



End-Stage Renal Disease  
Network Program

# Community Coalition High Performers PDSA Cycle

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# High Performers

## Community Coalition



- High performers throughout the Community Coalition have shared their RCA/PDSA Cycle success
- The Network would like to showcase these facilities and their continuous efforts to decrease acute incidents
- The following examples were compiled to provide guidance and examples as you work through your PDSA cycle



# Unplanned Readmissions

## DaVita Comprehensive Renal Care



Root Cause	Plan	Do	Study
Frequent readmissions	Incorporate the Registered Nurse (RN) in post-discharge follow-up appointments required.	All RNs have access to hospital records to ensure medications are up to date after hospitalizations, follow-up appointments are needed and RN made reminders for patients of post-discharge follow-up appointments, at times assisting in scheduling the appointments for the patient.	In making appointments we found it helpful to the patients that were unable/uncertain who to call to schedule. Provided patients with reminders of upcoming appointments. DaVita now offers a coordinator and RN to assist staff in making appointments for patients and checking in with patients' post-discharge.
Outcomes/ACT			
We decreased from 70% readmissions last year to currently 25%.			

# In-Patient Hospitalizations

## DaVita Hartford Dialysis



Root Cause	Plan	Do	Study
Patients' are non-complaint with fluid and diet restrictions	Improve education approaches and workflows and involve the patients support system	IDT educated patients and included Pt's support system including family, friends and caretakers. Educators included SW, RD, RNs and MDs. IDT made agreement with patients to come in on additional treatments to remove excess fluid gains. Patients were also provided with educational paperwork in multiple languages regarding fluid and diet restrictions and impacts of non-compliance. IDT continue to monitor fluid levels/IDWG between treatments	IDT monitored fluid gains and diet compliance by monitoring labs and IDWG. IDT observed hospitalizations and reasonings behind admissions and whether they were d/t fluid/diet compliance or for other identified reasons.
Outcomes/ACT			
Receiving additional treatments and increased education resulted in decreased hospitalizations relating to fluid/diet compliance. It was found that patients were willing to monitor when being supervised; however, patients would become increasingly more comfortable, and the cycle would start anew.			

# In-Patient Hospitalizations

## Fresenius Medical Care of Lebanon



Root Cause	Plan	Do	Study
Patient's noncompliance with fluid management and/or missed treatments contributed to frequent hospitalizations and ER visits.	Our 'Plan' was to begin passing out 'Fluid Report Cards', utilize clinical quality marketing materials in the patient lobby to reinforce education, re-educate our DPC staff, and offer chairs for sequential treatments and missed treatment make-ups.	RD and FA passed out fluid report cards and monthly education to all incenter hemodialysis patients. AA created educational bulletin boards in the lobby for patients to access additional information/materials. We began utilizing 'Tech Talks' in our clinic with educational talking points for our CCHTs to reinforce missed treatment and fluid management education with our patients. FA revised the patient schedule to allow for designated UF and missed treatment chairs. RNs and PCTs were given phone scripts to utilize when patients would call out of treatment. MSW collaborated with DPC staff to review missed treatments, identify barriers, and provide support to patients in order to have greater access to treatment.	Our 'Study' was comprised of reviewing our clinical quality score and quality metrics during our monthly quality improvement meetings.
Outcomes/ACT			
We found a significant decrease in missed treatments as well as patients in fluid action groups. This correlated with our decreased hospitalizations among incenter patients.			

# Emergency (ED/ER) Visits

## FMS-ALBANY REGIONAL KIDNEY CENTER



Root Cause	Plan	Do	Study
Patients are having to go to the ER because they miss two consecutive treatments.	The focus is on re-educating patients on missing treatments and avoiding ER visits.	Social Worker provided verbal and written education to patients regarding missed and shortened treatments and policy of need for ER evaluation after two consecutive missed treatments.	IDT will review missed and shortened treatments monthly after Social Worker provides education to patients.
Outcomes/ACT			
The clinic will see a reduction in ER visits related to missed dialysis treatments. Social workers will continue to provide verbal and written education to patients regarding missed and shortened treatments.			



# Emergency (ED/ER) Visits

## DCI EAST ALBANY



Root Cause	Plan	Do	Study
Patients that routinely miss treatment or terminate treatments early have a higher rate of ER visits and missed treatment due to hospitalizations.	Involve the entire treatment team to assist with education and identification of barriers to treatment compliance.	Distributed education to the patient population and educated staff to encourage compliance with treatment days, treatment duration, and fluid maintenance.	Review the correlation between an increase in early termination and excessive intradialytic gains and the increased percentage of missed treatment due to hospitalization.
Outcomes/ACT			
Monthly indicators show that specific populations with outliers in fluid gain, early termination, and missed treatment not due to hospitalization have a higher incidence of hospitalizations.			



