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:

QIA	GOAL	Data source	May 2022- April 2023
National Hospitalizations	20% Decrease	Medicare Claims Data	5% Decrease
30 Day Unplanned readmissions- following an admission	20% Decrease	Medicare Claims Data	5% Decrease
National ED Visits	20% Decrease	Medicare Claims Data	5% Decrease

Primary Diagnosis Codes (not all inclusive)

VA infections	Sepsis	Anemia
BSIs	Hyperkalemia	Hypokalemia
CHF	Clotted Access	Hyperglycemia
Fluid Overload	Chest Pain	

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)

VA infections	Sepsis	Anemia
BSIs	Hyperkalemia	Hypokalemia
CHF	Clotted Access	Hyperglycemia
Fluid Overload	Chest Pain	

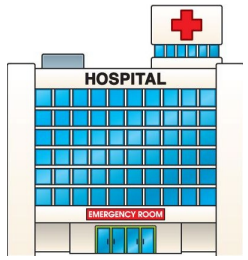
Improving Transitions of Care

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/ incenter 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

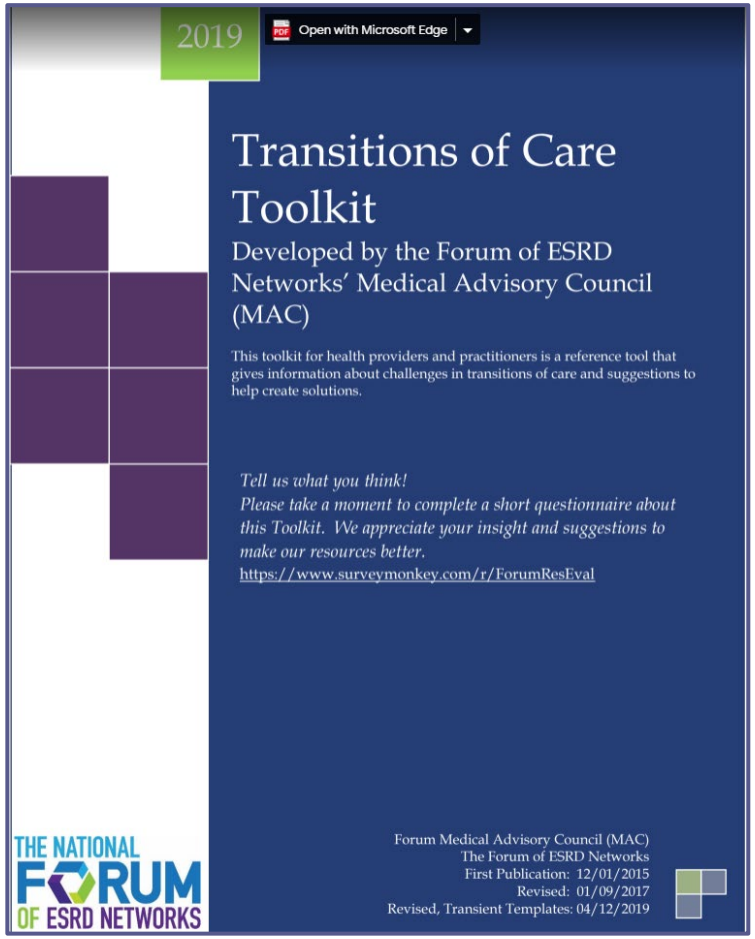
- Interview each patient after discharge from hospital or ER visit w/in 24 hours of d/c
- Assure medication reconciliation is complete post d/c
- Assist patient in understanding the importance of follow-up
  - Manage dialysis schedule to allow for visits
- Identify with patient the important S/S to report 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

