A Change Package To Reduce Hospitalizations

Key Change Ideas for Dialysis Facilities to Drive Local Action

Updated 2024

ESRD NCC
NATIONAL COORDINATING CENTER

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I. Introduction

This change package is intended to support dialysis facilities and End Stage Renal Disease (ESRD) Networks in reducing hospitalizations, re-hospitalizations, and emergency department (ED) visits for patients receiving dialysis care. The change package includes actionable change ideas, collected from top-performing dialysis facilities. The change ideas presented are intended as a menu of interventions from which program leaders can choose to implement within their facilities.

The original change package was released by the Centers for Medicare & Medicaid Services (CMS) in 2022. The change package was updated in 2023 and 2024 after additional interviews were conducted with high-performing facilities.

How to Get Started

Change happens at the local level. Dialysis facility Quality Assessment & Performance Improvement (QAPI) meetings are the perfect place to start. Giving interdisciplinary team (IDT) members this change package for review will allow them to identify and prioritize change ideas that could be implemented to reduce hospitalizations.

The change ideas presented are not meant to serve as the entire universe of approaches to keep patients out of the hospital. They can, however, serve as "tests of change" that drive performance improvement and quality improvement programs.

About QAPI: QAPI merges quality assessment (QA) and performance improvement (PI) into a comprehensive approach to quality management. QA is the process of meeting standards and ensuring care reaches an acceptable level. PI is the proactive, continuous study of processes with the intent to identify opportunities and test new approaches to fix the underlying causes of persistent, systemic problems. Data-driven QAPI programs may be customized to facility needs. Key steps include:

- Identifying the problem and defining the goal
- Deciding on a measurement to monitor improvement
- Brainstorming solutions based on barriers and root causes
- Planning an intervention
- Using plan-do-study-act (PDSA) to implement the improvement project

Learn more about QAPI: https://esrdnetworks.org/toolkits/professional-toolkits/qapi-toolkit/

Contacting ESRD Networks

Dialysis facilities can contact their local ESRD Networks for assistance with PDSA principles and practices and questions about change strategies. A complete listing of ESRD Networks can be found at https://esrdncc.org/en/ESRD-network-map/.

II. Change Package Methodology

The ideas presented in this change package were identified through interviews with high-performing dialysis facilities. The facilities were selected based on an analysis of Medicare claims data. During the interviews, systemic themes emerged, which were organized into driver diagrams, visual displays of what drives and contributes to achieving an overall aim.[1] The diagrams include drivers and associated change ideas, which were reviewed by six experts from ESRD Networks to ensure relevance to a broad range of dialysis facilities. The input from these experts was incorporated into the document.

The 2023 change package revisions were based on 10 additional interviews with high-performing facilities in late 2022/early 2023. The facilities were selected based on an analysis of Medicare claims data. The interviews resulted in the addition and/or modification of change ideas (indicated by asterisks) to reduce hospitalizations, re-hospitalizations, and ED visits for patients receiving dialysis care.

2024 Update: Information was added after 10 additional interviews were conducted with high-performing facilities, based on EQRS data. Change ideas were modified or added (indicated by asterisks) from information gathered from dialysis facility staff during the interviews.

III. Drivers to Reduce Hospitalizations

Interviews with high-performing dialysis facilities revealed primary and secondary drivers being utilized to reduce hospitalizations (Table 1). "Primary drivers are the most important influencers" that "contribute directly to achieving the aim." Secondary drivers are the actions and interventions that impact the primary drivers.[2]

The primary and secondary drivers (Tables 1–10), as well as the associated change ideas in the driver diagrams (Tables 2–10), are not in ranked order. They are numbered for easy reference.

Table 1. Primary and Secondary Drivers to Reduce Hospitalizations

AIM: REDUCE HOSPITALIZATIONS	
PRIMARY DRIVERS	SECONDARY DRIVERS
1. Adopt a culture that embraces patient-centeredness and high performance	1a: Keep the focus on patients and families 1b: Create a culture that contributes to low hospitalization rates 1c: Establish channels of communication to facilitate information sharing
2. Implement continuous quality improvement	2a: Track hospitalizations and related measures 2b: Review data in QAPI meetings and use data to drive QAPI processes
3. Implement processes to prevent hospitalizations and avoid readmissions	3a: Take proactive steps to prevent hospitalizations 3b: Give focused attention to patients who have been hospitalized

AIM: REDUCE HOSPITALIZATIONS	
PRIMARY DRIVERS	SECONDARY DRIVERS
4. Educate patients and staff	4a. Provide patients with knowledge, so they can play an active role in staying out of the hospital 4b. Prepare staff to prevent hospitalizations

IV. Key Change Ideas

The following driver diagrams (Tables 2–10) expand on the drivers to reduce hospitalizations (Table 1) and include specific change ideas for all the secondary drivers identified with high-performing dialysis facilities. The visualizations show the relationships between the primary and secondary drivers and the associated change ideas.

