Expert Teams – Hospitalization

Case-Based Learning & Mentorship

Tuesday, May 16, 2023

Facilitator: Julie Moss, ESRD National Coordinating Center

Meeting Logistics

- Call is being recorded
- Participants can unmute themselves
  - Please stay on mute unless you are speaking
  - Do not place the call on “hold”
- Everyone is encouraged to use the video and chat features
- Meeting materials will be posted to the ESRD NCC website.

Who Is On The Call?

- Clinician and Practitioner Subject Matter Experts
- Dialysis Facility and Transplant Professionals
- ESRD Network Staff
- Kidney Care Trade Association Members
- Centers for Medicare & Medicaid Services (CMS) Leadership

What are Expert Teams?

Participants from varying levels of organizational performance, each with lived experience and knowledge, come together to support continual learning and improvement

Help others learn faster by sharing what worked and what didn't work around a particular case, situation, or circumstance

Bring the best possible solutions to the table

Expert Team Call Objectives

- Prepare for improvement using shared clinical cases
- Test processes through the application of knowledge from the cases
- Use inquiry-based learning to problem solve
- Examine clinical reasoning, problem solving, and decision making through lived experience
- Act as a consultancy for behavior change and improvement

Questions to Run On. . . How Might We

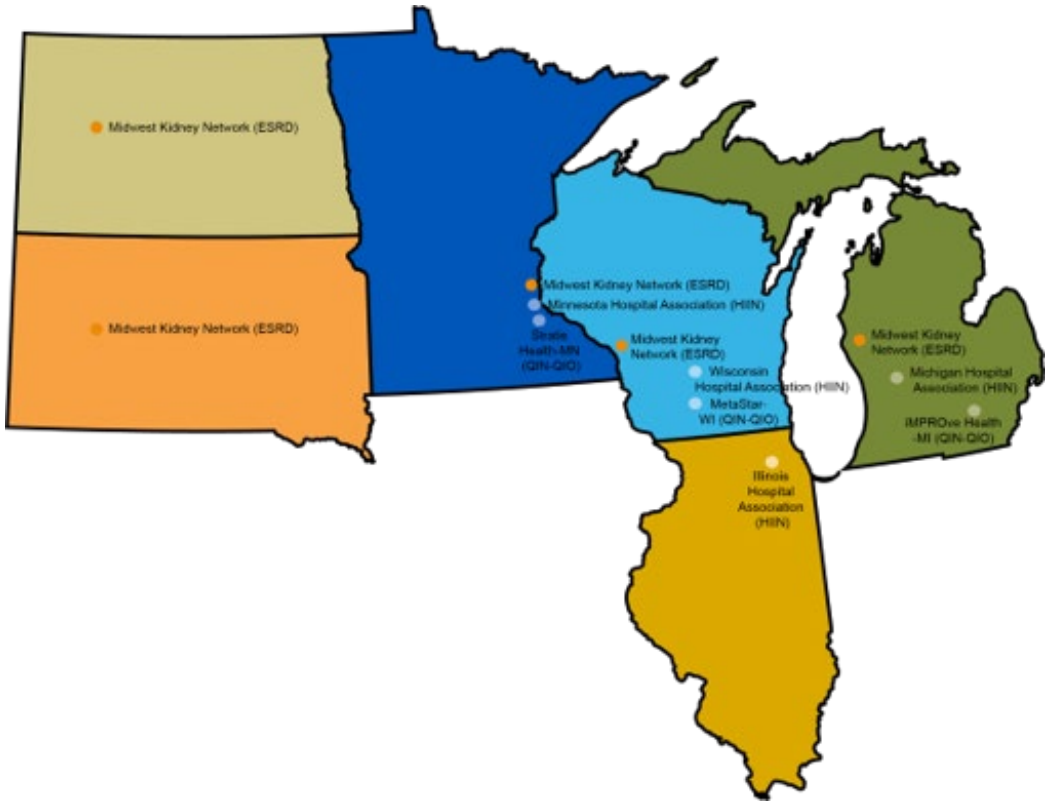
- Provide patients the knowledge and skills to prevent unplanned hospitalizations?
- Improve communication between hospitals and dialysis facilities to reduce hospital readmissions?
- Assist patients with unstable support systems or financial issues that may impact hospitalizations and Emergency Department visits?

A QIO-ESRD Collaboration to Improve Transitions Across the Care Continuum

Claire Taylor-Schiller, RN
Quality Improvement Analyst
Midwest Kidney Network

Superior Health Quality Alliance

- Partnership between 8 member organizations
  - Midwest Kidney Network
  - 4 Hospital Associations (Illinois, Michigan, Minnesota, Wisconsin)
  - 3 QIOs (Stratis, iMPROve Health, MetaStar)



Midwest Kidney Network | SUPERIOR HEALTH Quality Alliance

Superior Health Readmission Sprint

A QIO/ESRD Collaboration to Improve Transitions Across the Care Continuum

84 Participants from
31 Hospitals
17 Dialysis Facilities

Root Cause Analysis identified transitions in care processes as major contributors to readmission rates in dialysis patients

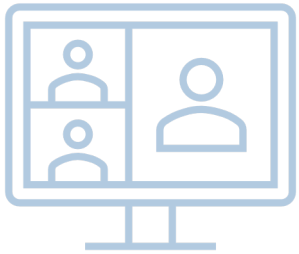
- Common goal to reduce readmissions for Medicare beneficiaries in both QIO and ESRD Network statement of work
- Collaborated to create and implement an improvement sprint for both hospital and dialysis facilities
- A sprint is a rapid implementation program designed to amplify the impact of a facility's efforts on a given topic

	Invited Superior Health hospitals and dialysis facilities to enroll - personalized invitations to dialysis facilities with high readmission rates and/or local hospital registration
	Four learning webinars January 2023 – April 2023 to facilitate in-depth learning and foster interactive dialogue, sharing evidence-based tools and resources to develop tactical steps to implement innovations
	Dialysis facilities completed Transitions in Care Assessment to identify opportunities for improvement in transitions in care processes. The assessment was created based on the Forum of ESRD Network's Transitions of Care Toolkit and the MN Hospital Association Transitions in Care Roadmap
	Provided toolkit of resources to aid in addressing gaps identified on Transitions in Care Assessment
	Group collaboration in the social networking site, Superior Health Connect, to share challenges and best practices, and promote networking with colleagues across care systems and specialties
	Provide one-on-one coaching calls May 2023 and beyond to assist with follow-up needs and track progress upon conclusion of the sprint

