Reducing Hospitalizations, Readmissions, and Emergency Department Visits 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. The listed barriers will be addressed through the associated interventions, tools, and resources to support a reduction in hospitalizations, readmissions, and emergency department visits.

May 2022 – April 2023 Goals

- **Achieve a 5% decrease in hospital admissions from the base period (June 2020 – April 2021) through April 2023.**
- **Achieve a 5% decrease in hospital 30-day unplanned readmissions from the base period through April 2023.**
- **Achieve a 5% decrease in outpatient emergency department visits from the base period through April 2023.**

Barriers	Interventions	Tools & Resources
Compliance with dialysis treatment, diet, fluid, medications	1. Assist patient with developing goals to address one area of plan of care compliance 2. Weekly interdisciplinary team meeting/staff huddle to review missed treatments and identify root cause/interventions 3. Reschedule missed treatments	1. "I Can Do It" goal setting worksheet 2. Goal Workbook 3. 10 Steps You Can Take 4. RCA tool
COVID-19/Immunizations	1. Promote COVID-19 vaccination and additional doses, and other recommended vaccines including influenza and pneumonia 2. Track and trend COVID-19 cases	1. Forum Vaccination Toolkit 2. KCER and Network COVID Screening Fatigue Tools: Putting the Pieces Together

	3. Follow current CDC guidelines for mitigation strategies 4. Utilize strategies to combat COVID-19 screening fatigue 5. Provide vaccinations onsite or establish clear referral process for off-site vaccination and subsequent tracking	3. COVID Booster Vaccination Patient Infographics 4. Be A Superhero 5. Up to date CDC Guidelines for COVID Infection Control
Facility processes	1. Track and trend hospitalizations and readmissions 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 4. Address target weight and potassium bath on first treatment post-hospitalization 5. Utilize post-hospitalization checklist 6. Utilize Transitions of Care Toolkit to identify opportunities for improvement in post-hospitalization processes 7. Establish clear communication path between inpatient unit/discharge planner and outpatient unit – assess level of	1. RCA Tool 2. Monthly facility specific report provided by the Network 3. Post-hospitalization checklist 4. Forum Transitions of Care Toolkit 5. Inpatient-outpatient Communication Sheet 6. Hospitalization Change Package

	stability for discharge and obtain key documents	
Appropriate use 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 3. Promote triaging concerns with dialysis clinic 4. Develop clear plan for addressing access concerns through the dialysis clinic coordinating directly with vascular access center rather than emergency department	1. RCA tool 2. Monthly facility specific report provided by the Network 3. Primary Care vs. Urgent Care vs. Emergency Department
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, and post-hospitalization.	1. CMS Guide to Reducing Disparities in Readmissions 2. Screening for Social Determinants of Health 3. Social Needs Screening Tool

Mental Health – Depression	1. Screen for depression after hospitalization and emergency department visit	1. PHQ-9
Infection Control/Sepsis	1. Promote infection control strategies in the dialysis unit for both patients and staff	1. Project Firstline Resources 2. CDC Dialysis Infection Prevention Tools 3. Infection Control Webinar for Michigan Dialysis Facilities
Comorbid Conditions	1. Promote establishing and following with a primary care provider 2. Promote follow-up with specialty providers as indicated (for example wound clinic, diabetes center, cardiology, etc.).	1. Medical Appointment Tracker 2. 10 Steps You Can Take