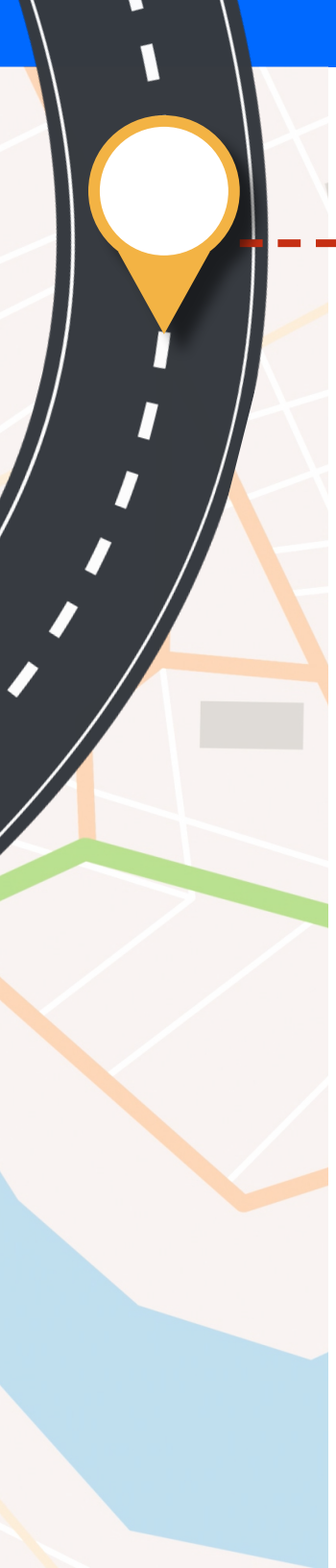
Hospitalization Roadmap Self-Assessment



Purpose

The purpose of this roadmap is 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. It can be used as a guide for implementation of best practices to reduce rates of ED visits and hospitalizations within the ESRD population.

Here are the basics:

- Keep your interdisciplinary team (IDT) and staff up-to-date with ESRD patients transitioning in/out of the hospital setting.
- Maintain complete, up-to-date patient records.
- Educate patients and family members on when to seek hospital assistance.
- Maintain communication with the hospital discharge planners and/or social workers.
- Evaluate and improve your practice's performance, then CELEBRATE!

Use this roadmap to help you implement or reinforce these best practices for your ESRD patients, including home patients, if applicable. Answer the following tasks with **Yes** (fully implemented), **No** (Not implemented), or **Partially** (In progress, not fully implemented).

1 Dialysis Facility Hospitalization Tracking

Yes	No	Partially	
			We have an individual or team designated for tracking patients:
			a) Transitioning in/out of the hospital
			b) Missed treatments

Tip: This could be the IDT or another team that includes staff, such as the charge nurse, the medical director, the administrative assistant, and the social worker.

			We routinely address patients within our internal designated team who are 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 inform all staff at the dialysis facility of clinical and non-clinical conditions resulting in hospitalization (ex. weekly IDT meetings, using a marker board in a neutral location that staff can see).
			We track follow-up appointments for hospitalization discharge diagnosis to ensure patients receive care to prevent readmission (e.g. may ensure rides are set up to medical appointment, or family member is notified).

2 Hospital Collaboration and Medical Records

Yes	No	Partially	
☐	☐	☐	We have identified the top one or two hospitals that our ESRD patients are utilizing for ED or hospital services.

Tip: Your ESRD Network QI Advisor can assist with this information if it is not available to your team.

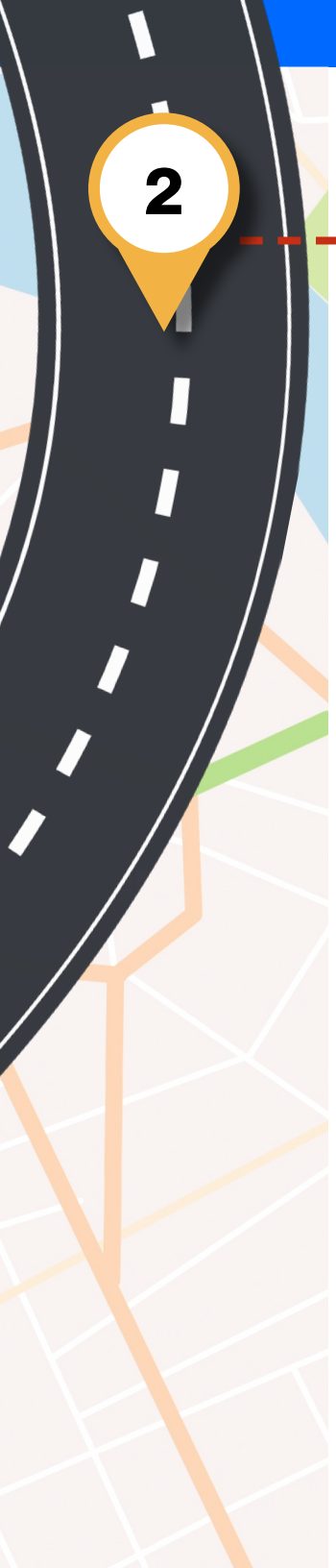
☐	☐	☐	We have engaged team members at the hospital to participate in an initial in-person or virtual meeting regarding shared ESRD patients.

Tip: Hospital team members may include a case manager or social worker, "patient navigator", a hospitalist, the inpatient dialysis staff, and the nephrologist. The team may be different at each hospital. For example, you may need to include the medical records supervisor to help with record sharing.

☐	☐	☐	We have frequent and/or regularly scheduled meetings with the hospital team to identify processes and areas of opportunity to improve communication and delivery of medical records.