SUPERIOR HEALTH Quality Alliance | Midwest Kidney Network

Midwest Kidney Network | SUPERIOR HEALTH Quality Alliance

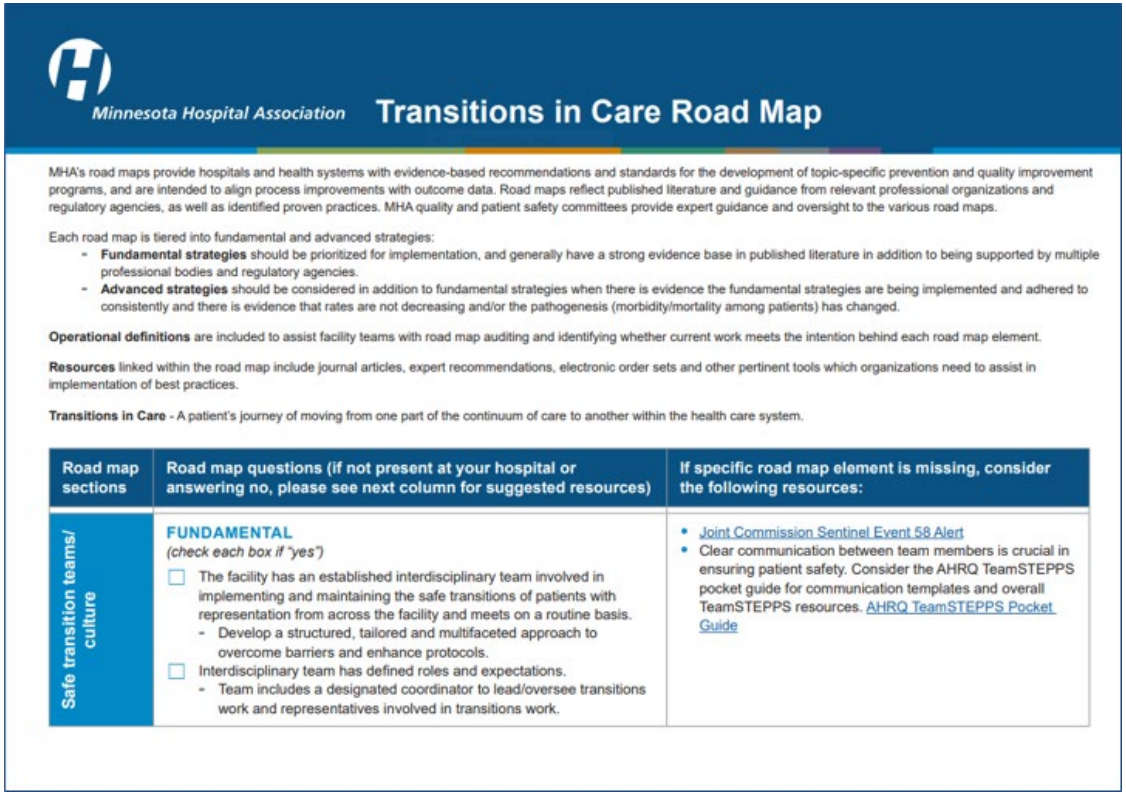
Sprint Webinars



1. Kickoff – Introduction and Assessment
2. Action Plan and Desired Performance
3. Implementation Planning
4. Sustainability and Maintenance
5. Informal – sharing project progress, new barriers, best practices

1:1 coaching calls prn during sprint and scheduled after Webinar 4

Assessment – MHA Roadmap



Minnesota Hospital Association

Transitions in Care Road Map

MHA's road maps provide hospitals and health systems with evidence-based recommendations and standards for the development of topic-specific prevention and quality improvement programs, and are intended to align process improvements with outcome data. Road maps reflect published literature and guidance from relevant professional organizations and regulatory agencies, as well as identified proven practices. MHA quality and patient safety committees provide expert guidance and oversight to the various road maps.

Each road map is tiered into fundamental and advanced strategies:

- **Fundamental strategies** should be prioritized for implementation, and generally have a strong evidence base in published literature in addition to being supported by multiple professional bodies and regulatory agencies.
- **Advanced strategies** should be considered in addition to fundamental strategies when there is evidence the fundamental strategies are being implemented and adhered to consistently and there is evidence that rates are not decreasing and/or the pathogenesis (morbidity/mortality among patients) has changed.

Operational definitions are included to assist facility teams with road map auditing and identifying whether current work meets the intention behind each road map element.

Resources linked within the road map include journal articles, expert recommendations, electronic order sets and other pertinent tools which organizations need to assist in implementation of best practices.

Transitions in Care - A patient's journey of moving from one part of the continuum of care to another within the health care system.

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Safe transition teams/ culture	**FUNDAMENTAL** *(check each box if "yes")* ☐ 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. - Develop a structured, tailored and multifaceted approach to overcome barriers and enhance protocols. ☐ Interdisciplinary team has defined roles and expectations. - Team includes a designated coordinator to lead/oversee transitions work and representatives involved in transitions work.	• Joint Commission Sentinel Event 58 Alert • Clear communication between team members is crucial in ensuring patient safety. Consider the AHRQ TeamSTEPPS pocket guide for communication templates and overall TeamSTEPPS resources. AHRQ TeamSTEPPS Pocket Guide