Table 2. Keep the Focus on Patients and Families

PRIMARY DRIVER #1: ADOPT A CULTURE THAT EMBRACES PATIENT-CENTEREDNESS AND HIGH-PERFORMANCE
Secondary Driver #1a: Keep the focus on patients and families
When patients see that they are at the center of everything that takes place in a facility, they feel safe to share concerns as they arise and ask for information. Staff can resolve concerns and issues early to prevent hospitalizations. **Change Ideas** 1. Be empathetic to the challenges that patients on dialysis face. Treat patients with kindness. 2. Smile. Be welcoming. Be approachable, so that patients will ask questions and trust that staff will care about an issue and take care of it 3. Recognize the unique culture of each community, e.g., community religious beliefs might not allow for the use of pork products (e.g., heparin) or cultures may not support that mental health issues may require medical intervention. 4. Engage families, especially in family-centered cultures. Ask for patient and family input. 5. Encourage the concept of "community" at the dialysis facility, so that patients help each other to be accountable for their treatments, e.g., not missing treatments. 6. Support patients with life and treatment goals. "If the patient has the will, the staff will find the way." 7. Use a collaborative approach between staff and patients to identify patient goals and modify them as needed. Meet patients where they are. 8. Solve problems with the family and community, e.g., food assistance/delivery; assistance with housing, utilities, or gas; getting supplies to patients who live in remote areas such as carrying boxes up a muddy road. 9. Treat patients like family. "If that were my mom or my father, my sister sitting in this chair, how would I treat that individual?" 10. Ensure patients know the clinical manager is available to them and has an open-door policy. Give patients the clinic manager's name.

PRIMARY DRIVER #1: ADOPT A CULTURE THAT EMBRACES PATIENT-CENTEREDNESS AND HIGH-PERFORMANCE
Secondary Driver #1a: Keep the focus on patients and families
11. Call patients and their families to share changes (e.g., new medication) and gather information. Inquire about specialists the patients should be seeing. Ask questions, such as "What is going on at home?" and "What can we do?" and "What do you need?" 12. Get to know the support systems for each patient and use them to reinforce the education around reducing hospitalizations.*

*Added 2024

Table 3. Create a Culture That Contributes to Low Hospitalization Rates

PRIMARY DRIVER #1: ADOPT A CULTURE THAT EMBRACES PATIENT-CENTEREDNESS AND HIGH PERFORMANCE
Secondary Driver #1b: Create a culture that contributes to low hospitalization rates

A positive environment in a dialysis facility incorporates a shared vision to provide high-quality care, teamwork, and involved leaders who are open to ideas. These elements form a solid framework that can support a facility's strategies to reduce hospitalizations.

Change Ideas

1. Share the facility's vision and quality outcomes via daily huddles, emails, staff meetings, and a communications book.
2. Ask, "What are high-performing organizations doing and how can we implement their best practice strategies?" "How can we do better with patient outcomes, even though we are meeting the goal?" "How can we improve our outcomes even better?"
3. Continually evolve policies and processes.
4. Emphasize safety. Report any problems or issues related to patients. "We don't hide anything."
5. Work together as a team diligently and purposefully to keep patients out of the hospital.
    a. Involve every team member (e.g., patient care technician [PCT], nurse, social worker, administrative assistant), e.g., the patient may tell the PCT about foot pain; the PCT removes the shoe and reports a wound to the nurse.
    b. Collaborate using a "how do we accomplish it?" approach.
    c. Educate, engage, and empower staff to make decisions and act as champions.
    d. Adopt a team approach where no one is more important or less important than the other, e.g., allow a PCT to tell the clinical manager that he/she is not following protocols.
6. Empower all staff to interact directly with nephrologists and ask questions, e.g., the PCT who may know the patient best speaks with the physician about a patient's fear of getting a vaccine or the nurse asks the physician about ordering an extra treatment.
7. Recognize that PCTs are the eyes and ears of the staff, that patients may be most comfortable with them, and that patients may tell the PCTs first if something is going on at home.
8. Communicate goals in a way that is not stressful to the staff.
9. As leaders, be approachable and listen to staff ideas and recommendations to improve care. Be present and available to patients; say hello to each patient every day, which builds trust and gives them the opportunity to speak with leaders about concerns.
10. Encourage patients to speak up without fear of retaliation, e.g., "You didn't wash your hands."
11. To address issues promptly, encourage a high level of involvement by the medical director/nephrologist, including:
    a. Reviewing critical elements, e.g., dry weights, during patient rounds.
    b. Being on-site at the facility two to three times a week and/or accessible at other times.
    c. Being approachable and open to talking with staff, e.g., PCTs talking with the nephrologist about patients.

