

[CBE ID and Measure Title] #5110 Standardized Readmission Ratio for Dialysis Facilities (SRR)

[Measure Description] The Standardized Readmission Ratio (SRR) for a dialysis facility is the ratio of the number of observed index discharges from acute care hospitals to that facility that resulted in an unplanned readmission to an acute care hospital within 4-30 days of discharge to the expected number of readmissions given the discharging hospitals and the characteristics of the patients and based on a national event rate. Note that the measure is based on Medicare-covered dialysis patients.

Inputs	Activities	Outputs	Outcomes	Impacts
<ul style="list-style-type: none"> 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) Post-discharge planning protocols including addressing fluid management; dialysis prescription; medication reconciliation 	<ul style="list-style-type: none"> 2-way communication with hospital prior to patient discharge Follow-up with patients within 3 days of hospital discharge for care coordination (follow up appointments, transportation) Identify high-risk patients and conduct root cause analysis for common readmission reasons (e.g. fluid management, medications) Transition of Care assessment after hospital discharge (dialysis prescription, target weight and BP control) Conduct post-discharge medication review Deliver education to patients about when to obtain hospital 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 re-admissions Use of Telehealth for remote monitoring and follow-up Staff Training Programs for Infection Prevention 	<ul style="list-style-type: none"> Number of patients where discharge summary was received Number of patients where a warm handoff was received? Number of patients classified as high-risk Number of post-discharge follow-up appointments scheduled Results of post-discharge medication review; medication reconciliation Update QAPI patient care plan if needed; follow-up appointments If needed, modify dialysis prescription to maintain target Kt/v 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) 	<p>Short Term</p> <ul style="list-style-type: none"> Increase patient engagement in post-discharge care Improved adherence to treatment and medications <p>Medium Term</p> <ul style="list-style-type: none"> Increased hospital follow-up appointments within 7-14 days of discharge. Fewer ED visits <p>Long Term</p> <ul style="list-style-type: none"> Reduce overall average of unplanned readmissions that occur between 4-30 days post-discharge (SRR) 	<ul style="list-style-type: none"> Sustained reduction in readmissions Control escalating medical costs, support provision of cost-effective health care, encourage effective coordination of care across inpatient and outpatient settings. Better patient quality of life and health outcomes Reduce strain on acute care providers

Feedback Mechanisms
<ul style="list-style-type: none"> • Patient and care partner feedback on care transitions and hospital experience • Reports from Dialysis Facility Care Compare and Dialysis Facility Reports • Feedback from QAPI team and dialysis facility staff
Assumptions
<ul style="list-style-type: none"> • Hospital readmissions can be meaningfully attributed to dialysis facility care and dialysis-related causes. • High hospital readmission rates are preventable with better 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. • Shared accountability of hospitals and dialysis facilities to support care coordination and post-discharge planning.
External Factors
<ul style="list-style-type: none"> • Regional variation in hospital discharge practices and threshold for readmission • Certain socioeconomic and comorbidity patient risk factors • Alternative payment models and CMS policy changes • Availability of primary and specialty care services to help with hospital follow up after discharge