# In-Patient Hospitalizations

## GREENVILLE DIALYSIS CENTER



Root Cause	Plan	Do	Study
Patients do not have a Primary Care Physicians (PCPs)	Provide information on PCPs in the local area that are accepting new patients. Encourage patients to utilize PCP's and urgent care facilities rather than the ED for non-emergent matters.	Follow up with patients following hospitalizations, ensure they are following up in an outpatient setting as directed by hospital.	Follow patients with frequent ED visits and hospitalizations. Study admission and discharge diagnosis. Determine if this could have been prevented by dialysis clinic or PCP.
Outcomes/ACT			
Patients are continuing to utilize ED rather than PCP. Others who are frequently hospitalized were for recurring health matters.			

# In-Patient Hospitalizations

## DaVita Santee Dialysis



Root Cause	Plan	Do	Study
Missed Treatments	The focus was to decrease missed treatments which in turn kept patients from needing to seek emergency medical help which ended up with hospitalization or ER visit.	The team reviewed every hospitalization or ER visit to see the correlation between missed treatment and hospitalization. The team reviewed every hospitalization to see the root cause of individual hospitalization. The team reviewed all patients missing treatment and the cause behind every missed treatment. Patients then received one on one education from FA on missed treatments including what it did to the patient. Each patient was called by the team if they did not come to treatment to offer a different chair time and to work through the issue of not coming to treatment. A game of all patients was created each month with prizes for coming to all treatments. Individual patient goals were set with each patient with recognition and a prize from the team for coming to all treatments. Processes were adopted for patients trying to call out of treatment (RN only speaks to the patient and encourages them to come to treatment with education if that did not work then the patient had to speak with FA). A process was also started post-discharge from hospitalization with a checklist of diagnoses, medicines, and appointments. The RN would follow to ensure this was completed and the patient was educated on all of the above.	Continue this for 5 months every month with each patient that is hospitalized or misses a treatment. Complete the Do with each patient.
Outcomes/ACT			
If hospitalizations and ER visits decrease in the patients then complete the process with each patient that misses a treatment, has hospitalization or ER visit. If steps or intervention of the Do does not decrease, then look for missed steps of the Action plan.			



# In-Patient Hospitalizations

## FMC - SOUTH PADUCAH



Root Cause	Plan	Do	Study
<p>The root cause for hospital readmissions was:</p> <ol style="list-style-type: none"> <li>1. Fluid Management</li> <li>2. Missed Treatments</li> <li>3. COVID.</li> </ol>	<p>Decrease fluid gains and missed treatments. For the COVID, encourage immunizations and good infection control measures to prevent infection.</p>	<p>Monitor and educate patients daily in real time on their fluid gains. Get orders for extra treatments if necessary. Talking with patients about what they are taking in daily to determine where the fluid is coming from. Also talking to them about salt and sugar intake. Giving them alternatives to help moisten their mouths so they don't feel as thirsty.</p> <p>Educating new admits on the importance of attending every treatment and if they know they have an appointment or another reason they will need to miss regular treatment to let staff know so we can reschedule for when they can come. When patients call to say they are not coming we give alternative times/days when possible, so they are still getting treatment. We had drawings for fluid and missed treatment. Patients were entered into a basket drawing if they were meeting goals and we would draw names for winners. Missed treatments are more challenging for us still.</p> <p>Encourage patients to stay current on their Covid vaccines. Teach patients signs and symptoms of covid to not infect others and to know when to stay away from others. Encouraged to keep hand sanitizer with them and to use it frequently when out in public.</p>	<p>We used the above actions and watched our goal indicators to track what actions were working and to see if we could do anything differently to improve quality</p>
Outcomes/ACT			
<p>We saw improvement in fluid management by looking at the gains every day and talking to patients every treatment whether they did well or needed improvement. It is important to acknowledge when they are meeting goals. We are still struggling with missing treatments. Have had some improvement, but we still have a ways to go. Covid has improved.</p>			

# In-Patient Hospitalizations

## FMC - LIBERTY NORWOOD



Root Cause	Plan	Do	Study
Hospitalizations based on high fluid gains, HTN	We have weekly monitoring of fluid gains and BP pre/post and adjust EDW based on BP and s/s of hypervolemia	Monitor the report weekly	Monitor the trends of pts that fall into certain buckets for fluid gains and BP
Outcomes/ACT			
After review of the report, EDW is changed to aid in high fluid gains which in turn may help to control HTN and hospitalizations			
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