Table 4. Establish Channels of Communication to Facilitate Information Sharing

PRIMARY DRIVER #1: ADOPT A CULTURE THAT EMBRACES PATIENT-CENTEREDNESS AND HIGH PERFORMANCE
Secondary Driver #1c: Establish channels of communication to facilitate information sharing

Facilities that figure out how to use informal as well as formal methods to communicate create pathways to share and gather vital information that can be used to prevent hospitalizations, readmissions, and ED visits.

Change Ideas

1. Foster open communication between management and staff, so staff feel comfortable coming to the charge nurse or manager with questions or concerns.
2. Maintain frequent and timely communication among all staff. Do not wait for formal meetings, e.g., facility administrator and charge nurse check in with staff on the floor to hear what is going on and roll out information as needed.
3. Keep a communication book that includes information about patient-specific issues, so staff know what happened during the previous treatment, e.g., if a patient was over his/her dry weight, then the staff know to challenge the dry weight on the next treatment. Keep the book at the nurses' station, accessible to all staff.
4. Create an environment where all staff members are approachable, regardless of position, e.g., PCT talks to manager or social worker and vice versa.
5. Hold daily huddles to discuss patients, e.g., who was admitted/discharged, why they were admitted, and any changes in care such as new medications. Focus on the cause of the hospitalization, e.g., an access issue.
6. Conduct weekly meetings with the IDT to discuss hospitalized patients.
7. Give all staff the opportunity to communicate with physicians and ask questions, e.g., a PCT with the best knowledge of a patient issue speaks directly with the nephrologist on rounds.
8. Utilize a liaison such as an administrative assistant to establish communications between the dialysis facility and the hospital, e.g., to obtain medical records.
9. Develop relationships with hospital discharge planners/case managers, so they can serve as a point of contact when patients are being discharged.
    a. Call them when patients are being discharged from the hospital.
    b. Meet with them quarterly to discuss discharge barriers or anything that can be improved.
    c. Educate case managers about facility goals, e.g., central venous catheter rates and discharge plans, such as each patient having at least an access plan before discharge or an appointment for access creation to speed up the process.
10. Communicate with nursing home staff.
    a. Develop a two-way communication form for patients residing in nursing homes that patients bring to every treatment and that the dialysis facility staff completes and sends back to the nursing home.
        - Include new medications; medications given during treatment, e.g., antibiotics; pre and post blood pressure readings; pre and post weights; changes in dialysis access; vaccines; changes in mental status; and if they saw the nephrologist.

PRIMARY DRIVER #1: ADOPT A CULTURE THAT EMBRACES PATIENT-CENTEREDNESS AND HIGH PERFORMANCE
Secondary Driver #1c: Establish channels of communication to facilitate information sharing

- Attach patient education handouts to the communication form, so the nursing home staff receives the same education as provided to the patients, e.g., how to care for catheters.
- Let the nursing home staff know about upcoming appointments and transportation needs.

b. Call the nursing home staff directly for any immediate issues to provide education, e.g., if a patient states, "I showered this morning and my dressing (catheter) got wet."

c. Send new lab results or monthly lab results to the nursing home.

d. Have the dietitian review the lab results with the patients, then send/fax a copy directly to the nursing home dietitian.

e. Call the nursing home directly with changes in medications or diet.

11. For organizations with multiple dialysis facilities, disseminate lessons learned and best practices across centers, e.g., improving handoff communications.

Table 5. Track Hospitalizations and Related Measures

PRIMARY DRIVER #2: IMPLEMENT CONTINUOUS QUALITY IMPROVEMENT
Secondary Driver #2a: Track hospitalizations and related measures

Facilities that improve rates for hospitalizations track data on a facility level to identify trends and issues that need to be addressed, e.g., increase in bloodstream infections (BSIs). "We need to know where we are to get where we are going." Those facilities also track and trend data on an individual patient level, so they can determine patients who are at risk for hospitalization and then take focused actions to keep those patients out of the hospital.

