFR), complete the **IPRO ESRD Network 2021 Patient Facility Representative (PFR) Application/Agreement**.  
Your facility should aim to have at least 1 PFR nomination submitted by the end of Month 1. |
Patient Integration into the Work

- Multiple research studies have shown that patients and caregivers who take an active role in their care have better outcomes.
- Patients bring a unique perspective to the challenges faced by a person living with kidney disease.
- Facilities who are working on a Quality Improvement activity will designate a minimum of one patient facility representative.
- Healthcare that results in the BEST outcomes revolves around teamwork.
Patient Integration into the Work

Ways of engaging your PFR:

● Ask your PFR to assist you in distributing patient education materials

● Have your PFR participate in Huddle Board discussions

● Invite your PFR to QAPI meetings to report on progress of their work

● Integrate your PFR into wallet card roll out
Patient Facility Representative Recruitment

Identify a patient to fulfill the requirement by June 1, 2022

- Utilize the Redcap link to submit patient information
  - complete patient information and participation and confidentiality form

https://redcap.ipro.org/surveys/?s=7L7FWP TPE7
Let’s Get Started!

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216-755-3053

IPRO Help Desk:  http://help.esrd.ipro.org/support/tickets/new

OPEN OFFICE HOURS:  12 noon-2pm Fridays to receive an appointment, fill out a help desk ticket requesting a 30 minute time slot.
Health Equity? What’s That

Health equity means increasing opportunities for everyone to live the healthiest life possible, no matter who we are, where we live, or how much money we make.

Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

CDC Resources on Health Equity

https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm