CREATING A CULTURE OF QUALITY:
The Critical Role of Communication In Improving ESRD Patient Safety

Improving Transitions of Care

Organized Chaos?
Identifying Barriers in Care Transitions

Jeffrey Perlmutter, MD
Maribeth Sommer, RN, CNN
Maggie Carey

Organized Chaos?
Identifying Barriers in Care Transitions

Dr. Jeff Perlmutter
Chair MRB ESRD Network 5

- Medical Advisory Council (MAC) of the Forum of ESRD Networks—MRB chairs plus representatives from BAC and EDAC
- Three toolkit work groups: Patient-centered care, Home dialysis, and
- Care Transitions toolkit work group chaired by Dr. Cynthia Kristensen
- Work group membership is open to those outside the MAC

- Care Transitions work group identified a plethora of care transitions relevant to kidney patients
- Surveyed patients and providers about care transitions that were "challenging", " a threat to patient safety", and "important"
- Most of those care transitions involved the in-center hemodialysis clinic
- My perspective as nephrologist and medical director is that those transitions need to be managed through the dialysis unit

My Story

Dr P sees the patient in the ED on a Friday, the usual day for dialysis for the patient (2nd shift). The patient has sepsis and is too unstable to undergo dialysis. Admitted to ICU. Dr. P signs out to weekend coverage. On Monday he rounds at the patient's dialysis unit but on third shift, as per his usual schedule. When he arrives at the hospital (which has a full EHR) to which the patient had been admitted he finds that the patient is no longer on the inpatient list. While he accesses the EHR, he calls the unit to find out if they had heard anything and learns that the patient had been there second shift.

What happened?

The patient is seen by the hospitalist, nephrologist, and intensivist during the stay. There is steady improvement and dialysis is done on Saturday. The intensivist note for Sunday says that the patient considered " leaving for son's wedding last night." Doctors for all three disciplines see the patient on Sunday with plans to continue care in the critical care unit. Before lunch the patient's daughter tells the nurse that the patient is "feeling fine" and wants to go home but the nurse convinces the patient to stay. After lunch, the patient again wants to leave the hospital but now the nurse is unable to convince the patient to stay who leaves AMA.

The nurse notified the intensivist but there was no record of notification to the hospitalist or nephrologist.

Dr. P learns from the record that the patient has blood cultures growing a gram negative bacillus. He contacts the patient's son and learns that no antibiotics were prescribed because the patient left the hospital AMA. The infection is sensitive to levofloxacin which Dr. P prescribes and which the patient starts on Monday.