Change Ideas

1. Develop a fluid management dashboard that provides information for the IDT, including patients' average fluid gains, missed treatments, shortened treatments, blood pressures, and dry weights. Review the information to improve outcomes, e.g., the nurse and the physician can examine the patient's dry weight during the IDT meeting to manage the patient's blood pressure.
2. Use multiple tools for tracking different components: fluids, fistulas, catheters, albumin, mineral management, and missed treatments.
3. Document, track, and trend:
    a. The number of hospitalizations, readmissions, and ED visits.
    b. The number of missed treatments.
    c. The reasons for the hospitalizations, readmissions, ED visits, and missed treatments to analyze at a facility level.
    d. Which patients have been hospitalized and missed treatments and why those patients were hospitalized or missed treatments, so individual care plans can be modified.
4. At each treatment, ask patients, "Have you been in the hospital since your last visit?" Document hospitalizations or ED visits on the flowsheet. Review in QAPI meetings.
5. Perform daily monitoring of absences/hospitalizations, e.g., have administrative assistants check hospital discharges every day and add to a list of patients being discharged.
6. Assign a nurse to a set of patients, i.e., one nurse covers the first shift on Monday-Wednesday-Friday to track hospitalizations, absences, and discharges and provides a report to the clinical manager.
7. Complete post-hospitalization summary sheets to be incorporated into the medical record.
8. Incorporate the social worker into monitoring missed treatments and reasons, including psychosocial or transportation issues.
9. Maintain a hospital log to be updated after hospitalizations.
10. Track results of audits (e.g., hand hygiene) by staff and patients to identify breaks in infection control.

Table 6. Review Data in QAPI Meetings and Use Data to Drive QAPI Processes

PRIMARY DRIVER #2: IMPLEMENT CONTINUOUS QUALITY IMPROVEMENT
Secondary Driver #2b: Review data in QAPI meetings and use data to drive QAPI processes
Effective QAPI meetings incorporate regular reviews of data with the medical director and IDT to look into the "nooks and crannies of existing issues." These root cause analyses determine facility-wide and patient-specific issues that contribute to hospitalizations. Facilities can address the causes and prevent hospitalizations. **Change Ideas** 1. Assign a specific individual to the hospitalization area of QAPI. 2. Hold monthly quality meetings with the medical director and the IDT. a. Review hospitalization data for the month as well as trends for the past three months. b. Conduct root cause analyses for all patients who were hospitalized or visited the ED. c. Determine interventions for facility-wide issues, e.g., increase in BSIs. 3. For each patient, take a deep dive into the data to identify the core issues using clinical data, e.g., outliers of lab results, missed treatments, anemia, fluid overload, mental health issues. 4. Interview patients to support identification of root causes, e.g., if the patient was admitted for pneumococcal pneumonia, verify that the patient received a pneumococcal vaccine, or for weight gain, discuss factors that could result in fluid overload such as holidays. 5. Discuss hospitalizations for each patient admitted and discharged. Identify patients at risk for readmission. 6. Review the risk management or incident occurrences during QAPI meetings to see if any patients fell in the facility. If so, perform root cause analyses. Assess the facility and property for outdoor lighting, cracked sidewalks, etc. 7. Be transparent. Review/share metrics monthly with the whole team. a. Review data and discuss action plans in a staff meeting after each QAPI meeting. b. Share via secure email. c. Post data on a board in the conference room or breakroom, e.g., hospitalizations, missed treatments. Include trends and quarterly percentages. 8. Repeatedly re-review data and patient status for opportunities to prevent hospitalizations, e.g., review all patients with a catheter >90 days and take action to get a permanent access placed. 9. Review hospitalization trending workbook and hospitalization discharge analysis. Identify the root cause of admissions. Focus on the top 3 diagnoses.*

*Added 2024

Table 7. Take Proactive Steps to Prevent Hospitalizations

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO PREVENT HOSPITALIZATIONS AND AVOID READMISSIONS
Secondary Driver #3a: Take proactive steps to prevent hospitalizations

A proactive approach to preventing hospitalizations encompasses early identification of patients who are at risk for hospitalization; immediate review and communication of risk factors (e.g., abnormal lab results); and prompt implementation of interventions to address risk factors.