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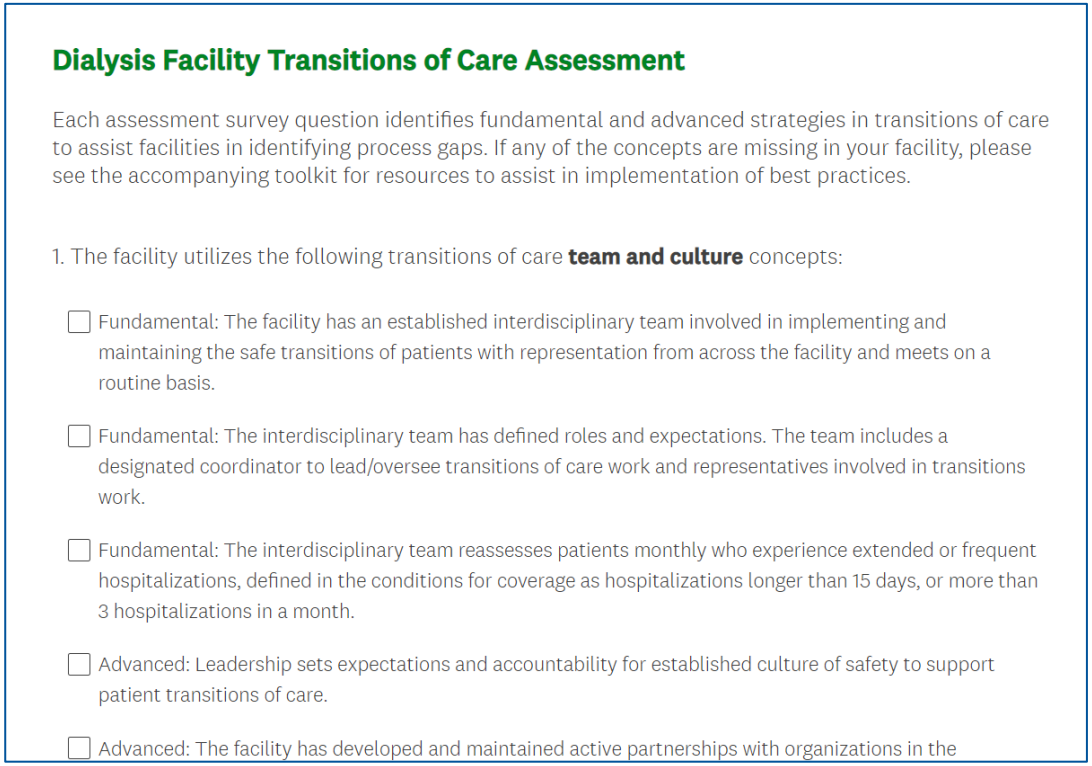
Assessment – Dialysis Facility Transitions in Care



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

- Survey Monkey
- Followed similar concepts from hospital road map
- Utilized Forum Transitions in Care Toolkit, Hospitalization Change Package, Conditions for Coverage to guide concept development
- Shared results back with individual facility and aggregate responses

Areas of Greatest Opportunity – Dialysis Facilities

Staff Education: Expectations and supporting education regarding transitions of care have been incorporated into orientation

Team and Culture: The IDT team has defined roles and expectations. Team includes a designated coordinator to lead/oversee transitions of care work.

Quality Improvement: Identifies metrics to analyze focused on reducing readmissions including: all-cause readmissions, potentially preventable readmissions, stratification by diagnosis, etc. Team reviews metrics as part of QAPI program

Medication Management: Reviews dialysis-related medications given in the hospital and updates nephrologist on changes made to dialysis medications during hospitalization

Patient Education: Patient and family are provided with written contact information for dialysis and primary care providers

Resource Toolkit

Midwest Kidney Network

READMISSION RESOURCE TOOLKIT

Resources and best practices to support improvement in transitions of care.

TEAM AND CULTURE

- A Change Package to Reduce Hospitalizations: Key Change Ideas for Dialysis Facilities to Drive Local Action: Hospitalization Change Package
- Culture Road Map: 8 focus areas to facilitate implementation of culture change: https://mnpatientsafety.org/culture-road-map
- CMS Conditions for Coverage Interpretive Guidelines, defining unstable patients, page 200-202: CfC Interpretive Guidelines

QUALITY IMPROVEMENT

- A Change Package to Reduce Hospitalizations: Key Change Ideas for Dialysis Facilities to Drive Local Action: Hospitalization Change Package
- Forum of ESRD Networks Transitions of Care Toolkit, pages 49 – 65, and sample templates page 96+: Transitions of Care Toolkit
- Sample Root Cause Analysis Tool: MKN Quality Improvement Plan
- Patient Engagement in QAPI: Patient Module: Understanding and Participating in QAPI ; Patient Module: Understanding and Participating in QAPI Spanish

STAFF EDUCATION

- A Change Package to Reduce Hospitalizations: Key Change Ideas for Dialysis Facilities to Drive Local Action: Hospitalization Change Package
- Forum of ESRD Networks Transitions of Care Toolkit, pages 49 – 65, and sample templates page 96+:

TRACKING READMISSION DATA

There are various ways to track readmission data for dialysis facilities, each with their pros and cons. The sections below will describe some of the different approaches in tracking readmission data.

STANDARDIZED READMISSION RATIO

The standardized readmission ratio is available to facilities on the dialysis facility report and updated on a quarterly basis. The ratio, however, is not as intuitive to understand, and based on a more complex calculation. Additionally, the ratio is typically not based on the most recent data. The ratio does include all-cause readmissions. The technical specifications can be found here: CY 2023 QIP Technical Specifications

READMISSION RATE PROVIDED ON NETWORK FACILITY REPORT

The readmission rate provided from the Midwest Kidney Network on the monthly facility specific report is expressed as a percentage of hospital admissions that occurred within 30 days of discharge from a previous hospital admission for Medicare patients. This rate the Network receives directly from the ESRD NCC Data Warehouse based on Medicare claims. The most recent data is from the previous month, making it a timely reflection of the rate.

However, the only hospitalizations that are included in this rate are those that have a primary diagnosis code on the Medicare claim from the list of Primary Diagnosis Categories found here: Primary Diagnosis Codes Although this rate is intuitively easy to understand and readily obtained from the Network, it is not inclusive of all-cause admissions and if used solely, can provide a false sense of a low rate as it does not capture all patients and all hospitalizations. Using this as the only metric to track readmission rates will not accurately show the true picture of readmissions at the dialysis clinic.

INTERNAL DATA TRACKING

Tracking all hospitalizations and readmissions within 30 days of discharge through internal tracking tools (using electronic health records, Excel spreadsheets, etc.) can be the most burdensome on time and resources, especially with initially establishing the process. However, this method will most accurately reflect the true rate at the clinic, as well as be easily understood. The recommended interval for completing this is monthly, as well as maintaining a rolling 12-month rate.

Questions?