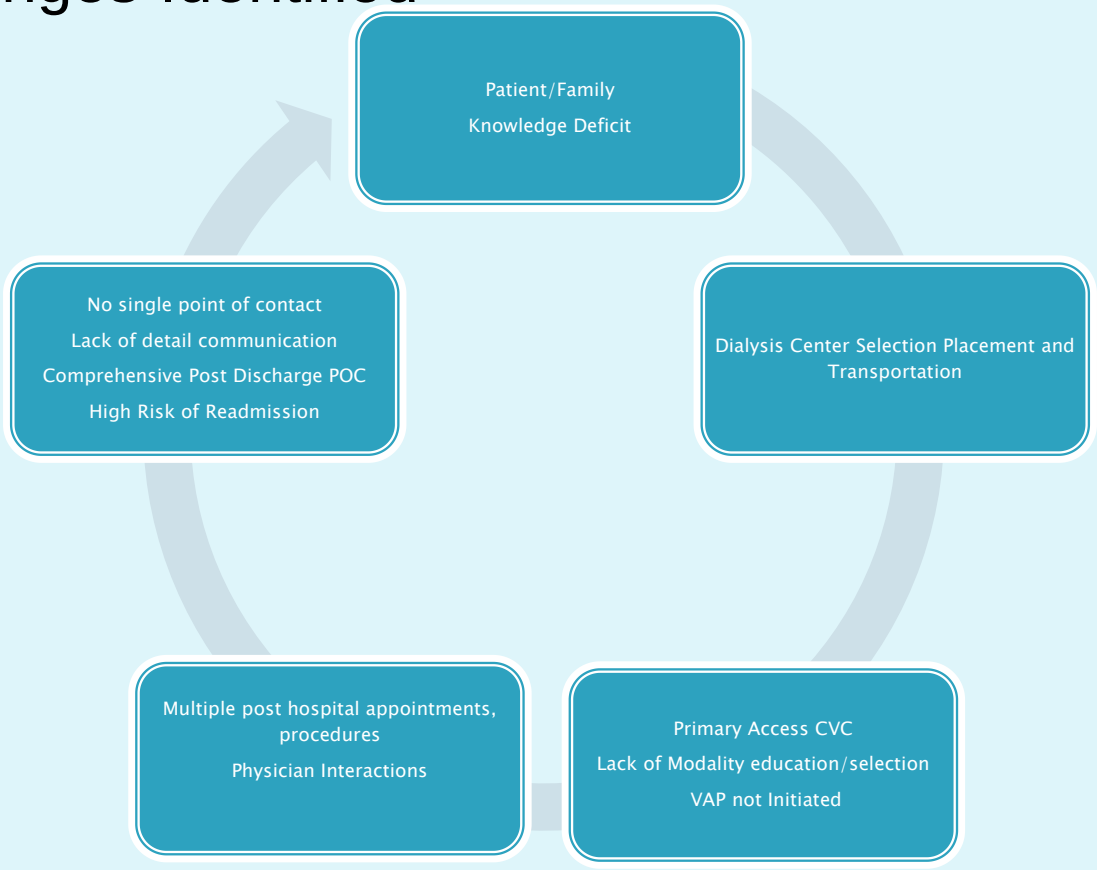
On Wednesday, a fax arrives at the dialysis center from the hospital with the recommendation for continued antibiotic therapy.

Disorganized chaos.

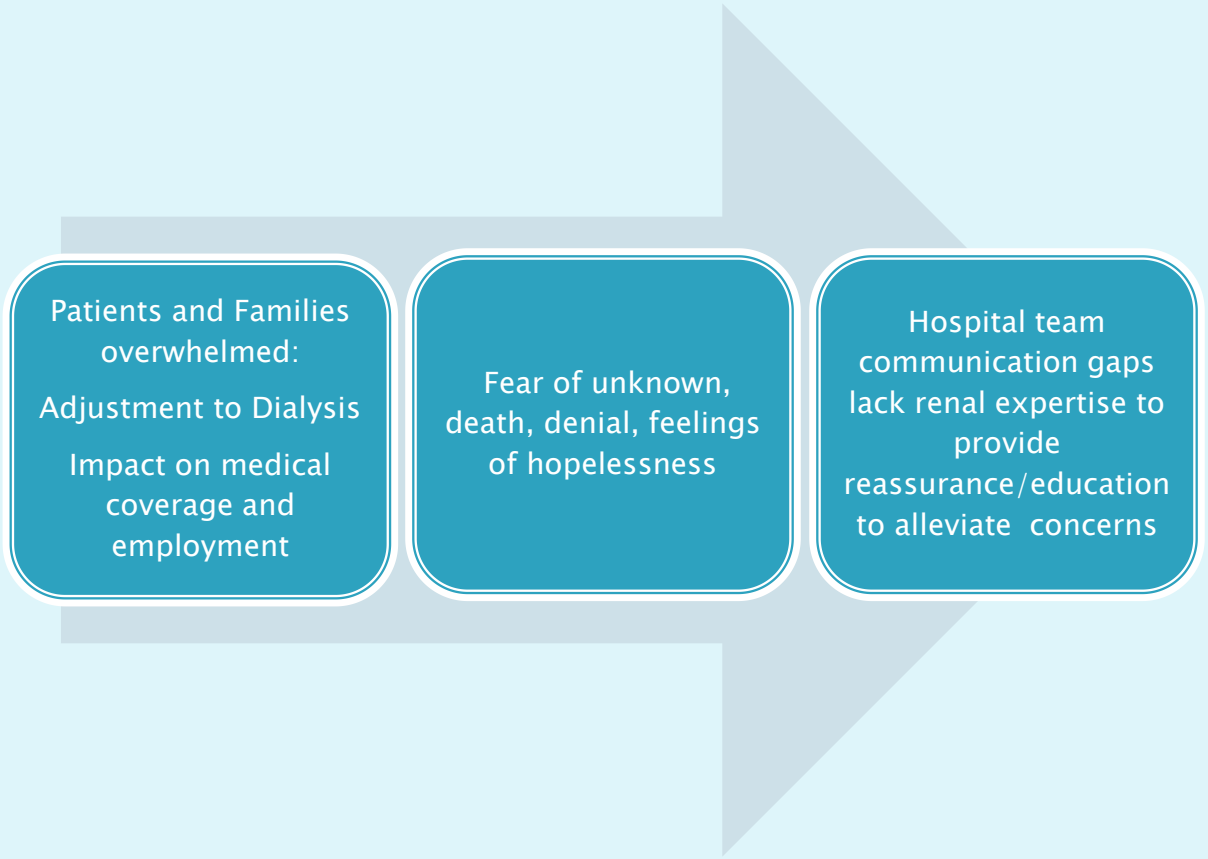
Hospital Transition Challenges
ESRD Patient

