Hospitalization Roadmap Self-Assessment

Purpose

1. Use as a roadmap to assess current processes at your facility related to end-stage renal disease (ESRD) patients utilizing the emergency department (ED) and being admitted/readmitted to the hospital.

2. Use as a guide for implementation and reinforcement of best practices to reduce rates of ED visits and hospitalizations for your patients, including home patients, if applicable.

Answer the following tasks with :

- **Yes** (Fully implemented)
- **No** (Not implemented)
- **Partially** (In progress, not fully implemented).

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1 Dialysis Facility Hospitalization Tracking

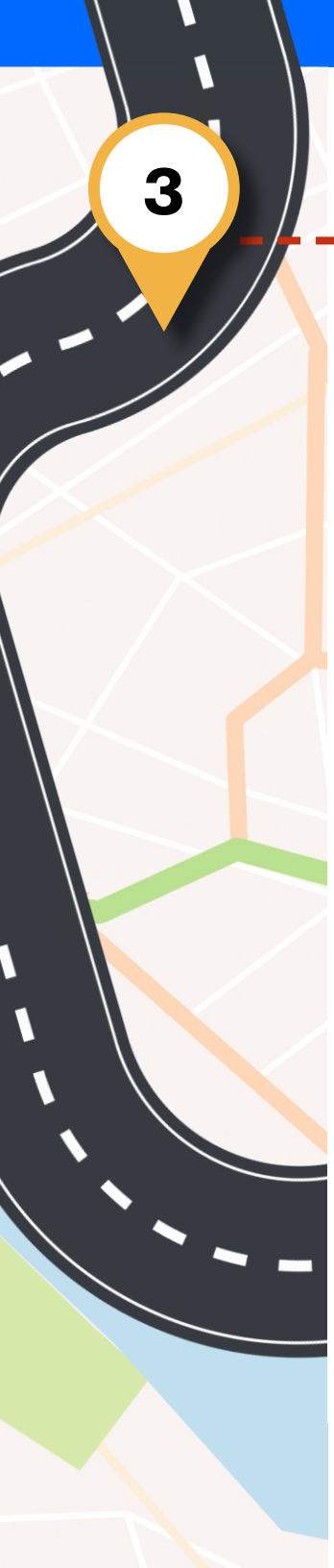
Yes	No	Partially	
			We document, track, and trend:
☐	☐	☐	a) The number of hospitalizations, readmissions, ED visits.
☐	☐	☐	b) The number of missed treatments.
☐	☐	☐	We conduct weekly IDT meetings to review patients at high risk of seeking treatment in the ED or hospital. • ESRD NCC Hospitalization Risk Assessment
			We have a tracking tool in place to identify patients':
☐	☐	☐	a) Hospitalizations/ED visits/readmissions primary diagnosis.
☐	☐	☐	b) Cause(s) of missed treatment(s).
☐	☐	☐	We have a designated person check hospital discharges every day and add to a list of patients being discharged.
☐	☐	☐	We have implemented a transition of care checklist for the IDT to complete starting the first day the patient returns from the hospital.
			During QAPI Meetings:
☐	☐	☐	a) We review hospitalization data for the month, as well as trends for the past three months.
☐	☐	☐	b) We conduct root cause analyses for all patients who were hospitalized or visited the ED.
☐	☐	☐	c) We focus on the top hospital admission diagnosis and determine interventions for facility wide issues. (e.g. Increase in BSIs).

2 Hospital Collaboration and Medical Records

Yes	No	Partially	
☐	☐	☐	We have regularly scheduled meetings with the hospital team to discuss facility goals (CVC rates, access appts scheduled prior to hospital discharge) and identify processes and areas of opportunity to improve communication and delivery of medical records.
☐	☐	☐	We have developed a robust and collaborative relationship with the staff at the hospital's inpatient dialysis unit to ensure continuity of care.
☐	☐	☐	The facility RN or manager is in contact with the hospital team prior to patient discharging from the hospital to address any needs that may be expected, or to address any concerns with the patient discharging.
☐	☐	☐	We have requested 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.

Tip: Contact hospital Health Information Manager (HIM) or Health Information and Technology (HIT) professional at the hospital to gain this access.

☐	☐	☐	We utilize transfer forms, paper or electronic, to communicate valuable information between the hospital and dialysis facility. • Dialysis Unit to Hospital Transfer Summary • Hospital to Dialysis Unit Transfer Summary
☐	☐	☐	We identify a contact at each hospital ED that our patients utilize for care to assure that key information is relayed to the practitioner evaluating the patient in the ED.



Missed Treatments and Fluid Overload

Yes	No	Partially	
☐	☐	☐	We address conflicting medical appointment times to ensure patients can make their dialysis treatment or are able to reschedule.
☐	☐	☐	We have one designated person, or role, at the facility that speaks with all patients that call into the facility who are needing to miss a scheduled treatment.
☐	☐	☐	The designated call-in person has a phone script to review with each patient when they call in, including a day/time to reschedule as they are on the phone with the patient.
☐	☐	☐	We utilize fluid report cards or a designated staff member reviews fluid control with each patient. • Your Fluid Intake Matters (esrdncc.org) • Your Fluid Intake Matters Spanish (esrdncc.org)
☐	☐	☐	We have an open chair on each shift to accommodate any reschedules that need to be completed.
☐	☐	☐	We review and adjust a patient's target weight (dry weight) the day they return from a hospitalization.
☐	☐	☐	We have implemented an ED diversion team to address fluid-related issues by working with the nephrologist to schedule extra treatment.
☐	☐	☐	For home dialysis patients, we 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.

