2020 ESRD Network of Texas Hospitalization QIA Project

Supporting Quality Care

Contract Number: HHSM-500-2016-00014C
Housekeeping Items

- Call scheduled for one hour
- Keep your lines muted
- Use the chat for questions
- Recorded presentation (will be available on webpage)
- Attestation required (keyword)
The ESRD Network of Texas, Inc. (Network 14) is a non-profit organization incorporated in Texas and provides services on behalf of the Centers for Medicare & Medicaid Services (CMS) to kidney patients and their providers.

**Our Mission**

To support equitable patient- and family-centered quality dialysis and kidney transplant health care through the provision of patient services, education, quality improvement, and information management.
Improve Dialysis Care Coordination with a Focus on Reducing Hospital Utilization

• Achieve a 1 percentage-point decrease in the average rate of ESRD related hospitalizations from the baseline period (January – September 2019).
• ESRD related hospitalizations determined by specific ICD-10 codes
• Demonstrate that at least two root causes for hospitalizations have been identified with appropriate evidenced based interventions implemented.
Facility Selection

- **10%** of patient population in the Network Service Area, not to exceed 30 facilities
- Network is only able to recruit facilities from **FKC** due to data capabilities
- Facilities in the **top 25th percentile** of hospitalization rates according to baseline
- Include facilities having high rates of LTC patients as well as home dialysis patients
- **37** facilities met project criteria and final selection in collaboration with FKC and CMS included a **total of 15 FKC focus facilities**
- Beneficiaries to be impacted – **1900-2000** patients
## Facility Breakdown by Location

<table>
<thead>
<tr>
<th>City Location</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCKINNEY</td>
<td>Collin</td>
</tr>
<tr>
<td>ODESSA</td>
<td>Ector</td>
</tr>
<tr>
<td>BEAUMONT</td>
<td>Jefferson</td>
</tr>
<tr>
<td>KINGSVILLE</td>
<td>Kleberg</td>
</tr>
<tr>
<td>LUBBOCK</td>
<td>Lubbock</td>
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<tr>
<td>LUBBOCK</td>
<td>Lubbock</td>
</tr>
<tr>
<td>WACO</td>
<td>McLennan</td>
</tr>
<tr>
<td>CORSICANA</td>
<td>Navarro</td>
</tr>
<tr>
<td>FORT WORTH</td>
<td>Tarrant</td>
</tr>
<tr>
<td>ABILENE</td>
<td>Taylor</td>
</tr>
<tr>
<td>ABILENE</td>
<td>Taylor</td>
</tr>
<tr>
<td>ABILENE</td>
<td>Taylor</td>
</tr>
<tr>
<td>MOUNT PLEASANT</td>
<td>Titus</td>
</tr>
<tr>
<td>WICHITA FALLS</td>
<td>Wichita</td>
</tr>
<tr>
<td>FORT WORTH</td>
<td>Tarrant</td>
</tr>
</tbody>
</table>
## Goal and Baseline Rates

<table>
<thead>
<tr>
<th></th>
<th>Num 121819</th>
<th>Den 121819</th>
<th>121819 Baseline Rate</th>
<th>Home</th>
<th>LTC Rate</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1366</td>
<td>17490</td>
<td>7.810%</td>
<td>Yes</td>
<td>*12.48%</td>
<td>6.810% or below</td>
</tr>
</tbody>
</table>

*LTC rate in this group is above national average of 10.81%*
Requirements

- Conduct - by February 28th - a “QIA kick off” Webex meeting with the selected project **dialysis facilities and other stakeholders**
- Disseminate to QIA participants (dialysis facilities and other providers) the **Transitions of Care Toolkit** developed by the Forum of ESRD Networks (Ch. 1, 5, and 8-10)
- Perform RCA of unplanned hospital admissions in QIA dialysis facilities, identifying/developing and implementing evidenced based interventions that **improve** the overall rate of **unplanned hospitalizations** in the Network area
Attributes

- Commitment to Boundarilessness and Unconditional Teamwork
- Customer Focus and Value of the QIAs to Patients, Participants, and CMS
- Value Placed on Innovation
- Patient and Family Engagement
- Rapid Cycle Improvement in QIAs and Outputs
- Ability to Prepare the Field to Sustain the Improvement
Intent of QIA

• Identify the drivers of ineffective care transitions such as:
  ➢ Lack of timely and complete communication
  ➢ Poor patient activation
  ➢ Other system level process deficiencies that can lead to poor health outcomes resulting in hospitalizations.
• Aid the Network in identifying and implementing appropriate facility-level interventions that improve coordination of care for ESRD patients and their family members between care settings
• Develop relationships between Dialysis facilities, hospitals, and other providers to reduce hospitalizations
January-February Interventions*

1. Select two Lead staff members
2. Notify your regional leadership
3. Complete the Facility RCA & Initial Survey by 1/30/2020 (Completed)
4. Kick off webinar (2/28/2020)
5. FPR Recruitment (February forward)

*This does not encompass the complete list of project interventions.
February Interventions: Facility Patient Representative (FPR)

