# A QIO-Renal Network Collaboration Experience: Addressing Care Transitions

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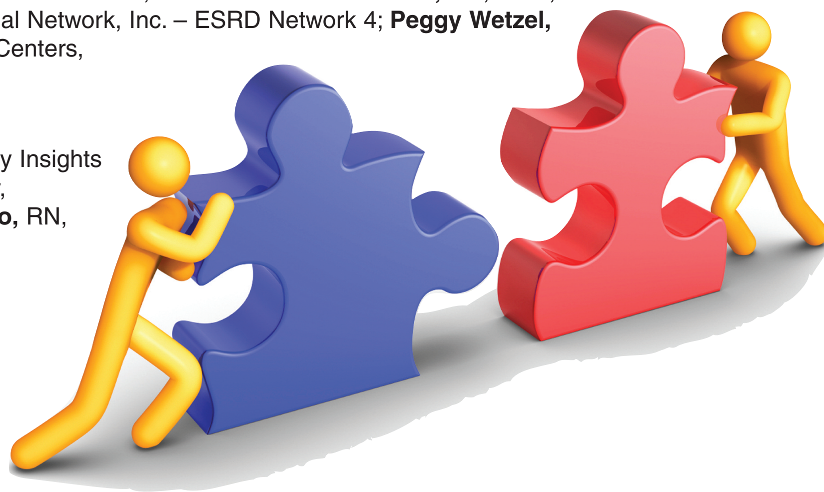

*"Alone we can do so little; together we can do so much." – Helen Keller*

**QUALITY INSIGHTS** of Pennsylvania is a federally designated Medicare Quality Improvement Organization (QIO), contracted by the Centers for Medicare & Medicaid Services (CMS) to improve the quality of health care received by Medicare beneficiaries. In August 2009, Quality Insights was awarded a CMS *Care Transitions Theme* contract, with the goal of improving the quality of care for Medicare beneficiaries who transition between care settings. The ultimate goal of Quality Insights' work under the Care Transitions Theme is to reduce 30-day hospital readmission rates in the target community – the Medicare population in 53 contiguous ZIP Codes in Allegheny, Fayette, Washington and Westmoreland counties in Western Pennsylvania. These ZIP Codes were selected because they form a geographic area largely serviced by hospitals with relatively high readmission rates and discharge volume sufficient to infer a statistically significant readmission reduction outcome.

As we embarked upon this project, we were convinced that success would depend on breaking down long-established "silos" of care, while deepening existing relationships and developing new community partnerships. Care "silos," in which facilities operate without regard to either upstream or downstream care providers, have long been the norm in health care, resulting in sometimes-catastrophic outcomes for patients. Medication errors, treatment errors, inaccurate or missing test results and/or physician orders are just some of the problems that can be caused by lack of understanding and poor communication between care settings.

**"Almost 27% of patients in our study community who were diagnosed with renal failure and discharged from a hospital in 2009 had a subsequent readmission within 30 days of discharge, according to CMS' Medicare claims data. This rate (26.9%) is significantly higher ($p<0.01$) than the 30-day readmission rate of 20.9% for community residents who were hospitalized with any diagnosis (statewide: 18.7%)."**

To carry out the work of this project, Quality Insights agreed to partner with the End Stage Renal Disease (ESRD) Network that is responsible for the state of Pennsylvania (ESRD Network 4) and a selected group of community providers. Across the U.S. and its territories, eighteen ESRD Network Organizations serve as liaisons between the federal government and the

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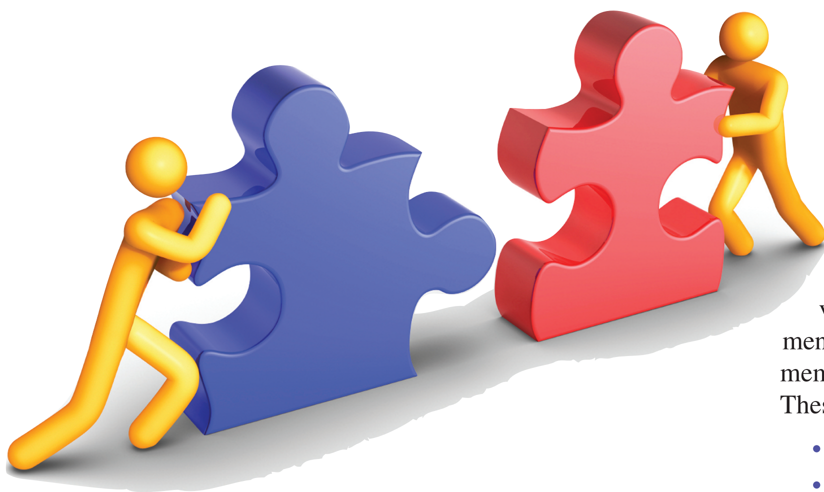
providers of ESRD services, under contract with CMS. Network 4 covers Pennsylvania and Delaware. As of December 2010, Pennsylvania had a total of 254 chronic dialysis providers. These chronic dialysis facilities provided services for 15,234 patients, of which 47.6% were age 65 and older, and 6% were age 85 and older. As of December 2010, the target community had 10 dialysis providers. These chronic dialysis facilities provided services for 430 dialysis patients, of which 51.4% were age 65 and older, and 8.8% were age 85and older.