Maribeth Sommer
VP Clinical Services
Davita VillageHealth

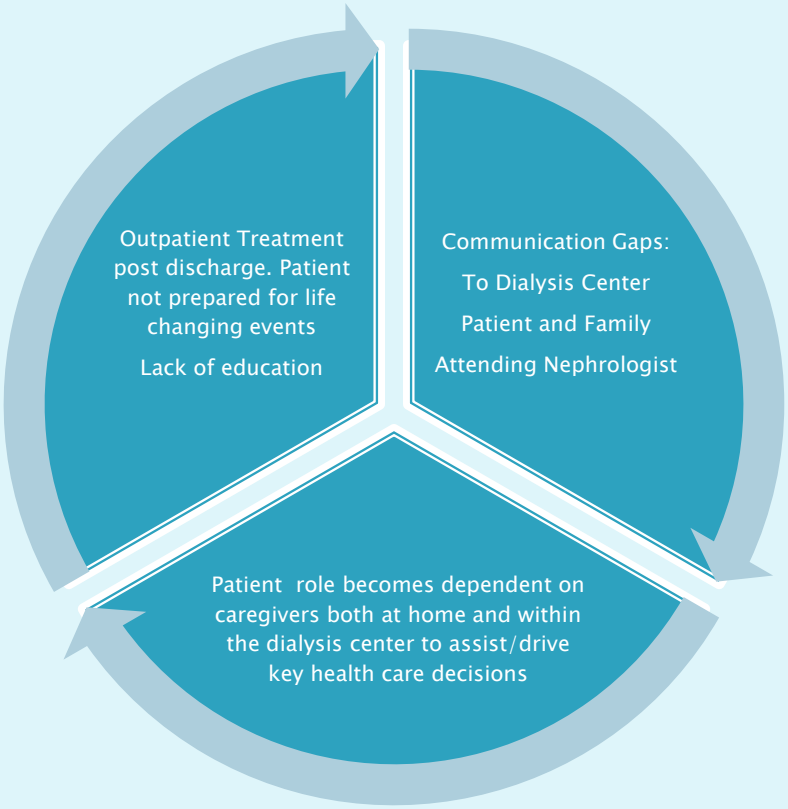
Challenges Identified



Widespread Implications of the Challenges



Transition to the Dialysis Unit



ORGANIZED CHAOS?

