Improvement Sprints: Collaborating Across the Care Continuum

SUPERIOR HEALTH Quality Alliance

Midwest Kidney Network

A QIO, HQIC, and ESRD Network Partnership

Using Rapid Improvement Cycles to Improve Patient Quality Outcomes

Background: The QIO, HQIC and ESRD Network Statements of Work include common goals to reduce readmissions and hospitalizations in Medicare beneficiaries. Root cause analyses identify transitions in care processes and sepsis as major drivers of readmissions and hospitalizations in Medicare beneficiaries.

Transitions in Care Sprint – Reducing Readmissions

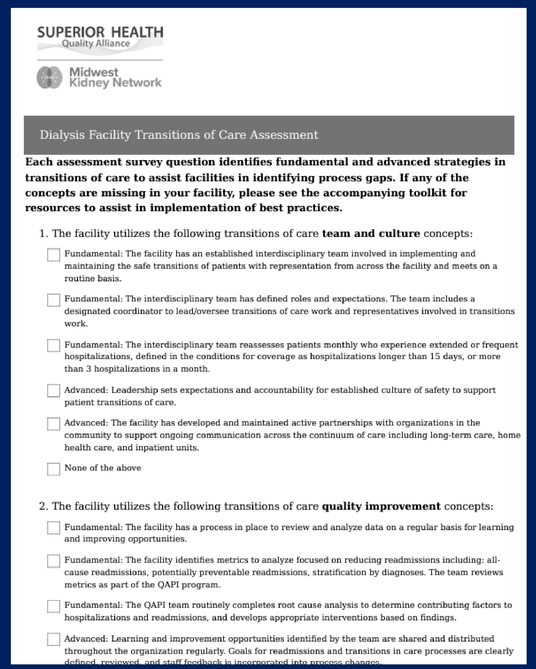
January 2023 – April 2023

Plan

- Structured 4 learning webinars with guided improvement homework for dialysis facility and hospital participants
- Facilitated learning and communication on transitions of care between inpatient and outpatient care settings
- Group learning and 1:1 coaching

Do

- Dialysis participants completed Midwest Kidney Network Transitions of Care Gap Analysis
- Participants implemented action plan for intervention from the Forum of ESRD Network's Transitions of Care Toolkit or ESRD NCC Hospitalization Change Package based on identified gap



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Dialysis Facility Transitions of Care Assessment

Each assessment survey question identifies fundamental and advanced strategies in transitions of care to assist facilities in identifying process gaps. If any of the concepts are missing in your facility, please see the accompanying toolkit for resources to assist in implementation of best practices.

1. The facility utilizes the following transitions of care **team and culture** concepts:

- ☐ Fundamental: The facility has an established interdisciplinary team involved in implementing and maintaining the safe transitions of patients with representation from across the facility and meets on a routine basis.
- ☐ Fundamental: The interdisciplinary team has defined roles and expectations. The team includes a designated coordinator to lead/oversee transitions of care work and representatives involved in transitions work.
- ☐ Fundamental: The interdisciplinary team reassesses patients monthly who experience extended or frequent hospitalizations, defined in the conditions for coverage as hospitalizations longer than 15 days, or more than 3 hospitalizations in a month.
- ☐ Advanced: Leadership sets expectations and accountability for established culture of safety to support patient transitions of care.
- ☐ Advanced: The facility has developed and maintained active partnerships with organizations in the community to support ongoing communication across the continuum of care including long-term care, home health care, and inpatient units.
- ☐ None of the above

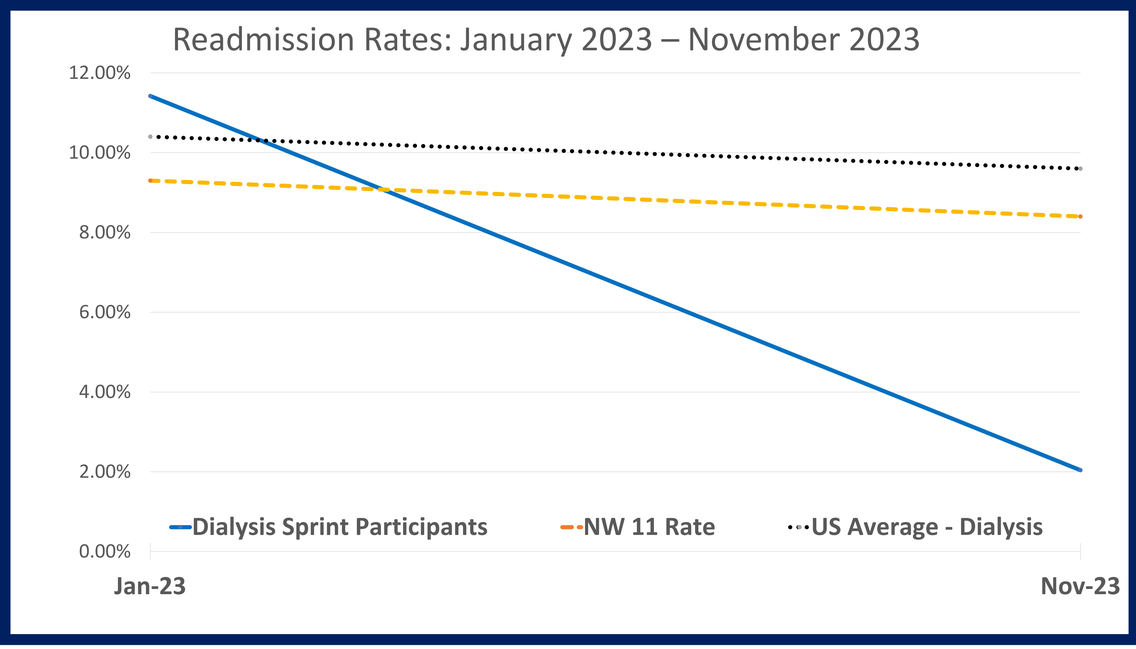
2. The facility utilizes the following transitions of care **quality improvement** concepts:

- ☐ Fundamental: The facility has a process in place to review and analyze data on a regular basis for learning and improving opportunities.
- ☐ Fundamental: The facility identifies metrics to analyze focused on reducing readmissions including: all-cause readmissions, potentially preventable readmissions, stratification by diagnoses. The team reviews metrics as part of the QAPI program.
- ☐ Fundamental: The QAPI team routinely completes root cause analysis to determine contributing factors to hospitalizations and readmissions, and develops appropriate interventions based on findings.
- ☐ Advanced: Learning and improvement opportunities identified by the team are shared and distributed throughout the organization regularly. Goals for readmissions and transitions in care processes are clearly defined, reviewed, and staff feedback is incorporated into process changes.

Network Gap Analysis tool was created based on the Minnesota Hospital Association Transitions in Care Roadmap and ESRD best practices.

Study

Dialysis Facility Sprint Participants reduced their readmission rate by about 9% compared with the Network and National readmission rate trends.



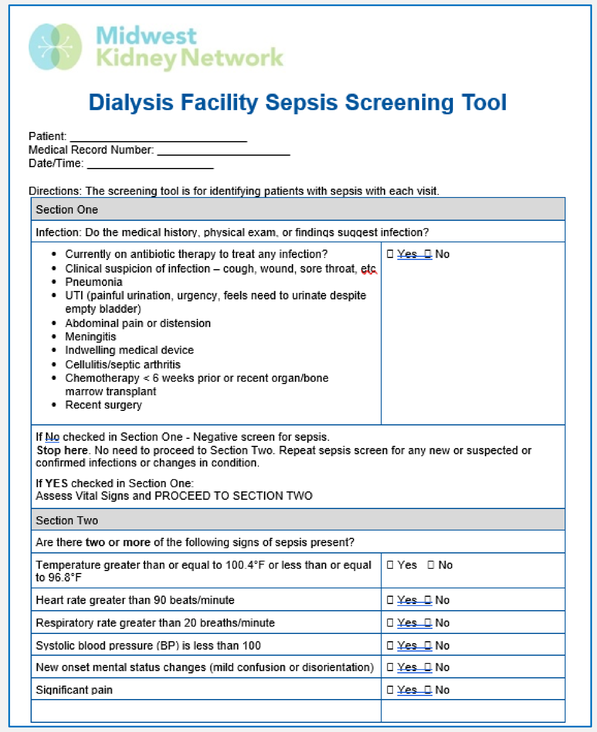
Act

Next Step: Spreading Best Practices In Collaborative Sprints

Sepsis Improvement Sprint

September 2023 – January 2024

- Hospital, Dialysis Facility, Skilled Nursing Facility, and Home Health Participants
- Followed same Sprint structure including webinars with a guided improvement cycle
- The intervention is the implementation of the sepsis screening tool and education
- Results pending as work is on-going



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Dialysis Facility Sepsis Screening Tool

Patient: _____
Medical Record Number: _____
Date/Time: _____

Directions: The screening tool is for identifying patients with sepsis with each visit.

Section One	
Infection: Do the medical history, physical exam, or findings suggest infection?	
• Currently on antibiotic therapy to treat any infection? • Clinical suspicion of infection – cough, wound, sore throat, etc. • Pneumonia • UTI (painful urination, urgency, feels need to urinate despite empty bladder) • Abdominal pain or distension • Meningitis • Indwelling medical device • Cellulitis/septic arthritis • Chemotherapy < 6 weeks prior or recent organ/bone marrow transplant • Recent surgery	☐ Yes ☐ No
If No checked in Section One - Negative screen for sepsis. **Stop here**. No need to proceed to Section Two. Repeat sepsis screen for any new or suspected or confirmed infections or changes in condition. If YES checked in Section One: Assess Vital Signs and PROCEED TO SECTION TWO	
Section Two	
Are **there two or more** of the following signs of sepsis present?	
Temperature greater than or equal to 100.4°F or less than or equal to 96.8°F	☐ Yes ☐ No
Heart rate greater than 90 beats/minute	☐ Yes ☐ No
Respiratory rate greater than 20 breaths/minute	☐ Yes ☐ No
Systolic blood pressure (BP) is less than 100	☐ Yes ☐ No
New onset mental status changes (mild confusion or disorientation)	☐ Yes ☐ No
Significant pain	☐ Yes ☐ No

www.midwestkidneynetwork.org

This material was prepared by Superior Health Quality Alliance ESRD Network 11 a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS).
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