Improving Transitions of Care for Kidney Patients

Hospitalization

Post-workgroup evaluation

October 6, 2017

Presentations this morning focused on optimizing transitions of care for ESRD patients. Communication to patients and between Provider settings is essential for a successful process. The setting may include admissions and discharge from a hospital to a dialysis facility or a skilled nursing facility.

Based on the presentations this am and your own experiences, please discuss issues such as

- **Process or algorithm that may help evaluate patients for hospital admission vs outpatient dialysis treatment**
- **Communication from setting to patient and facility**
- **Communication from patient and facility to setting**
- **Medication reconciliation**
- **Provider medical record retrieval**
- **Admission and discharge instructions**
- **Patient and family education.**

What is currently successful, what process does not exist or could be improved upon and are there any tools that could be developed for patient use to assist with communication to hospital or other settings.

What is working?

Fluid management- extra treatments
Use of Crit lines, 1 week per month
If pt. is "admitted" for fluid- sending them to dialysis for treatment vs. inpt.
ER tallies with nephrologist on every pt. to determine when to dialyze
Care manager notification on all hospitalizations- secure text
"will dialyze" program- dialysis within 2 hours in outpatient setting
ESCO :waiver for transportation"
Analytics= predictive who will be admitted
Talk with other patients about access
Med review RN in unit, careful monitoring
PCP, other provider appts., esp. hospitalization and transfusions
Labs, dialysis orders, providers, medical apt, med list, emergency diet

Designated case managers- reduce readmission with this process
Hospital and outpatient unit do med rec, make sure they have these appts scheduled, communicate dry weight upon dismissal.
Med rec is improving- picture of meds and pill boxes to check frequency, patient friendly med list to indicate purpose of each med.
Transitions of care toolkit

Improving Transitions of Care for Kidney Patients

Hospitalization

Post-workgroup evaluation

October 6, 2017

Realization of this problem
Coordinator at the hospital who sees all dialysis patients with the renal team and works on placement of patients
EMR reminder for PCP to refer to nephrology for CKD patients
Call from the nephrologist to the ED, discussing what needs to be done for the patient
Interdisciplinary communication so dialysis is not a big unknown.
Medication therapy management (MTM) pharmacists work with patients' medication list
Bring medications in every 3 months

What needs improvement?

1. Fluid management- extra chair for those extra treatments
2. Notification from acute hospitals and communication with the nephrologist
3. Dry weight challenges
4. Transportation- especially after treatment
5. Needs good data
6. MD to do a focuses assessment- to determine risk
7. Case management- need data and intervene
8. Strategy session for vascular access placement (1 year, not 90 days)
9. Get rid of catheters
10. Involve patient and family- speak to "quality of life" not infection/ death
11. Communication to/from ED- ??
12. Review discharge instructions with patient to verify changes
13. Larger units need more resources for pt. education.
14. Pharmacist for medication reconciliation.
15. Staff education of existing resources/ toolkits
16. Superficial communication from medical records
17. Med reconciliation already priority but need basic overview included
18. Nursing home & dialysis unit communication sheet (Specific)- filled by NH and dialysis unit at every treatment & with med changes on the sheet
19. Comfort level of other providers with dialysis related issues so they should know who to call (transition manager) with issue.
20. Ease of looking up the dialysis unit contact number and information
21. Communication with other pharmacist regarding medication changes.
22. When providers round (nephrology) they make recommendations, they do not get followed all the time.
23. EMR is not interactive especially the LDOs
24. PCP and nephrologist have no regular communication and PCPs are not comfortable with patient.
25. Calling provider from the ED to discuss whether patient needs admission
26. ER triage to dialysis

Improving Transitions of Care for Kidney Patients

Hospitalization

Post-workgroup evaluation

October 6, 2017

27. Need to call nephrologist during working hours.
28. Medication reconciliation on treatment post discharge
29. Access to dialysis nurses in unit to look up hospital EMR information.

What process or tools need to be developed? Please be as specific as you can.

- Fistula placement protocols
- Physician persistence- provide engagement
- "CMS" submitted education, patient choice to ???, get a reduction of payment
- Nephrologist/ provider for post dialysis recap: multidisciplinary approach: did you feel ready? "Why not?"
- Proactive medication reviews
- Post hospitalization process: Care manager see pt. once a week for 4 weeks. Assess risk
- Medication review- Pharm D, nephrologist
- Home visit post hospitalization
- Pharmacy travels to facility quarterly: "Any new medications or antibiotics?"
- CHF- monitor, video visit by provider, apple watch, scale
- Verizon, Sprint (provides hot spot for pts to use, grants?)
- Education- TV based education and documentation into the EMR. (Education, screening tools, touch screen)
- Translation: Medical literacy, grade appropriate education
- Network: Come up with tool kits for hospitalization, items used to deal with this and best practices. Infection control (best practice)
- Care coordinator to help with post discharge
- Assessment tools or education about existing resources
- SBAR tools for dyspnea (Situation/background/assessment/ recommendation)
- Still need more pharmacy involvement for further improvement.
- Need standards imposed on EMR companies for standardization of the data within a dismissal
- Could we start with a state run admission/ dismissal to refer to- pt., facility, and dates
- Could we connect patient with various providers- who's first MD, which specialty is seen first.
- Standardized form from hospital to unit:
- Contains: Reason for admission, meds upon dismissal- highlight new meds to be given by dialysis, target dry weight, ? transfusions given, ESA given, Labs, Hg, Blood cultures, or a copy of hospital dialysis medications
- Specific communication sheet developed for dialysis patients when is used by the nursing home

and the dialysis unit at the end of each treatment session with any med changes.

- Educators (education champs) are dedicated to teaching about diet/ lifestyle modification
- Have a card with dialysis unit information and the information for the contact person (both during and after hours) Have contact info updated on website
- Start educating early as advanced CKD patients should be prepared for what is going to happen with pamphlets, etc.
- When pts. Get discharged from hospital, they have a sheet which is filled out at discharge
- Bring medications every 2-3 months to the HD unit
- For inpatient rounding, nephrologist can put in orders.
- EMR should be able to pull patient records from all over the country and orders should transmit.
- More education for patients so that they know who the dialysis providers are and which unti to contact
- PCPs round on dialysis patients on HD if we can get paid for it.
- Have set algorithms to decide what is appropriate to the treatment at dialysis unit
- Training for nurses at nursing home specifically regarding home dialysis
- Call from hospitalist to the dialysis unit at discharge
- Standardized discharge form
- Ability to view inpatient dialysis data
- Discharge summary to dialysis form inpatient nephrologist.
- Ability to directly fax info from inpatient EMR to dialysis
- Vascular access ability on weekend for declotting or cath placement
- Medication list sent to dialysis unit by discharge planner/ acute dialysis nurse
- Labs send to dialysis at discharge