Improving Transitions of Care for Kidney Patients

Consumer Committee Comments

Post-workgroup evaluation

October 6, 2017

Presentations this morning focused on optimizing transitions of care for ESRD patients. Communication to patients and between settings is essential for a successful process. The setting may include admissions and discharge from a hospital to a dialysis facility or a skilled nursing facility.

- **Based on the presentations this am and your own experiences, please discuss issues such as**
- **Communication from setting to patient**
- **Communication from patient to setting**
- **Medication reconciliation**
- **Admission and discharge instructions**
- **Patient and family education.**

What is currently successful, what process does not exist or could be improved upon and are there any tools that could be developed for patient use to assist with communication to hospital or other settings.

What is working?

- Some staff are good at training and encouraging
- Using portals of transplant centers and health systems
- Educational patient trained support groups/ peer mentors (role models)
- Educational games/ challenges
- Portals are good
- Stop card if available (needs to be on the MKN website)
- People are given written discharge info
- Pharmacist coming to dialysis unit

What needs improvement?

- More communication with nephrologists
- Communication between nephrologist and surgeon
- People in the ED and Hospitals don't let dialysis unit know when I am admitted
- Keep ESRD pts in hospital patients longer at start of dialysis for education and adjustment
- Going to the ED= long waits, they are "scared of me"
- Access to dialysis unit labs and medications
- Need "teach back" for discharge instructions
- Hand washing/ washing access arms- needs to be more monitored
- VA coordination for meds- drug interaction
- Encouragement of patients to bring support person(s)
- Better education re: portal usage
- Stop card usage and postings not always done

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- Communication between facilities, MDs
- More direct communication via phone calls if portal is not compatible

What needs to be developed? (Process or tools)

- Revisit: STOP card wallet size- Put on MKN website
- Solicit permission for pts to release information/ discharge summary to dialysis unit. View only stipulation.
- Solicit permission from pts to release/ choose to whom they want into released to (on discharge/ or at admission
- Patient assisted option classes by patient for patient arranged by MSW or nurse practitioner.
- Procedure or point person to let dialysis unit know status
- Opening up dialysis unit for people being discharged
- Training/ education at the front end- to be an advocate
- Standards for patient training for transplant
- Portals for dialysis information for patients
- Lay persons terms vs. medical terms= careful listening to individuals
- Home dialysis- Patient and family education- “care partner” like in transplant workup
- Could be peer mentor or “buddy”, plant the seed for pt. to think about someone
- Monitoring Skilled nursing facilities for readmissions need more information or who is being readmitted.
- Readmission- more education, discharging too soon???