We believed that a collaborative effort to improve communication across the continuum of care for ESRD patients had the potential to significantly improve care for a particularly vulnerable patient population. ESRD Network 4 has been a robust Care Transitions project stakeholder, participating in analyzing and sharing information to identify root causes of system and communication breakdowns. These analyses revealed an opportunity to improve communication and care processes for ESRD patients who transition among multiple care settings.

## Overview

At the outset of the project, Judy A. Stevenson, MSN, CPHQ, ESRD Network 4 Associate Director -Pittsburgh, reported that Network 4 had an excellent working relationship with the renal community in the Pennsylvania Care Transitions project area. However, she described relationships with acute care and skilled nursing facilities as minimal, even though ESRD patients were frequently admitted to such facilities. The Care Transitions project provided an opportunity for Network 4 to collaborate with a QIO that could help implement information flow strategies across care settings.



ESRD patients experience frequent hospital admissions related to vascular access, infection, fluid imbalance, and/or medication management. These patients often require continued therapy after discharge. As a result, pertinent information must follow the patient to provide uninterrupted delivery of care, regardless of the setting. According to Jencks, et al, (2009), information transfer between care settings can be a significant patient safety issue, and communication gaps often contribute to unnecessary readmissions[1].

## Community ESRD Profile

Almost 27% of patients in our study community who were diagnosed with renal failure and discharged from a hospital in 2009 had a subsequent readmission within 30 days of discharge, according to CMS' Medicare claims data. This rate (26.9%) is significantly higher ($p<0.01$) than the 30-day readmission rate of 20.9% for community residents who were hospitalized with any diagnosis (statewide: 18.7%).

## ESRD Workgroup Collaboration: Timeline And Activity

After preliminary discussions during 2009 between Quality Insights and Network 4 leadership, we determined that we would form an ESRD workgroup to focus on the improvement of cross-setting care for ESRD patients. The first ESRD workgroup conference call with Quality Insights, Network 4 leadership, and selected community providers was held in January 2010. The goal of the first call was to discuss potential cross-setting ESRD patient management and communication barriers and to identify partners for the collaboration. The partners selected for this workgroup were:

- University of Pittsburgh Medical Center (UPMC) McKeesport Hospital
- John J. Kane McKeesport Regional Center(MRC) – long-term and skilled nursing care
- Two community dialysis treatment centers contracted by MRC: DaVita West and Renal Care of White Oak.

During this meeting, the group identified three major quality care management barriers: communication disconnects, cross-setting transition workflow gaps between providers, and the lack of standardized, evidence-based documentation across providers. With these barriers identified, group members were able to quickly set goals to help overcome them. These goals were:

- Improve communication among providers
- Improve transitions workflow between providers


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**Table 1. Documentation Audit Results**

| Location | Documentation Indicator | Compliance Rate |
|---|---|---|
| Community Dialysis Center | Medications given during dialysis | 75% |
| Community Dialysis Center | Lab results | 75% |
| Kane MRC | Catheter site dressing location and condition | 75% |
| Community Dialysis Center | Post-dialysis weight | 62% |

**Table 2. Care Issues Audit Results**

| Location | Care Indicator | Resolution |
|---|---|---|
| Community Dialysis Center | Skin Integrity | • Dialysis centers were educated on the use of positioning devices<br>• Kane (MRC) Nursing was instructed to send positioning devices with residents to dialysis centers<br>• Dialysis centers implemented "rock & roll" along with a positioning schedule<br>• Dialysis centers will change incontinent briefs as necessary |
| Community Dialysis Center | Dignity | • Dialysis centers will provide privacy areas for changing<br>• Dialysis centers will provide individualized patient centered choices based upon patient needs |

