

PATIENT SAFETY AND TRANSITIONS

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Transitions of Care – Realization: It can happen here

- ▶ Patient Care Event:
 - patient returned from brief hospitalization at hospital NOT affiliated with doctors at HD facility
 - NO information regarding hospital stay
 - NO Discharge data available
- ▶ Patient stated “everything was fine”

Transitions of Care – Patient event

- ▶ Target weight remained unchanged
- ▶ Pre-Dialysis evaluation-B/P, HR, Temperature all at usual baseline, pre treatment assessment complete, stable, appropriately charted
- ▶ Dialysis began as usual
- ▶ Developed significant hypotensive episode on dialysis
- ▶ Responded to treatment without sequela

Transitions of Care

- ▶ QAPI committee reviewed event with Mini-root cause approach: what, why, how to prevent future episode
- ▶ Areas evaluated:
 - staffing: number available, training
 - dialysis equipment: accuracy of UF rate
 - dialysis set up: membrane, dialysis bath
 - water treatment/RO
 - policies: existence and implementation
 - patient factors: changes in estimated weight, clinical changes, medication changes

Transitions of Care

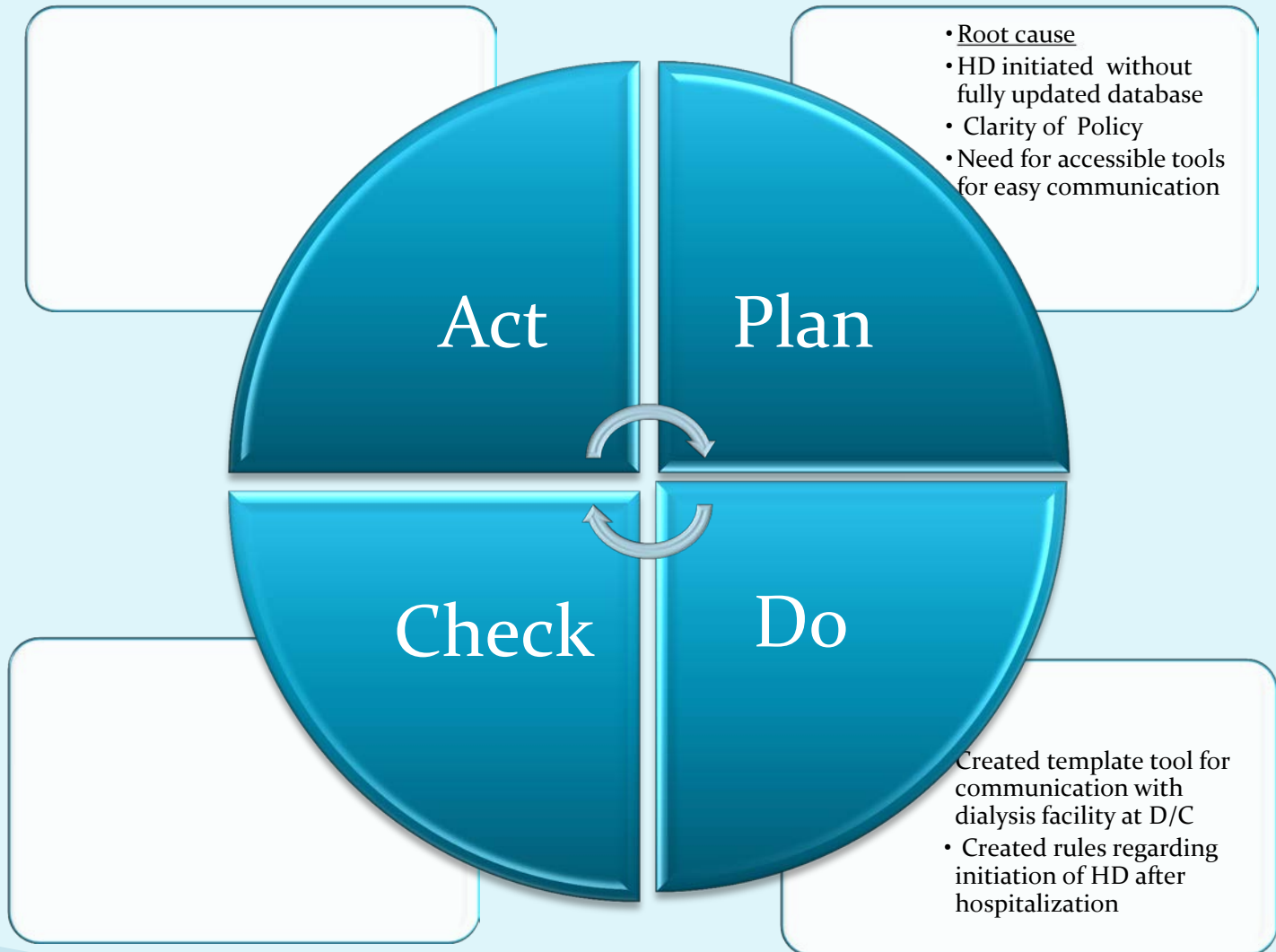
Root cause evaluation

- ▶ Discharge summary obtained from other hospital
(first needed to find correct hospital)
- ▶ Patient was admitted for episode of chest pain
 - Cardiac cath was done- non-obstructive disease
