Plan All-Cause Readmissions (PCR)

APPLICABLE LINES OF BUSINESS

- Commercial
- Medicare

MEASURE DESCRIPTION

The number of acute inpatient and observation stays for patients 18 years of age and older during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.[i]

- For the commercial population, the measure applies to patients 18-64 years of age.
- For the Medicare population, the measure applies to patients 18 years of age and older.

EXCLUSIONS

Patients are excluded if they:

- Died during hospital stay
- Received hospice care at any time during the measurement year
- Have a primary diagnosis of pregnancy on the discharge claim
- Had a primary diagnosis of a condition originating in the perinatal period on the discharge claim
- Had an acute hospitalization where the discharge claim has a diagnosis for
    - Chemotherapy maintenance
    - Principle diagnosis of rehabilitation
    - Organ transplant
    - Potentially planned procedure without a principal acute diagnosis

TIPS FOR SUCCESS

Before or During Acute Inpatient/Observation Stay

- Connect with an Admission, Discharge, and Transfer (ADT) system as well as health plan ADT alerts.
    - Include ED visits, inpatient admissions/discharges, and facility transfers (SNF, IRF).
- Deploy transition care managers to support inpatient care and transition planning, especially for patients who are at high-risk for readmissions.
    - Reinforce existing care plan and relationship with the medical home.
    - Coordinate post-discharge follow-up scheduling.

After Acute Inpatient/Observation Stay

- Implement a multi-disciplinary post-discharge process to track, monitor, and follow-up with patients.
    - Review ADT reports at office opening, midday, and at end of day.
    - Include a multi-disciplinary team (health coach, pharmacy, social work, behavioral health).
    - Stratify the population based on risk (e.g., readmission history, polypharmacy, social determinants of health, presence, or absence of family and social support), and re-stratify as needed after team review.
- Outreach based on high risk (same day), medium risk (24-48 hours) and low risk (3 days)
    - Discuss the discharge summary with patients and ask if they understand the instructions and if they have filled new prescriptions.
    - Review all medications with patients, including post-discharge medication changes, OTC, and supplements. Provide patients with a current medication list.
        - Document and date the medication reconciliation in the patient's medical record and submit a claim with CPT®[ii] II code 1111F (discharge medications reconciled with the current medication list in the outpatient medical record).
    - Develop a patient action plan for warning signs that their condition is worsening and educate on how to respond including who to contact, even after hours.
    - Ask the patient to explain their condition and warning signs back to you.
- Schedule a follow-up PCP or post-acute home visit appointment, as appropriate. Keep a few open appointments available so patients can be seen within 7 days of discharge.
    - Ask patients about barriers or issues that might have contributed to their hospitalization and discuss how to prevent them in the future.
    - Ask patients if they completed or scheduled prescribed outpatient workups or other services. This could include physical therapy, home health care visits, or obtaining durable medical equipment.
- Obtain test results from when the patient was discharged and track tests that are still pending.
- Conduct multi-disciplinary retrospective readmission reviews to understand opportunities for improvement.

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[i] National Committee for Quality Assurance. *HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans* (2023), 448-449