HMS Performance Measure #6

Increase Discharge / Post-Discharge Care Coordination for Sepsis Cases Discharged to a Home-like Setting

SCORING FOR PERFORMANCE YEAR 2026

To Receive Full Points (15 points):

≥ 86% of All Patients discharged to a Home-Like Setting must receive **1 out of 4** Care Coordination Measures

AND

≥ 74% of High Risk Patients discharged to a Home-Like Setting must receive **2 out of 4** Care Coordination Measures

To Receive Partial Points (8 points):

≥ 86% of All Patients discharged to a Home-Like Setting must receive **1 out of 4** Care Coordination Measures

OR

≥ 74% of High Risk Patients discharged to a Home-Like Setting must receive **2 out of 4** Care Coordination Measures

If you achieve neither goal, you will receive 0 points for the measure.

CASES **INCLUDED** IN MEASURE

Patients discharged to a Home-Like Setting.

Home-like settings include:

- Home
- Assisted living facility
- Custodial nursing facility
- Temporary shelter

CASES **EXCLUDED** FROM MEASURE

Patients transferred to another acute care hospital

Patients discharged to:

- Skilled nursing facility
- Inpatient or sub-acute rehab facility
- Long-term acute care hospital (LTACH)
- Home or inpatient hospice
- Correctional facility
- Inpatient psychiatric facility

WHICH PATIENTS ARE CONSIDERED **HIGH RISK FOR READMISSION**?

High risk patients are those who are **deemed by your site-specific readmission risk score to be high risk.**

As risk scores are updated daily, abstractors will **capture the last documented risk score prior to discharge.**

WHAT IF MY SITE DOESN'T USE A READMISSION RISK SCORE?

If a site doesn't have a readmission risk score in place, or if the score is not documented for an individual patient, **the patient will be scored using the HMS Readmission Score.**

The **HMS Sepsis Readmission Score** is based upon elements from published literature such as:

- LACE score
- Sepsis Transition and Recovery (STAR) program high risk readmission definition

HMS Sepsis Readmission Score	
Element	**Score**
Length of Stay	1-6 Days: 0 Points 7-10 Days: 1 Point 11-14 Days: 2 Points 15+ Days: 3 Points
Admitted from SNF/SAR/LTAC	1 Point
Admitted to the ICU during hospital encounter	1 Point
Hospitalization in the 90 days prior to hospital encounter	1 Point
Baseline functional limitation (partially/fully dependent)	1 Point
Mild, moderate or severe liver disease	1 Point
Baseline cognitive impairment	1 Point
Hematologic malignancy (Leukemia/Lymphoma)	1 Point
Congestive heart failure	1 Point
Cardiovascular disease	1 Point
Peripheral vascular disease	1 Point
Moderate or severe kidney disease	1 Point
High Risk for Readmission = ≥ 4 Points	

Hospital Contact Number included in Discharge Paperwork

Requirements to Pass this Measure:

- Phone Number must be prominently displayed in discharge paperwork with instructions to call the number if the patient has any questions, concerns, or complications post-discharge.
- Phone line must be manned 24/7.
- Number must connect patient to a provider within 1 hour.

Note: You may include a PCP or Specialist number if that provider **meets both of the following requirements:**

- The PCP or Specialist saw the patient during their hospitalization
- The PCP or Specialist assumed the patient's care upon discharge

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Scheduled for Outpatient Follow-up within 2 Weeks

Requirements to Pass this Measure:

- Follow up visit with a PCP (MD or APP) or Specialist (MD or APP) must be scheduled prior to patient discharge
- Appointment details must be placed in the patient's discharge paperwork
- Note: To pass this measure, the patient is not required to complete the visit. HMS only considers whether the visit was scheduled at the time of discharge.

Telephone Call or PCP/Specialist Visit within 3 Calendar Days

Requirements to Pass this Measure:

Telephone Call:

- Patient received a post-discharge telephone call within 3 calendar days of discharge.
- All of the following must be true:
  - Caller was a clinician (Provider, Nurse, Pharmacist, Case Manager, or Social Worker)
  - Caller had access to the patient's hospitalization records in the EMR
  - Caller placed a record of the call in the EMR

Note: Automated (robo) calls will only count toward this measure if the patient is connected with a clinician at the end of the call. If the patient only speaks with the automated call service, the call will not count.

OR

PCP/Specialist Visit:

- Patient had a PCP or Specialist Visit (MD or APP) within 3 Calendar days of discharge

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Patient is discharged to a home-like setting with home health services

Requirements to Pass this Measure:

- Patient is ordered to receive home nursing services or home palliative care services at time of discharge
- Note: Exclude Physical Therapy, Occupational Therapy, and infusion services.

Collaborate with other hospitals in your system to identify opportunities for process improvement to meet the 2026 Discharge Care Coordination Measure. The questions below are intended to serve as prompts to guide your discussion. This brainstorming document is for your reference only and does not need to be submitted at the conclusion of the session

Does your hospital have a process / scoring method for determining which patients are at high risk for readmission?

- Is this score automatically calculated by your EMR or do you use a manual scoring process?

- Where is this score documented? Who has access to the score?

- Is this score currently used by providers or case management to determine care at discharge?

- Are patients deemed to be high risk for admission managed differently during discharge planning? What is your current process for these patients?

- Does your hospital have a process for tracking patients deemed to be at high risk for readmission? Who is responsible for tracking these patients?

- For patients deemed to be high risk for readmission, which two coordination of care measures would be most feasible to provide?

Collaborate with other hospitals in your system to identify opportunities for process improvement to meet the 2026 Discharge Care Coordination Measure. The questions below are intended to serve as prompts to guide your discussion. This brainstorming document is for your reference only and does not need to be submitted at the conclusion of the session

How is your hospital currently performing on the Discharge Care Coordination Performance Measure (Measure #6)?

Refer to pages 5-9 of your Sepsis Quarterly Report.

- Which of the four coordination of care measures is your hospital performing best on?

- Which of the four coordination of care measures are most challenging for your hospital? Why?

- Are you currently working on any quality improvement projects related to this measure?

What is your current process for Discharge Care Coordination?

- Do you include a hospital contact number in all discharge paperwork? If not, why?

- What is your process for completing follow-up calls within 3 days of discharge? What barriers are you encountering?

- Are all patients treated for sepsis scheduled for a 2 week follow up visit? Who is in charge of scheduling these visits? What are your current barriers to scheduling visits?

- How does your hospital determine which patients should be referred to Home Health? What barriers are you encountering in referring patients to Home Health?