Midland Quality Alliance

Focus Measure Helpful Hints: Avoidable Admissions & Readmission Rate

MEASURE DESCRIPTIONS

Source: 2018 HEDIS Technical Specifications

AVOIDABLE ADMISSIONS (Avoidable Inpatient Hospitalization Utilization)

- **Definition:** Number of acute inpatient discharges for ambulatory care sensitive conditions (ACSC) per number of member years in the eligible population, multiplied by the total number of covered lives.
- **Numerator:** All acute inpatient discharges identified as chronic or acute ACSC that occur while a member has active CIN coverage.
- **Denominator:** Total number of months per member that the population had active CIN eligibility during the measurement period. Member months are annualized and multiplied by the total number of covered lives. For a complete list of acute and chronic ACSCs, please refer to the HEDIS 2018 Technical Specifications.
- **Exclusions:**
    - Non-inpatient stays
    - Any discharge with a diagnosis of traumatic amputation of the lower extremity, toe amputation procedure, cystic fibrosis or anomaly of respiratory system, sickle cell anemia, HB-S disease, chronic renal failure, or kidney/urinary tract disorder
    - Any discharge with a diagnosis of stage I-IV kidney disease with a dialysis procedure
    - Any discharges with a cardiac procedure
    - Any discharge with a procedure or diagnosis of immunocompromised state

30- **DAY ALL-CAUSE READMISSION RATE**

- **Definition:** Number of acute inpatient stays or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.
- **Numerator:** At least one acute readmission for any diagnosis within 30 days of index discharge date.
- **Denominator:** All eligible inpatient discharges or observation discharges that occur while a member has active CIN coverage.
- **Exclusions:**
    - A principal diagnosis relating to rehab unit
    - A principal diagnosis indicating psychotic care
    - Admission with a planned procedure
    - Admission with a potentially planned procedure that does not have a principal diagnosis
    - Readmission to another admission
    - Member death during stay
    - Member discharged against medical advice
    - Observation stays that resulted in an admission

HOW TO IMPROVE PERFORMANCE

- Manage scheduling capacity to be able to see patients who have been discharged from a hospital stay within seven days
    - Consider having extended hours during the week and/or weekends.
    - If unable to have extended care hours, educate clinicians and office staff on closest in-network extended care so that they can communicate it to patients.
    - If your clinic already has extended hours, ensure that patients are aware.
- Train clinicians and office staff to identify risk factors that could lead to a preventable admission (e.g. lack of social support, barriers to medication adherence, difficulty with ADLs, etc.).
- Connect patients to community and/or health plan resources to help remove barriers to care and/or access to resources.
- Conduct medication reconciliation upon first visit post-discharge
- Assess patient's understanding and ability to manage chronic disease.
    - Refer to support or educational programs when needed (e.g. Diabetes Self-Management Education).
- Refer medically complex patients to the Comprehensive Care Management Department
    - Under this department, the Transitional Care Management Team contacts patients who visit the ED and who are discharged from the hospital