

## *Executive Summary*

### **CREATING A CULTURE OF QUALITY**

Pursuing Excellence in Care Transitions Enhancing Safety in Kidney Patient Care

September 11-12, 2012

Core Objectives:

1. Why is it important to improve transitions?
2. What are the barriers to safe transitions?
3. What success at overcoming the barriers have been accomplished?
4. Take home messages

The Quality Conference was planned and executed by providers and thought leaders from numerous disciplines that included physicians, nurses, Network executive directors and quality staff with the support of several key individuals from CMS. Below is a summary of the key points related to each objective followed by more detailed descriptions of the individual presentations. The actual slide sets used for most presentations can be found on the Forum website (<http://esrdnetworks.org/quality-conference-september-2012>). We have included patient descriptions of experiences with care transitions that highlight the necessity of including the patient voice and will guide the content of the 2013 Quality Conference.

We show what themes are common to the various care transition forms that are used in the different presentations. While the importance of these documents in improving safe transitions of care was demonstrated, the various speakers were united in stating that improving care safety and reducing hospitalizations requires substantial infrastructure changes in addition to whatever forms or formats might be used in transferring information.

The 2013 Quality Conference will focus on the details of barriers to safe transitions and safe care in general. It will be a unique collaboration between providers and patients, with the intent of making patient centered care more than a slogan and demonstrate how meaningful inclusion of the patient voice has the potential to improve patient safety and the quality of care; there is a business case to be made for patient centered care. The conference will advance patient safety by addressing patient experiences and describing means of developing patient-provider partnerships to identify and solve safety issues and other problems. It will also address the culture that exists in busy facilities where the various providers are often under high levels of stress which may lead to placing blame on fellow providers and patients when things go wrong. We will examine whether safety initiatives that have been presented over the past several years have made an impact, and look at how to productively use complaints, errors and reporting of “near misses” to improve safety and quality.

The 2012 conference generated considerable interest in proceeding with a unified transition plan and document particularly for the hospital to dialysis facility patient transfer. The Medical Advisory Committee of the Forum is taking the lead to create a Transitions Toolkit which will assist providers, in a QAPI format, in identifying opportunities for making the transition process safer and improve patient care. We anticipate engagement by other renal stakeholders and will incorporate the lessons from the 2012 and 2013 conferences.

#### **Take Home Messages from the 2012 Creating a Culture of Quality Conference**

- 1) Why is it important to improve transitions:
  - a) The ESRD population is complex, with a high burden of comorbidity.

- b) Patients have multiple medical providers and care venues, take a large number of medications prescribed by different providers, are at high risk of hospitalization due to their intrinsic medical and social conditions.
  - c) Hospitalizations and readmissions are frequent and expensive.
  - d) While intuition tells us that hospital readmissions may be reduced by improving care transitions between venues and between providers, improved care transitions may have a small effect on reducing hospitalizations but a great impact on patient safety.
- 2) Barriers to safe transitions include:
- a) Urgent transfers of very complex patients
  - b) Multiple comorbidities requiring numerous interventions using several different specialties and specialized services;
  - c) Multiple providers such that no one individual takes ownership of the process
  - d) Multiple venues of care (hospitals, dialysis units, medical offices, long term care facilities, outpatient agencies)
  - e) Lack of access to specific electronic systems by many of the care providers, lack of interoperability between electronic health information systems and high noise to signal ratio of the existing systems
  - f) Illegible non-electronic transfer information
  - g) Competing interests of information sharing, privacy and security
  - h) Lack of financial incentives that support coordination across the continuum of care
  - i) Lack of knowledge about what information is needed by other providers for a safe transition
  - j) Overlooking patient/family engagement
  - k) Lack of patient education and attention to transitions from CKD to ESRD
  - l) High cost medications that require prior authorization, lack of prescriber knowledge of medication cost and authorization issues
- 3) Successes; what are the components of safe transitions?
- a) The use of care coordinators (coaches, navigators, case managers), generally RN's or with RN leadership, who have access to information systems, providers and patients/family
    - i) address patient education, care planning, monitoring, patient self-management, assistance with social supports
  - b) Transitioning between venues requires:
    - i) a designated coordinator – someone to take ownership of the process
    - ii) coordinated discharge plan
    - iii) knowledge of what information is needed by the various venues, e.g. the dialysis facility, PCP, etc
    - iv) institutionalized exchange of information
    - v) discharge form, preferably electronic, with specific information
    - vi) post discharge personal contact to evaluate needs
    - vii) accurate medication reconciliation post discharge; pharmacist involvement ideal
    - viii) timely post discharge patient reassessment to include patient stability, dry weight, changes in and additions to diagnoses, needs for subspecialist care, facility administered medications (antibiotics, anticoagulation); always be skeptical of “resume previous orders”
    - ix) activated patient/family engagement and ownership of the process