Change Ideas

1. Identify patients who are at risk for hospitalizations.
    a. Use a software program that captures all labs, highlights outliers, and breaks the data into categories such as Kt/V or albumin.
    b. Meet weekly with the IDT to identify potential red flags per patient such as Kt/V (adequacy), anemia, fluid overload, signs of infection, psychosocial issues. Ask who has the potential for hospitalization or who has just been hospitalized. Review all quality indicators to determine anything out of range.
2. Involve the whole team with one person serving as the lead, e.g., if a patient is not getting enough protein, the dietitian would direct efforts but the whole team would reinforce the plan.
3. Educate patients, caregivers, and families about any issues that could lead to hospitalization, such as long-term catheters, and follow up with them on actions patients need to take, e.g., making sure they are going to their PCP or vascular surgeon appointments for catheter removal. Discuss in the plan of care meetings.
4. Use proper technique to weigh patients to prevent fluid overload.
5. Make sure staff are conducting 30-minute access checks for needle dislodgment.
6. Conduct floor audits, e.g., on weighing patients.
7. Monitor dry weights.
    a. Schedule extra treatments or longer treatments or add one hour of ultrafiltration, as needed, e.g., if a patient is identified as a high fluid gainer.
    b. Keep chairs open for patients needing extra treatments.
8. If patients need to stop dialysis early, notify the physician and add to the next treatment, so by the end of the week, patients get 12 hours of dialysis.
9. Conduct medication reconciliation monthly and with changes in care. For patients residing in nursing homes, reconcile the medication list with the nursing home monthly.
10. Securely email monthly lab results to the medical director, nephrologist, nurse manager, administrator, and all nurses, so they can review lab results early and immediately intervene.
11. Implement protocols (e.g., vascular access/AV fistula creation, anemia management, treating peritonitis) to decrease hospital admissions.
12. Adapt protocols based on current situations, e.g., a protocol for COVID, requiring handwashing for all staff in all instances to enhance infection control versus using alcohol-based solutions.
13. Related to infections:
    a. Notify the medical director/nephrologist of lab results or early symptoms.
    b. Increase auditing of staff by staff and patients for hand hygiene, housekeeping,

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO PREVENT HOSPITALIZATIONS AND AVOID READMISSIONS

Secondary Driver #3a: Take proactive steps to prevent hospitalizations

accessing the site (e.g., always scrub the hub).

c. Implement CDC Core Interventions.

d. Adopt a "report everything" culture, e.g., when monitoring infection rates, report contamination.

e. Collaborate with an infection preventionist to address patients at risk for being hospitalized.

14. Engage the nephrologist to refer patients to their PCPs if patients have not seen them in a while or other specialists, as applicable.
15. Investigate which patients have been referred to specialists and see if they are following up with them and their PCPs.
    a. Reach out to specialists to share findings.
    b. Let patients know they need their PCPs and/or specialists involved, e.g., for blood pressure or blood glucose control or anemia management to prevent transfusions or to get transfusions at an infusion center instead of a hospital.
    c. Help patients make appointments.
    d. Have the social worker help patients find a PCP, if they do not have one*
16. Monitor for missed treatments and reschedule.
    a. Ask patients to call the facility if they cannot make their treatments.
    b. If a patient is a "no show," call the patient first, then the family, to find out why. If it is a clinical issue, have the nurse explore it in detail, as a treatment may resolve the issue.
    c. Manage patients' schedules. If patients need to reschedule, never say no.
    d. Offer to re-schedule treatments to avoid hospitalization. Instead of asking patients, "When do you want to come in?" say, "We have a chair available at 2 p.m. tomorrow." Give alternative times or days, so treatments are not missed.
    e. Refer patients to another clinic within the organization if a chair is not available, so patients can dialyze for at least two hours.
    f. Use consistent communication by all staff (e.g., administrative assistant, PCT, nurse) to patients calling about missed treatments, so that patients get the same message to reschedule the treatments.
    g. Engage family members, especially younger ones, to encourage their elders to follow treatment protocols.
    h. Involve the social worker for missed treatments. Use motivational interviewing to reduce the number of missed treatments.*
    i. Implement an ED diversion team to address fluid-related issues. Work with the nephrologist to schedule extra treatments.
    j. Put scripts by each phone in the facility that instruct staff to direct calls from patients about missing treatment to the social worker or clinical manager.*
17. Offer private, in-person patient/family care planning meetings to all patients for information sharing through open dialogue, so staff, patients, and families are operating from the same base of knowledge. Collaborate on identified challenges linked to hospital utilization and on solutions and goals.