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Introducing Nephrocardiology

Andrew Bland, MD
Tri-State Dialysis Medical Director

Introducing Nephrocardiology

Or Cardiorenal Readmissions Group

Andrew Bland MD

Parta Hatamizadeh

CJASN 17: ●●●–●●●, 2022. doi: https://doi.org/10.2215/CJN.10940821

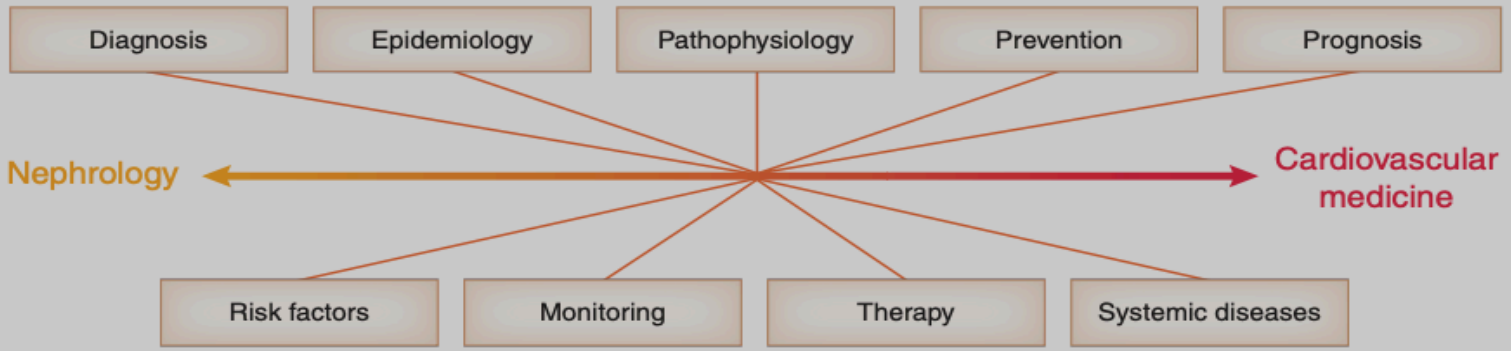
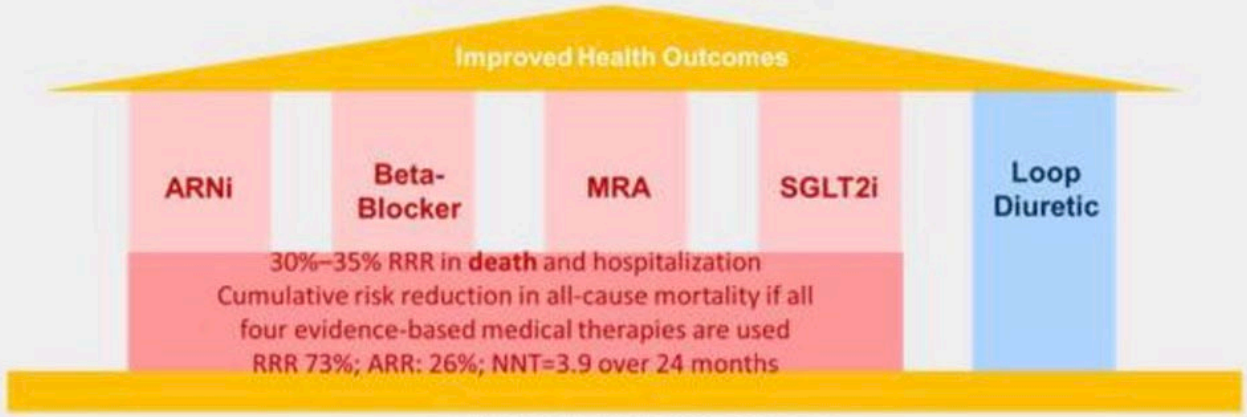


Figure 1. | The nine elements of the interaction between nephrology and cardiovascular medicine that compose the subject matter of nephrocardiology. Each of these elements can be viewed from different standpoints (see text for an explanation and examples).