 - Medications changed- ACEi increased
 - Beta Blockers added
- ▶ Patient took all medications the morning of dialysis

Transitions of Care



Transitions of Care



Transitions of Care Communication Tool

HOSPITAL DISCHARGE REPORT

Patient: _____

Home Clinic: _____

Date(s) of hospitalization: _____

Date of discharge: _____

Admission Diagnosis: _____

Discharge Diagnosis if other than admission: _____

Hospital Course: _____

Procedures: _____

Hemodialysis Prescription (CHANGES): _____ dialyzer _____ EDW
_____ tx time _____ BFR _____ DFR
_____ heparin bolus _____ heparin hourly

Discharge Labs: _____ K+ _____ Na+ _____ Hbg _____ Hct _____ Fe _____ %Sat

If new patient, date of hepatitis profile _____

Results: HBsAg _____ HBsAb _____ HCVAB _____

Discharge Medications, including erythropoietin therapy: _____

Signature: _____

Date: _____

Transitions of Care

Tracking Tools

- ▶ Spread sheet with
 - Patient
 - Site of hospitalization
 - LOS
 - Diagnosis
 - Significant Events/ New Diagnoses
 - Change in Dialysis prescription
 - Change in medications/ antibiotics
 - New follow up required

Transitions of Care - Opportunities

12/01/11 – 7/31/12

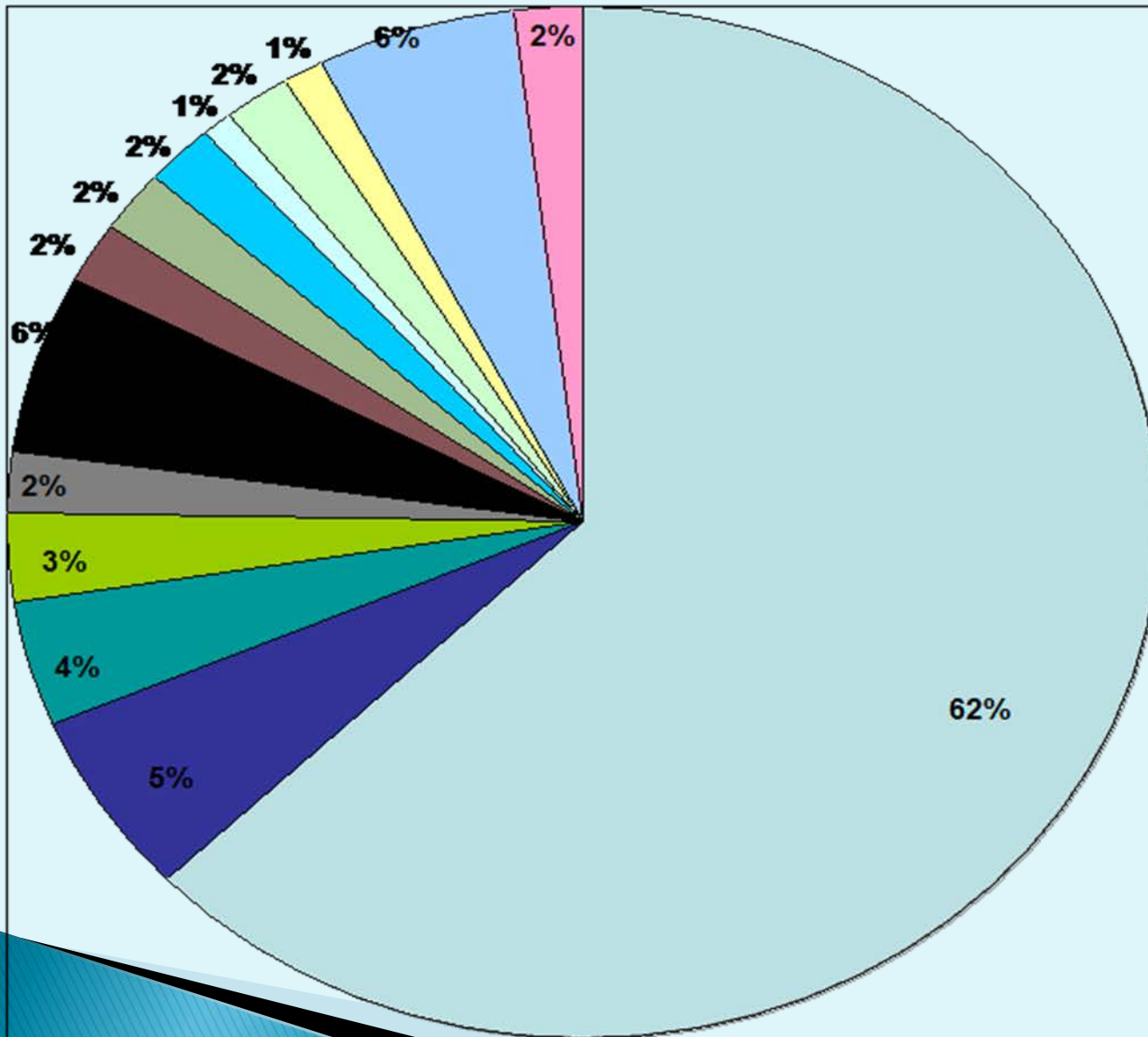
Patients hospitalized	57
Hospitalizations 7 patients accounted for 43 stays (3 pts accounted for 25 stays 9/9/7) (4 pts accounted for 18 stays 5/5/4/4)	106
Number of Patients with more than one admission	13