## Presentations

### ❖ **Framing the Issue:** Marc Turenne, PhD

- Readmissions are high frequency, high cost events; 18% within 30 days, \$15billion annually
- May reflect lack of coordination of care across settings due to “silos” of care and financial disincentives for providers, e.g., a provider has no means of offsetting the costs associated with reducing readmissions
- Many readmissions may not be avoidable, i.e., they reflect necessary care for patients with high comorbidity
- While the initial focus is on hospitals, there are multiple post hospitalization providers who have a role to play
- ESRD patient readmission rates are almost double that of the Medicare population as a whole
- In ESRD, multiple providers have influence, including hospitals and dialysis units
- Some diagnoses are associated with very high readmission rates, e.g., device complications (e.g. catheters), congestive heart failure, hypertensive and diabetic complications, septicemia, fluid and electrolyte disorders, surgical complications, dysrhythmias, coronary artery disease
- Clinical risk factors include cancer, malnutrition, end stage liver disease, drug and alcohol disorders, neurologic disabilities, seizures, obstructive lung disease, septicemia, pancreatic disease
- Readmissions are not limited to a small subset of patients or diagnoses; need to broaden the range of solutions.
- Some specific risk factors e.g., individual comorbidities, may require more targeted interventions
- He has reservations about whether readmission rate is a quality of care indicator

### ❖ **Hospital Readmissions:** Cathy Koppelman, RN, University Hospital System, Ohio

- Unplanned, related readmissions create greatest opportunity for interventions, account for 45-50% of readmissions
- Top DRG readmissions are hospital-specific
- Evaluated hospital trends – CHF, MI, COPD, pneumonia, psychiatric
- Categories evaluated and addressed at these institutions;
  - Discharge planning – interdisciplinary team effectiveness, underutilization of home care, end of life needs, readmissions from extended care facilities
  - Insurance/financial – medication costs, different payors, access to post-acute care – addressed issues with commercial payors, evaluated problems by payor source, educated physicians re; medication ordering
  - Physician –related; lack of PCP, post procedure infections, MD approval for pre-authorized meds
- Evaluation by diagnosis;
  - Heart failure – risk factors were non-adherence, low EF, not following up with appointments, new diagnosis, lack of social supports, not home-care eligible; home care visits reduced readmissions
  - Pneumonia – improved readmissions by home care, post discharge RN visit and provider followup contacts, addressing hand offs (ICU transfers)

- All patients care coordination – Core teams of RN, CM, SW – found that addressing processes alone was not sufficient; programmatic infrastructure was required with specific roles and care maps and continuum based management – not just episodes of care - and community partnerships.

❖ **Panel Discussion: Patient Safety and Transitions**

- Moderator Jean Moody Williams, RN, MPP Group Director, Quality Improvement Group, CMS Office of Clinical Standards and Quality
- Michael Lazarus MD FMC
  - Errors often are due to poor transitions – undocumented allergies, fall risk, blood loss from access issues, dry weight missed. Presented case reports in which failure of communication was a major root cause of catastrophic events. Many of the reports involved multiple providers with responsibilities for different aspects of care but who were not communicating with each other.
- Renee Garrick MD RPA
  - Reported on 57 patients, 106 hospitalizations, 15 different care sites, >100 different providers involved in care, mean age of patients 65 years with 4-8 comorbid conditions, new referrals post discharge to 16 specialties and subspecialties. Most stays not ESRD related. Short stays associated with significant procedures. Transition issues involved changes in BP meds, changes in dialysis prescription, new diagnoses including cancer or anticoagulation needs, significant medication changes, need for i.v. antibiotics post discharge. They initiated QAPI for transitions. Made rules and created a template; they required an updated data base before dialyzing a patient post discharge. Found that most admissions not preventable, patients have high disease burden. Need effective content based forms and tools.
- Lana Spencer, RN DCI
  - Transitions from CKD to ESRD Problems seen include the lack of transition preparation CKD to ESRD; lack of vascular access, patients “crashing” into ESRD, dialysis treatment complications, patients unprepared for ESRD, more hospitalizations. First month of dialysis is very expensive. Need more patient engagement, more education. Need integrated care coordinator for the transition and initiation of dialysis.
- Audience comments;
  - high signal to noise ratio in electronic reports, especially in ESRD given high frequency of events.