- Every dialysis unit in Texas should have a FPR who will act as a link between patients and the facility staff.
  - Recommend 1 FPR for every shift
  - Consider diversity and predominant and secondary languages spoken by patients
  - Use Network FPR Toolkit to orient staff and patients to FPR role

- Responsibilities
  - Options listed in toolkit
  - Assist facility
    - Gather information and ideas from patients
    - Distribute information to patients
    - Share ideas from patients with facility staff
    - Co-design strategies to improve the delivery of care and patient information
    - Support Patient and Family Engagement activities, including QI activities
    - Promote Patient and Family Centered Care
2020 Root Cause Analysis (RCA) Results

**Facility Specific Root Causes:**

1. Lack of follow-up by Doctor (62%)
2. Perception that "patient is non-compliant" instead of assessing for barriers (50%)
3. Lack of designated staff to discuss/follow-up on hospitalizations (50%)
2020 Root Cause Analysis (RCA) Results

Patient Specific Root Causes:

1. Lack of follow up with appointments (i.e., missing and not rescheduling) (62%)
2. Socioeconomic: Home environment, unstable housing, etc. (54%)
3. Documented severe non-compliance, cognitive impairment, illegal immigrants etc. **AND** Lack of family support or involvement (46%)

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**Patient Specific Root Causes**

<table>
<thead>
<tr>
<th>Root Cause</th>
<th>% of Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socioeconomic: Home environment, unstable housing, etc.</td>
<td>54%</td>
</tr>
<tr>
<td></td>
<td>54%</td>
</tr>
<tr>
<td>Health literacy: Language barrier</td>
<td>19%</td>
</tr>
<tr>
<td>Demographics: Cultural differences/beliefs/religion</td>
<td>23%</td>
</tr>
<tr>
<td>Education: Patient/Family unaware of options, misconceptions about hospital cleanliness</td>
<td>27%</td>
</tr>
<tr>
<td>Motivation (lack thereof): Fear, grief, anger, guilt, body image, etc.</td>
<td>35%</td>
</tr>
<tr>
<td>Perception of other patients, socialization, familiarity/conformity with in-center hemo, etc.</td>
<td>15%</td>
</tr>
<tr>
<td>Patient cognitive status is poor at the time of education</td>
<td>23%</td>
</tr>
<tr>
<td>Eligibility: Documented severe non-compliance, cognitive impairment, illegal immigrants etc.</td>
<td>27%</td>
</tr>
<tr>
<td>Lack of family support or involvement</td>
<td>31%</td>
</tr>
<tr>
<td>Time constraints for: work-up process, transportation, scheduling, etc.</td>
<td>46%</td>
</tr>
<tr>
<td>Financial status (Explain below)</td>
<td>46%</td>
</tr>
<tr>
<td>Lack of follow up after education has been provided to patient and family</td>
<td>62%</td>
</tr>
<tr>
<td>Lack of innovative ideas to engage patient/family</td>
<td>12%</td>
</tr>
<tr>
<td>Lack of follow up with appointments (i.e., missing and not rescheduling)</td>
<td>23%</td>
</tr>
</tbody>
</table>
2020 Root Cause Analysis (RCA) Results

**Organizational Specific Root Causes:**

1. No protocol or process in place regarding frequency of follow up and/or revisiting hospitalized patients (46%)
2. Ineffective teaching practices: no teach-back, no peer-to-peer, no assessment of teaching effectiveness (35%)
3. No protocol for data sharing between the hospital and dialysis facility (31%)
Interventions Moving Forward

- At least 3 patient-created and tested interventions
  - Use feedback from patients in project facilities to drive interventions
  - Review RCA top three causes for your facility
- Tools to increase transitions of care
  - Transitions of Care Toolkit (Ch. 1, 5, and 8-10 are required)
  - 7-day readmission checklist
  - Hospital to dialysis unit transfer summary
- Utilize Patient education tools
- Medical Review Board Intervention
  - Looked at educational algorithms
  - ICD-10 code analysis & revision
- There will be a Sustainability task at the end of the project
- Other interventions and resources on Network’s webpage
PAC SME Designed Interventions

Suggestions on How to Help Avoid Hospitalization

- Complete all treatments
- Follow your fluid intake orders
- Follow renal and diabetic diet
- Keep hands and access clean
- Keep all appointments with doctors
- Follow medicine schedule
- Get your vaccinations

Remember, you know your body. You are your best advocate.