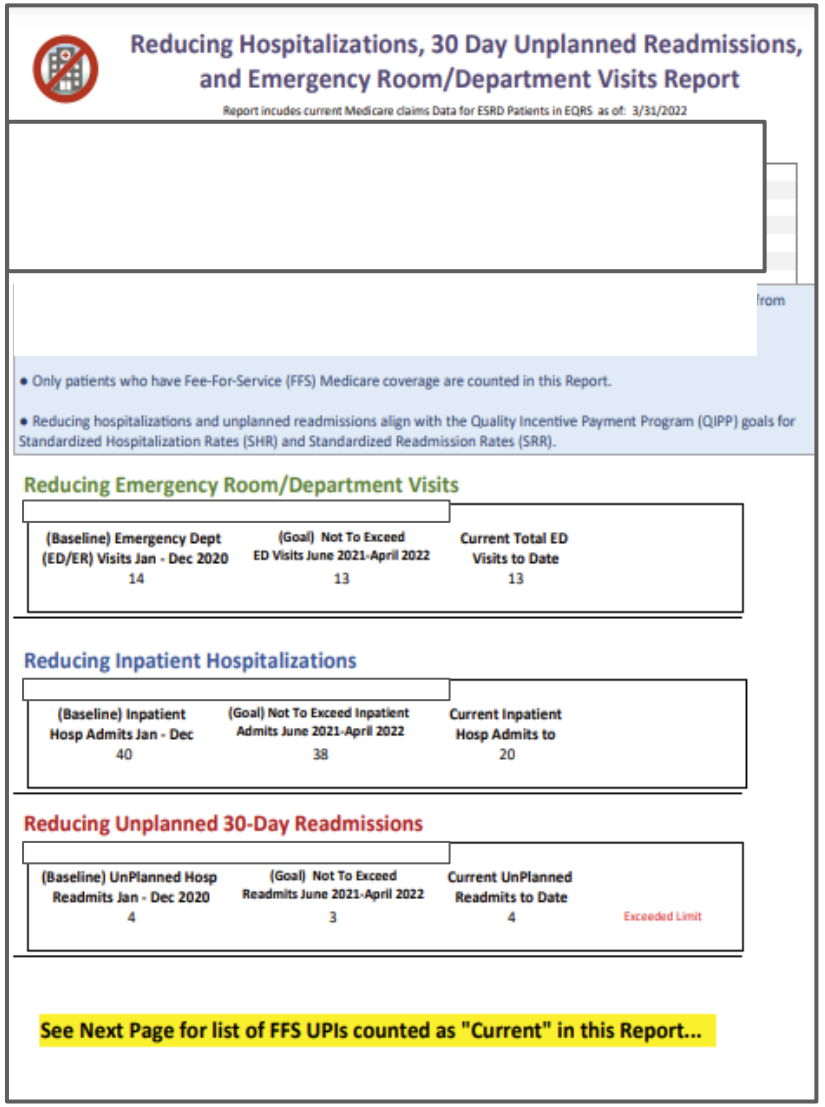
- Review of common RCA of difficulties with Transitions between Hospitals and ICHD
- Presents many common root causes for increased hospital and emergency room visits, accompanied with strategies/interventions to correct
- Guide Book for the Transitions Champion
  - Chapter 8
  - Very readable



https://media.esrdnetworks.org/documents/Transitions_of_Care_Toolkit_2020_0319_combined.pdf

Performance Score Cards

New for 2022-2023!



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

Report incudes current Medicare claims Data for ESRD Patients in EQRS as of: 3/31/2022

- 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 (ED/ER) Visits Jan - Dec 2020	(Goal) Not To Exceed ED Visits June 2021-April 2022	Current Total ED Visits to Date
14	13	13

