

Measure at a Glance

CBE #5110: Standardized Readmission Ratio (SRR) for Dialysis Facilities

Measure Summary (Where does this measure seek to improve care?)

The Standardized Readmission Ratio (SRR) shows how often patients from a dialysis facility return to the hospital within 4-30 days after they are discharged. The measure compares the actual number of readmissions to the expected number of readmissions based on patient and hospital characteristics. Both hospitals and dialysis facilities are responsible for preventing such readmissions.

The measure only includes Medicare patients with end-stage renal disease (ESRD) who are in Fee-for-Service or Medicare Advantage programs.

A lower score shows better performance (fewer readmissions than expected). Better performance may be linked to care during and after hospital discharge.

Meaningfulness (Why does this matter to patients, and how could it improve their care?)

The SRR focuses on unplanned readmissions (unexpectedly going back to the hospital). Understanding unplanned readmissions can provide information on patient health and daily life.

Dialysis patients are hospitalized about 1.5 times per year, and hospital care makes up about 35% of total Medicare costs for these patients. In 2021 and 2022, about 31-33% of dialysis patients had unplanned readmission within 30 days following hospital discharge. These numbers show that hospital stays and returns to the hospital are common for this group.

Patients with ESRD and their caregivers say that hospital stays matter to them. Hospital visits can disrupt daily life and cause stress. In a study with over 4,000 hemodialysis (HD) patients, participants ranked reduction in hospital stays among the highest priority outcomes. Because patients care about staying out of the hospital, the SRR may reflect a meaningful outcome for patients.

Usability (How will providers use this measure to improve care delivery?)

Public reporting programs, including Dialysis Facility Care Compare, use the SRR to share information about dialysis facility performance. Patients can use this information to compare dialysis facilities and learn about the quality of care they may receive. The measure may help patients understand how often people return to the hospital after treatment at a dialysis facility.

Facilities also receive feedback through review periods and helpdesk support, allowing them to see their performance and ask questions about result calculations. Feedback often focuses on patient assignments and how facilities handle patient differences. This process may help dialysis facilities better understand their results and identify care processes to improve.

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Feasibility (How can this measure be implemented without adding burden for providers and patients while still improving care?)

The SRR uses data that dialysis facilities already collect as part of routine care. These data come from sources such as the End Stage Renal Disease Quality Reporting System (EQRS) and Medicare claims.

Because the data are already available in structured formats (meaning the data comes from reliable and organized pre-existing systems), facilities do not need to create new systems to report this measure and cases of missing or incorrect data were rare. As such, the measure does not add extra cost or workload for facilities. This may make using and maintaining the measure overtime easier.

The developer did not identify any major challenges with using the measure. This suggests the measure can be used without adding burden.

Impact (How will using this measure improve patient experiences and outcomes?)

The SRR focuses on reducing unplanned hospital readmissions, which may improve patient health and quality of life. Evidence links unplanned readmissions to patient health problems and lower quality of life. Efforts such as better care coordination and treatment management may help reduce readmissions. Readmission reduction also has a cost advantage. For dialysis patients, hospital care makes up about 35% of Medicare costs.

The measure looks at actions that dialysis facilities can take after hospital discharge, including managing fluid levels, reviewing medications, and coordinating follow-up care. Studies show that these may reduce the chance of returning to the hospital. One study found a 2% decrease in readmissions when facilities coordinated care better. These findings suggest that the measure could support care practices that may lower readmission risk.

Performance Gap (Based on current performance, where and how much care can improve?)

The measure's performance data are from 2023 and include 7,710 dialysis facilities and 460,594 index discharges. The measure compares the number of observed unplanned hospital readmissions to the expected number of readmissions.

Results are grouped into deciles, which divide facilities into 10 equal-sized groups based on performance to show variation across facilities.

Decile performance ranged from 0.44 to 1.53, with a mean (average) score of 1.04. Lower scores mean fewer readmissions than expected and higher scores mean more readmissions than expected.

The number of readmissions may show differences in care across facilities. Because the measure compares actual readmissions to expected ones, it may highlight where outcomes are higher or lower than expected. This makes it useful for identifying potential gaps in care coordination, discharge planning, or follow-up processes. The measure can help point to where improvements in patient management and transitions of care may lead to better outcomes.

Disclaimer: Battelle used generative artificial intelligence in the initial drafting of this document. Actual humans with relevant expertise subsequently validated and revised the content.