Reducing Hospitalization and Increasing Vaccinations Best Practices Call

March 1, 2023
Today’s Agenda

- Meeting Reminders
- Hospitalization Interventions
- Guest Speaker 1
- Vaccination Interventions
- Guest Speaker 2
- Closing Remarks
Meeting Reminders

• Please mute your line when not speaking to avoid background noise

• Be present and engaged

• Participants are encouraged to utilize chat to ask questions and make comments using “EVERYONE”

• All meeting materials are available via IPRO Learn or the Network Program Website
Objectives

At the completion of the program, the participant will be able to:

• State the CMS goals for hospitalization and COVID 19 hospitalization reduction
• List the CMS goals for COVID 19, Influenza and Pneumococcal vaccination
• Educate your team on tools and resources to assist in preventative infection control measures
• List the reasons bi-directional communication between care providers is important to ensure quality of care for the patient.
• Build a facility plan to increase the uptake in vaccinations
Building Trust and Communication to Decrease Hospitalizations, Readmissions and ER Visits

March 1, 2023
RCA Review:
What 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%
Learning From Technical Assistance Calls with Low and High Performers

- More difficulty with communication in rural facilities
  - Hospitals many miles away, as far as 50 miles (that provide dialysis care)
  - Much more difficult to get access when patients aren’t treated locally
  - Nephrologist has limited communication with the admitting hospital
# Impact of Working with Rural Facilities

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<th>NETWORK</th>
<th>TOTAL FACILITIES</th>
<th>Facilities with rural patients</th>
<th>% of Facilities with rural patients</th>
<th># of total census</th>
<th># rural patients</th>
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Best Practice Clinic Outcomes

Two Hospitalizations, rate of 1.37
- Below National Average
- Below Network Average

Readmissions ZERO

ER Visits ZERO
Best Practice Speaker

Lorna Vautour, RN

DCI Skowhegan, ME
DCI Skowhegan
The community we serve

- Population of Town ~ 9000
- Rural Patients
- Most patients are living independently
- Hospital in area is DOES NOT provide dialysis services
- Patients needing inpatient or emergency care must be transferred to Bangor ME

- 12 ICHD stations
- 42 patients
- Operate M-Sa
- 80% have a primary care physician that manages non-dialysis issues
How We Do It

The Main Ingredients of our Secret Sauce

- TRUST
- COMMUNICATION
- FOLLOW UP
- ADVOCACY
- IMPROVED PATIENT OUTCOMES
TRUST

Everything builds off this principle

• It is important to build trust with patients and their caregivers and families
  • Building trust with patients and families empowers them to allow you to assist them in making better care decisions

• It is also essential to build trust with other care partners
  • Primary Care Physicians- to trust your concerns when trying to get appointments for non-dialysis care
  • Emergency Services Departments and EMS
  • Hospitals
  • Nursing Home and Skilled Nursing Providers
COMMUNICATION

Who and How we provide bi-directional communication

• With Nursing Homes- Some facilities we were able to implement integrated care-planning
  • Anemia
  • Access Care
  • Medications
• Primary Care Physicians- to stress importance of patient care as outpatients
• Patient and Families- To provide them with information to empower them to make better decisions
• Important to keep communicating to reinforce: teaching, gain knowledge of patient concerns and needs to
FOLLOW UP

• Speak with patients and family members during the hospital stay to get a clear picture of their understanding of the diagnosis and after hospital care
• Spend time post hospitalization with patient and family to coordinate post hospital appointments with dialysis schedule
• Make sure the patient has follow up if possible close to home and does not have to travel the 1 hour to the hospital for after care
• Once post hospital care needs are determined all members of the dialysis staff are updated to maintain continuity of care and plan for patient success
Advocacy

• Patient is asked if they are ready to go home by dialysis manager
  • If yes, that is great! Make sure the patient can provide teach back on their current situation: med changes, wound care etc
  • If yes with limitations, obtain services for patient ahead of time- Meals on Wheels, Home Health Nurse or Aide
  • If NO- empowers patient and family to advocate for post discharge care in the community nursing or skilled facilities
    Educate post care staff, of the patients dialysis care plans, to prevent readmissions related to medication dosages and schedule failures, dialysis specific labs and the NORMALS
Case Study #1

