Barriers to Care ?

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Our Experience to Decreasing the Barriers in Peoria, Il

- Background – 2010 large Hospital changed process for delivery of Medical records
- After thought was the ESRD patients
- New Process to send electronic records to primary nephrologist
- How to get the records to the Dialysis Center

Our Experience with 1 Hospital

- Can the hospital give access to the Hospitals EMR?
- Will the Company allow IT download for access to outside Emr systems
- One signed agreement for all clinics completed.
- Setting up access and training.

The Electronic Health Care Records

- In our area we work with 6 primary hospitals. Each with their own unique system of a EMR.
- Acute Services access to the OP records
- The OP clinics access to the Hospital records
- With access to one hospital system the Clinics can continually track and monitor their patients while hospitalized.

Without access to the Electronic Health Care Records

- Where is your patient ?
- What is the process to track your patients ?
- Finding what hospital they are at
  - Charge nurse calls each hospital daily for the no shows
- Who do you call once you find them ?
  - Floor nurse - Discharge Planner - Nephrologist
  - SW - Patient Care Facilitator?

Opportunities for the ESRD Pt

- Developing teams with the hospital and the Dialysis Clinics.
- Team 1 – Decreasing Readmissions
- Team 2 – Decreasing Dialysis on the Day of Discharge

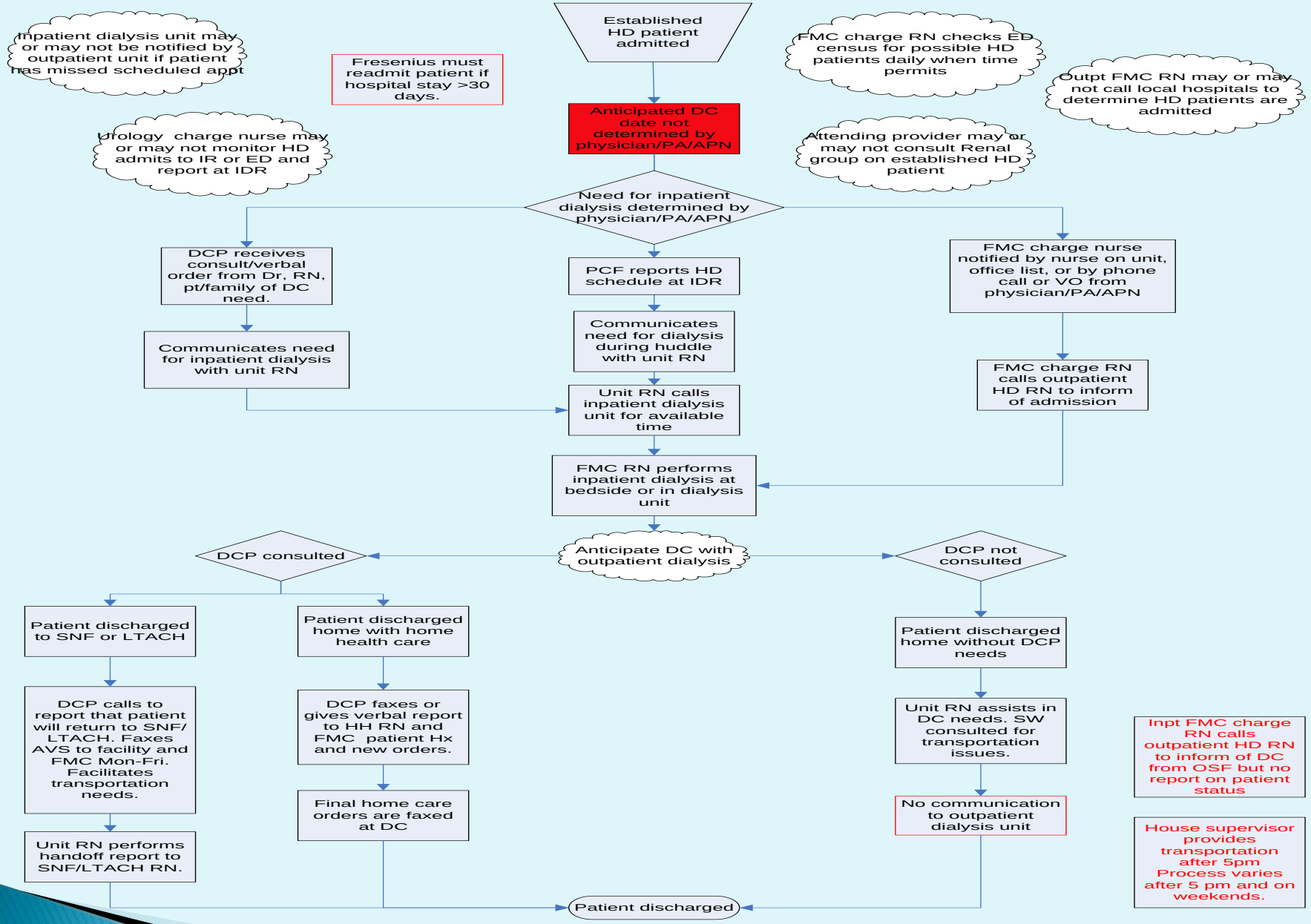
Care Transitions Team

- Initial Training for all team members in basic Six Sigma
- Team members from the Hospital – Hospitalist, Case managers, Patient care facilitators.
- Team Members from the Clinics – Social Worker, Clinic Manager, Acute Services Manager and Director of operations.
- AND the NEPHROLOGIST

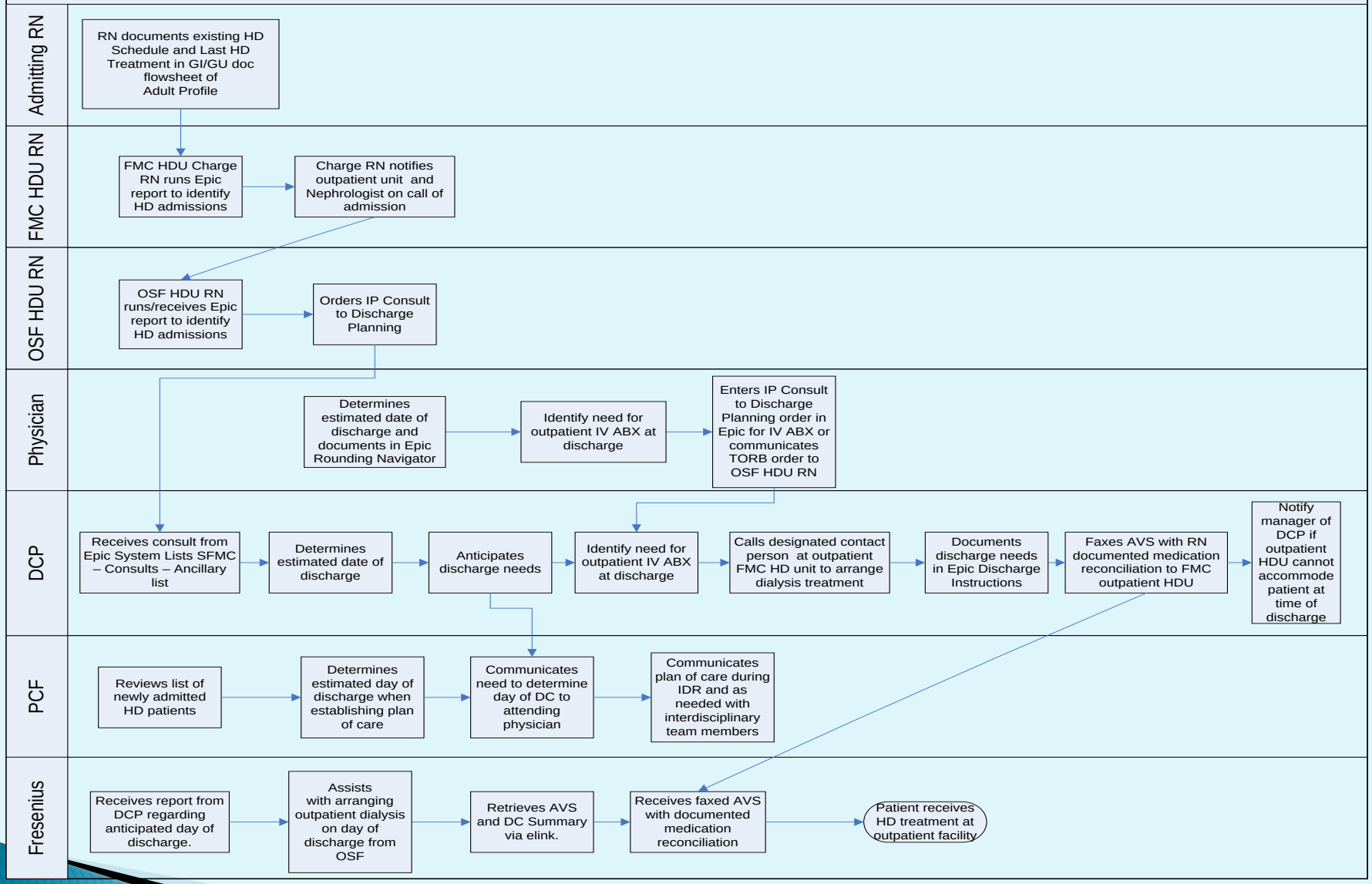
POTENTIAL ROOT CAUSES	VALIDATION TEST METHOD	FINDINGS FROM TEST	CONCLUSION ROOT CAUSE Y/N?	PORTION OF PROBLEM
Inconsistent process of identifying established dialysis patient is admitted and will need dialysis.	Inpatient HDU charge RN collected data for 30 patients that required inpatient dialysis, specifically tracking date of admission to notification of dialysis need.	• Multiple point of entry to the hospital with the most of admissions on 2400 which is 47%. • 53% admitted throughout hospital. • 69% of the patients notified HDU on day of admission, 23% on the next day. • 42% had inpatient dialysis performed within 2 days of DC.	Yes	
DCP not consulted for every dialysis patient.	Process knowledge indicated that DCP only see established dialysis patients when consulted. DCP consults assessed for three days	• 2400 – 1 • 2700 – 4 • 5000 – 4	Yes	
Estimated date of DC not established.	Data for three units analyzed 6/16/10	• 2400 – 0 of 22 patients • 5000 – 6% • AHS – 15%	Yes	

