CREATING A CULTURE OF QUALITY: Pursuing Excellence in Care Transitions Enhancing Safety in Kidney Patient Care

Patricia B. McCarley RN, MSN, ACNPc, CNN
Objectives:

Examine the effective transition programs:

- What are the components of a safe handoff?
- What steps can dialysis providers take to impact care transitions for patients with ESRD?
JM is a 78 year old female with ESRD secondary to diabetes mellitus 2. She was hospitalized for 5 days for an infected ulcer on her right foot.

Other comorbidities include HTN, COPD, CAD with h/o MI and h/o CHF. She presents on Friday for her first dialysis after discharge.

The charge nurse calls the doctor on call for orders and is told to “continue previous orders.” He does not order continuation of her IV medication nor does he adjust the dose of ESA. No adjustments are made to her dry weight.
No discharge summary is available. JM does bring in her discharge sheet. She is unsure of any new medications.
Creating a Culture of Quality
Case Presentation

JM presents at her target weight. Her blood pressure is 172/90. She undergoes dialysis without complications. No fluid is pulled as she is at her target weight. No labs are checked. The usual meds are given.

The discharge coordinator is off today. Attempts to reach JM’s family are unsuccessful.
Case Presentation

Five days after discharge JM is readmitted to the hospital with c/o SOB and fever.
Hospitalizations and Readmissions

19.6% of nearly 12 million Medicare beneficiaries (1 in 5) discharged from the hospital were re-hospitalized within 30 days; 34% within 90 days

Leading diagnosis
- CHF, PNA

Predictors
- # of Rehospitalizations, LOS > DRG

ESRD

Increase Risk of Rehospitalization

- Risk Assessment Tool: 8Ps
  - Problem medication
  - Psychology (depression)
  - Principle diagnosis (diabetes, CHF)
  - Polypharmacy (> 5 meds)
  - Poor health literacy
  - Patient support
  - Prior hospitalization (past 6 months)
  - Palliative Care

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/06Boost/03_Assessment.cfm
Patients with ESRD
The “Perfect” Storm

- Prior hospitalization – 2/year
  14 hospital days per year
- Polypharmacy – ↑pill burden
- Problem medications
- Problem diagnosis (DM, CHF)
- Psychology – Depression
- ESRD – predictor of re-hospitalization
Patients with ESRD
The “Perfect” Storm

“Resume Previous Orders”
Care Coordination Models

- BOOST – Better Outcomes for Older adults through Safe Transitions
- RED – Reengineered Discharge
- Transitional Care Model for Heart Failure
- EverCare
- Care Transition Program
- FMS – Care Partners
Objectives

- What are the components of a safe handoff?
- What steps can dialysis providers take to impact care transitions for patients with ESRD?
Components of Successful Care Coordination

- Targeting patients at risk of hospitalization
- In-Person Contact – did use telephonic contact with face to face once per month
- Access to timely information
- Demonstrated close interaction between care coordinators and PCP
- Provided services that focused on assessing, care planning, educating, monitoring, coaching on self management, teaching how to take medications, and assistance with social supports
- Relied on registered nurse to deliver the bulk of the intervention

Brown, R. 2009. The National Coalition on Care Coordination N3C
BOOST

**Better Outcomes for Older adults through Safe Transitions**

- Developed from 1.4 million dollar grant – National initiative led by Society of Hospital Medicine
- Provides project management tools, QI tool kit
- Key elements
  - Broad assessment of admitted patients
  - Follow-up calls in 72 house of discharge
  - Risk-specific patient/caregiver discharge preparation using teach back method

http://www.hospitalmedicine.org/boost
"Take with meals? No problem! I eat all the time!"
Teach Back

- Asking patients to repeat **in their own words** what they need to know or do, in a non-shaming way.
- **NOT** a test of the patient, but of how well you explained a concept.
- A chance to check for understanding and, if necessary, re-teach the information.

http://www.hospitalmedicine.org/boost

“Asking that patients recall and restate what they have been told” is one of the 11 top patient safety practices based on the strength of scientific evidence.”