The Intersection between HFrEF and Cardiorenal

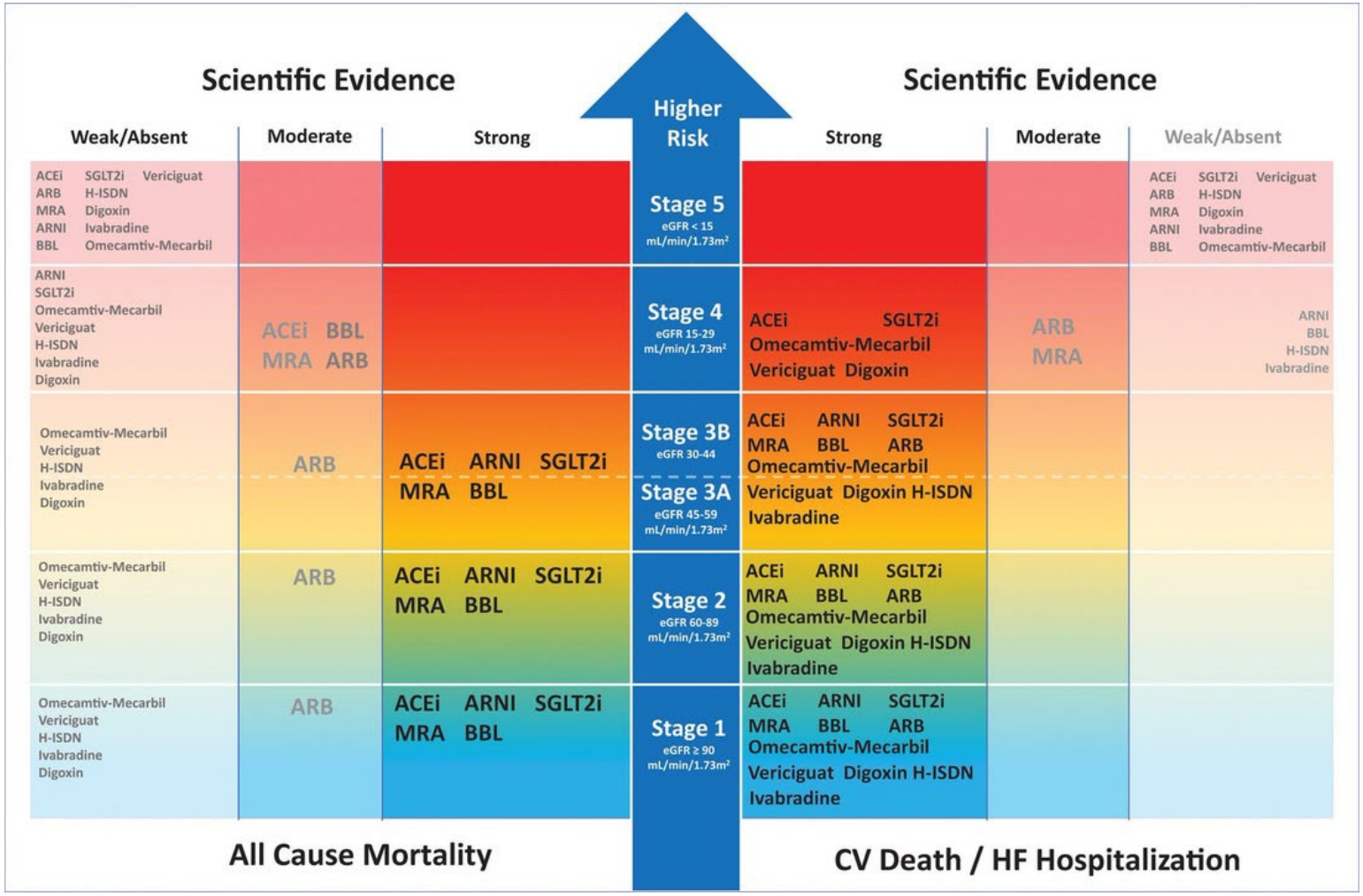


Additional HF Clinical Trials

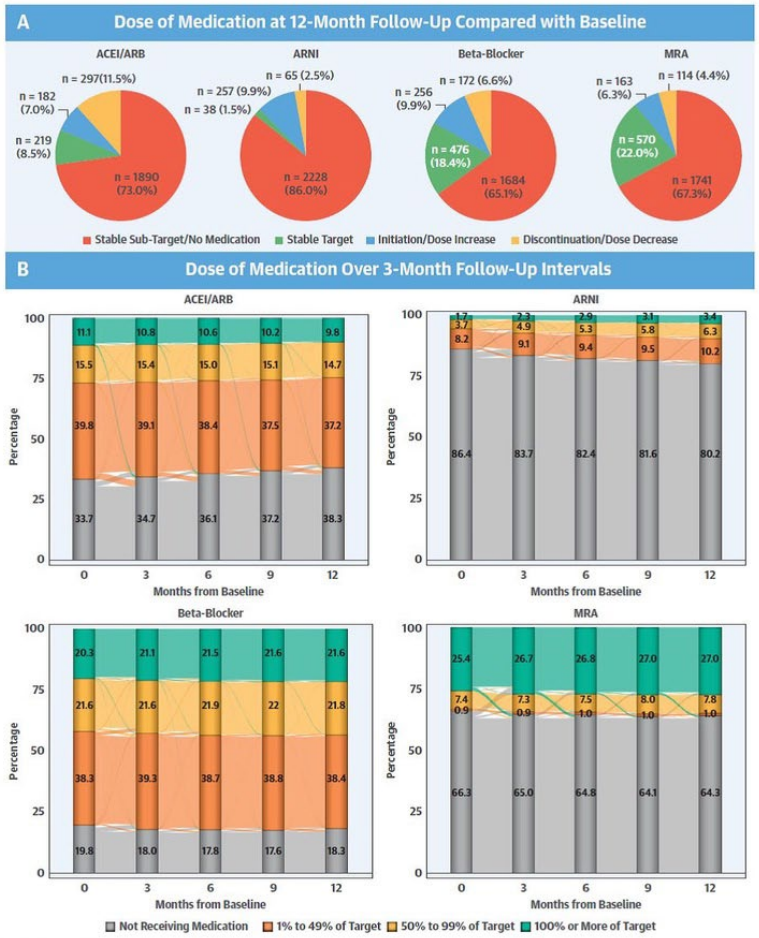
Omecamtiv Mecarbil (GALACTIC)	Vericiguat (VICTORIA)	Ferric Carboxymaltose (AFFIRM-HF)	Devices (GUIDE-HF, COAPT, RAFT, SCD-HeFT)

ARNi, angiotensin receptor-neprilysin inhibitor; ARR, absolute risk reduction; HF, heart failure; HFrEF, heart failure with reduced ejection fraction; MRA, mineralocorticoid receptor antagonist; NNT, number needed to treat; RRR, relative risk reduction; SGLT2i, sodium-glucose cotransporter-2 inhibitor. *Circulation*. 2020;142:717-719; *JAMA Cardiol*. 2021. doi:10.1001/jamacardio.2021.0496; *Eur Cardiol*. 2015;10:42-47; JAMA Cardiol. 2020;5:1-5; *N Engl J Med*. 2004;351:2049-2057; *Diabetol*. 2020;19. doi:10.1186/s12933-020-01088-3. 7. Armstrong *N Engl J Med*. 2020;382:1883-1893.; *Am Heart J*. 2019;214:18-27.

