Reducing Hospitalizations and Emergency Department Visits: Resource Toolkit

End-stage renal disease patients experience higher rates of hospitalization, readmission, and emergency department utilization compared to the general public, all of which are associated with significant morbidity, mortality, and economic impacts. Health deficits impacting health care utilization are related to underlying health conditions, as well as patient behaviors and social determinants of health. Additionally, there may be facility and system barriers impacting hospital utilization. The listed barriers in the left column may be impacted through the associated interventions, tools, and resources to support a reduction in hospitalizations, readmissions, and emergency department visits.

May 2025 – April 2026 Goals

- **Achieve a 15% decrease in inpatient hospital admissions**
- **Achieve a 15% decrease in outpatient emergency department visits**

Barriers	Interventions	Tools & Resources
Staff Oriented	1. Track and trend hospitalizations and emergency department visits. 2. Complete root cause analysis on hospitalizations, readmissions, and emergency department visits and review at monthly quality meeting. 3. Track post-hospitalization follow-up appointments – assist patients with reminders and education.	1. MKN QI Plan 2. Monthly facility specific report provided by the Network 3. Post-hospitalization checklist 4. Forum's Transitions in Care Toolkit 5. Inpatient-outpatient Communication Sheet 6. MKN Transitions in Care Assessment 7. MKN Readmission Resource List

	4. Address target weight and potassium bath on first treatment post-hospitalization. 5. Utilize a post-hospitalization checklist with patients after discharge from the hospital. 6. Complete a Transitions in Care Assessment to identify gaps in the facility processes. 7. Establish clear communication path between inpatient unit/discharge planner and outpatient dialysis unit – assess level of stability for discharge and obtain key documents, as well as complete a verbal and written hand-off report. 8. Identify "Transitions Champion(s)" or "Hospitalizations Champions" in the facility to complete necessary tasks post-discharge. 9. Develop a team culture of quality that supports reductions of hospitalization rates. Share unit rates and goals on a staff bulletin board, assess for needs in staff education, and provide educational materials/learning modules to staff.	8. ESRD NCC Hospitalization Change Package 9. Hospitalization Risk Assessment 10. How Dialysis Staff Impact Hospitalizations 11. ESRD NCC Hospital Barriers Resource 12. Sit Don't Stand Questionnaire 13. Patient Discharge Checklist English 14. Patient Discharge Checklist Spanish

	10. Screen patients to identify those at highest risk of hospitalization – complete focused and more frequent interdisciplinary rounding with these patients.	
Infection Control/Sepsis	1. Promote infection control strategies in the dialysis unit for both patients and staff – establish culture of safety 2. Recognize sepsis early and intervene early – screen and refer as indicated. Consider screening high risk patients every treatment. 3. Complete root cause on infections, track and trend organisms. 4. Complete an ICAR assessment at your facility to identify gaps in infection prevention processes – contact MKN to assist with scheduling. 5. Provide ongoing infection prevention education to both patients and staff.	1. MKN Sepsis Resources and Best Practices 2. MKN Sepsis Screening Tool
Patient Oriented: Utilization of emergency department	1. Track and trend cause of emergency department utilization 2. Educate patients on when to use emergency department versus urgent care versus primary care versus dialysis clinic.	1. Primary Care vs. Urgent Care vs. Emergency Department 2. Where Should You Go For Medical Care - English 3. Where Should You Go For Medical Care - Spanish

	3. Promote triaging concerns with dialysis clinic first when appropriate. 4. Develop clear plan for addressing access concerns through the dialysis clinic coordinating directly with vascular access center rather than emergency department. 5. Complete root cause on vascular access complications resulting in emergency department usage	
Patient Oriented: Adhering with dialysis treatment, diet, fluid, medications, etc.	1. Assist patient with developing goals to address area(s) of opportunity for improvement in the plan of care – utilize life plan and KDQOL. 2. Weekly interdisciplinary team meeting/staff huddle to review missed treatments and identify root cause/interventions. 3. Reschedule missed treatments routinely and proactively. Develop a script for staff to utilize when patient calls in to miss treatment. 4. Provide ongoing, tailored education to patients on fluid management. 5. Screen for social determinants of health needs – see next section.	1. "I Can Do It" goal setting worksheet 2. Goal Setting Workbook 3. Missing Treatment Domino – English 4. Missing Treatment Domino - Spanish 5. 10 Steps to Avoid Unnecessary Hospitalization, English and Spanish Version 6. Fluid Management Flyer, English and Spanish Versions 7. Fluid Management Workbook, English and Spanish Versions 8. Your Fluid Intake Matters, English and Spanish Versions

Patient Oriented: Social Determinants of Health	1. Develop toolkit of local resources/organizations that address housing and food assistance, etc. and promote those resources based on findings of SDOH screening tool 2. Provide local transportation service information to patients. 3. Provide prescription assistance resources to patients. 4. Provide information on local support groups. 5. Screen patients for social needs upon admission, annually with care conference, post-hospitalization, or when meeting unstable patient criteria.	1. Guide to Screening for Social Determinants of Health 2. Social Needs Screening Tool 3. Neighborhood Navigator: https://navigator.aafp.org/
Patient Oriented: Mental Health – Depression	1. Screen for depression after hospitalization and emergency department visit. 2. Encourage follow-up with mental health as applicable and help promote referrals to mental health.	1. PHQ-9 2. Staff resource: Understanding Mental Health Myths and Facts
Patient Oriented: Comorbid Conditions	1. Promote establishing and following with a primary care provider. Assist with setting up appointments as needed for patients. 2. Have the unit champion create a communication pathway with local clinics – know which providers are	1. Medical Appointment Tracker 2. 10 Steps to Avoid Unnecessary Hospitalizations – English and Spanish Versions 3. Engage Your Care Team, English and Spanish Versions

	accepting new patients for primary care. 3. Promote follow-up with specialty providers as indicated (for example wound clinic, diabetes center, cardiology, etc.).	
Patient Oriented: Immunizations	1. Promote recommended vaccinations including influenza and pneumococcal pneumonia. 2. Track and trend respiratory illness. 3. Follow current CDC guidelines for infection mitigation strategies. 4. Provide vaccinations onsite or establish clear referral process for off-site vaccination and subsequent tracking. 5. Complete routine immunization reconciliation with patients to ensure doses received off-site are recorded in the medical record and NHSN and/or EQRS. 6. Routinely compare vaccination rates in Network facility report compared to internal tracking to ensure data integrity.	1. Forum's Vaccination Toolkit 2. Vaccination Change Package 3. You Call the Shots web-based training modules for clinicians for various vaccines – CEUs available 4. Managing Patient Pneumococcal Pneumonia Status 5. Vaccine Clinic Checklist