- Minimize unnecessary readmissions for ESRD patients
- Improve the effectiveness and consistency of documentation across providers
- Create a cross-setting Dialysis Communication Form

Peggy Wetzel, RN, Deputy Director of John J. Kane Regional Centers (Kane) reported that the four Kane long-term and skilled nursing care facilities had developed a Dialysis Communication Form in 2007 that was used by Kane and its dialysis treatment centers. This form was sent from Kane to the dialysis treatment center and then back to Kane with the patient's individual medical binder. After reviewing this form, the ESRD workgroup decided to enhance this existing form rather than start from scratch, as the existing form had many of the basic elements determined to be necessary for clear, patient-centered communication. These elements included essential assessment information, such as the presence of a bruit and thrill, a vascular access plan if a catheter was in place, and the need to include a complete medication list rather than just changes or new orders.

Based on the decision to enhance the existing form, the group formed MRC Kane sub-workgroup to create a form that met standards of care for patients. UPMC McKeesport Hospital developed a second subgroup to ensure that pertinent information regarding complications and treatment changes was being effectively communicated to other facilities and providers.

## Subgroup Activity And Feedback

While the Dialysis Communication Form was being reviewed and enhanced, the MRC Kane subgroup conducted an audit of existing documentation, patient care issues, and process effectiveness for both itself and the two contracted dialysis treatment centers. This audit was designed to review both documentation compliance and care issues and their resolutions. The results of the audits are shown in **Tables 1 and 2**.

Once the results of the documentation and care audits were tabulated, the MRC workgroup leadership visited the participating community dialysis treatment centers to share the audit results and determine how to improve staff sharing and education between the dialysis treatment center and nursing homes.

## Testing The Enhanced Dialysis Communication Form

An eight-week pilot was launched with MRC and one of the community dialysis treatment centers on July 19, 2010, to test the newly created cross-setting Dialysis Communication Form. The pilot included ongoing monitoring and evaluation with additional audits scheduled for three and eight weeks to evaluate effectiveness, indicators, processes, and the need for modifica-

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tion of the form. Results of the pilot showed that staff were adjusting to the use of the form and found it valuable. Staff agreed it should become a permanent component of clinical practice.

## Keys To Collaboration Success

Throughout this project, the QIO found that a key to the success of the ESRD workgroup was participant sharing. ESRD Network 4 participants updated all workgroup members on the most current standards in the management of the ESRD patient. They learned that providers were not completely aware of the cross-setting needs of their patients nor the patient specific information required for safe, dignified, efficient care. As a result, the members of the workgroup were able to recognize gaps in care and determine strategies to overcome these issues collaboratively.

Through the experience with this project, the QIO discovered several keys to successful collaboration in a cross-setting quality improvement effort:

- Robust facilitation
- Early involvement of the right people
- Defined workgroup responsibilities
- A defined product development process
- Effective collaboration technology – conference calls, e-mails, etc.
- Engagement of front-line staff
- Open discussion of opportunities/barriers
- Weekly data collection and documentation of progress
- Ongoing monitoring, support, and communication

## Practice Implications

The Dialysis Communication Form is not only a useful way to record pertinent patient information, but also has been designed to serve as a legal document to be placed on the patient's chart. As such, both the sender of the information and the receiver are required to sign and date entries on the form.

## Transparency And Spread

This ESRD workgroup's collaboration was the topic of the September 28, 2010, Care Transitions Project quarterly learning session. During the session, Peggy Wetzel, RN, Deputy Director of John J. Kane Regional Centers, stated, "By working together, the group has found the power of communication and the difference it can make in quality of life for the patient and resident in transition." She elaborated, "[We] witnessed this with collaboration that has led to the enhancement of the form and the sharing of knowledge."

Doris Gaudy, RN, MSN, Director of Patient Services, UPMC McKeesport Hospital, noted that "being involved in the Care Transitions Project and participating in this collaborative workgroup has motivated me to think differently about how we move patients across care settings." Typically, Doris explained, the hospital staff:

"… had assumed they knew what information was needed by the next care provider to transition care for a patient. However, they have learned that their assumptions were short sighted, and that building a process for effective flow of information is accomplished only when the care providers involved design the process together."