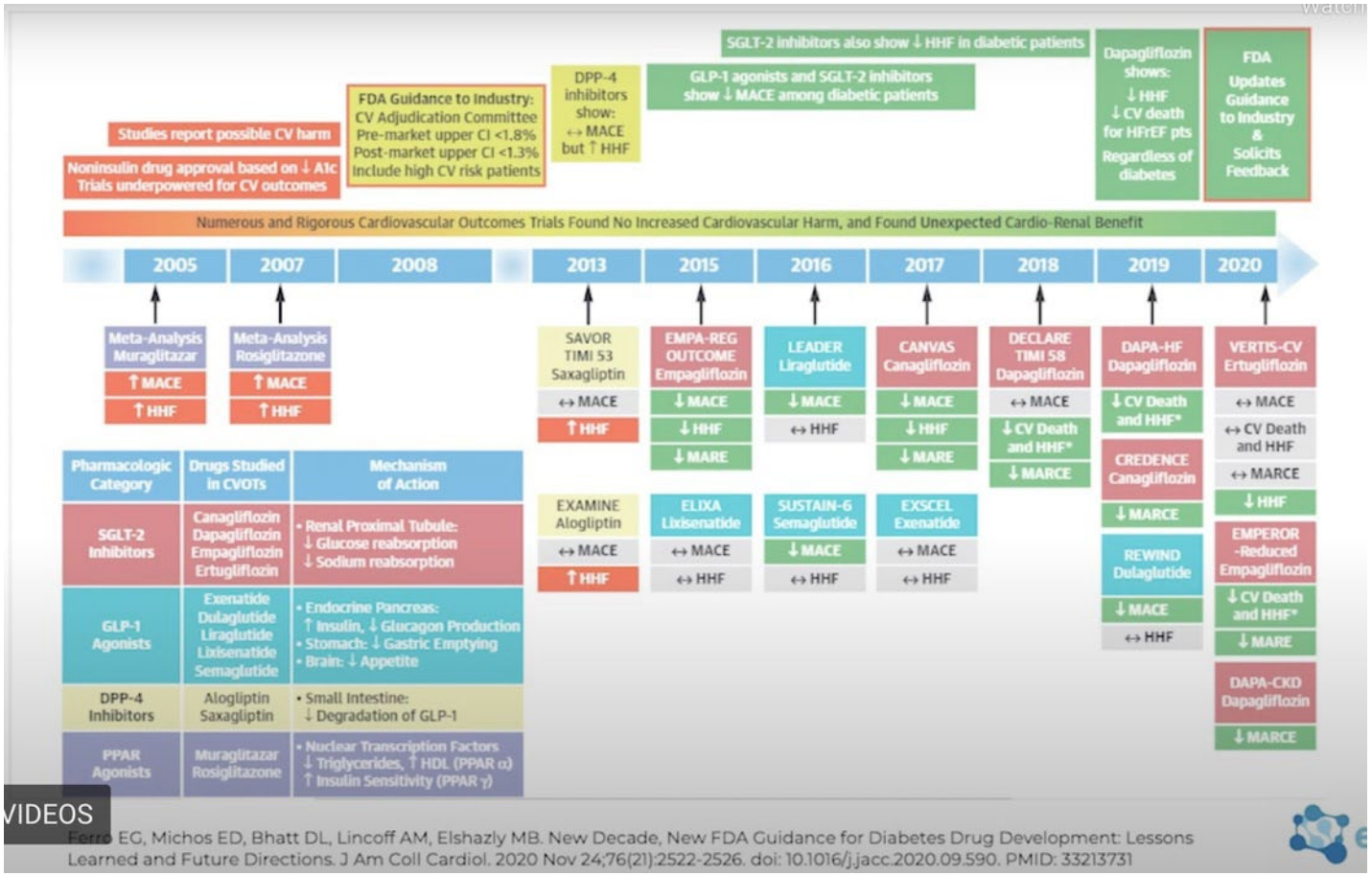
Circulation. 2022;0:10.1161/CIR.0000000000001063. Available at: https://www.ahajournals.org/doi/10.1161/CIR.0000000000001063


Scientific Evidence
Scientific Evidence
Higher Risk
Weak/Absent
Moderate
Strong
Strong
Moderate
Weak/Absent
ACEi SGLT2i Vericiguat
ARB H-ISDN
MRA Digoxin
ARNI Ivabradine
BBL Omecamtiv-Mecarbil
Stage 5
eGFR < 15 mL/min/1.73m²
ARNI
SGLT2i
Omecamtiv-Mecarbil
Vericiguat
H-ISDN
Ivabradine
Digoxin
ACEi BBL
MRA ARB
Stage 4
eGFR 15-29 mL/min/1.73m²
ACEi SGLT2i
Omecamtiv-Mecarbil
Vericiguat Digoxin
ARB
MRA
ARNI
BBL
H-ISDN
Ivabradine
Omecamtiv-Mecarbil
Vericiguat
H-ISDN
Ivabradine
Digoxin
ARB
ACEi ARNI SGLT2i
MRA BBL
Stage 3B
eGFR 30-44
Stage 3A
eGFR 45-59 mL/min/1.73m²
ACEi ARNI SGLT2i
MRA BBL ARB
Omecamtiv-Mecarbil
Vericiguat Digoxin H-ISDN
Ivabradine
Omecamtiv-Mecarbil
Vericiguat
H-ISDN
Ivabradine
Digoxin
ARB
ACEi ARNI SGLT2i
MRA BBL
Stage 2
eGFR 60-89 mL/min/1.73m²
ACEi ARNI SGLT2i
MRA BBL ARB
Omecamtiv-Mecarbil
Vericiguat Digoxin H-ISDN
Ivabradine
Omecamtiv-Mecarbil
Vericiguat
H-ISDN
Ivabradine
Digoxin
ARB
ACEi ARNI SGLT2i
MRA BBL
Stage 1
eGFR ≥ 90 mL/min/1.73m²
ACEi ARNI SGLT2i
MRA BBL ARB
Omecamtiv-Mecarbil
Vericiguat Digoxin H-ISDN
Ivabradine
All Cause Mortality
CV Death / HF Hospitalization

CENTRAL ILLUSTRATION Changes in Use and Dose of GDMT Over 12 Months Among Patients With Chronic Heart Failure With Reduced Ejection Fraction in Contemporary U.S. Outpatient Practice



Greene, S.J. et al. J Am Coll Cardiol. 2019;73(19):2365–83.



Ferro EG, Michos ED, Bhatt DL, Lincoff AM, Elshazly MB. New Decade, New FDA Guidance for Diabetes Drug Development: Lessons Learned and Future Directions. J Am Coll Cardiol. 2020 Nov 24;76(21):2522-2526. doi: 10.1016/j.jacc.2020.09.590. PMID: 33213731

GDMT: Simultaneous/Rapid Sequence Strategy

Comprehensive disease-modifying medical therapy (CDMMT) from Day 1

Hospitalized or outpatient

Day 1	Day 7-14	Day 14-28	Day 21-42	Beyond
ARNI	…	(Titrate, as tolerated)	Titrate, as tolerated	• Maintenance / further optimization of foundational therapies • Consideration of EP device therapies/Mitraclip • Consideration of add-on therapies or advanced therapies, if refractory • Manage comorbidities
BB	Titrate, as tolerated	Titrate, as tolerated	Titrate, as tolerated	
MRA	…	Titrate, as tolerated	…	
SGLT2i	…	…	…	
Low starting doses Prioritize beta-blocker titration	Benefits of each Rx demonstrated within 30 days of initiation Cumulative benefits within 30 days (>75% relative risk reduction)			Focus on complete set of CDMMT being implemented

Greene, Butler, Fonarow. *JAMA Cardiology* 2021 doi:10.1001/jamacardio.2021.0496.