❖ **Keynote:** Patrick Conway, MD CMS Chief Medical Officer and Director of Office of Clinical Standards and Quality

- CMS is the largest purchaser of health care in the world.
- Recent work; new QIO funding directed toward learning networks, care transitions, safety, patient/family engagement; value based purchasing programs; align quality measures across programs.
- Priorities of National Quality Strategy; reduce harm, patient/family engagement, effective communication and care coordination, promote effective prevention and treatment practices for leading causes of mortality, promote best practices for health in communities, make care affordable.

- 3 T's Roadmap; 1. Clinical efficacy research; 2. Outcomes and comparative effectiveness research; 3. Test how to deliver quality care reliably and in all settings
- ESRD; Transitions – technical assistance for Community based organization work, care transitions
- Audience; CMMI looking for innovative models of Care. Need digital platform to exchange info.

❖ **Legal Considerations to Safe Transitions of Care:** Louis Riley

- It is required that patient health information be protected but at the same time be shared between providers.

❖ **Barriers to Safe Transitions**

- Jean Moody Williams, RN, MPP CMS Office of Clinical Standards and Quality, Group Director, CMS Quality Improvement Group
  - National goal is to reduce 30 day readmissions by 20% over 3 years. Community coalitions need to do root cause analysis on local data.
- Michael Lazarus, MD FMC
  - System issues
    - Failure to understand importance of communication at multiple levels of transition
    - Lack of IT system integration or interface
    - Urgency in transfer; urgent hospitalizations and the need for prompt discharges
    - Complex patients, multiple caregivers
    - Shared accountability – leads to errors
    - Lack of patient/family involvement, lack of identified health care proxy
    - Physicians absent for much of the outpatient treatment
    - Cultural and language differences
    - Indifferent attitude of providers
    - Poor education re: importance of handoffs
    - Failure of nursing staff to do comprehensive patient assessment or review paperwork
    - Transfers occur at times of suboptimal staffing e.g. weekends
    - Questionably appropriate transfers of patients who would be best treated elsewhere
  - Transfer template requirements
    - Outpatient facility needs to know What did you do to my patient?
    - Hospital needs to know; Why is this patient here?
    - Transfer templates must be pertinent and concise, one page
- Doug Johnson, MD DCI
  - CKD transitions are unmanaged. Need care navigators, education.
- Becky Lee, RN Davita
  - Pilot; embed renal nurses in the hospital. Use a universal transition tool. Need renal RN contact with patient within 48 hours of discharge; confirm physician follow up, testing, procedures, medication reconciliation; Phone contact weekly for 4 weeks. No data yet on pilot.
- Darlene Rodgers, RN ESRD Networks