AHRQ, 2001 Report, *Making Health Care Safer*
St Louis, Mo – St. Mary’s Medical Center
- Twice weekly team meetings
- Risk patients identified, charts flagged, “BOOSTED”
- Teach back (used I-phone video)
- Patient PASS form used
- Call patient in 72 hours

Results
- Decreased its 30-day readmission rates from 12% to 7% within 3 months
- Patient satisfaction increased 53% to 68%

http://www.hospitalmedicine.org/boost
BOOST – Results

- Atlanta, Ga – Piedmont Hospital
  - Patient Pass is the DC form
  - Teach back medication instructions
  - White Board – tracks patient’s goal
  - DC diagnosis – librarian accesses handouts
  - Pt called in 72 hours

- Results: Intervention unit vs non-intervention unit
  - Lower length of stay 4.09 vs 4.96 days for patients under 70
  - Lower mortality for all patients
  - Fewer 30 day re-admissions 8.5% vs 25.5% < 70yo
    - 22.16% vs 26.1% > 70yo

http://www.hospitalmedicine.org/boost
<table>
<thead>
<tr>
<th>I was in the hospital because</th>
<th>I should ...</th>
<th>Important contact information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I have the following problems ...</td>
<td></td>
<td>1. My primary doctor:</td>
</tr>
<tr>
<td>1.</td>
<td>1.</td>
<td>(____) ________</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>My appointments:</td>
<td>Tests and issues I need to talk with my doctor(s) about at my clinic visit:</td>
<td>2. My hospital doctor:</td>
</tr>
<tr>
<td>1. On: <strong>/</strong>/__ at <strong>:</strong> am/pm</td>
<td>1.</td>
<td>(____) ________</td>
</tr>
<tr>
<td>For: ________________________</td>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>On: <strong>/</strong>/__ at <strong>:</strong> am/pm</td>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>For: ________________________</td>
<td>5.</td>
<td>Other:</td>
</tr>
<tr>
<td>3.</td>
<td>6.</td>
<td>(____) ________</td>
</tr>
<tr>
<td>On: <strong>/</strong>/__ at <strong>:</strong> am/pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For: ________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>7.</td>
<td>I understand and my treatment plan.</td>
</tr>
<tr>
<td>On: <strong>/</strong>/__ at <strong>:</strong> am/pm</td>
<td></td>
<td>I feel able and willing to participate actively in my care:</td>
</tr>
<tr>
<td>For: ________________________</td>
<td></td>
<td>____________________________</td>
</tr>
</tbody>
</table>

Other instructions: 1. ________________________
2. ________________________
3. ________________________
## Creating a Culture of Quality

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### Discharge Date: 7-19-22

**ACCOMPANIED BY**
- Employee: No
- Volunteer: No
- Self: Yes

**DESTINATION**
- Home: Yes
- Work: No
- Home healthcare: No

**ACTIVITIES**
- No restrictions

**SHOWER**
- No restrictions

**TUB BATH**
- No restrictions

**CLIMB STAIRS**
- No restrictions

**IMPORTANT**
- Consult your physician if:
  - Pain begins or becomes more severe.
  - Temperature above 101°F.
  - Wound drainage changes, increases, or becomes foul smelling.
  - Nauseated or vomiting.
  - Redness around incision.
  - Sudden onset of chest pain or electrocardiogram

**SPECIAL INSTRUCTIONS OR TREATMENTS**
- Inhale Yourself first thing every morning.
- Stop smoking.
- Limit sodium intake.
- Don’t exceed weight gain 2-3 lbs. or more than 13 lbs. in one week.
- Restrict fluids if instructed by physician.

**MEDICATIONS**

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Action/Nurse</th>
<th>Comments</th>
<th>ASSISTING NURSES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICIAN FOLLOW-UP**

You are scheduled to see:
- **Physician:** [Name]
- **Date:** [Date]
- **Phone:** [Phone]

**SIGNATURES**

- [Signature]
  - Date: [Date]

**DISCHARGE INSTRUCTIONS**

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*CCQ*  
Creating a Culture of Quality
Boston College project located at an urban hospital that serves low-income, ethnically diverse population

- Intervention: Standardized DC, DC advocate (nurse) focused on a number of components:
  - educate patient throughout stay, assess understanding
  - organize post DC services
  - reconcile medications
  - review what to do if problems arise
  - written DC plan and expedite the transmission of DC plan
  - call to reinforce DC plan, problem solving 2–3 days post DC

## RED – Results

Primary Outcome: Hospital Utilization within 30d after Discharge

<table>
<thead>
<tr>
<th></th>
<th>Usual Care (n=368)</th>
<th>Intervention (n=370)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Readmissions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # of visits</td>
<td>76</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Rate (visits/patient/month)</td>
<td>0.20</td>
<td>0.15</td>
<td></td>
</tr>
<tr>
<td><strong>ED Visits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # of visits</td>
<td>90</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Rate (visits/patient/month)</td>
<td>0.24</td>
<td>0.16</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Utilizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # of visits</td>
<td>166</td>
<td>116</td>
<td>0.009</td>
</tr>
<tr>
<td>Rate (visits/patient/month)</td>
<td>0.45</td>
<td>0.31</td>
<td></td>
</tr>
</tbody>
</table>