Maggie Carey
Chair of the Forum's
Beneficiary Advisory Council
Network 11 Consumer Committee Chair
ESRD Patient

Beneficiary Advisory Council

Each Network selects one patient or family member representative to serve on the BAC

Charge

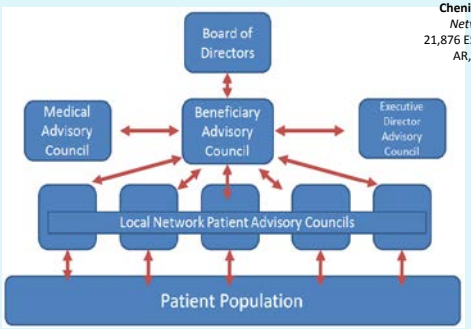
The Beneficiary Advisory Council (BAC) shall serve as the primary group to advise the Board of Directors and the Forum membership on the direct affect of healthcare related issues on ESRD patients.

Objectives

The BAC shall provide a diverse perspective and:

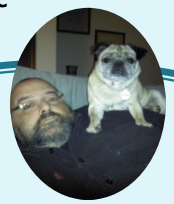
- Ensure patients are the center of quality activities
- Review and provide input on Forum products
- Serve as a liaison between the Forum and the patient community
- Actively participate in specific projects in support of the Forum's mission

Forum Organizational Chart



Roger Gravgaard
Network 16
18,278 ESRD Patients
AK, ID, MT, OR, WA

Thomas Carr
Network 18
49,274 ESRD Patients
S.CA



Michael Hillson
Network 1
21,780 ESRD Patients
CT, MA, ME, NH, RI, VT

Peter Woods
Network 2
38,688 ESRD Patients
NY

Ken Noonan
Network 3
22,268 ESRD Patients
NJ, PR, VI

Quality Insights Renal Network 3

No Photo Available

Derek Forfang
Network 15
29,514 ESRD Patients
AZ, CO, NV, NM, UT, WY
and
Network 17
32,520 ESRD Patients
AS, GU, HI, MP, N.CA

The End Stage Renal Disease Network Of Texas

Ana Rodriguez
Network 14
51,759 ESRD Patients
TX

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Chenise Dennis
Network 13
21,876 ESRD Patients
AR, LA, OK

Ardy Boucher
Network 12
23,133 ESRD Patients
IA, KS, MO, NE

Maggie Carey
Network 11
43,656 ESRD Patients
MI, MN, ND, SD, WI

Lana Schmidt
Network 10
23,894 ESRD Patients
IL

Network 9
40,200 ESRD Patients
IN, KY, OH

The Renal Network ESRD Networks 9 & 10

Ruth Crenshaw-Love
Network 8
32,029 ESRD Patients
AL, MS, TN

Network 8, Inc.

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FMQAI

Network 7
33,017 ESRD Patients
FL

Dixie passed away on August 12, 2013. Rest in Peace, Dixie

No Photo Available

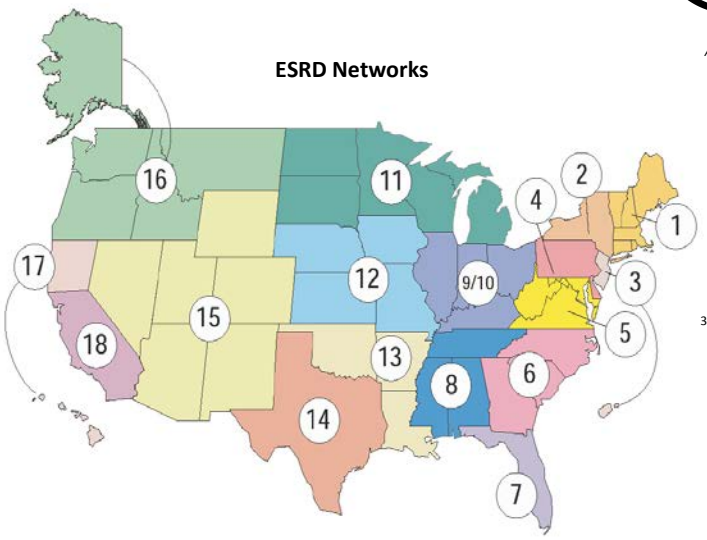
Dixie Moncus
Network 6
50,493 ESRD Patients
GA, NC, SC