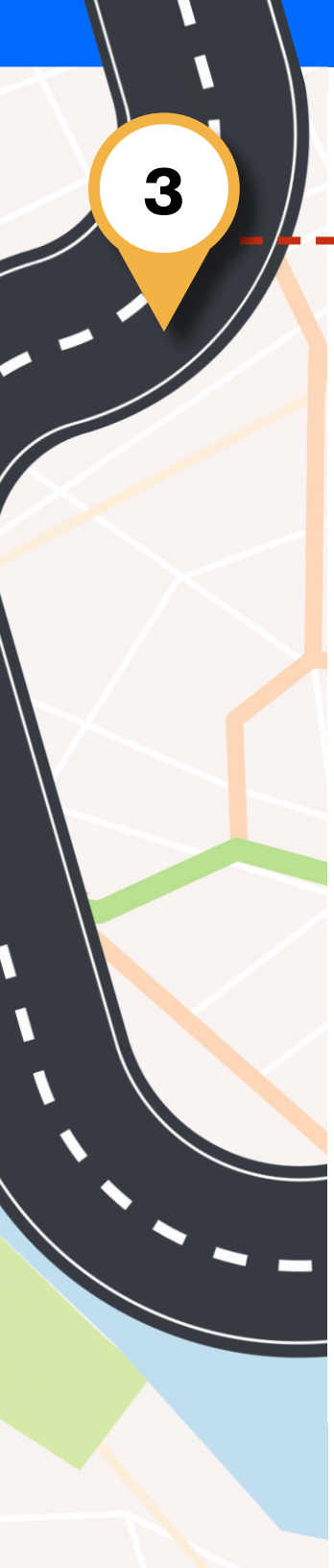
- Dialysis Clinic-Hospital Communication Pilot Test

☐	☐	☐	We have educated hospital team members about facility goals (e.g. CVC rates and discharge plans, such as each patient having an access plan before discharge or an appointment for access creation before leaving the hospital).



Hospital Collaboration and Medical Records (cont.)

Yes	No	Partially	
☐	☐	☐	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 request or have electronic access to medical records within 24 hours of a patient discharge from the hospital.
☐	☐	☐	We utilize a dialysis to hospital transfer form, paper or electronic, to communicate valuable ESRD information regarding the patient (example below). • Dialysis Unit to Hospital Transfer Summary
☐	☐	☐	We utilize a hospital to dialysis transfer form for hospital discharges that contains valuable communication to the dialysis facility (example below). • 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.
☐	☐	☐	We have a plan in place with the ED and nephrologists at the hospital to evaluate if a patient can be sent to dialysis from the ED vs admitted to the hospital.
☐	☐	☐	We serve as a resource to hospital ED staff regarding needs and current recommendations for clinical assessment, treatment, and discharge of dialysis patients with ESRD-related hospital visits.



3 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 provide tools and education to help patients learn about the importance of attending their dialysis treatments. • Missed Treatment and Reducing Hospital Visits Workbook
☐	☐	☐	We utilize fluid report cards or a designated staff member reviews fluid control with each patient.
☐	☐	☐	We have an open chair on each shift to accommodate any reschedules that need to be completed.
☐	☐	☐	We conduct a root cause analysis on patients that chronically miss treatments and identify opportunities when staff can address patients to assist them in attending scheduled treatments.
☐	☐	☐	We review and adjust a patient's target weight (dry weight) the day they return from a hospitalization.

4

ESRD Patient and Family Education for Hospital Utilization

Yes	No	Partially	
☐	☐	☐	We use patient advocates or Peers in Action that have experienced hospitalizations to tell stories of avoidable hospitalizations related to the top medical primary diagnoses indicated in the data. • Reducing Hospitalizations Pocket Cards
☐	☐	☐	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
☐	☐	☐	We engage and educate patients and families after discharge, upon return to the facility, regarding their specific diagnosis, medication changes and target weight (dry weight) adjustments..
☐	☐	☐	We ask all patients to bring in their discharge summaries from their hospital stay.
☐	☐	☐	We have a process where hospital staff can speak with dialysis staff without fear of violating patient privacy regulations. The hospital may require written consent from the patient to allow hospital staff to speak freely with the dialysis staff.
☐	☐	☐	We communicate follow-up appointment reminders with patients and/or family members to ensure the patient attends the scheduled appointment.

Infection Prevention and Training

Yes	No	Partially	
☐	☐	☐	We utilize the CDC Guidelines and Recommendations for infection prevention and control at our facility.
☐	☐	☐	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.
☐	☐	☐	We require staff to complete the Hemodialysis Infection Training from the CDC.
☐	☐	☐	We know how to contact our state Healthcare Associated Infection team that offers infection prevention education free to our facility.
☐	☐	☐	We have completed an ICAR (Infection Control Assessment and Response Program) from our State HAI group within the past 12 months.

- Protect Your Patients From Sepsis Fact Sheet
- Protect Your Patients From Sepsis Infographic
- 4 Ways to Get Ahead of Sepsis
- CDC Core Interventions
- BSI Prevention in Dialysis Facilities

Tip: Your Network QI Advisor can provide you with this contact information.

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 or lab result reports to the two-way communication form.
☐	☐	☐	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, to provide education, and to provide updates on any medication or diet changes.
☐	☐	☐	We fax new labs or monthly labs to the nursing home.
☐	☐	☐	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.

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.

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Additional Resources

ESRD National Coordinating Center Hospitalization Change Package

For additional resources on reducing hospitalizations, please visit our website.

esrd.qsource.org

This material was prepared by Qsource, an End-Stage Renal Disease (ESRD) Network under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 23.ESRD.11.194

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