https://www.bu.edu/fammed/projectred/presentations.html
## RED – Results

<table>
<thead>
<tr>
<th>Cost (dollars)</th>
<th>Usual Care (n=368)</th>
<th>Intervention (n=370)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital visits</td>
<td>412,544</td>
<td>268,942</td>
<td>+143,602</td>
</tr>
<tr>
<td>ED visits</td>
<td>21,389</td>
<td>11,285</td>
<td>+10,104</td>
</tr>
<tr>
<td>PCP visits</td>
<td>8,906</td>
<td>12,617</td>
<td>-3,711</td>
</tr>
<tr>
<td>Total cost/group</td>
<td>442,839</td>
<td>292,844</td>
<td>+149,995</td>
</tr>
<tr>
<td>Total cost/subject</td>
<td>1,203</td>
<td>791</td>
<td>+412</td>
</tr>
</tbody>
</table>

Reducing readmissions from 20 – 15% saves Medicare 17 billion over 5 years

[https://www.bu.edu/fammed/projectred/presentations.html](https://www.bu.edu/fammed/projectred/presentations.html)
EACH DAY follow this schedule:

## MEDICINES

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Why am I taking this medicine?</th>
<th>Medication name and Amount</th>
<th>How much do I take?</th>
<th>How do I take this medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>Blood pressure</td>
<td>PROCARDIA XL NIFEDIPINE 90 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>Blood pressure</td>
<td>HYDROCHLOROTHIAZIDE 25 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>Blood pressure</td>
<td>CLONIDINE HCl 0.1 mg</td>
<td>3 pills</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>cholesterol</td>
<td>LIPICTOR ATORVASTATIN CALCIUM 20 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
<tr>
<td></td>
<td>stomach</td>
<td>PROTONIX PANTOPRAZOLE SODIUM 40 mg</td>
<td>1 pill</td>
<td>By mouth</td>
</tr>
</tbody>
</table>

https://www.bu.edu/fammed/projectred/presentations.html
Creating a Culture of Quality

** Bring this Plan to ALL Appointments **
John Doe

What is my main medical problem?
Chest Pain

When are my appointments?

<table>
<thead>
<tr>
<th>Tuesday, October 24th at 11:30 am</th>
<th>Thursday, October 26th at 3:20 pm</th>
<th>Wednesday November 1st at 9:00 am</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Brian Jack (Doctor) at Boston Medical Center ACC – 2nd floor</td>
<td>Dr. Jones Rheumatologist at Boston Medical Center Doctor’s Office Building 4th floor</td>
<td>Dr. Smith Cardiologist at Boston Medical Center Doctor’s Office Building 4th floor</td>
</tr>
</tbody>
</table>

For a Follow-up appointment

For your arthritis

to check your heart

Office Phone #: (617) 444-2222

Office Phone #: (617) 444-7777

Office Phone #: (617) 555-1234

October 2006

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thu</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>20</td>
<td>21</td>
<td>Left hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>23</td>
<td>Pharmacist will call today or tomorrow</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>Dr. Jack at 11:30 am at Boston Medical Center ACC – 2nd floor</td>
<td>Dr. Jones at 3:20 pm at Boston Medical Center Doctor’s Office Building – 4th floor</td>
<td>27</td>
</tr>
<tr>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>31</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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https://www.bu.edu/fammed/projectred/presentations.html
Questions for
Dr. Jack
For my appointment on
Tuesday, October 24th at 11:30 am

Check the box and write notes to remember what to talk about with Dr. Jack

I have questions about:

☐ my medicines ___________________________

☐ my pain ________________________________

☐ feeling stressed __________________________

What other questions do you have? __________________________

Dr. Jack:
When I left the hospital, results from some tests were not available. Please check for results of these tests.

https://www.bu.edu/fammed/projectred/presentations.html
Evercare™ Care Model

Founded in 1987 by 2 NPs – Awarded Demonstration Status 1995 by CMS

- Large Health Coordination Program for patients with advanced illness, older or with disabilities, complex needs
- Enhanced primary care by NP or case manager:
  - Enhanced monitoring of the “big” picture
  - Strong emphasis on preventions
  - Strong advocacy for patients
  - Increased involvement of patient and families and more consistent communication

http://www.innovativecaremodels.com/care_models/17/overview
Evercare™ Care Model – Results

- Reduce hospitalization by 45%: the incidence reduced from 4.63 to 2.43 per 100 patient in 15 months (p<0.001)
- Reduced ED visits by 50%
- Cost savings $103,000 a year in hospital costs per NP