Benefits of Simultaneous or Rapid Initiation of ARNi, BB, MRA, and SGLT2i for HFrEF are Multifaceted

ARNi, angiotensin receptor-neprilysin inhibitor; BB, beta blocker; HF, heart failure; HFrEF, heart failure with reduced ejection fraction; LVEF, left ventricular ejection fraction; MRA, mineralocorticoid receptor antagonist; SGLT2i, sodium-glucose cotransporter-2 inhibitor.

1. Kharbon Y, et al. *JACC Heart Fail*. 2019;7:933-941; 2. Desai AS, et al. *JAMA*. 2019. doi:10.1001/jama.2019.12843; 3. Morrow DA, et al. *Circulation*. 2019;139:2285-2288; 4. Bhatt AS, et al. *Eur J Heart Fail*. 2020;22:313-324.

Cost, Value, and Access for Comprehensive "Add-On" Medical Therapy for Heart Failure

Updated from Fonarow GC, et al. *Am Heart J.* 2011;161:1024-1030 and Sassi NS, et al. *JAMA Cardiol.* 2020; May 6. e200898.
Parizo JT et al *JAMA Cardiol* 2021, May 26 doi:101001; Grazzano TA, et al. *JAMA Cardiol.* 2016;1(8):869-72; Banka G, et al. *J Am Coll Cardiol.* 2013;61(13):1440-6; McEwan P, et al. *Eur J*

Estimating lifetime benefits of comprehensive disease-modifying pharmacological therapies in patients with heart failure with reduced ejection fraction: a comparative analysis of three randomised controlled trials

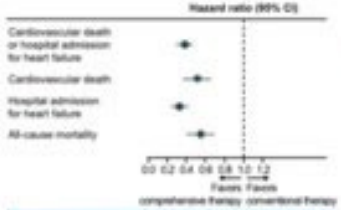
[illegible]

Baseline patient characteristics and background medical therapy

	EMPHASIS-HF (n=2737)	PARADIGM-HF (n=8399)	DAPA-HF (n=4744)
	Eplerenone vs placebo	Sacubitril–valsartan vs enalapril	Dapagliflorin vs placebo
Enrollment period	2006–10	2009–12	2017–18
Median follow-up, months	21 (10–33)	27 (19–36)	18 (13–21)
Age, years	69 (8)	64 (11)	66 (11)
Sex			
Male	2127 (78%)	6567 (78%)	3635 (77%)
Female	610 (22%)	1832 (22%)	1109 (23%)
Systolic blood pressure, mmHg	124 (17)	121 (15)	122 (16)
Heart rate, bpm	72 (13)	72 (12)	72 (12)
Left ventricular ejection fraction, %	26 (5)	30 (6)	31 (7)
New York Heart Association class			
1	0	389 (5%)	0
2	2737 (100%)	5919 (70%)	3203 (68%)
3	0	2018 (24%)	1498 (32%)
4	0	60 (1%)	43 (1%)
Atrial fibrillation	844 (31%)	3091 (37%)	1818 (38%)
Diabetes	859 (31%)	2907 (35%)	1983 (42%)
Previous hospital admission for heart failure	1440 (53%)	5274 (63%)	2251 (47%)
Diuretics	2326 (85%)	6738 (80%)	4008 (84%)
ACE inhibitor, ARB, or ARNI	2557 (93%)	8379 (100%)	4442 (94%)
β blocker	2374 (87%)	7811 (93%)	4558 (96%)
Mineralocorticoid receptor antagonist	-	4671 (56%)	3370 (71%)

Data are n (%) or mean (SD) unless otherwise stated

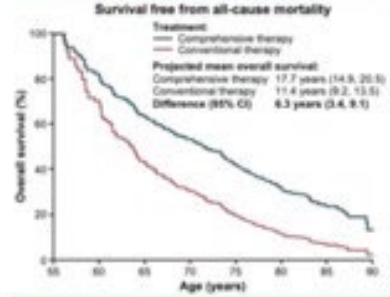
Estimation of relative treatment effects of comprehensive disease-modifying pharmacologic therapy on key cardiovascular events



Compared with ACEI/ARB+BB:
Comprehensive Rx including ARNI+BB+MRA+SGLT2i
HR 0.38 CV death / HF hospitalization
HR 0.50 CV death
HR 0.32 HF hospitalization
HR 0.53 mortality

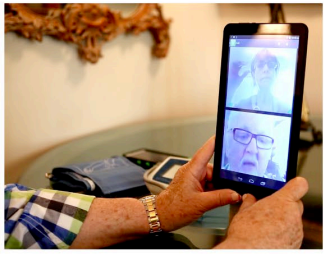
Compared with ACEI/ARB + BB:
1. Switch to ARNI
2. Start MRA therapy
3. Start SGLT2i therapy

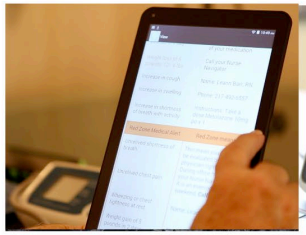
Survival free from all-cause mortality

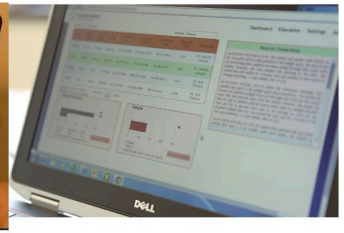


Extend your HFrEF patient's life by 6.3 years*

Outcomes





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                    DischargeDispositionName PrimaryCareProviderID      LOS
01 HOME SELF CARE                  :3260      NOPCP    : 498        Min.   : 0.000
03 SKILLED NURSING FACILITY:       579        PATESAM2:  367        1st Qu.: 2.000
06 HOME w HOME HEALTH              : 504      UNKPCP   : 276        Median : 3.000
65 PSYCH FACILITY                  : 119      DNOS     : 265        Mean   : 4.727
02 SHORT-TERM HOSPITAL             : 112      NIDPCP   : 265        3rd Qu.: 6.000
20 EXPIRED                         :  93      BUKHFAI  : 246        Max.   :95.000
(Other)                            : 334      (Other)  :3084

