Reducing Dialysis Readmissions and Emergency Department Visits

Welcome!

- All lines are muted to preserve audio quality.
- Please enter questions in Q&A.
- For technical issues, chat with the Technical Support panelist.

We will get started shortly!

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CENTERS FOR MEDICARE & MEDICAID SERVICES
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Reducing Dialysis Readmissions and Emergency Department Visits

Presented by:
Carolyn Kazdan, MHSA, NHA

September 22, 2022

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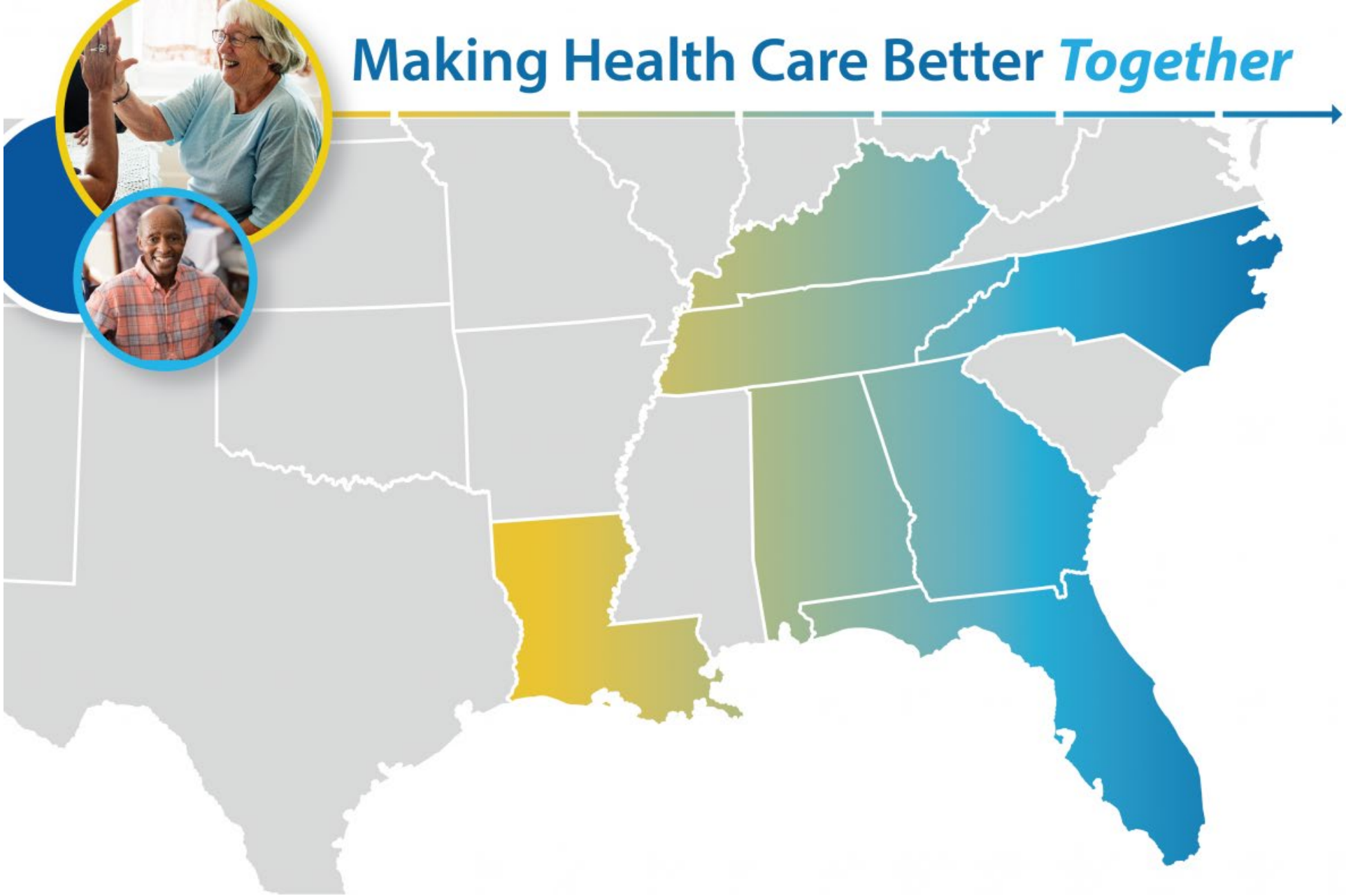

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Carolyn Kazdan, MHSA, LNHA

SENIOR DIRECTOR, HEALTH CARE QUALITY IMPROVEMENT

Ms. Kazdan is the senior director of health care quality improvement for IPRO, the Medicare quality improvement organization for New York and 11 other states. Ms. Kazdan led IPRO's work with Project ECHO® and serves as a care transitions and nursing home subject matter expert for Alliant Health Solutions.