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO PREVENT HOSPITALIZATIONS AND AVOID READMISSIONS
Secondary Driver #3a: Take proactive steps to prevent hospitalizations

a. Include the IDT (clinic manager, nurse, social worker, dietitian).
b. Spend as much time as the patient and family need.
c. Focus on patient issues as well as patient goals.
d. Share information and explore solutions, e.g., collaborate on an approach to a patient taking his/her blood pressure medicine.
e. Observe the patient-family dynamic. Learn from the patient/family, e.g., social issues impacting the patient or a patient's favorite food being spinach and tomato sauce, which could affect potassium levels.
f. Engage the family. Provide education.
g. Dedicate a portion of the meeting to focus on the patient's goals. Ask, "What are your goals?" "What gets in the way of meeting your goals?" "What can you and your family do?" "What can we do to help you meet these goals?"
h. Conclude the meeting by telling the family that there is an open-door policy for them to call and/or securely e-mail the manager.

18. Hold daily huddles on the treatment floor to discuss patients or any topics, as needed, e.g., hospitalization of a specific patient or missed treatments.
19. Have the social worker screen for mental health issues, such as depression, that could affect compliance with treatment protocols.
20. Discuss the option of offering a home therapy for patients who are missing treatments.
21. Advise patients to go to urgent care instead of the ED as appropriate, e.g., for skin rash.
22. Use telehealth as an option for patients who are not doing well and who do not see the nephrologist weekly. Set up a virtual meeting using a tablet, so the nephrologist can see the patients virtually.
23. Increase the frequency of clinicians being on the unit, e.g., nurse practitioner on the unit every day or the medical director at the facility two to three times per week to address issues quickly and make changes to the plan of care as needed.
24. Implement foot checks to avoid wound care issues that could result in hospitalization.
25. Work with EDs to dialyze patients in the facility versus admitting patients for fluid overload. If needed, contact other facilities within the organization to find an open chair.
26. Distribute highly effective interventions to sister clinics for implementation and adaptation, e.g., anemia management protocol.
27. Implement interventions for facility-wide issues, e.g., increase in BSI rates.
28. Keep one or two "open chairs" on the last shift of the day to use for patients that need to reschedule their treatment.*
29. For home dialysis patients:
    a. Instruct them to call the home training unit or the nurse on call before going to the hospital to triage issues like high blood pressure or extra fluid.
    b. Provide patients antibiotics for potential peritonitis that they can add to their PD solution, if directed by the nephrologist.
    c. Ensure they have over-the-counter medication on hand to deal with smaller issues like stool softener for constipation.*

*Added 2024

Table 8. Give Focused Attention to Patients Who Have Been Hospitalized

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO PREVENT HOSPITALIZATIONS AND AVOID READMISSIONS
Secondary Driver #3b: Give focused attention to patients who have been hospitalized

A patient leaving the hospital is in a state of transition and vulnerable to readmission. Dialysis facilities can safeguard against a patient's return to the hospital by orchestrating a secure handoff from the hospital, adjusting the plan of care, conducting medication reconciliation, and assisting patients to complete follow-up activities such as going to physician appointments and getting prescriptions filled.

Change Ideas

1. Appoint a dialysis staff member to serve as the hospital liaison to communicate with the hospitals regarding hospitalized patients and the transition back to the dialysis facility.
2. Build good relationships with hospitals to obtain copies of flowsheets and to get updates on patients like dry weights and treatment order changes post-hospitalization.
3. Offer to meet with hospital discharge planners to have a face-to-face meeting and introduction. Share the facility's goals and expectations.
4. Develop a robust and collaborative relationship with the staff at the hospital's inpatient dialysis unit to ensure continuity of care.
5. Obtain medical records.
    a. Call the nurse at the hospital for information while the patient is hospitalized or ask the medical director to reach out to the facility.
    b. Request access to the electronic medical record (EMR) at the local hospital to follow the patient and obtain the discharge summary and other medical records post-hospitalization. Assign the administrative assistant to pull reports from the system.
    c. Ask the medical director to facilitate gaining access to the hospital's EMR and/or to directly access the history and physical.
    d. Obtain medical records post-hospitalization by connecting with the hospital discharge planner or PCP.
    e. Ask the patient to bring in the discharge summary and the discharge instructions with the physician's name.
6. Collaborate with the hospital, nephrologist, and PCP while the patient is in the hospital and prepare for the patient's care and return to dialysis, e.g., revised orders for treatment, new medications, new dry weight.
7. Review the discharge summary, lab results, medication changes, etc., and contact the nephrologist for updates to the treatment plan before the patient arrives for his/her next treatment.
8. After hospitalization, evaluate the patient's dry weight; adjust as needed and monitor.
9. Draw blood for labs, e.g., hemoglobin, the first day back from the hospital if the patient missed lab day or if medically indicated.
10. Update the patient's status using a nursing summary sheet after hospitalization and add to the EMR. Updates may include:
    a. Transfusions
    b. EKG

