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 65 years of age and older.

Data are reported in the following categories:

- Count of index hospital stays (IHS) (denominator)
- Count of observed 30-Day readmissions (numerator)
- Count of expected 30-Day readmissions

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

TIPS FOR SUCCESS

- Connect with your state's automated electronic Admission, Discharge, and Transfer (ADT) system to receive timely discharge data.
- Consider implementing:
    - A post-discharge process to track, monitor, and follow up with patients
    - Transitional care management for patients who are at high-risk for readmissions
- Keep a few open appointments available so patients who are discharged from the hospital can be seen within 7 days of discharge.
- Discuss the discharge summary with your patients and ask if they understand the instructions and

filled new prescriptions.

- Obtain any test results that weren't available when patients were discharged and track tests that are still pending.
- Ask your 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.
- Develop a patient action plan for chronic conditions like asthma and congestive heart failure. The plan should include what symptoms would trigger the patient to:
    - Start as needed (PRN) medications
    - Call you (during and after office hours)
    - Go to the emergency room
- After explaining the patient's condition and red flags to watch for, ask them to explain their condition and warning signs back to you.
- Schedule a follow up appointment, as appropriate. You may want to see them back in just a few days or a week. Or if they are doing well, in a longer follow up period, such as 3 months.

POST-DISCHARGE MEDICATION RECONCILIATION

- Review all medications with the patient, including post-discharge medication changes, OTC, and supplements.
- Ask patients and/or caregivers to describe their new medication regimen back to you.
- Document and date the medication reconciliation in patients' 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).
- If not using CPT II code 1111F or Transitional Care Management codes, please see the Transitions of Care Tip Sheet for details on chart documentation requirements for medication reconciliation.
- Provide the patient with a current medication list.

[i] National Committee for Quality Assurance. *HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans* (2020), 504-513

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