Transitions of Care - Opportunities

12/01/11 – 7/31/12

Number of care sites (4 pts were in 3 different sites) (3 pts were in 2 different sites)	15
Number of different providers involved in care	Over 100
Average age of patients admitted	65.17 years

Sites of admissions:



62% admitted to one hospital

38% distributed among 14 other sites.

Transitions of Care - Opportunities

12/01/11 – 7/31/12

Patients with transition data available	92%
Admissions with transition data available	81%
Data unavailable due to death or transfer (SNF, moved etc)	7% (4/57)

Transitions of Care - Opportunities

12/01/11 – 7/31/12

Average LOS	7.67 days
number of stays 1-2 days	31 (six were directly related to ESRD issues – primarily access related)
Number of stays 3-5	21
Number of stays 6-10	28
Number of stays 11-19	15
Number of stays over 20 days	11

Transitions of Care – (missed opportunities)

12/01/11 – 7/31/12

Of admissions without readily available transition data	77% were admitted to regional hospitals (not main teaching hospital near dialysis facility)
LOS 1-2 days	36%
LOS 3-5 days	27%
Of admissions to main teaching hospital	1 patient was observational stay 2 patients were on surgery service

Transitions of Care

12/01/11 – 7/31/12 significant events

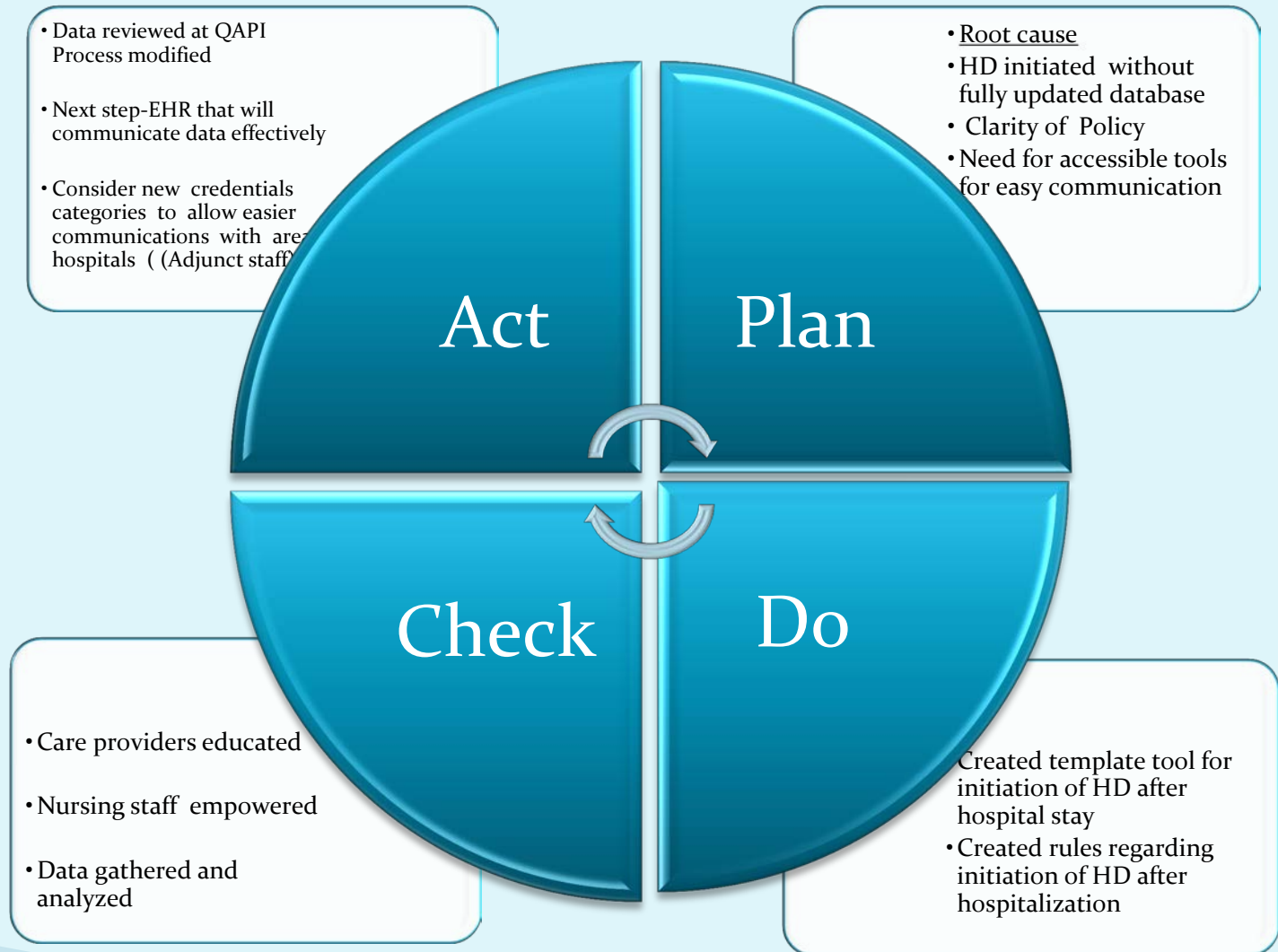
Admissions requiring continued antibiotics as outpatient	34%
Patients requiring changes in blood pressure medications	17.5%
Patients with changes in dialysis prescription /EDW/ diet	28%
New diagnoses	4 (malignancies) 4 Cardiac caths/stents 2 new atrial fibrillation 2 new significant PVD
Significant changes in medications	prednisone/warfarin/psychiatric medications/ diabetic therapy

Transitions of Care

12/01/11 – 7/31/12 significant events

Admissions with new referrals for follow up after discharge	37% (1-3/patient)