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO PREVENT HOSPITALIZATIONS AND AVOID READMISSIONS
Secondary Driver #3b: Give focused attention to patients who have been hospitalized

c. Medication changes
d. Information from the discharge summary
e. Follow-up cultures
f. Referrals
g. Follow-up appointments
h. Steps to prevent readmission

11. Implement a Transition of Care Checklist to be completed on the first day the patient returns from the hospital.
12. Conduct medication reconciliation within one week after hospitalization.
    a. Request that the patient brings in his/her medications. Ask, "How do you take your medicine?" and "Why do you take this medicine?"
    b. Partner with a pharmacist for medication reconciliation post-hospitalization.
    c. Identify a medication reconciliation champion and use a checklist to review medications that includes collaboration with the hospital.
    d. Engage the facility administrative assistant to a send reminder for the patient that needs medication reconciliation to bring in his/her medications.
13. Communicate with the patient/family directly about follow-up appointments. Assist the patient with making new appointments. Give the patient a piece of paper with the details, e.g., date, time, address, phone number.
14. Have the patient see the nephrologist within two treatments after hospital discharge.
15. Engage the social worker to assist the patient with post-hospitalization follow-ups, e.g., filling prescriptions, scheduling appointments with referral physicians, transportation to appointments.
16. Explore the option of having a delivery service bring new medications to the dialysis facility.
17. Hold daily huddles to discuss each patient that is planned for release in the next 24 hours, patients that have been released, and patients at risk for readmission.
18. Conduct an IDT meeting weekly to discuss patients at high risk for hospitalization or rehospitalization, i.e., patients with labs for Kt/V trending down, missed treatments, recent hospitalizations, new patients, patients whose support systems have changed.
    a. Look at all aspects of the patient, e.g., lab results, home environment.
    b. Assign specific care activities to individual IDT members, e.g., social worker or dietitian, with a timeline for completion.
    c. Have different disciplines approach the same issue from their area of expertise, e.g., for a patient fall, the social worker may evaluate the home while the nurse may assess the patient's blood pressure or perform an assessment for fall risk.
19. Work hand-in-hand with other key providers, e.g., Indian Health Service.
20. Complete a head-to-toe assessment the first day they return from the hospital that includes a fluid assessment.*

*Added 2024

Table 9. Provide Patients with Knowledge

PRIMARY DRIVER #4: EDUCATE PATIENTS AND STAFF
Secondary Driver #4a: Provide patients with knowledge, so they can play an active role in staying out of the hospital

When patients understand potential causes of hospitalization, they take an active part in staying healthy and out of the hospital and the ED. They see the connections between adherence to treatment protocols, lifestyle choices such as fluid restriction, and hospitalization. They also recognize concerns that should be brought to healthcare professionals, such as early signs of infection and psychosocial issues that cause them to miss treatments.

