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. 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 2023 – April 2024 Goals

- **Achieve a 4% decrease in hospital inpatient admissions**
- **Achieve a 4% decrease in hospital 30-day unplanned readmissions**
- **Achieve a 4% decrease in outpatient emergency department visits**

Barriers	Interventions	Tools & Resources
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 – assist patients with reminders and education	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. Transitions in Care Assessment 7. Readmission Resource List 8. Hospitalization Change Package

	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 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)" to complete necessary post-hospitalization tasks	
Immunizations	1. Promote COVID-19 vaccination and additional doses, and other recommended vaccines including influenza and pneumonia 2. Track and trend COVID-19, influenza, and pneumonia cases 3. Follow current CDC guidelines for infection mitigation strategies	1. Forum Vaccination Toolkit 2. Change Package to Increase Vaccination 3. Up to date CDC Guidelines for COVID Infection Control 4. You Call the Shots web-based training modules for clinicians for various vaccines – CEUs available 5. Pneumococcal Vaccine Timing for Adults

	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 6. Routinely compare vaccination rates in Network facility report compared to internal tracking to ensure data integrity in NHSN reporting	
Potentially preventable emergency department usage	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 4. Where Should You Go For Medical Care - English 5. Where Should You Go For Medical Care - Spanish

	5. Complete root cause on vascular access complications resulting in emergency department usage	
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 4. Screen for social determinants of health needs – see next section	1. "I Can Do It" goal setting worksheet 2. Goal Workbook 3. 10 Steps You Can Take 5. RCA tool 6. Guide to a Healthier You - English 7. Guide to a Healthier You - Spanish 8. ESRD NCC Patient Education
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 – establish culture of safety 2. Recognize sepsis early and intervene early – screen and refer as indicated 3. Complete root cause on infections	1. Sepsis Resources
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