Metrics:
Avoidable ED Visits per 1000 Patients
and
Plan All-Cause Readmissions (30-day) (PCR)

Shared Learning Webinar

May 15, 2025

Today's Agenda

- Welcome-Laurel Avila
- Metrics Topic Introduction– Laurel Avila
- Racheal Inman, Population Health Manager Kadlec Regional Medical Center
- Client Case Discussion-Mobile Integrated Health Attendees
- Next Shared Learning Webinar: Screening for Health-Related Social Needs on June 26

Purpose of Today's Shared Learning Webinar

- Explore two commonly used healthcare metrics frequently referenced by payors and healthcare organizations.
- Our goal is to understand how the work we do in primary care and mobile integrated healthcare settings influence these metrics and contributes to improved outcomes across the care continuum

Avoidable ED Visits per 1,000 Patients

Measures ED use for conditions treatable or preventable in primary or urgent care

Focuses on visits that don't require ED-level care

Highlights system gaps like:

Limited access to care

Poor Chronic disease management

Lack of Care Coordination

Formula

Calculation:

$$\left(\frac{\text{Number of Avoidable ED Visits}}{\text{Total Patients}}\right) \times 1,000$$

Example:

- 300 avoidable visits / 10,000 patients
- = **30 visits per 1,000 patients**

What Counts as “Avoidable”?

- Emergent conditions preventable through appropriate preventive or chronic care management
- Non-emergent or semi-urgent cases
- Diagnoses often include:
  - Sore throat, UTI, ear infections
  - Mild asthma, skin infections
  - Based on algorithms

