[**CBE ID and Measure Title**] #3566 Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge (ED30) for Dialysis Facilities

[Measure Description] The Standardized Ratio of Emergency Department Encounters Occurring Within 30 Days of Hospital Discharge for Dialysis Facilities (ED30) is defined as the ratio of observed over expected events. The numerator is the observed number of index discharges from acute care hospitals that are followed by an outpatient emergency department encounter within 4-30 days after discharge for eligible adult Medicare dialysis patients treated at a particular dialysis facility. The denominator is the expected number of index discharges followed by an ED encounter within 4-30 days given the discharging hospital's characteristics, characteristics of the dialysis facility's patients, and the national norm for dialysis facilities.

Inputs	Activities	Outputs	Outcomes	Impacts
• Quality Improvement Staff (Medical Director, Nurse manager, Dietician Social Worker, RN/PCT) • Facility specific Policies and Procedures that reflect requirements in CMS' CfC 494 Conditions for Participation in the Medicare ESRD Chronic Dialysis Program • Clinical data systems (EHR, quality dashboards) • Clinic data reports (Dialysis Facility Reports, Dialysis Facility Care Compare)	• Assessment of current dialysis prescription (target weight; fluid removal rate; BP control; control of electrolytes; adequacy of small solute clearance) • Identify high-risk patients and conduct root cause analysis for common ED visits (e.g. fluid overload, hyperkalemia, vascular access, shortened / missed treatments) • Adherence to Infection Prevention and Control Standards specified in CMS CfC494 and CDC • Reconcile medications after hospitalization • Deliver education to patients about when to obtain ED care vs. care at facility or by other providers and who to contact if questions arise between treatments. • Conduct team meetings to discuss high risk patients with focus on avoiding ED encounters • Staff Training for avoidable ED triggers and alternative strategies. • Staff Training Programs for Infection Prevention	• Obtain patient discharge summary, see patient within 3 days of discharge • Results of post-discharge medication review; medication reconciliation • Update QAPI patient care plan if needed; follow-up appointments • Modify dialysis prescription if needed to maintain target Kt/V and support volume status • QAPI output evaluating facility-level status of electrolyte and other dialysis-specific laboratory test control (particularly potassium, magnesium, calcium, phosphorus, intact PTH) • QAPI output documenting rates of intradialytic morbidities (e.g. intradialytic hypotension, loss of consciousness, cardiac arrest, hemorrhage, etc)	Short Term • Increased awareness among providers of avoidable ED visits • Improved identification of high-risk patients • Improved patient engagement and education Medium-term • Reduced risk of return outpatient emergency encounters due to inpatient medication changes; increase in patients seen at the dialysis facility within 3 days of discharge; fewer missed/shortened dialysis treatments and blood stream infections • Enhanced continuity of care and use of preventative care Long-term • Reduced overall average of unplanned outpatient emergency encounters that occur between 4-30 days (ED30) • Improved clinical outcomes (hospitalization and mortality)	• Control escalating medical costs, support provision of cost-effective health care across inpatient and outpatient settings. • Fewer preventable emergency department visits can result in better quality of life for patients • Reduce strain on acute care providers

Feedback Mechanisms
• Patient and care partner feedback on care transitions and ED experience • Reports from Dialysis Facility Care Compare and Dialysis Facility Reports • Feedback from QAPI team and dialysis facility staff
Assumptions
• ED encounters can be meaningfully attributed to dialysis facility care and dialysis-related causes • High ED encounter rates are preventable with better chronic dialysis management. • Providers and patients have the capacity and motivation to implement changes. Patient participation in the dietary, behavioral and medical requirements for successful dialysis care likely vary from patient to patient. Given the requirements for patient education and patient participation in development of dialysis treatment plans of care, we assume that a significant portion of patient behavior and adherence to the plan of care is related to the quality and quantity of education and training the patient, family and caregivers receive by the dialysis facility.
External Factors
• Regional variation in Emergency Department access (vs. urgent care centers) • Certain socioeconomic and comorbidity patient risk factors • Alternative payment models and CMS policy changes • Availability of primary and specialty care services