Virna Elly
Network 5
34,671 ESRD Patients
D.C., MD, VA, WV

Network 4
27,684 ESRD Patients
DE, PA

Network 4

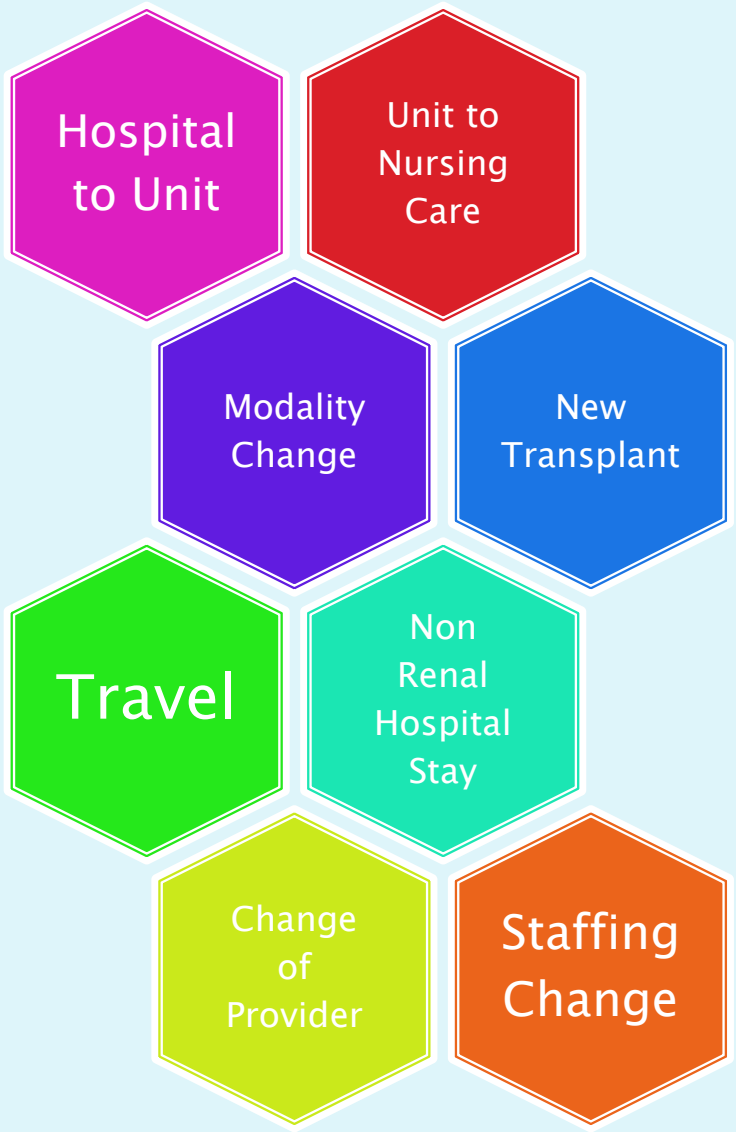
ESRD Networks



Patient counts accurate as of 12/01/2012;
BAC members accurate as of 08/21/2013.