                                                                  MSDRG_Title
PSYCHOSES                                                                : 816
VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES                              : 248
NORMAL NEWBORN                                                           : 198
REHABILITATION W CC/MCC                                                  : 171
MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC:       168
NEONATE W OTHER SIGNIFICANT PROBLEMS                                     : 160
(Other)                                                                  :3240
```

```
> power.prop.test(p1 = .2000, p2=.0500, sig.level = .05, power = .8, alternative = "one.sided")

     Two-sample comparison of proportions power calculation

              n = 59.05272
             p1 = 0.2
             p2 = 0.05
      sig.level = 0.05
          power = 0.8
    alternative = one.sided

NOTE: n is number in *each* group
```

```
> t.test(big6_Control$LOS, y=big6_NorthDecatur$LOS, alternative="greater")

        Welch Two Sample t-test

data:  big6_Control$LOS and big6_NorthDecatur$LOS
t = 1.7036, df = 45.854, p-value = 0.04761
alternative hypothesis: true difference in means is greater than 0
95 percent confidence interval:
 0.009869241         Inf
sample estimates:
mean of x mean of y
 3.967302  3.289474

> prop.test(x=c(79,2), n=c(367,38), alternative = "greater", conf.level = .95)

        2-sample test for equality of proportions with continuity correction

data:  c(79, 2) out of c(367, 38)
X-squared = 4.7209, df = 1, p-value = 0.0149
alternative hypothesis: greater
95 percent confidence interval:
 0.07885838 1.00000000
sample estimates:
    prop 1     prop 2
0.21525886 0.05263158

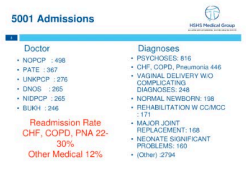
> prop.test(x=c(534,38), n=c(4693,308), alternative = "greater", conf.level = .95)

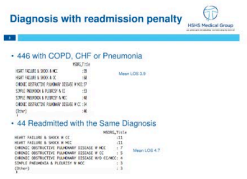
        2-sample test for equality of proportions with continuity correction

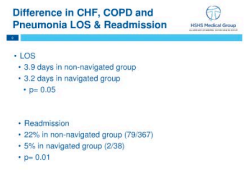
data:  c(534, 38) out of c(4693, 308)
X-squared = 0.17629, df = 1, p-value = 0.6627
alternative hypothesis: greater
95 percent confidence interval:
 -0.04307208  1.00000000
sample estimates:
    prop 1     prop 2
0.1137865 0.1233766
```

```
                    DischargeDispositionName PrimaryCareProviderID      LOS          ReadmitDays      AdmitDiag      DRG                                                  MSDRG_Title
01 HOME SELF CARE                  :211       BUKHFAI: 52           Min.   : 0.000   Min.   : 0.00   486    : 81   Min.   :190.0   HEART FAILURE & SHOCK W MCC                :90
03 SKILLED NURSING FACILITY:       79         AHMAAHM: 19           1st Qu.: 2.000   1st Qu.: 0.00   428    : 58   1st Qu.:192.0   HEART FAILURE & SHOCK W CC                 :62
06 HOME w HOME HEALTH              : 46       JATONAE: 19           Median : 3.000   Median : 0.00   491.21 : 46   Median :194.0   CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC:53
20 EXPIRED                         :  8       CHIC   : 17           Mean   : 3.967   Mean   :10.51   428.23 : 22   Mean   :237.3   SIMPLE PNEUMONIA & PLEURISY W CC           :50
07 AGAINST MEDICAL ADVICE          :  5       NIDPCP : 14           3rd Qu.: 5.000   3rd Qu.:11.50   496    : 21   3rd Qu.:291.0   SIMPLE PNEUMONIA & PLEURISY W MCC          :42
62 REHAB FACILITY                  :  4       BILYTHO: 13           Max.   :14.000   Max.   :98.00   786.09 : 19   Max.   :293.0   CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC :31
(Other)                            : 14       (Other):233                                            (Other):120                    (Other)                                    :39

                    DischargeDispositionName PrimaryCareProviderID      LOS          ReadmitDays      AdmitDiag      DRG                                                  MSDRG_Title
01 HOME SELF CARE                  :31        HANNKIM:10            Min.   : 0.000   Min.   : 0.000  493.21 : 6   Min.   :190.0   HEART FAILURE & SHOCK W MCC                :9
06 HOME w HOME HEALTH              : 4        COVAJDA: 7            1st Qu.: 2.000   1st Qu.: 0.000  428    : 5   1st Qu.:192.0   HEART FAILURE & SHOCK W CC                 :6
02 SHORT-TERM HOSPITAL             : 1        MULTKIR: 7            Median : 3.000   Median : 0.000  428.21 : 3   Median :194.0   SIMPLE PNEUMONIA & PLEURISY W MCC          :6
03 SKILLED NURSING FACILITY:       1          HENDTHE: 5            Mean   : 3.289   Mean   : 8.684  486    : 3   Mean   :239.2   CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC :4
20 EXPIRED                         : 1        BILYSCO: 4            3rd Qu.: 4.000   3rd Qu.: 0.000  496    : 3   3rd Qu.:291.0   CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC:4
01 DCFS                            : 0        HOLDELI: 3            Max.   :11.000   Max.   :95.000  428.23 : 2   Max.   :293.0   CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC :3
(Other)                            : 0        (Other): 2                                             (Other):16                     (Other)                                    :6
```







Questions and Answer Discussion

Top Take-Aways – Putting Knowledge Into Action

What is one thing you learned today that you could start doing immediately?

How will this action improve your current way of doing the practice/process?

Who is involved and how can they support the action to make it sustainable?

Recap & Next Steps

- Additional pathways for learning
  - Sharing Best Practices to a greater community through coalition meetings
  - Using Case Study examples to identify new ways of doing something or missed opportunities

- Next meeting – June 20, 2023 @ 2 pm ET

Visit the ESRD NCC website to find materials and share

https://esrdncc.org/en/professionals/expert-teams/

Social Media

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Thank You

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