Ms. Kazdan previously led IPRO's work with the NYS Partnership for Patients and the Centers for Medicare & Medicaid Services (CMS) Special Innovation Project on Transforming End of Life Care in Nassau and Suffolk counties of New York State. Before joining IPRO, Ms. Kazdan was a licensed nursing home administrator and the interim regional director of operations in skilled nursing facilities and continuing care retirement communities in New York, Pennsylvania, Ohio and Maryland.

Ms. Kazdan has served as a senior examiner for the American Healthcare Association's National Quality Award Program. She currently serves on the NY State MOLST Statewide Implementation Team and Executive Committee and PALTC's Education Subcommittee. Ms. Kazdan earned a master's degree in health services administration at The George Washington University.

"We live in a rapidly changing world, where we need to spend as much time rethinking as we do thinking" – Adam Grant

Contact: ckazdan@ipro.org

Danyce Seney RN, BSN, RAC-CTA

QUALITY IMPROVEMENT SPECIALIST

Danyce has more than 28 years of experience in acute care, long-term care and dialysis care in various leadership roles. Danyce is a quality improvement specialist and registered nurse with Lean, Infection Control Preventionist, Advanced Resident Assessment Coordination (MDS) and Educator for Adult Learner certifications. At IPRO, Danyce is responsible for supporting skilled nursing facilities in utilizing a quality improvement framework to implement evidence-based interventions and strategies to improve patient safety, improve immunization rates and reduce avoidable readmissions.

Dany Anchia, BSN, RN, CDN

QUALITY EDUCATION AND ENGAGEMENT DIRECTOR

Dany Anchia is a Registered Nurse and the Education & Engagement Director for the End Stage Renal Disease (ESRD) Networks 8 & 14, as part of Alliant Health Solutions. Alliant Health Solutions holds the Centers for Medicare & Medicaid Services contracts for ESRD Networks 8 & 14, which serve the States of Alabama, Mississippi, Tennessee, and Texas.

Mr. Anchia is responsible for ensuring compliance with ESRD clinical quality, quality improvement activities, provide expert guidance to the Networks' team, and support ESRD providers in Texas. Mr. Anchia possesses over 19 years of experience in healthcare with a special emphasis on end stage renal care. Additional areas of expertise include knowledge on various ESRD treatment modalities and equipment, home health pediatrics, project management, and Federal and State ESRD rules and regulations. Before joining Alliant Health Solutions, Mr. Anchia served a variety of roles as an experienced Registered Nurse for distinct dialysis providers.

As an experienced patient care technician, Mr. Anchia obtained an Associate of Science in Nursing degree from Brookhaven College in Dallas, Texas, Mr. Anchia then attended Texas Tech University Health Sciences Center and graduated Magna Cum Laude with a Bachelor of Science in Nursing. He possesses a Certified Dialysis Nurse certification from the Nephrology Nursing Certification Commission. He served as the 2018-2019 American Nephrology Nurses Association (ANNA) Dallas Chapter President. And in January 2020, Mr. Anchia was appointed by Governor Abbot to the Texas Chronic Kidney Disease Task Force, where he currently serves as the Chair for the Education & Prevention Subcommittee.

Sam Trevino

GUEST SPEAKER

Sam is a former dialysis patient of 17 years, transplant recipient, and now a patient advocate/motivational speaker. Sam's upbeat attitude and humor enabled him to develop "Urine Inspiration," a presentation aimed at educating everyone about living a full life in the face of medical challenges. Sam shares a powerful message that will resonate with the renal community including patients, incenter staff, nephrologists, and care partners. He talks about his experience as a patient in HD, HHD, and transplant, and is focused on education regarding the benefits of patient empowerment, and home therapies. Sam's message inspires patients to become empowered and THRIVE while living a life with CKD. Sam reminds care teams that what we do each and every day has a ripple effect that is far-reaching and incredibly powerful.