My Doctor’s Phone Number: ______________________

My Facility Phone Number: ______________________

My Hospital Phone Number: ______________________

To file a grievance please contact Network 14 at
1-877-886-4435 and www.esrdnetwork.org
ESRD Network of Texas, Inc. 4099 McEwen Rd, Ste. 820 Dallas, TX 75244
972-503-3215 office 972-503-3219 fax 877-886-4435 toll free
info@nw14.esrd.net http://www.esrdnetwork.org/
Created under CMS contract number: HHSN500-2015-0W014C...
A Quick Look at What We Learned in 2019
2019 QIA Outcomes Recap

![ESRD Related Hospitalizations Chart]

<table>
<thead>
<tr>
<th>Total Baseline</th>
<th>Nov-18</th>
<th>Dec-18</th>
<th>Jan-19</th>
<th>Feb-19</th>
<th>Mar-19</th>
<th>Apr-19</th>
<th>May-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non QIA ESRD Rate</td>
<td>0.11</td>
<td>0.13</td>
<td>0.14</td>
<td>0.13</td>
<td>0.14</td>
<td>0.12</td>
<td>0.13</td>
</tr>
<tr>
<td>QIA ESRD Rate</td>
<td>0.12</td>
<td>0.13</td>
<td>0.14</td>
<td>0.13</td>
<td>0.14</td>
<td>0.14</td>
<td>0.14</td>
</tr>
</tbody>
</table>

Facilities
QIA = 72
Non QIA = 162
2019 Hospitalization D/T Infections

2778 total hospitalizations based on CROWNWeb data

- 2605 (94%) Infection Admits
- 173 (6%) Other Admits

<table>
<thead>
<tr>
<th>DX</th>
<th>Admits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis unspecified organism</td>
<td>56</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>33</td>
</tr>
<tr>
<td>Infection of the skin and subcutaneous tissue</td>
<td>31</td>
</tr>
<tr>
<td>Infection due to other cardiac and vascular devices implants and grafts</td>
<td>13</td>
</tr>
<tr>
<td>Sepsis due to Methicillin resistant Staphylococcus aureus</td>
<td>10</td>
</tr>
<tr>
<td>Other specified bacterial agents as the cause of diseases classified elsewhere</td>
<td>8</td>
</tr>
<tr>
<td>Unspecified infection due to central venous catheter</td>
<td>5</td>
</tr>
<tr>
<td>Sepsis due to Methicillin susceptible staphylococcus aureus</td>
<td>4</td>
</tr>
<tr>
<td>Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere</td>
<td>3</td>
</tr>
<tr>
<td>Other streptococcal sepsis</td>
<td>3</td>
</tr>
<tr>
<td>Gram negative sepsis unspecified</td>
<td>2</td>
</tr>
<tr>
<td>Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere</td>
<td>2</td>
</tr>
<tr>
<td>Severe Sepsis with septic shock</td>
<td>2</td>
</tr>
<tr>
<td>Sepsis due to Enterococcus</td>
<td>1</td>
</tr>
</tbody>
</table>

6% of these hospitalized patients reside in a nursing home/Rehab/SNF
Next Steps: Facilities

- Complete Kick off Webinar Attestation by Friday 03/06/20
  - [https://app.smartsheet.com/b/form/cef96d061ab84f56a9cd76bee050e979](https://app.smartsheet.com/b/form/cef96d061ab84f56a9cd76bee050e979)
  - **Keyword:** Hosp20 (case sensitive)
- Begin the process of recruiting at least one facility patient representative (FPR) to participate in this project
- Be on the lookout for monthly tasks and requirements
- Review materials on the Network webpage monthly
- Collaborate with your local hospitals to identify barriers
  - Get to know your local hospital(s) team
  - Provide your local hospital contact information with your staff
  - Partner with your physician(s) to be your hospital ambassador
Network Watch List

• Facilities failing to submit required documentation for projects will receive:
  ▫ One written or emailed notice
  ▫ One notification via phone

• If no response received from facility, the facility will be placed on the CMS Watch List, which will include:
  ▫ Report of non-compliance to corporate leaders (if applicable)
  ▫ Report of non-compliance with DSHS on monthly calls
  ▫ Report of non-compliance to CMS
Reducing Hospitalizations QIA

In 2020, the ESRD Network of Texas has been directed by the Centers for Medicare and Medicaid Services (CMS) to collaborate with outpatient dialysis facilities within the state of Texas and to achieve a 1 percentage point decrease in the average rate of overall ESRD related hospitalizations.

Network Project Lead:

Dany Anchia, BSN, RN, CDN - Quality Improvement Director

office (469) 916-3813, email Dany.Aничia@alianthealth.org

For resources please click here

Webinars

Stay tuned and be ready to register for the Kick-Off Webinar to be held on February 28, 2020 at 12 PM

1. The Kick-Off webinar will go over more details about the project
2. You will receive an email with instructions to register

Save the date and access the Webex using the following info:

Meeting Information: 12:00 PM - 1:00 PM Friday, Feb 28 2020 (UTC-06:00) Central Time (US & Canada)
Meeting link: https://alianthealthgroup.webex.com/alianthealthgroup/j.php?MTID=macc00db543b79099d2053892d393d41
Meeting number: 719 758 328
More ways to join
Join by phone: Dial +1-415-666-0003 United States Toll, Access code: 719 758 328

Interventions

Complete the Facility RCA & Initial Survey by Thursday January 30, 2020

Care Transitions and Coaching
Questions

For questions contact

Dany Anchia, BSN, RN, CDN
Quality Improvement Director
dany.anchia@allianthealth.org

Thank you for your time!