Number of different referral services requested at discharge	16 specialties and subspecialties
Burden of Chronic disease	Co-morbid conditions: (4-8)

Transitions of Care



Transitions of Care - Hospitalization tracking tool

Dates	Place / Type	Principal Diagnosis	Outcome	Practitioner \ Institution	Specialty	Diagnosis and Procedures		
						Code	Date	Description
06/08/12 - 06/10/12	Hospital Admitted to Inpatient Care	799.02	Discharge to Home	<input type="text"/>		799.02	06/08/12	+ Hypoxemia Prelim. Diagnosis: AVG placement

Patient Name <input type="text"/>								
Dates	Place / Type	Principal Diagnosis	Outcome	Practitioner \ Institution	Specialty	Diagnosis and Procedures		
						Code	Date	Description
05/14/12 - 05/26/12	Hospital Admitted to Inpatient Care	486	Discharge to Home	<input type="text"/>		486	05/14/12	+ PNEUMONIA, ORGANISM UNSPECIFIED Prelim. Diagnosis: dyspnea

Transitions – Summary and conclusions

- ▶ Very active population- with enormous numbers of transition opportunities and risk
- ▶ Transition tools and hospital admission tracking tools are extremely valuable
- ▶ Novel medical staff appointments (e.g. Adjunct staff, voluntary teaching, etc.) have proved helpful
- ▶ Once key participating centers are identified, specific approaches should be developed to improve communications between those hospitals and the facility.

Transitions – Summary and conclusions

- LOS data suggest that SOME but NOT MAJORITY of the admissions (and readmissions) may be preventable
- Most patients with multiple admissions have very high disease burden. Judging from LOS , in many cases concept that they should (or could) be “kept out of hospital” may be misguided.
- The renal community has a responsibility to both identify and control “unnecessary” admissions and to appropriately direct needed resources to and “defend” those admissions that are clearly required