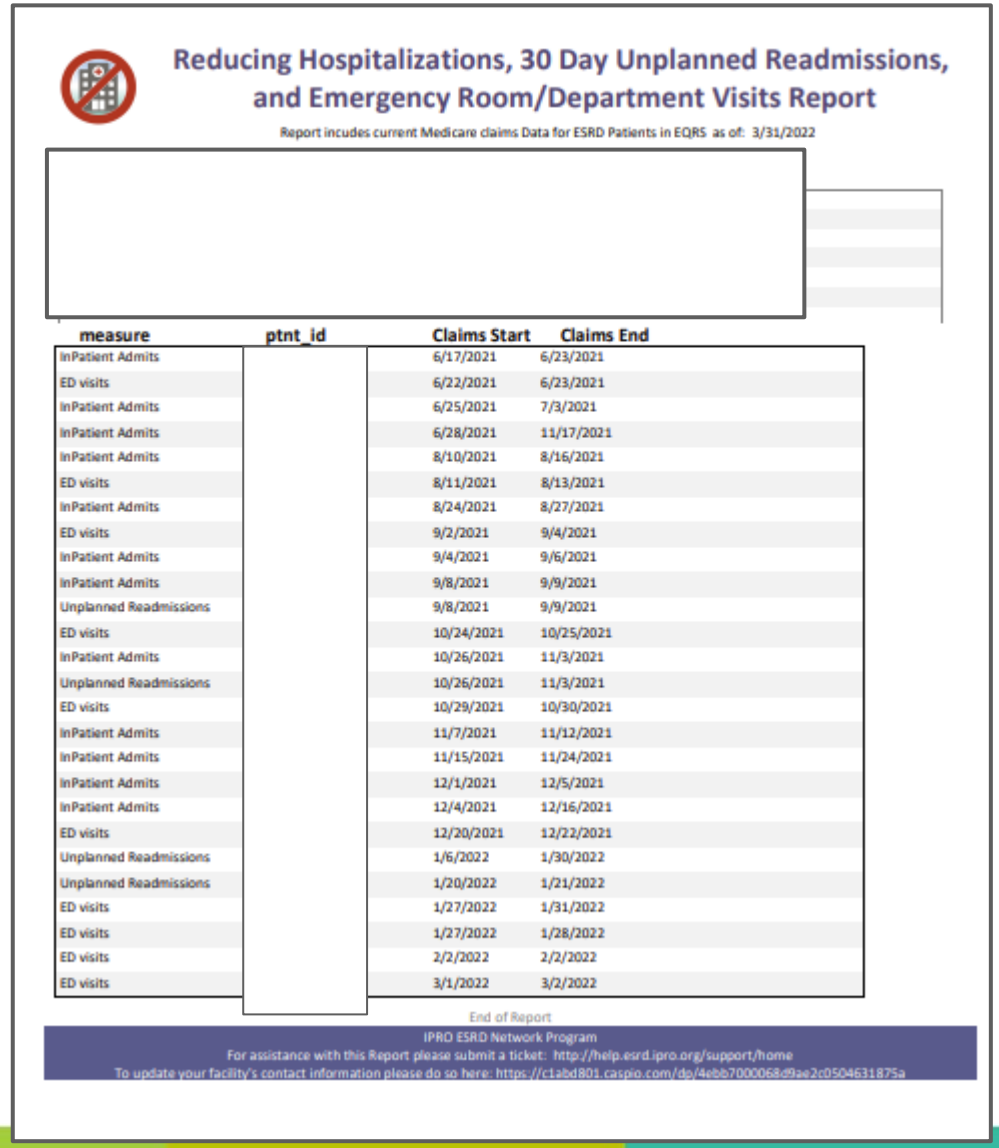
Reducing Inpatient Hospitalizations

(Baseline) Inpatient Hosp Admits Jan - Dec	(Goal) Not To Exceed Inpatient Admits June 2021-April 2022	Current Inpatient Hosp Admits to
40	38	20

Reducing Unplanned 30-Day Readmissions

(Baseline) UnPlanned Hosp Readmits Jan - Dec 2020	(Goal) Not To Exceed Readmits June 2021-April 2022	Current UnPlanned Readmits to Date	
4	3	4	Exceeded Limit

See Next Page for list of FFS UPIs counted as "Current" in this Report...



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

Report incudes current Medicare claims Data for ESRD Patients in EQRS as of: 3/31/2022

measure	ptnt_id	Claims Start	Claims End
InPatient Admits		6/17/2021	6/23/2021
ED visits		6/22/2021	6/23/2021
InPatient Admits		6/25/2021	7/3/2021
InPatient Admits		6/28/2021	11/17/2021
InPatient Admits		8/10/2021	8/16/2021
ED visits		8/11/2021	8/13/2021
InPatient Admits		8/24/2021	8/27/2021
ED visits		9/2/2021	9/4/2021
InPatient Admits		9/4/2021	9/6/2021
InPatient Admits		9/8/2021	9/9/2021
Unplanned Readmissions		9/8/2021	9/9/2021
ED visits		10/24/2021	10/25/2021
InPatient Admits		10/26/2021	11/3/2021
Unplanned Readmissions		10/26/2021	11/3/2021
ED visits		10/29/2021	10/30/2021
InPatient Admits		11/7/2021	11/12/2021
InPatient Admits		11/15/2021	11/24/2021
InPatient Admits		12/1/2021	12/5/2021
InPatient Admits		12/4/2021	12/16/2021
ED visits		12/20/2021	12/22/2021
Unplanned Readmissions		1/6/2022	1/30/2022
Unplanned Readmissions		1/20/2022	1/21/2022
ED visits		1/27/2022	1/31/2022
ED visits		1/27/2022	1/28/2022
ED visits		2/2/2022	2/2/2022
ED visits		3/1/2022	3/2/2022

End of Report

IPRO ESRD Network Program
For assistance with this Report please submit a ticket: http://help.esrd.ipro.org/support/home
To update your facility's contact information please do so here: https://c1a8d801.caspio.com/dp/4ebb7000068d9ae2c0504631875a

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.

EXAMPLE

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

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

Plan	Do	Study	Act
Select a Transitions Champion	Utilize Transitions Champion Interview Tool (or tool of organization) 24-48 hours post d/c	Continue this for 5 months every month selecting new patients each month from performance scorecard admissions to complete the “DO”	If hospitalizations decrease in the selected population, institute practice with all patients discharged from ER and hospital

Consider the Patient Whys to Instances of Admissions, Readmissions and ER Visits? Is it related to health equity?

Consider the patients that are your super-utilizers:

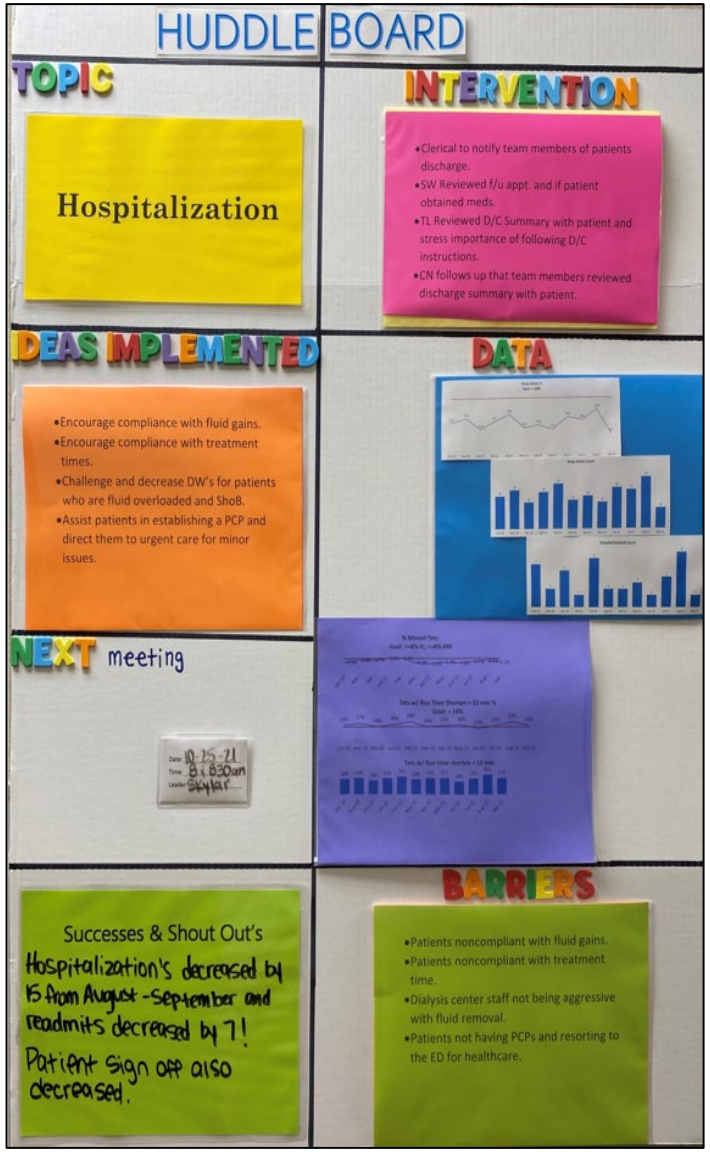
- Do they have access to a primary care physician?
- When do their admissions occur?
- Is their primary language English?
- Transportation issues that prevent them getting to follow up appointments?
- Are they homeless?
- Do they have a Medicaid spend down that prevents them from utilizing outpatient services or refilling prescriptions until a certain among 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?

Share Your Work with the Team

Goals that are shared are the ones that are made!

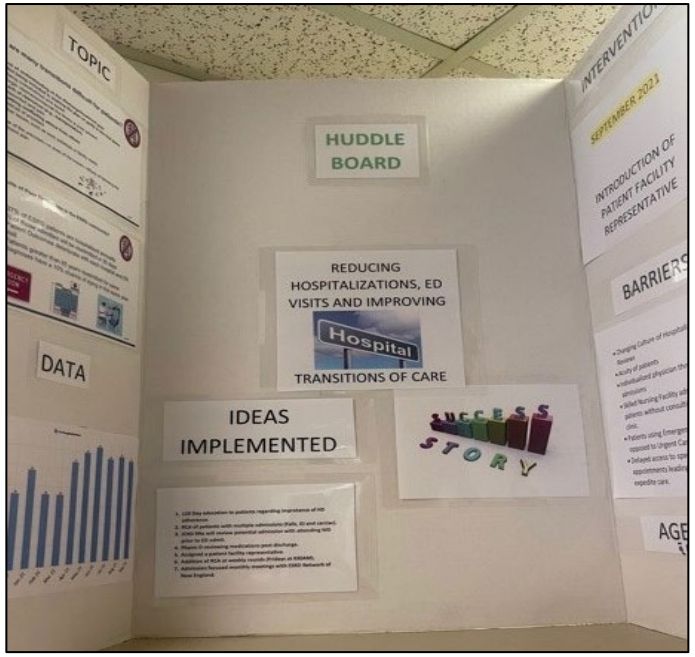
Use a Huddle Board or Bulletin Board to share progress to goal, new resources, strategies that are working or need to be revise

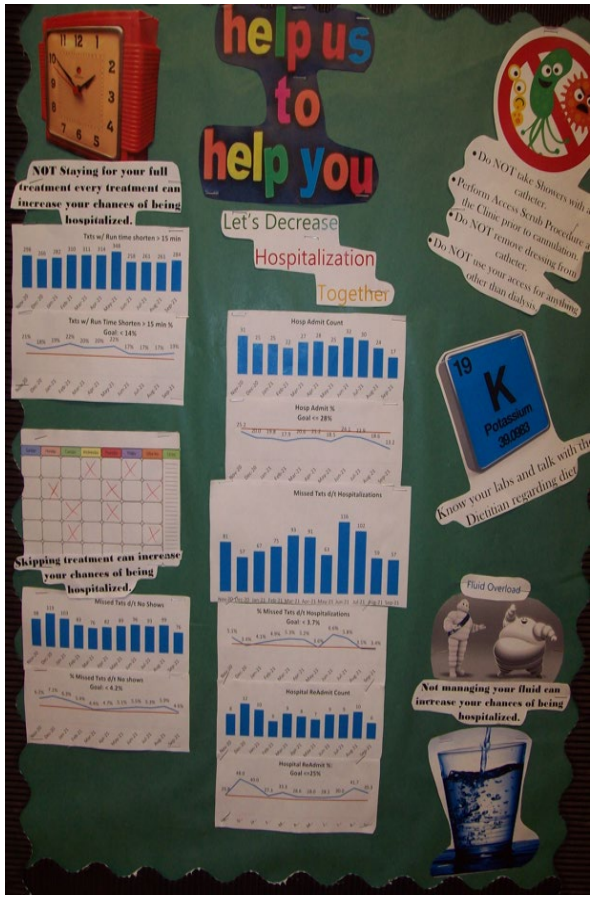
- Have patient(s) facility representative help you create a visual display
  - You will be asked to upload to IPRO Learn as an activity