Patient Demographics:

- 49 y/o White Male
- Resides with wife and son
- Twice has been admitted to facility
- First time independent
  - Transported self to and from dialysis
  - Able to communicate needs
  - Knowledgeable of med and therapies
- Second time
  - Totally dependent on wife and family to relay needs, transport and provide much needed support

After second diagnosis which followed a living donor transplant from father:

Patient had 4 hospitalization d/t

- subdural hematoma
- abdominal ascites.
- suspected liver disease requiring paracentesis, as outpatient (finally scar tissue developed ending the success of the procedure

PALLIATIVE Care was set up to reduce any future hospitalizations and provide comfort care
Case Study #2

Patient Demographics:

- 77 year old white male
- Lives alone ~ 30 minutes from dialysis
- Transports self to dialysis
- Partner lives separate, has advanced dementia and patient is sole caregiver
- Patient maintains both residences
- On dialysis 4 years

Patient problem:

- Intolerant to ESA medications and IV Iron therapy
- Worked with PCP to write standing order for blood transfusions as an outpatient when Hgb fell below 9 and/ or patient was symptomatic
Thank You!

Deborah DeWalt, MSN, RN
Quality Improvement Director, IPRO ESRD Network Program
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Decreasing COVID-19 Hospitalizations and Vaccination Best Practices

Aisha Edmondson
Contract Manager, Quality Improvement
Barriers Related to Vaccination

- Lack of knowledge
- Fear
- Accessibility
- Mistrust in the healthcare system
- Vaccine hesitancy
- COVID-19 Fatigue
- Lack of Infection Control
Breaking Barriers

• Help make their Vaccinations Happen
• Be Patient and Follow Up
• If Hesitancy Persists, Prevention is Key
• Help them understand why it’s important
• Educate
How PFRs Can Help!

- By helping patients receive information through sharing resources and information that will be provided to them
- To act as a member of the quality improvement team
- Can assist with letting your facility project lead know about any concerns or issues they encounter in working with the patients
- Hand out materials and share information provided by the Network
- Develop a bulletin board to educate patients
- Participate in a lobby day
Welcome to the new IPRO Learn website!
https://esrd.iprolearn.org/
Best Practices from the Network Service Area

We always offer all vaccines on admissions, if patients state they received we try to track down their vaccine history.

We spend a lot of time establishing relationships with our patients, they trust us.

We give out handouts and talk to the patients about the benefits. We also communicate with the nursing homes and let them know we will give the vaccines at the clinic and send them the information after they are given.

MD strongly encourages vaccination based on ESRD immunocompromised status and potential; risks to patients.

Patients vaccinations are reviewed on admission and offered at time of admission and during 30 day, 90 day and annual plan of cares.
Vaccination Best Practices Speaker

Jassy Custer, Facility Administrator, CCHT-A
Katrina Taylor Charge Nurse
Fresenius Medical Care of Lebanon
Fresenius Kidney Care Lebanon

Jassy Custer, Facility Administrator, CCHT-A
Katrina Taylor, Charge Nurse
Influenza Vaccination

- 87% of patients were vaccinated for Influenza as of February 2023
- 12% of patients declined the Influenza vaccination
- 15 of patients have an unknown status
  - The 1% accounts for patients who are pending admissions
Pneumonia Vaccination

- 67.8% of patients have completed the Pneumonia vaccination series
- 10.1% of patients are candidates and due to be vaccinated
- 7.9% of patients refused vaccination
- 56.6% of patients are in-progress in the vaccination series.
Hepatitis B

- 90.4% of patients have completed the Hepatitis B vaccination series and/or are immune
- 18% of patient's are in progress
- 19.2% of patients refused the vaccine.
Our Process:

• We ask patient’s early into the admission process for vaccination consents
• We have an RN designated as vaccination champion for the Lebanon dialysis clinic
• When patients decline vaccination, we wait a week or two and follow up with the physician and education reinforcement
• We employ our patient care technicians to reinforce patient education and the importance of vaccination among the ESRD patient population
Thank you

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