Pre and post discharge co-ordination of care for high-risk, elderly patients with chronic illness by TCNs

- TCN – primary coordinator of care
- In-hospital visit and assessment
- Home visit with patient in 24 – 48 hours
- Evidenced based plan of care, focused on patient
- Emphasis on early identification and response to health care risks, symptoms and avoidance of AE
- Active engagement of patient and family
- Communication to, between and among all parties
- Web-based clinical information system, tools

Naylor, MD, et al. JAMA, 1999; 281:613–620
http://www.innovativecaremodels.com/care_models/21/key_elements
Significantly less likely to be re-hospitalized at least once within six months (37.15 vs. 20.3%; p < 0.001)

Patients in the TCM group incurred half the average health care costs at six months than control patients ($3630 vs. $6661; p < 0.001)

Care Transition

- Fosters improved self-management program in 4 week program
- Transition coach – home visit in 72 hours, call post discharge day 2, 7, 14
- 4 main components
  - Medication self management
  - Patient Centered Health Record
  - Follow-up with physician
  - Knowledge of “red flags” and warnings/signs and how to reasons

http://www.caretransitions.org/documents/Evidence_and_Adoptions_2.pdf
Care Transition Results

- 158 elderly patients admitted with 1/10 conditions (HF, COPD, Diabetes, stroke, hip fracture, peripheral vascular disease, spinal stenosis, arrythmias and DVT/PE)
- Patients in program significantly less likely to be re-hospitalized than controls at 30, 90 and 180 days (adjusted adds ratio at 30 days = 0.52; 95% CI=0.28–0.96)
- Time to re-hospitalization was significantly longer (225.5 days vs 217.0 days; p=0.003)
- Adopted by 470 organizations in 30 states
- Anticipated cost saving: 1 coach for 350 pt. $330,000 over a period of 12 months

Personal Health Record of:

(NAME)

If you have questions or concerns, contact ______________________
at (_____) _____ - _______

REMINDER to take this record with you to all doctor visits

© Eric A. Coleman, MD, MPH

http://www.caretransitions.org/
Questions for my Primary Care Doctor:

My Health Conditions:

1. __________________________
   - Red Flags: ___________________
   - Action Steps: ___________________

2. __________________________
   - Red Flags: ___________________
   - Action Steps: ___________________

3. __________________________
   - Red Flags: ___________________
   - Action Steps: ___________________

4. __________________________
   - Red Flags: ___________________
   - Action Steps: ___________________

5. __________________________
   - Red Flags: ___________________
   - Action Steps: ___________________

http://www.caretransitions.org/
Discharge Preparation Checklist

Before I leave the care facility, the following tasks should be completed:

- I have been involved in decisions about what will take place after I leave the facility.
- I understand where I am going after I leave this facility and what will happen to me once I arrive.
- I have the name and phone number of a person I should contact if a problem arise during my transfer.
- I understand what my medications are, how to obtain them and how to take them.
- I understand the potential side effects of my medications and whom I should call if I experience them.
- I understand what symptoms I need to watch out for and whom to call should I notice them.
- I understand how to keep my health problems from becoming worse.
- My doctor or nurse has answered my most important questions prior to leaving the facility.
- My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation.
ESRD Demonstration Project

- Fresenius Health Partners – Care Management Team
- Nurse Care Managers – centerpiece of the integrated care model
- Included in activities:
  - Address the needs of high-risk patients (follow-hospital patients and assist with discharge planning and conduct follow-up contacts post discharge)
  - Assist patient with new or changed medications
  - Work with patient’s healthcare team to facilitate continuity of care
  - Telehealth monitoring for daily communication and collection of Patient information

http://www.fmchp.com
Fresenius Health Partners

Fresenius Health Partners Utilization Savings vs. FFS Medicare (Case Mix Adjusted)

- Hospital Admissions
- Hospital Re-admissions
- Physician Visits
- SNF Stays
- ER Visits
- Costs of Care

http://www.fmchp.com

Creating a Culture of Quality
Care Coordination – Challenges

- Decreased length of stay (LOS), continuing therapy after discharge
- Aging population – greater complexity, many co-morbidities
- Many care venues, many providers, poor communication
- Practice defined by location (i.e. hospitalist, PCP)
- Current Fee for Service does not reimburse care coordination
Care Coordination – Dialysis Providers

- Multidisciplinary Team
- Knowledge of patient history
- Patient seen within 72 hours of discharge
  - Assessment
  - Medication reconciliation
  - Social and Dietary issue addressed
- Providers in common
Activity

Your Multidisciplinary QI Team is meeting. You have decided to identify short-term action steps to address a specific barrier. There are 8 barriers.