Share you work!

Include:
Resources
Interventions
Performance Score Cards





HUDDLE BOARD

REDUCING HOSPITALIZATIONS

IPRO QUALITY IMPROVEMENT ACTIVITY

FACILITY PROFILE
Rogosin Manhattan Eastside

Jan - Jun 2021 IPRO Survey
Six-month Average Census = 320
Six-month Hospitalizations = 160
Top 3 causes for Hospitalizations:
1. SOB / Respiratory (29)
2. GI related (23)
3. Vascular Access related (17)

Top 3 Hospital providers:
1. NYP - Cornell
2. NYP - Columbia
3. Mount Sinai Hospital

BEST PRACTICE
- Inform patients what to do when unwell
- Discuss discharge summary with the patient
- Reconcile medications post hospitalization
- Follow up on follow-up appointments
- Ask about needed support
- Collaborate with providers outside of dialysis

HOSPITALIZATION FACTS
- 37% of ESRD patients are hospitalized annually
- 33% of those will be readmitted w/in 30 days
- Patient outcomes deteriorate with each visit
- Those aged ≥ 65 readmitted for same diagnosis have a 10% chance of dying in the same year

HOSPITALIZATION ROUNDS
- Mondays with Dr. Bohmart

TRANSITIONS OF CARE
- Patients move between healthcare settings as conditions change
- Transitions of Care are not just about discharges form a hospital. Kidney patients and their families have many unique transitions, including a massive shift in what they expect for their futures.
- Kidney failure does not go away, though treatments may change
- Communication is critical
- Respect is essential

HOME | DIALYSIS | HOSP | LTC | REHAB

Staff Transition Champion: Martha Desta, NP
Facility Patient Representative: Stephanie Dixon - MWF4

TARGET = Reduce hospitalizations by 4% over 1 year	JUN '21	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN '22
Census - all programs	314	314	314	313									
Total # of Hospitalizations - all programs	45	52	48	31									
Total # of Patients Hospitalized - all programs	41	46	42	29									

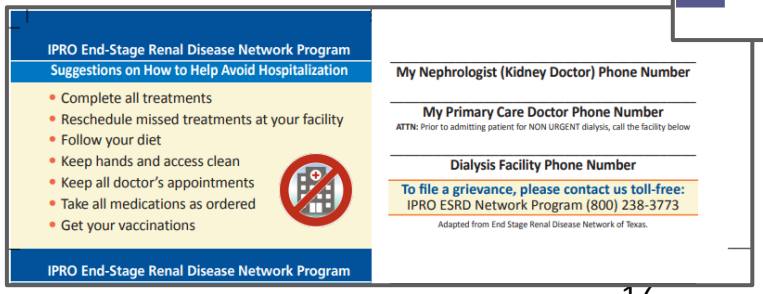
PRO TIP Include the patients concerns about increased hospitalization and emergency room visist

Available on IPRO Learn

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 individuals post
- Share how they are using their Patient Facility Representative in the work

Toolkit


IPRO End-Stage Renal Disease Network Program
Suggestions on How to Help Avoid Hospitalization
- Complete all treatments
- Reschedule missed treatments at your facility
- Follow your diet
- Keep hands and access clean
- Keep all doctor's appointments
- Take all medications as ordered
- Get your vaccinations