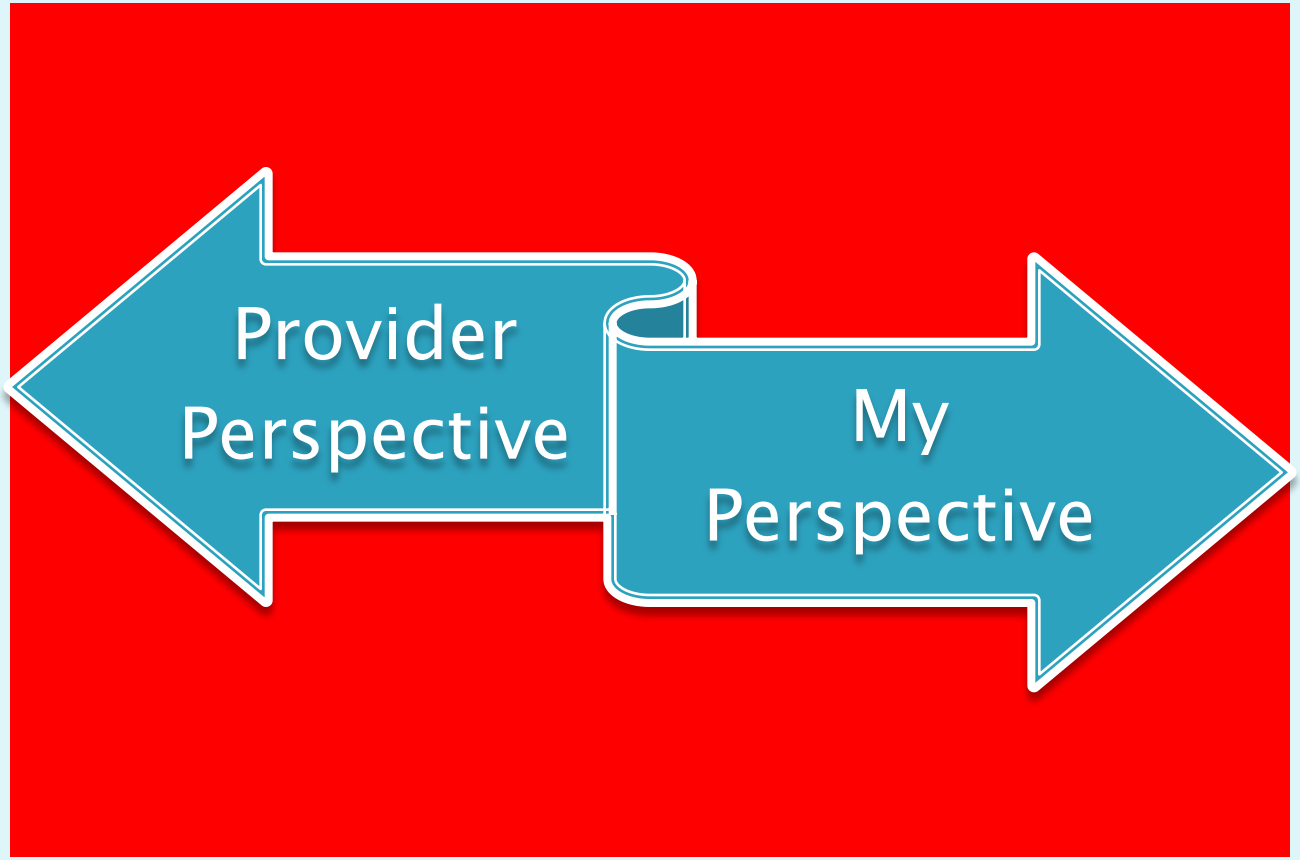
The National FORUM of ESRD NETWORKS
Improving Care Through Collaboration

ESRD Transitions



The Never Ending Story

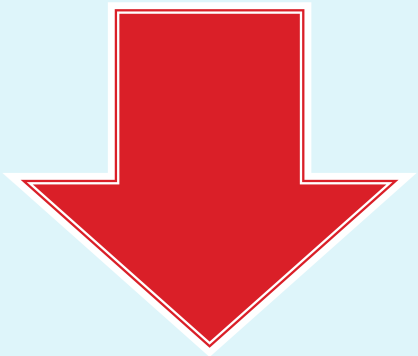
Story One – Hospital to Dialysis Unit



Internalize

Externalize

Story Two – Modality Change



Trepidation

Familiarity

What Made The Difference?

- Was it because a 90 year old blind man could do it?
- Was it because Lee held my hand and said she would take care of me?
- Was it just that I was feeling better and could process information again?

I don't know – but these two transitions were only 3 months apart