Summary of Admissions

- 90% of the notification were verbal or Telephone orders
- 23% were dialyzed on day of admission
- 60% of attending physicians were not Nephrologists
- 33% had same nephrologist for IP and OP care
- 56% had IP dialysis performed within 1 day of DC


Established HD patient admitted
Inpatient dialysis unit may or may not be notified by outpatient unit if patient has missed scheduled appt
Fresenius must readmit patient if hospital stay >30 days.
FMC charge RN checks ED census for possible HD patients daily when time permits
Outpt FMC RN may or may not call local hospitals to determine HD patients are admitted
Urology charge nurse may or may not monitor HD admits to IR or ED and report at IDR
Anticipated DC date not determined by physician/PA/APN
Attending provider may or may not consult Renal group on established HD patient
Need for inpatient dialysis determined by physician/PA/APN
DCP receives consult/verbal order from Dr, RN, pt/family of DC need.
PCF reports HD schedule at IDR
FMC charge nurse notified by nurse on unit, office list, or by phone call or VO from physician/PA/APN
Communicates need for inpatient dialysis with unit RN
Communicates need for dialysis during huddle with unit RN
FMC charge RN calls outpatient HD RN to inform of admission
Unit RN calls inpatient dialysis unit for available time
FMC RN performs inpatient dialysis at bedside or in dialysis unit
DCP consulted
Anticipate DC with outpatient dialysis
DCP not consulted
Patient discharged to SNF or LTACH
Patient discharged home with home health care
Patient discharged home without DCP needs
DCP calls to report that patient will return to SNF/ LTACH. Faxes AVS to facility and FMC Mon-Fri. Facilitates transportation needs.
DCP faxes or gives verbal report to HH RN and FMC patient Hx and new orders.
Unit RN assists in DC needs. SW consulted for transportation issues.
Unit RN performs handoff report to SNF/LTACH RN.
Final home care orders are faxed at DC
No communication to outpatient dialysis unit
Inpt FMC charge RN calls outpatient HD RN to inform of DC from OSF but no report on patient status
House supervisor provides transportation after 5pm Process varies after 5 pm and on weekends.
Patient discharged

New Discharge Planning Process for Established HD Patients



How are we doing ?

Not so well ☹

Our Next Step

Refocusing our efforts to developing a specific person who can own the process and work with the team to move the pt from the hospital to the Clinic..

Focus in 2012

1. Continue to decrease dialysis on the day of discharge.
2. Work through the patients who are frequent flyers. – Develop a relationship to connect with the pt.
3. Look at providing HD treatment at OP clinic near the hospital. Make it as easy as possible for all.
4. Continue ongoing relationship with Hospital for improvement opportunities