IPRO End-Stage Renal Disease Network Program

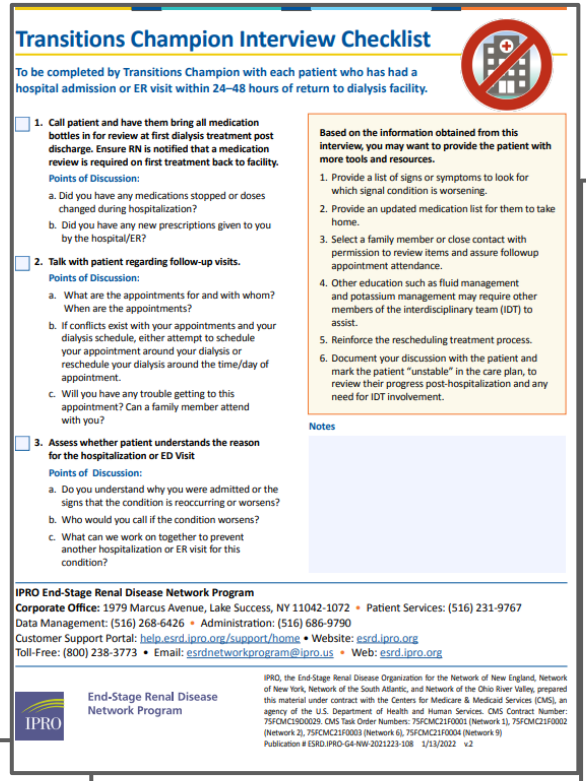
My Nephrologist (Kidney Doctor) Phone Number

My Primary Care Doctor Phone Number
ATTN: Prior to admitting patient for NON URGENT dialysis, call the facility below

Dialysis Facility Phone Number

To file a grievance, please contact us toll-free:
IPRO ESRD Network Program (800) 238-3773

Adapted from End Stage Renal Disease Network of Texas.


Transitions Champion Interview Checklist

To be completed by Transitions Champion with each patient who has had a hospital admission or ER visit within 24–48 hours of return to dialysis facility.

1. Call patient and have them bring all medication bottles in for review at first dialysis treatment post discharge. Ensure RN is notified that a medication review is required on first treatment back to facility.
   Points of Discussion:
   a. Did you have any medications stopped or doses changed during hospitalization?
   b. Did you have any new prescriptions given to you by the hospital/ER?
2. Talk with patient regarding follow-up visits.
   Points of Discussion:
   a. What are the appointments for and with whom? When are the appointments?
   b. If conflicts exist with your appointments and your dialysis schedule, either attempt to schedule your appointment around your dialysis or reschedule your dialysis around the time/day of appointment.
   c. Will you have any trouble getting to this appointment? Can a family member attend with you?
3. Assess whether patient understands the reason for the hospitalization or ED Visit
   Points of Discussion:
   a. Do you understand why you were admitted or the signs that the condition is reoccurring or worsens?
   b. Who would you call if the condition worsens?
   c. What can we work on together to prevent another hospitalization or ER visit for this condition?

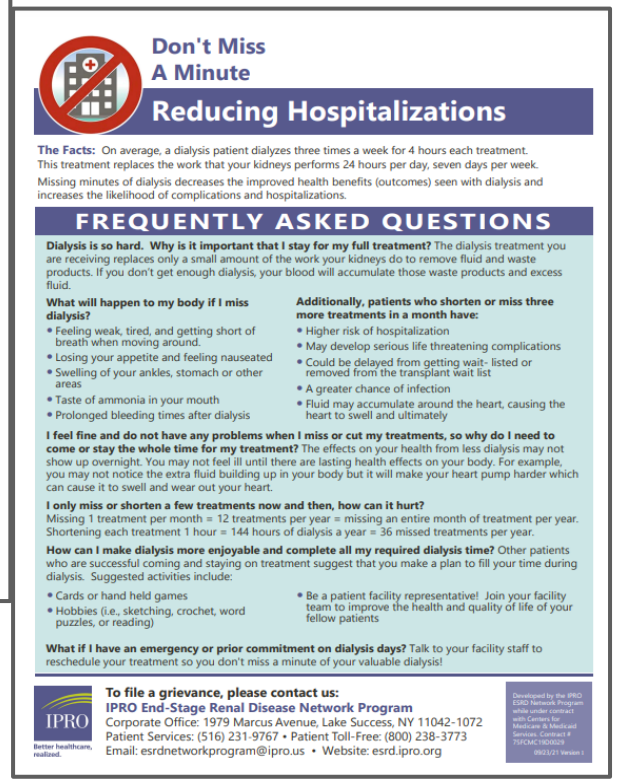
Based on the information obtained from this interview, you may want to provide the patient with more tools and resources.
1. Provide a list of signs or symptoms to look for which signal condition is worsening.
2. Provide an updated medication list for them to take home.
3. Select a family member or close contact with permission to review items and assure followup appointment attendance.
4. Other education such as fluid management and potassium management may require other members of the interdisciplinary team (IDT) to assist.
5. Reinforce the rescheduling treatment process.
6. Document your discussion with the patient and mark the patient "unstable" in the care plan, to review their progress post-hospitalization and any need for IDT involvement.