- The number on your table matches your barrier
- A facilitator has been chosen to lead the discussion
- Brainstorm ideas
- Identify 3–4 action steps to address the barrier
- Choose a team member to present your action steps to the group—you will have 3 minutes for your presentation
Example

“Resume Previous Orders”

1. Identify Critical Information to communicate
   - Date of discharge, discharge diagnosis
   - Dry weight, Medication changes
   - F/U appointment, tests
2. Work with IT dept to develop phone app for physicians for communicating the information.
3. Work with nephrologist (in hospital) to utilize the app – Acute inpatient nurses to facilitate use of app and delivery to outpatient clinic
#1

“Where’s the Hospital Discharge Summary?”
Lack of real-time communication

Facilitator: Glenda Payne
Action Steps – Real time Communication

1. Identify hospital
2. Consider mandatory exchange of Information – “2730 e-script”
3. Proactive:
   ◦ Establish relationships
   ◦ Start Early in hospital stay
   ◦ Request information daily
4. Get access to Electronic Health Record (EHR)
5. Patient Education – engagement “you are the only one present”
6. Care Coordinator – Nurse
“I can’t read this!”
Forms complicated and illegible

Facilitator: Denise Van Valkenburg
Action Steps – Discharge Form

1. Communicate with hospital regarding ownership of the form. Who completes the form?
2. Educate and empower nursing staff to collect information that is needed if the form is unreadable (immediate)
3. Medical Director to reach out to the CMO of hospital for a longer term solution, such as electronic communication both ways (long term plan)
4. No MD’s complete the form due to poor handwriting (kidding aside)
"Resume previous orders"

Facilitator: Doug Johnson
Action Steps – Discharge Orders

1. Set in place a policy to question nephrologists upon receiving “resume previous order”
2. Need additional staff: a transition care coordinator (TCC)
3. Develop better process with each partner hospital
4. Develop a backup plan for “TCC” so there’s a single point of contact – one phone number for hospital to call
“I’m back!”
Need for patient assessment
Facilitator: Billie Axley
Action Steps – Patient Assessment

1. Need the 411 – needed information
   ◦ Where was pt?
   ◦ Why?
   ◦ Current assessment
   ◦ Paperwork? Discharge summary

2. Contact Nephrologists

3. Interdisciplinary Team Involvement
   ◦ psychosocial
   ◦ transportation
   ◦ meds
   ◦ diet
   ◦ stable/unstable
   ◦ pt concerns
“No UF today– you’re at your target weight!”
Risk of volume overload
Facilitator: Lynda Ball
Action Steps
Avoid Volume Overload

Develop protocol that will be instituted when Patient’s weight is questionable

1. Complete RN physical assessment/report to MD because of:
   - Hospitalization
   - New orders not yet received
   - GI issues
   - Scale discrepancy

2. Interview patient

3. Compare prior treatments deviation from baseline

4. Education to staff

5. Education to patients
Creating a Culture of Quality

#6

One “True” List – Poor medication reconciliation

Facilitator: Melinda Martin-Lester

Creating a Culture of Quality
Action Steps
Medication Reconciliation

1. Patient Empowerment
   ◦ Written tools
   ◦ Brown bag
   ◦ Change in meds

2. Facility Sharing
   ◦ Med list
   ◦ ECF sharing

3. Transition Coordinator
#7

Frequent Flyer

Facilitator: Terry Ketchersid
Action Steps
Frequent Hospitalizations

1. Frequent Flyer Definition = readmission, unplanned within 30 days. Follow for 6 months
2. Hospital – Dialysis communication transition form
3. Follow up within 72 hours by care coordinator liaison/flu assessment
4. Interdisciplinary team members to round and assess patient
“I’m not sure!”
Lack of patient involvement
Facilitator: Glenda Harbert
Action Steps
Increasing Patient Involvement

1. Targeted patient interview “CSI Investigation”
   - images for visual cues
   - open ended questions
   - Who took you home? ID for family contact to gain info
2. Target family interview if possible
3. Contact hospital/physician
4. Develop patient/family education
   - folder
   - written information
   - forms – things you should know at discharge
5. Contact by dialysis unit staff during hospitalization
6. Staff education concerning targeted interview
   - Provide script and patient/family education
Patient “Costs”

- Decline in functional capacity
- Nosocomial Infection
- Adverse event
- Decreased quality of life
- In hospital – mortality
“Change does not come easy! Nurses pushed back. Hospital physicians resented the process.
It was all about breaking down history, changing people’s workflow and job duties. The first 4 – 6 weeks are like diet and exercise, you just have to get through it!”
Just Do It!!!!