Learn more about Sam and his journey at:
www.urineinspiration.com

Objectives

Learn Today:

- Know and understand mitigation strategies that will reduce readmission and ED visit rates.
- Improve the patient and care partner transfer experience.

Use Tomorrow:

- Analyze your handoff process for dialysis patients across the continuum of care.

Sam's Story and Insights

CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

Care Giver vs. Care Partner

- The impact of visitor restrictions
- The impact of a care partner on a patient's journey

Noncompliant vs. Human

- Human striving to adhere to plans of care and the reality of living with dialysis
- Incorporating goals of care and accommodating personal choice

ED and Readmission Drivers: Opportunities to Impact

CHRONIC DISEASE SELF-MANAGEMENT

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Identify patients at high-risk for kidney disease and improve outcomes

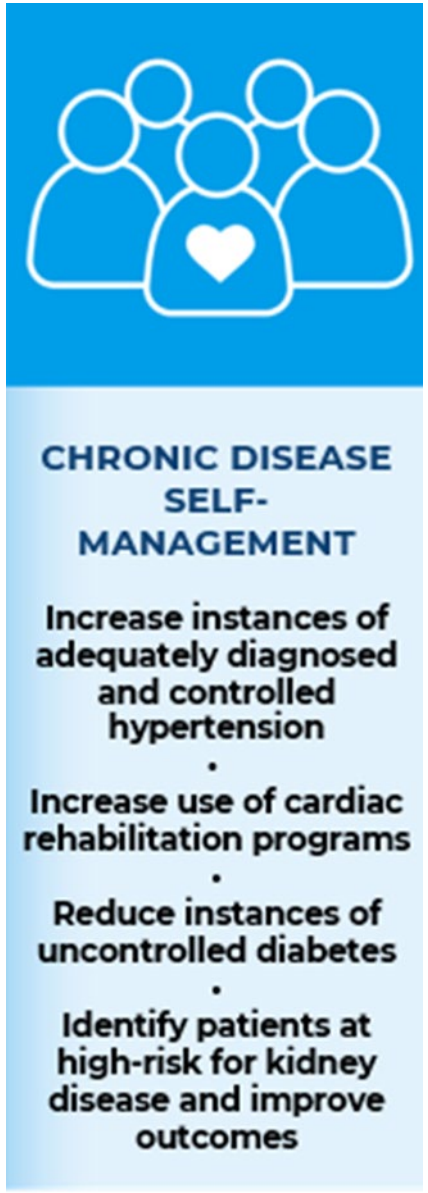
Engaging Providers and Identifying the Best Setting for Care

- Establishing relationships with key partners – Nephrology
- Urgent Care vs. ED visit
- Assessment and shared decision-making: Could an additional dialysis session resolve the change in condition?

Care Plans to Proactively Address Common Causes of ED Visits/Readmissions

- Addressing barriers to monitoring or adhering to fluid and/or diet restrictions
    - Engaging Patients, Families and Care Partners
- Identifying and planning for barriers to adherence to dialysis schedule

ED and Readmission Drivers: Opportunities to Impact



Transportation Issues

- Appointments, treatments
- Follow ups, Labs, Pharmacy
- Grocery Store

Inter-Facility Communication

- Between providers
- Health literacy- residents, patients, care partners, families

ESRD Contact Information

Alliant ESRD Network 8 (AL, MS, TN)
Office: 601-936-9260
Toll-free: 877-936-9260
Email: nw8info@allianthealth.org
Website: https://quality.allianthealth.org/topic/esrd-nw8/

Alliant ESRD Network 14 (Texas)
Office: 972-503-3215
Toll-free: 877-886-4435
Email: nw14info@allianthealth.org
Website: https://quality.allianthealth.org/topic/esrd-nw14/

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CMS Critical Element Pathway

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Dialysis Critical Element Pathway

Observations:

- ☐ Infection prevention and control policies and procedures must be implemented (i.e., hand hygiene immediately before and after contact with a resident or any equipment used on resident, access site care for hemodialysis and catheter site care for peritoneal dialysis).
- ☐ Is soap, water, and a sink readily accessible in locations where dialysis care is provided?
- ☐ Does staff perform hand hygiene (even if gloves are worn) in a manner consistent with the current standards of infection control practices?
- ☐ Is PPE appropriately implemented?
- ☐ Are qualified personnel accessing and providing maintenance of central venous catheters (CVCs), shunts, fistulas, or other vascular access catheters using aseptic technique:
  - The access insertion date is documented and the indication for use is documented and assessed regularly;
  - Dialysis access site dressings are clean, dry, and intact and the dressing is changed with clean (aseptic) technique using clean gloves or sterile gloves;
  - Only sterile devices are used for dialysis vascular access.
- ☐ Does the resident require injections related to dialysis care:
  - Injections are prepared using aseptic technique in an area that has been cleaned and is free of contamination (e.g., visible blood, or body fluids);
  - The rubber septum on any med vial, whether unopened or previously accessed, is disinfected with alcohol prior to piercing;
  - Med vials are entered with a new needle and a new syringe; and
  - Med administration tubing, connectors, and bags of IV solutions are used for only one resident (and not as a source of flush solution for multiple residents).
- ☐ Are care-planned and ordered interventions in place and followed?

- ☐ For a resident receiving dialysis **<u>at a certified dialysis facility</u>**, did the nursing home:
  - Assess and document vital signs, including the blood pressure in the arm where the access site is not located, weights if ordered and communicate the information including the resident's status with the dialysis facility prior to and post dialysis;
  - Provide assistance and safe transportation to and from dialysis;
  - Administer meds or meals before or after dialysis as ordered;
  - Provide direct visual monitoring of the access site before and after dialysis; and
  - Provide ongoing monitoring and care of the resident's vascular access (fistula, graft, or central venous catheter) for HD, catheter for PD as ordered, and provide ongoing monitoring for dialysis related complications (e.g., bleeding, access site infection, or hypotension).

Questions?

Complete the Post-Event Assessment to Receive Credit

https://bit.ly/NAB_ANCC_ClaimCredit

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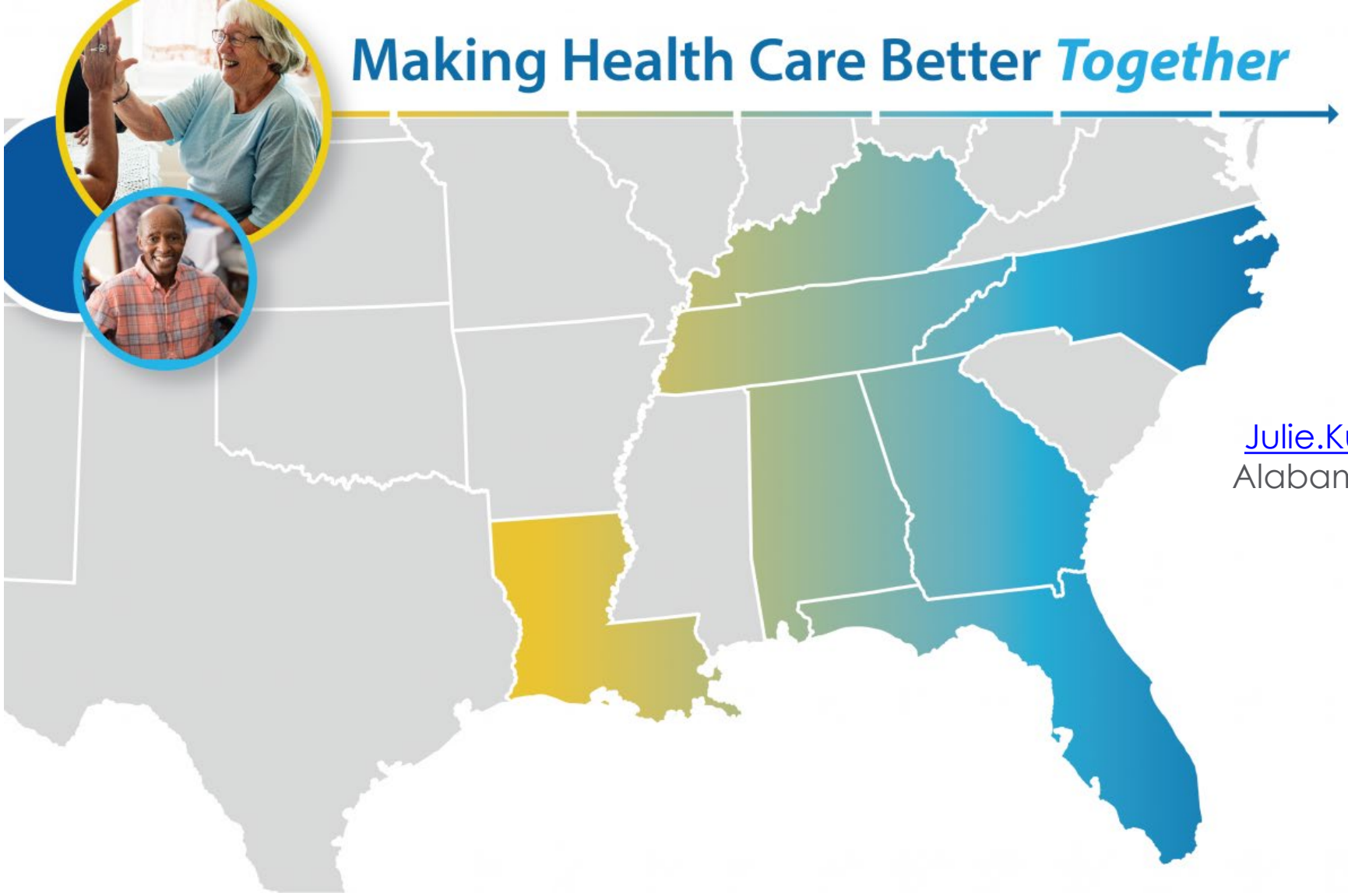