ESRD Patient and Family Education for Hospital Utilization

Yes	No	Partially	
☐	☐	☐	We have a patient Peer in Action enrolled to share experiences and strategies to prevent visits to the ED and Hospital.
☐	☐	☐	We use a "Call Us First" approach at the dialysis clinic to triage whether a patient should present to dialysis, the ED, or hospital. • Quick Patient Guide: How to Choose Medical Care • Where Should You Go for Medical Care
☐	☐	☐	We engage and educate patients and families after discharge regarding their specific diagnosis, medication changes and target weight (dry weight) adjustments. • Questions About You
☐	☐	☐	We ask all patients to bring in their discharge summaries from their hospital stay.
☐	☐	☐	We investigate which patients have been referred to specialists and see if they are following up with them and their PCP. If they do not have a PCP, we will assist them in finding one. • Medical Appointment Tracker (esrdncc.org)
☐	☐	☐	We educate patients and family members on the effects of repeated hospitalizations. • 10 Steps You Can Take to Avoid Unnecessary Hospitalizations • 10 Steps You Can Take to Avoid Unnecessary Hospitalizations-Spanish • The Effects of Repeated Hospitalizations
☐	☐	☐	We educate patient and family members of situations in which they need to inform the dialysis facility, including medication changes, excessive bleeding, etc. • Staying Connected English • Staying Connected Spanish

Infection Prevention and Training

Yes	No	Partially	
☐	☐	☐	We utilize the CDC Audit Tools and Checklists to promote CDC recommended practices for infection prevention in the dialysis facility.
☐	☐	☐	We provide education to dialysis clinic staff regarding warning signs of top infections and chronic conditions that ESRD patients present to the hospital with and how to report concerns. • 4 Ways to Get Ahead of Sepsis • CDC Core Interventions • Making Dialysis Safer Coalition Conversation Starter (cdc.gov)
☐	☐	☐	We know how to contact our state Healthcare Associated Infection team that offers infection prevention education free to our facility. **Tip:** Your Network QI Advisor can provide you with this contact information.
☐	☐	☐	We have completed an Infection Control Assessment and Response Program (ICAR) from our State HAI group within the past 12 months.
			For Home Patients:
☐	☐	☐	a) We provide patients with antibiotics for potential peritonitis, if directed by the nephrologist.
☐	☐	☐	b) We ensure patients have their over-the-counter medication on hand to deal with smaller issues, such as stool softeners for constipation.
☐	☐	☐	We perform foot checks to avoid wound care issues or infections.
☐	☐	☐	We repeatedly review all patients with a catheter more than 90 days, and take action to get a permanent access placed. • Hemodialysis Vascular Access-English • Hemodialysis Vascular Access-Spanish

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Nursing Home Communication

Yes	No	Partially	
☐	☐	☐	We attend bi-weekly or monthly calls with the Director of Nursing (DON) at the nursing homes where our patients reside.
☐	☐	☐	We utilize a two-way communication form between the nursing home and the dialysis facility. • Nursing Home Dialysis Patient Communication Form.
☐	☐	☐	We attach patient education and lab results to the two-way communication form or fax to the nursing home monthly.
☐	☐	☐	We communicate upcoming appointments and transportation needs with the nursing home.
☐	☐	☐	We call the nursing home staff or DON directly for any immediate issues, to address any concerns, provide education, or provide updates on any medication or diet changes.
☐	☐	☐	We attend and are included in the patient's plan of care meetings at the nursing home facility.
☐	☐	☐	We provide education to nursing home staff over how to care for dialysis accesses, or what to look for when caring for a dialysis patient. • Nursing Home Toolkit
☐	☐	☐	We request updated patient vaccination records monthly.

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Celebrate Your Success!

Congratulations! You have reached your destination!

Use the following strategies and talk to your quality advisor to ensure ongoing success.

1. **Monitor Your Processes and Outcomes**
   Review your data to identify trends and address special cause variation. Data plays an important role in identifying when you've achieved predictable, consistent results.

2. **Create a Sustainability Plan**
   Sustainability is about ensuring that the improvements you have made will last. In order for these enhancements to be lasting, you must establish a plan for sustainability. As you build your plan for sustainability, ask yourself the following questions:
   - What can be done to ensure the most successful interventions will become part of the culture in your facility?
   - How will you ensure that these steps will continuously support your current processes?
   - Will this require that you modify training in your facility?
   - How will you track these interventions to ensure improvements in performance measures are sustained?
   - If you have a corporate partner, what is their role in supporting this sustainability plan?

   Use our Sustainability Planning Tool to help you create your plan.

3. **Assign a Process Owner**
   A process owner is the person who is responsible for maintaining and improving a process, and is responsible for the outcomes of the process and sustaining the changes according to the sustainability plan. Choose a person that will be impacted by the gains of the project.

Additional Resources

- ESRD National Coordinating Center Hospitalization Change Package
- For additional resources on reducing hospitalizations, please visit our website.