Change Ideas

1. Educate patients on key issues and related consequences that can result in hospitalization, e.g., missed treatment, fluid overload, pneumonia, infection related to vascular access.
2. Discuss issues that could lead to hospitalization (e.g., abnormal lab values) during rounds.
3. Conduct patient education monthly, choosing a different topic each month, e.g., reasons to go to the PCP in June, managing fluids in July, proper foot care in August.
4. Provide extra education for patients that have issues related to adherence.
5. Tailor education to each individual patient.
    a. Focus on the issue the patient is facing or the patient's comorbidities, e.g., if the patient was hospitalized for fluid overload, discuss what happened, show the history of the fluid gain, and explain what to do to avoid it.
    b. Adapt education to the patient's culture and preferences, e.g., talk with the patient about his/her favorite foods and make good alternative suggestions.
6. Provide dietary education around the holidays or seasons, e.g., during winter months, discuss an emergency diet that can be used during a snowstorm; in the summer, focus on ways to manage thirst and fluids; around Thanksgiving, refer patients to local pantries and provide a Thanksgiving menu with foods that are kidney friendly.
7. Discuss eating foods with high fluid content in moderation, like limiting the amounts of salads and fruits that have a lot of water, e.g., watermelon.
    a. For patients who like to eat ice, show them how much liquid it is when it melts. Describe alternatives such as eating frozen grapes.
    b. Do not tell patients "No." Reframe and say, "We understand you like this, but how can we make it work within moderation?"
8. Use printed materials, corporate intranet, verbal 1:1 instruction, self-paced education on site, posters, company or Network flyers, and YouTube videos.
9. Make information easy to read and succinct, use bullets and color, and keep to one page.
10. Review information thoroughly with patients. Use the teach-back method, having the patients repeat back the information or demonstrate the action.
11. Educate as opportunities arise, e.g., after an infection or a hospitalization or if a trend indicates a potential issue.
12. Ensure all team members present the same message per topic (e.g., potassium or fluids) with the level of detail depending on the staff member's role.
13. Identify staff who have good connections with patients to provide education.

PRIMARY DRIVER #4: EDUCATE PATIENTS AND STAFF
Secondary Driver #4a: Provide patients with knowledge, so they can play an active role in staying out of the hospital

14. Provide a nutritional report card. Point patients to resources for kidney-friendly recipes.
15. Include families in the education.
16. Provide education in the language in which patients are most comfortable. Engage the family, if possible, to support translation and education for languages that are less common (e.g., Zuni).
17. Educate on the importance of a PCP or specialist for continuity of care.
    a. Share a list of PCPs, so patients can call for their own appointments.
    b. Enlist a social worker to help patients find a PCP.
    c. Help patients make appointments.
18. Ask patients to call the on-call nurse 24/7 for questions or issues or if they do not feel well, so that trips to the hospital can be avoided, e.g., by giving an extra treatment for fluid overload.
19. Ask patients key questions after hospitalization, such as, "Do you know why you were in the hospital?" Address specific reasons for the hospitalization with the IDT, e.g., dietitian to follow up with patients for fluid overload.
20. Track patient education in the EMR.
21. Explain why dialysis facilities need the discharge summary, instructions, changes in medications. Ask patients to request the paperwork and bring it to the facility.
22. Implement a bulletin board that contains information on where and when to go for treatment. For example, go to the ED if you broke an arm or have chest pain. Call your PCP for flu-like symptoms.*

*Added 2024

Table 10. Prepare Staff to Prevent Hospitalizations

PRIMARY DRIVER #4: EDUCATE PATIENTS AND STAFF
Secondary Driver #4b: Prepare staff to prevent hospitalizations

Educating staff about causes of hospitalization and ED visits increases their ability to act early and help patients stay healthy and out of the hospital.

Change Ideas

1. Provide education for staff on all topics related to hospitalization to include fluid overload, infections, missed treatments, and anemia.
2. Discuss the root causes of hospitalization, so staff can act early to implement interventions and protocols.
3. Incorporate education into daily staff huddles.
4. Provide opportunities for staff to improve clinical assessment skills, which will help them identify early risk factors for hospitalization.
5. Assign everyone a role in educating patients. Coordinate efforts for consistent messaging.
6. Involve the PCTs, so they can reinforce the education.

V. Conclusion and Next Steps

The ideas presented in this change package are being implemented in high-performing dialysis facilities across the United States. These ideas can be tailored and adapted to fit the needs of dialysis facilities and the patients with ESRD that they serve across the country.

As with any change, a best practice is to start small and build improvement toward systemic change. Facilities can start with one test of change and do it well. This will relieve the burden on staff and encourage buy-in when change begins. Measuring and monitoring performance improvement will ensure the facility stays on track with goals. Celebrating every success with staff, patients, families, and community partners at every change will be contagious. Above all, the best time to start performance improvement is now. With this change package in hand, program leaders, administrators, and staff should ask themselves, "What can I do by next Tuesday to get this started?"

VI. References

1. Institute for Healthcare Improvement. *QI Essential Toolkit* [ebook]. 2017; pp. 7–8. Available at: http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=Whiteboard-Video&utm_source=ihi. Accessed February 5, 2020.

2. Institute for Healthcare Improvement. *QI Essential Toolkit* [ebook]. 2017; pp. 7–8. Available at: http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=Whiteboard-Video&utm_source=ihi. Accessed February 5, 2020.

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