Inpatient and Emergency Department Utilization for Ambulatory Care Sensitive Conditions

Description

Composite measure including inpatient admissions and emergency department visits per 1,000 member months for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, dehydration, bacterial pneumonia, or urinary tract infection. **Numerator**

Discharges and emergency department visits that meet the inclusion and exclusion rules for the numerator in any of the following Prevention Quality Indicators (PQI):

PQI #1 Diabetes Short-Term Complications Admission Rate
PQI #3 Diabetes Long-Term Complications Admission Rate
PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
PQI #7 Hypertension Admission Rate
PQI #8 Heart Failure Admission Rate
PQI #10 Dehydration Admission Rate
PQI #11 Bacterial Pneumonia Admission Rate
PQI #12 Urinary Tract Infection Admission Rate
PQI #14 Uncontrolled Diabetes Admission Rate
PQI #15 Asthma in Younger Adults Admission Rate
PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

More information about the PQIs can be found here:
http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v70.aspx

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Each visit to an ED for one of the above PQIs is included in the numerator. Multiple ED visits on the same date of service are counted as one visit. Emergency Department visits are specified by the codes identified in the OHA ED Utilization specifications found here: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/Ambulatory-Care-Outpatient-ED-2018.pdf

Required exclusions for numerator: Mental health and chemical dependency services are excluded, using the codes in the above specifications.

Denominator

Member months for all CO assigned population aged 19 and older

Data elements required denominator: 1,000 Member Months

Cost of Care Measure FAQ

Q: Where did this measure come from and how is it aligned with state priorities?

A: The Cost of Care ACSC measure is adapted from the Agency for Healthcare Research and Quality (AHRQ)'s PQI 90. PQI 90 is one of the measures that OHA monitors as part of the CCO waiver. In addition, the measure is aligned with work CareOregon has been doing with network partners. It focuses specifically on conditions that are impactable by primary care and reinforces concepts of population health management, care coordination and use of PreManage.

Q: What is an Ambulatory Care Sensitive Condition (ACSC)?

A: Ambulatory Care Sensitive Conditions are conditions that are treatable in primary/ambulatory care settings, and that if are well managed should not result in emergency department or inpatient hospital use. Conditions can be acute (e.g. dehydration, bacterial pneumonia, UTI) or chronic (e.g. diabetes, hypertension, COPD, asthma).

Q: How is an ACSC different that an avoidable ED visit?

A: Avoidable ED visits are visits for conditions that do not require treatment in the emergency room. The ACSC measure looks at both inpatient and emergency department utilization. In addition, while avoidable ED visits look at "inappropriate" utilization or misuse of the ED, an ACSC event may be an appropriate utilization of ED/inpatient resources. However, it is an event that may have been prevented with early ambulatory-based intervention.

Q: How is this measure calculated?

A: The cost of care ACSC measure is:

$$\frac{\#\ of\ Inpatient\ admissions\ or\ ED\ visits\ for\ an\ ACSC}{Member\ Months}\ x\ 1000$$

It is calculated using claims data. Only the primary diagnosis code on the ED or inpatient claim is used to identify the event as an ACSC.

Q: What are member months?

A: Member months are a measure of both how *many* members fall into population and *how much time* they are in that population. For example, a member who was covered by CareOregon for 6 months of the measurement period will have 6 member months.

Q: Is the measure risk adjusted?

A: No, the measure is not risk adjusted. However, each participating organization will be measured against their *own* baseline data rather than a standard benchmark. This will account differing complexity between organizations.

Q: If my clinic is working on risk recapture, will this result in more patients becoming eligible for the ACSC numerator?

A: No. Risk recapture focuses on appropriately recoding conditions during primary care visits. ED and inpatient stays will only enter the numerator if an eligible diagnosis code is the primary diagnosis code on the *inpatient or ED* claim.

Q: How can I monitor my performance on this measure?

A: CareOregon will provide participating clinics with a quarterly aggregate data report. We are also working with Collective Medical, the Premanage vendor, to produce an ACSC cohort that clinics will have access to. Finally, there may be a proxy measure that you can use to monitor progress in your high priority populations. For instance, if you choose to focus on diabetes, Diabetes HbA1c Poor Control could act as a proxy measure that allows you to monitor whether there have been improvements in the management of that population.

Q: What do I have to do to report this measure?

A: Participating clinics will not need to report this measure to CareOregon. CareOregon will calculate and assess performance and share it with clinics. The clinic is however responsible for monitoring their performance and any relevant interventions.

Q: What can I do to improve on this measure?

1. Using baseline data CareOregon will provide to you, identify 1-2 ACSC-related populations of high priority to focus in on.

2. Assess current care processes surrounding **these populations**. Consider examining your approaches to:

   - Panel Management: Do you chart/schedule scrub, leverage health maintenance alerts, have workflows in place for in-reach and outreach?

   - Team-Based Care: How are you optimizing visits and patient touches through your care team? What roles do you have on your care team(s), and in what ways are they working/could work with these patient populations/conditions? How are you communicating patient needs across your team? Do you hold huddles and team meetings?

   - Self-Management Support: What types of educational materials, classes, and health coaching support do you offer? What community-based programs and services do you know of and refer patients to?

   - Access: How do you handle patient urgent/acute care needs? What types of appointments do you offer, (telephone, virtual, etc.), and at what hours? Are patients able to access a nursing advice line during and after clinic hours?

- Coordination and follow-up: How do you know when a patient has been to the ED or has been hospitalized? What ways are you monitoring utilization, and connecting with patients to ensure they receive post-ED or post-hospital discharge care?

3. Using your assessment results, create an improvement plan to address clinic capacity in caring for and managing these populations.

4. Leverage PreManage
    - Monitor ACSC cohorts, and enter care recommendations/patient insights to guide care and follow-up.

Q: My premanage data doesn't match the data you shared exactly. Why?

A: The ACSC measure will be calculated using the primary diagnosis on the claim submitted to CareOregon. Because Premanage operates in real time, it does not wait for a claim to be submitted. Instead, it sorts patients into a cohort based on the chief complaint the ED/hospital documented. Premanage can approximate the ACSC numerator but will never exactly match because of this difference in data source/methodology.

Q: Who do I contact if I have questions?

A: If you have questions please email paymentmodel@careoregon.org.