Julie Kueker
Julie.Kueker@AlliantHealth.org
Alabama, Florida and Louisiana

Leighann Sauls
Leighann.Sauls@AlliantHealth.org
Georgia, Kentucky, North Carolina and Tennessee

Program Directors

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Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS

OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

CARE COORDINATION

Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers

COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

TRAINING

Encourage completion of infection control and prevention trainings by front line clinical and management staff

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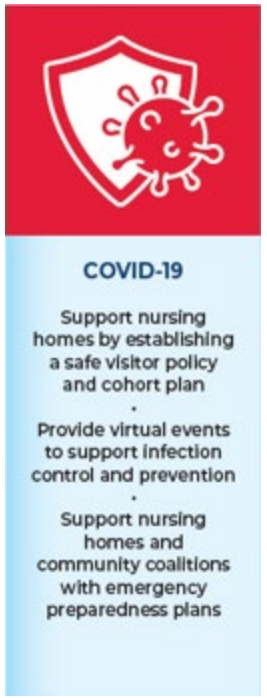
Scan the QR codes or Click the Links to Complete the Assessments!

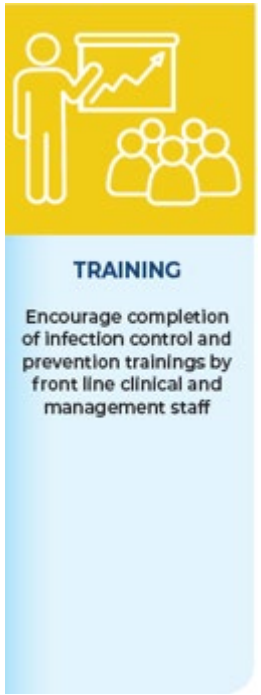
CMS requested Alliant Health Solutions, your QIN-QIO, to work with select nursing homes to understand emerging healthcare needs in nursing homes. Alliant Health Solutions is engaging nursing home leadership on each of these key areas to ensure plans are in place to achieve and maintain health quality and equity!

Please scan the QR codes below and complete the assessments.



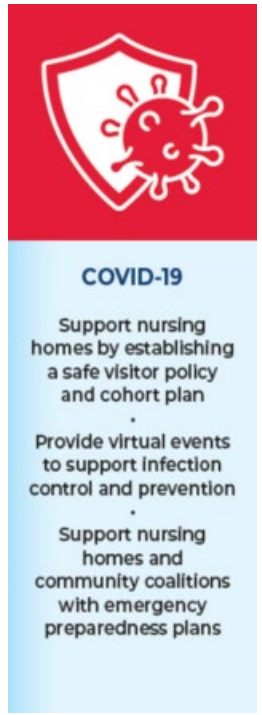
Nursing Home Emergency Preparedness Program (NH EPP) Self-Assessment

https://bit.ly/AHS_NHEPPAssessment



Nursing Home Infection Prevention (NHIP) Initiative Training Assessment

https://bit.ly/NHIPAssessment



Nursing Home Safe Visitor Policy and Cohorting Plan Verification

https://bit.ly/SafeVisitorVerification

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