# Dialysis Facility and Nursing Home Collaboration – Improving the Transition of Care

Background: CMS recognizes there is an opportunity for improvement in the care of dialysis patients transitioning between outpatient dialysis clinics and nursing home (NH) settings, therefore they have tasked the Network to identify and spread highly effective practices clinics develop or have developed to provide and maintain high quality of care during these transitions. At a minimum, CMS expects increased/improved the communication between these two organizations. To assist clinics in their achievement of this CMS expectation, the Network is providing some Strategies and Tips for Success for your consideration.

## Communication Strategies for Dialysis Facilities

- **Use a Standardized Form of Communication** – A standardized process such as the use of a communication book which travels between the dialysis center and the nursing home[1] or a standardized form checklist[2] such as the LTCF-Dialysis COVID-19 Communication Form (07/30/2020).*
  *****This form has been endorsed by several nursing home organizations and is designed to be used as a transition tool by both the dialysis clinic and the nursing home (NH). It includes COVID-19 screening data.
- **Appoint a Transitional Care Coordinator**[3] – a staff member(s) who is designated to reach out to the NH(s) prior to the patients' arrival to the clinic and communicates patient status to appropriate staff members. They would also maintain a log of transition calls and any problems that arise.
- **Regularly scheduled communication with each nursing home -** Review the care of each shared patient at least quarterly. This should be a discussion and problem solving session about patient problems and system barriers between the two providers. The dialysis clinic may want to focus on problems that could affect the ESRD Quality Incentive Payment (QIP) such as BSIs from wounds, UTIs, pneumonia, CVC infections and CVC loose, wet or soiled dressing which could lead to CVC infection.
  - *Examples of communication processes*
    - QAPI/FHR/QI team meeting - Add nursing home patient review to the agenda. Invite NH representative to attend either in-person or via telephone. They can be dismissed after the patient discussion is completed.
    - Standalone Teleconference
    - Standalone in-person meeting
- **Develop a Highly Effective Practice[4] for the transition process -** The National Forum of ESRD Networks (aka The Forum) is looking for innovative approaches which streamline the transition process and address existing barriers.
  - The Forum defines a Highly Effective Practice as a "procedure or set of processes that has been shown by research and/or experience to produce optimal results and is established or proposed as a practice suitable for widespread adoption."[1]
  - If you think your clinic may already be using an innovative highly effective practice, please submit your practice to Jeannette Shrift – jshrift@qualityinsights.org for evaluation and possible submission to The Forum's Highly Effective Practices Initiative. If your practice is published on the Forum website, the Network will acknowledge this accomplishment by publishing your clinic name and innovative practice it in our newsletter and spreading it to all clinics in PA and DE

# Tips for Success

(Adapted from The National Forum of ESRD Networks [2])

1. Embed a new/improved process ("hardwire") into the routine of the dialysis clinic and work with the NH to embed their part of the process. Redesign the process if it does not work.
2. Remember that communication is a two-way street.
   a. The NH needs information from the clinic. They do not know as much about kidney patients as you do, and they rely on your expertise. They may not know how the dialysis clinic works or what it needs from them.
   b. The dialysis clinic needs information from the NH. Be clear about what information you need each time the patient comes to the clinic or before they even arrive
3. Have a system in place to track and trend transitions (i.e. transition forms (paper or electronic). Know if the processes in place are working.
4. Transitions between settings are high-risk events. The dialysis team, including the clinic's medical director, should review them regularly to evaluate improvement possibilities. Anticipate the need to "tweak" the processes in collaboration with the NH.
5. Engage and educate patients and families. Ask for their feedback. However, do not make them the primary source of communication between settings.
6. Do not get into the "blame game." Cooperation and collaboration are necessary to make transitions safe and efficient.

## References


1. Øyvind Thomassen,[1] Ansgar Espeland,[2] Eirik Søfteland,[1] Hans Morten Lossius,[3,4] Jon Kenneth Heltne,[1,5] and Guttorm Brattebø[1] Implementation of checklists in health care; learning from high-reliability organisations. J Trauma Resusc Emerg Med. 2011; 19: 53. Published online 2011 Oct 3. doi: 10.1186/1757-7241-19-53
2. The National Forum of ESRD Networks – 2019 Transitions of Care Toolkit. pp. 48-64. file:///C:/Users/jshrift/Downloads/Transitions%20of%20Care%20Toolkit%202020%200319%20combined.pdf Accessed October 7, 2020.
3. National Transitions of Care Coalition – Dialysis to/from NSF or LTAC pp.62-64.Transitionshttps://static1.squarespace.com/static/5d48b6eb75823b00016db708/t/5e837a30f7518a6872e34876/1585674803444/SevenEssentialElements_NTOCC+logo.pdf Accessed October 6, 2020
4. The National Forum of ESRD Networks –Sharing Highly Effective Practices in the Kidney Community https://esrdnetworks.org/education/sharing-best-practices-in-the-kidney-community. Accessed October 6, 2020