Notes

IPRO End-Stage Renal Disease Network Program
Corporate Office: 1979 Marcus Avenue, Lake Success, NY 11042-1072 • Patient Services: (516) 231-9767
Data Management: (516) 268-6426 • Administration: (516) 686-9790
Customer Support Portal: help.esrd.ipro.org/support/home • Website: esrd.ipro.org
Toll-Free: (800) 238-3773 • Email: esrdnetworkprogram@ipro.us • Web: esrd.ipro.org

End-Stage Renal Disease Network Program

IPRO, the End-Stage Renal Disease Organization for the Network of New England, Network of New York, Network of the South Atlantic, and Network of the Ohio River Valley, prepared this material under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. CMS Contract Number: 75FCMC19D0029. CMS Task Order Numbers: 75FCMC21F0001 (Network 1), 75FCMC21F0002 (Network 2), 75FCMC21F0003 (Network 6), 75FCMC21F0004 (Network 9)
Publication # ESRD.IPRO-G4-NW-2021223-108 1/13/2022 v.2


Don't Miss A Minute

Reducing Hospitalizations

The Facts: On average, a dialysis patient dialyzes three times a week for 4 hours each treatment. This treatment replaces the work that your kidneys performs 24 hours per day, seven days per week.

Missing minutes of dialysis decreases the improved health benefits (outcomes) seen with dialysis and increases the likelihood of complications and hospitalizations.

FREQUENTLY ASKED QUESTIONS

Dialysis is so hard. Why is it important that I stay for my full treatment? The dialysis treatment you are receiving replaces only a small amount of the work your kidneys do to remove fluid and waste products. If you don't get enough dialysis, your blood will accumulate those waste products and excess fluid.

What will happen to my body if I miss dialysis?
- Feeling weak, tired, and getting short of breath when moving around.
- Losing your appetite and feeling nauseated
- Swelling of your ankles, stomach or other areas
- Taste of ammonia in your mouth
- Prolonged bleeding times after dialysis

Additionally, patients who shorten or miss three more treatments in a month have:
- Higher risk of hospitalization
- May develop serious life threatening complications
- Could be delayed from getting wait- listed or removed from the transplant wait list
- A greater chance of infection
- Fluid may accumulate around the heart, causing the heart to swell and ultimately

I feel fine and do not have any problems when I miss or cut my treatments, so why do I need to come or stay the whole time for my treatment? The effects on your health from less dialysis may not show up overnight. You may not feel ill until there are lasting health effects on your body. For example, you may not notice the extra fluid building up in your body but it will make your heart pump harder which can cause it to swell and wear out your heart.

I only miss or shorten a few treatments now and then, how can it hurt? Missing 1 treatment per month = 12 treatments per year = missing an entire month of treatment per year. Shortening each treatment 1 hour = 144 hours of dialysis a year = 36 missed treatments per year.

How can I make dialysis more enjoyable and complete all my required dialysis time? Other patients who are successful coming and staying on treatment suggest that you make a plan to fill your time during dialysis. Suggested activities include:
- Cards or hand held games
- Hobbies (i.e., sketching, crochet, word puzzles, or reading)
- Be a patient facility representative! Join your facility team to improve the health and quality of life of your fellow patients

What if I have an emergency or prior commitment on dialysis days? Talk to your facility staff to reschedule your treatment so you don't miss a minute of your valuable dialysis!

To file a grievance, please contact us:
IPRO End-Stage Renal Disease Network Program
Corporate Office: 1979 Marcus Avenue, Lake Success, NY 11042-1072
Patient Services: (516) 231-9767 • Patient Toll-Free: (800) 238-3773
Email: esrdnetworkprogram@ipro.us • Website: esrd.ipro.org

Better healthcare, realized.

Developed by the IPRO ESRD Network Program while under contract with Centers for Medicare & Medicaid Services. Contract # 75FCMC19D0029
09/21 Version 1

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

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

1. 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

Project Outline

Month	Staff Focused Activities	Patient Focused Activities
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:

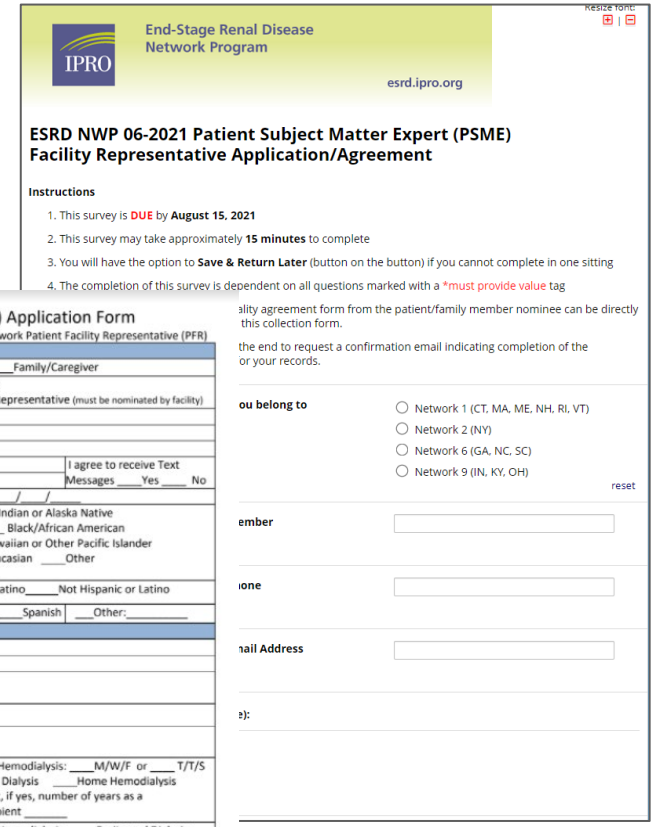
- Ask your PFR to assist you in distributing patient education materials
- Have your PFR participate in Huddle Board discussions
- Invite your PFR to QAPI meetings to report on progress of their work
- Integrate your PFR into wallet card roll out