Why This Metric Matters

Quality Indicator

Reflects primary care access and care coordination

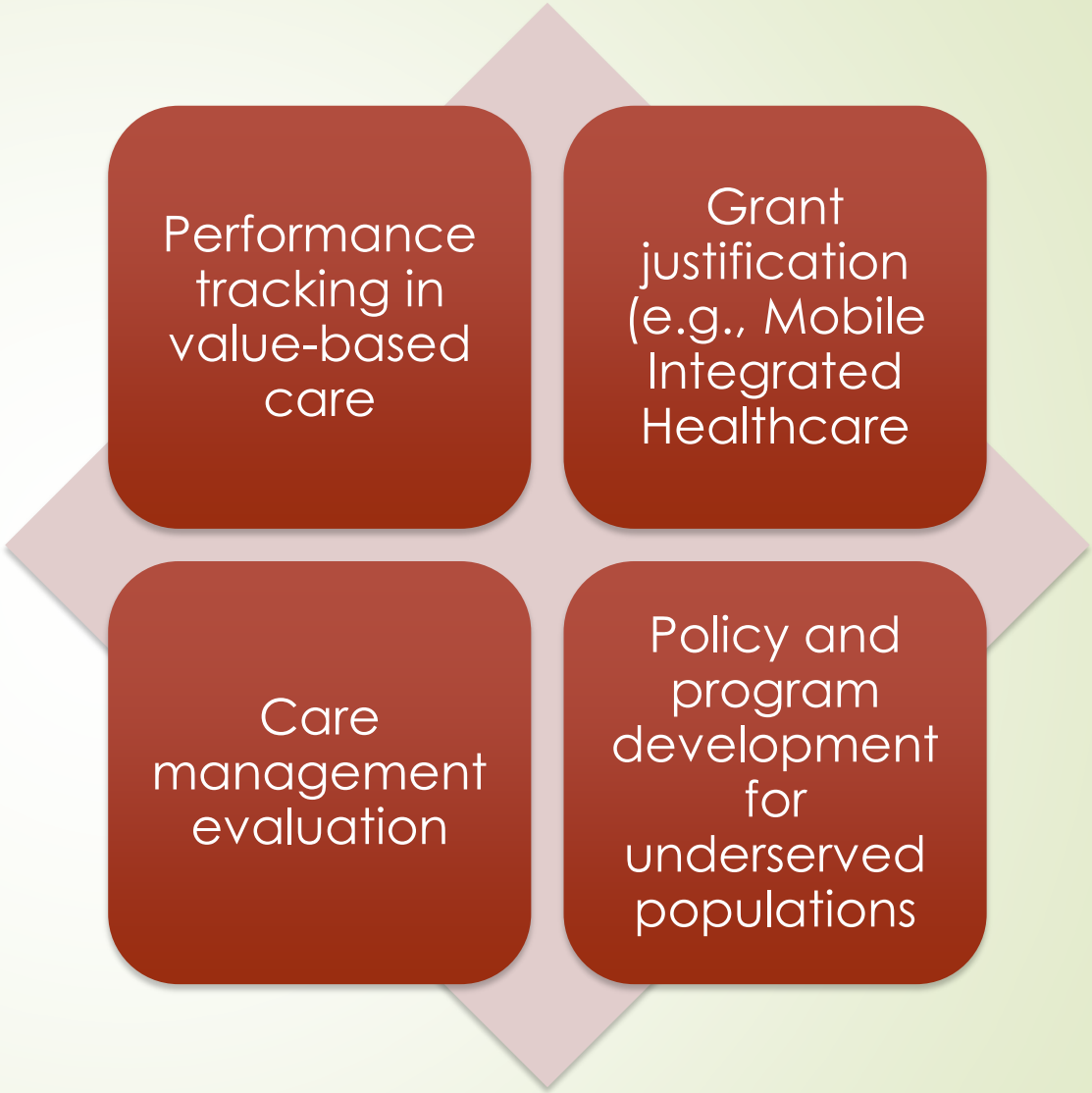
Cost Containment

ED care is more expensive than outpatient care

Population Health Insight

High rates signal opportunities for improvement

How It's Used


Performance tracking in value-based care
Grant justification (e.g., Mobile Integrated Healthcare
Care management evaluation
Policy and program development for underserved populations

Plan All-Cause Readmissions (30-day) (PCR)

Tracks patients readmitted to a hospital within 30 days of discharge

Focuses on **unplanned** readmissions for patients 18 and up

Used to assess **care quality, coordination**, and **follow-up**

Formula

- Calculation:

$$\left(\frac{\text{Unplanned Readmissions within 30 Days}}{\text{Eligible Discharges}}\right) \times 100$$

- Example:
- 50 unplanned readmissions/1000 discharges
- = 5% readmission rate

What Counts as a Readmission?

- An unplanned acute readmission for ***any*** diagnosis **within 30 days**
- Not elective or scheduled
- An acute discharge can be from any type of facility, including behavioral health facilities

Examples:

- CHF patient readmitted for shortness of breath
- CHF patient readmitted for broken hip from fall

What's Excluded?

- Planned readmissions (e.g., planned procedure, chemo)
- Patients who:
  - Are currently receiving hospice or use hospice services anytime during the measurement year
  - Died during the hospital stay
  - Directly transferred to another facility (count discharge date from 2nd facility only)

Why It Matters

- Care Quality Indicator
  - Highlights problems in patient care, discharge, or follow-up
- Cost Reduction Target
  - Readmissions are expensive and often preventable
- Value-based Care Metric
  - Affects reimbursement and penalties

Applications

Hospitals: Improve discharge planning and transitional care

Payers: Evaluate provider performance

Care Teams: Target high-risk patients for intervention

Programs: Demonstrate impact of case management and home-based care

Links for Reference

Washington State Common Measure Set

- https://www.hca.wa.gov/about-hca/who-we-are/washington-state-common-measure-set

HEDIS Guide by John Hopkins

- https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/2025-hedis-quality-measures-tip-sheet.pdf

Racheal Inman

Population Health Manager
Kadlec Regional Medical Center

Client Case Discussion

Mobile Integrated Healthcare

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Next Shared Learning Webinar:
Screening for Health-Related Social Needs
on Thursday, June 26 at 11:00 am

Thank you for attending today!