The acute dialysis unit manager at UPMC McKeesport Hospital, Jill Molinaro, RN, explained that frequent and prolonged hospitalizations can result in significant changes in the medical and functional status of ESRD patients. Thus, "pertinent information regarding patient complications and treatment changes must be effectively and efficiently communicated to other facilities and providers to achieve optimal outcomes." The transferring hospital dialysis nurse completes the Dialysis Communication Form and faxes it to the community dialysis center. If the patient is readmitted, the community dialysis center faxes the form back to the hospital dialysis unit. She also noted that even though the social service department was not a part of the workgroup, information was solicited from them regarding the form as they were a critical component of the process.

## Lessons Learned

Cross-setting collaboration is not easy. It takes a shared vision, time, flexibility, and commitment to the targeted outcome. The lessons learned from this collaborative experience can benefit any provider or stakeholder that may be considering this type of patient-centered intervention. Ongoing education and communication is essential to effective collaboration across settings and with community partners. It is important for participants to have a voice in development of new tools for cross-setting communication and be able to provide their own perspective on the essential elements of ESRD patient quality care.

Finally, we must emphasize that it also takes a champion to drive this process, ensure that the collaboration does not get stalled, and that work commitments are kept. In this project the QIO was able to serve in this role. We achieved collaboration among members of our community – now the challenge is to maintain the momentum for expansion and sustainability. We are confident this can occur as this partnership continues to broaden its scope of influence. **RR**

1. Jencks, S., Williams, M., & Coleman, E (2009). Rehospitalizations among patients in the Medicare Fee-for-Service program. The New England journal of Medicine, 360: 1418-1428.

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**DIALYSIS COMMUNICATION FORM**

GLEN HAZEL ❑ McKEESPORT ❑ ROSS ❑ SCOTT ❑

**ADDRESSOGRAPH** PHONE NUMBER: ____________________

**TO BE COMPLETED BY NURSING HOME**

Vital Signs:

Pre: T ______ P______ R ______ BP ______

Post: T ______ P______ R ______ BP ______

Vascular Access: (circle) Fistula/Graft Cath. Site ____________________

Cath. site: Dressing dry & intact: Yes No N/A Caps on: Yes No N/A

Fistula/Graft: Bruit/Thrill present: Y N N/A

**ACUTE PROBLEMS SINCE LAST APPOINTMENT:** (i.e., falls, skin tear, infections or significant incident)

____________________

____________________

**NEW ORDERS/MEDICATION CHANGES:** ____________________ NO ____________________

YES (If yes, list below) Full Medication list attached Y N

____________________

____________________

**DIETARY CONCERNS:** ____________________ NO YES (if yes, describe in detail)

____________________

____________________

**SIGNIFICANT SOCIAL CHANGES:** (i.e., death of family member/roommate, request to withdraw from treatment, transportation issues)

____________________

**Physician ordered laboratory tests requested to be done during dialysis:** Other Comments: (Care Issues: i.e. Incontinence, Pressure Ulcers, Infections, Confusion, etc.)

____________________

**NURSE PRINT NAME**____________________ **SIGN SIGNATURE** ____________________ **DATE** ____________

**TO BE COMPLETED BY DIALYSIS UNIT**

**DIALYSIS TREATMENT:**

Pre-Weight: ____________Kg Pre-BP ____________ Temp: _________

Post-Weight: ____________Kg Pre-BP ____________ Temp: _________

**Fistula/Graft:** Bruit/Thrill present: Y N N/A

Bleeding time: ____________

**Cath. site: Dressing dry & intact:** Yes No N/A **Caps on:** Yes No N/A **Date Inserted:** ____________________

**If Cath.: Vascular Access Plan:** Y N Unknown

Vessel mapping/Date: _____________ Surgeon appt. Y N Surgery date ______________ Cath. removal ____________

**Comment:** (Specifically about fever, chills, hypertension, excessive weakness, prolonged bleeding from needle sites, unusual complications or occurrences)

____________________

**MEDICATIONS GIVEN DURING DIALYSIS:**

____________________

**Procedural/Changes:** (i.e., dialysis duration, change target weight, medication, diet)

____________________

**RECOMMENDATIONS FOR FOLLOW-UP:** Y N

____________________

Labs: Y N DATE and LAB tests done: ____________________ ATTACH COPIES OF LAB RESULTS

**SIGNATURE**____________________ **DATE** ____________________

**TITLE** ____________________ **PHONE NUMBER AND EXTENSION** ____________________



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