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=7L7FWPTPE7



IPRO

End-Stage Renal Disease Network Program

esrd.ipro.org

ESRD NWP 06-2021 Patient Subject Matter Expert (PSME) Facility Representative Application/Agreement

Instructions

1. This survey is DUE by **August 15, 2021**
2. This survey may take approximately **15 minutes** to complete
3. You will have the option to **Save & Return Later** (button on the button) if you cannot complete in one sitting
4. The completion of this survey is dependent on all questions marked with a *must provide value tag

ality agreement form from the patient/family member nominee can be directly this collection form.

the end to request a confirmation email indicating completion of the or your records.

ou belong to

- Network 1 (CT, MA, ME, NH, RI, VT)
- Network 2 (NY)
- Network 6 (GA, NC, SC)
- Network 9 (IN, KY, OH)

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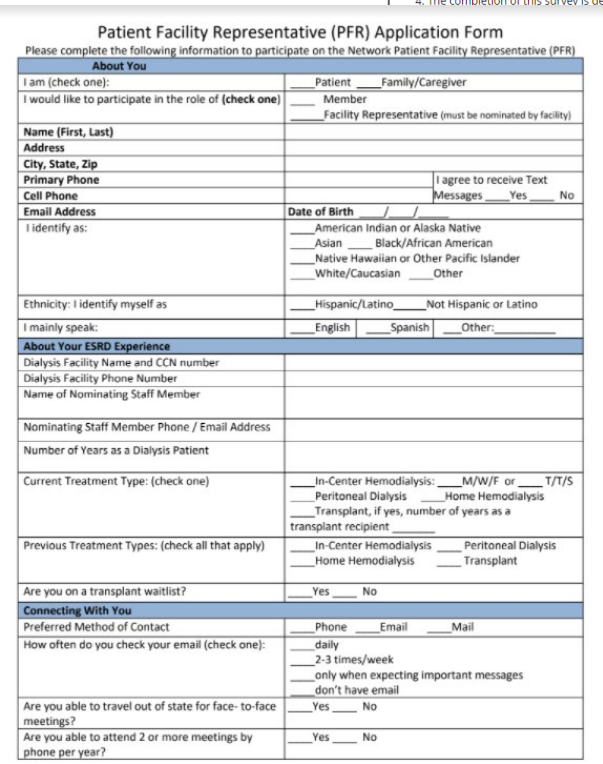

Patient Facility Representative (PFR) Application Form

Please complete the following information to participate on the Network Patient Facility Representative (PFR)

About You	
I am (check one):	____Patient ____Family/Caregiver
I would like to participate in the role of **(check one)**	____ Member ____Facility Representative (must be nominated by facility)
Name (First, Last)	
Address	
City, State, Zip	
Primary Phone	I agree to receive Text Messages ____Yes ____ No
Cell Phone	
Email Address	**Date of Birth** ____/____/____
I identify as:	____American Indian or Alaska Native ____Asian ____ Black/African American ____Native Hawaiian or Other Pacific Islander ____White/Caucasian ____Other
Ethnicity: I identify myself as	____Hispanic/Latino____Not Hispanic or Latino
I mainly speak:	____English ____Spanish ____Other:_____
About Your ESRD Experience	
Dialysis Facility Name and CCN number	
Dialysis Facility Phone Number	
Name of Nominating Staff Member	
Nominating Staff Member Phone / Email Address	
Number of Years as a Dialysis Patient	
Current Treatment Type: (check one)	____In-Center Hemodialysis: ____M/W/F or ____ T/T/S ____Peritoneal Dialysis ____Home Hemodialysis ____Transplant, if yes, number of years as a transplant recipient _____
Previous Treatment Types: (check all that apply)	____In-Center Hemodialysis ____ Peritoneal Dialysis ____Home Hemodialysis ____ Transplant
Are you on a transplant waitlist?	____Yes ____ No
Connecting With You	
Preferred Method of Contact	____Phone ____Email ____Mail
How often do you check your email (check one):	____daily ____2-3 times/week ____only when expecting important messages ____don't have email
Are you able to travel out of state for face- to-face meetings?	____Yes ____ No
Are you able to attend 2 or more meetings by phone per year?	____Yes ____ No

Let’s Get Started!

Deb DeWalt
IPRO ESRD Program, Quality Director
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http://ipro.org

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.

Better healthcare,
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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