- ◆ Initial data shows improved hospitalizations
- QIO-NW Collaborative Care Transitions Project
  - ◆ 2 hospitals, 10 dialysis providers in 4 counties
  - ◆ Major barriers identified
    - Cross setting transition workflow gaps between providers; providers unaware of what information the next provider needs
    - Communication disconnects, not enough specific information
    - Lack of standardized evidence based documentation across providers
  - ◆ ESRD-specific transition communication forms developed, 8 week pilot
  - ◆ Staff found the communication forms to be valuable; no outcome data re: re-hospitalization rates
- Patricia McCarley, RN Examine effective transition programs
  - ESRD patients present the “perfect storm” of risk factors that predict rehospitalizations
    - Prior hospitalizations, polypharmacy, problem medications, high comorbidity burden including DM, CHF and depression.
  - Care Coordination Models - BOOST, RED, Transitional Care Model for Heart Failure, EverCare, Care Transition Program, FMS-Care Partners
  - Components of successful care coordination;
    - Target patients at risk
    - **In-person contact**
    - Access to timely information
    - Interaction between care coordinators and PCP
    - Provide services that focus on patient education, care planning, monitoring, patient self-management, assistance with social supports
    - Rely on RN to lead the charge – whether called the coach, team leader, case manager, coordinator, care manager
  - Programs all showed decreased hospitalizations
  - Challenges to Care Coordination
    - Short length of hospital stay, need for continuing therapy post discharge
    - Large burden of comorbidity
    - Many care venues, many providers, poor communication
    - Current Fee for Service does not reimburse care coordination
  - Conclusions; ESRD patients need a multidisciplinary team that knows the patient history, need to be seen and assessed with 72 hours of hospital discharge, need medication reconciliation, need social and dietary issues addressed, and need providers who are on the same page
- Action Steps; Small groups addressed 8 questions regarding safe transitions Conclusions;
  - Need a Multidisciplinary Quality Improvement Team to address barriers and potential solutions
  - Mandatory exchange of information
  - Access to EHR
  - Contacts between hospital and dialysis facility daily during the hospital stay
  - Patient education/engagement

- Care coordinator – the RN
- Have a discharge form, decide who is responsible for it, best if electronic, don't let those with poor handwriting fill out the form
- Facility should question the order “resume previous orders”
- Need additional staff; transition care coordinator - with a backup plan if care coordinator is not available
- Post discharge patient assessment, review discharge summary, involve interdisciplinary team, identify meds, determine if patient is stable, identify patient concerns, reassess dry weight
- Medication Reconciliation is **critical** – needs patient empowerment, information sharing, transition coordinator
- Need f/u within 72 hours of hospital discharge by care coordinator; interdisciplinary team should reassess the patient
- Increase patient involvement; targeted interview of patient and family (scripted)

**Closing Remarks:** Peter DeOreo, MD Centers for Dialysis Care

- ESRD is complicated and there are not simple answers that will improve transitions of care, reduce hospitalizations and improve safety. Patients are older, have multiple comorbid conditions, take many medications, have multiple provider relationships, and are at high risk for hospitalizations and death.
- ESRD care is fragmented, provided at multiple sites by different providers; transitions are not safe, effective, patient centered, timely equitable or efficient. Patient care staff operate in an inefficient system with incomplete and potentially inaccurate information. The idea that perfecting transitions will improve care is intuitive but may be mistaken. Improving transitions is a safety issue that may or may not reduce readmissions. Patient and environmental factors and the systems of care are critical to readmissions.
- A 2009 review of randomized trials of care coordination found that multidisciplinary care coordination did not, overall, reduce hospitalizations or save money. The review stressed the importance of intervention at the time of hospitalization and personal contact and the necessity of incorporating a transitional care model in the care coordination model.
- A 2011 systematic review of rehospitalizations found that patient centered discharge instructions, a post discharge phone call (but not as the sole intervention), a discharge coach, patient engagement and bundled interventions were important in reducing rehospitalizations. Medication reconciliation at discharge, a coordinated discharge plan, timely followup and provider continuity are important.
- Clinical data suggests that few admissions are truly preventable due to comorbidities, mental illness, poor social support, poverty. A 2009 trial demonstrated that pharmacist calls to patients within days of discharge, RN patient “advocates” and the creation of an “After hospital care plan” given to the patient and the PCP reduce readmissions.
- Readmission rate may not be a measure of quality. That said, there are variations in hospital and dialysis care that explain some of the observed variation in readmission rates. Systems of care do affect admission rates; these require infrastructure changes e.g., RN led interdisciplinary

teams, more home care, RN office visits, evidence based practices. Care management across the continuum is required, rather than episodic care management.

- Ownership of the problem lies on multiple shoulders. We need to resolve privacy and security issues. RNs leading multidisciplinary teams is a common feature of successful programs. We need to activate patient ownership-engagement. For transitions we need to identify essential transfer information and institutionalize the exchange of information.

*This Executive Summary was prepared by members of the Forum of ESRD Networks' Executive Committee. May 6, 2013*