Plan All Cause Readmission (PCR)

Overview

- PCR measure assesses whether members who had acute inpatient and observation stays had an unplanned acute readmission for any diagnosis within 30 days after an acute inpatient or observation discharge
- Health plans must report observed rate and predicted probability of readmission to account for the prior and current health of the member
- The observed-to-expected ratio is multiplied by the readmission rate across all health plans to produce a risk-standardized rate which allows for national comparison

https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/

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WHY IS IT IMPORTANT

- Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge, increasing support for patient self-management or providing home health service and or initiating home base community services, if member has this benefit

https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/

Understanding the Measure

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- How is someone identified for the measure:
  - Members 18 years of age and older, who had acute inpatient and observation stays during the current year between January 1 and December 1, and was followed by an unplanned acute readmission for any diagnosis within 30 days

- How is it measured:
  - Identifying all the acute and observation stays and discharge dates from the first setting with the admission date from the second setting that are 2 or more calendar days apart from any type of facility (including behavioral healthcare)

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TALKING POINTS WITH PROVIDER GROUPS

- Remind provider groups that PCR is based on patients that were readmitted within 30 days after acute inpatient and observation stays during the current year between January 1 and December 1
- Discuss with the provider groups the importance of the follow-up visit within 7 days post hospital discharge, to complete medication reconciliation, discuss the discharge summary to ensure understanding and have filled new prescriptions, if there are any
- Remind provider groups that follow-up can be provided via telehealth, telephone, or virtual visit
- Discuss and share the provider analytic member detail report with provider groups showing members who were readmitted with 30 days after being discharged from hospital for acute or observation stays
  - Review these members(s) medical record to determine if they have issues accessing the resources necessary to prevent a readmission
  - For Wellcare LOB only, only rate of PCR can be found on Medicare Executive Scorecard
- Confirm with provider groups if they reserve appointment spots for patients who need follow up visits within 7 days of inpatient or observation stays
- Remind provider groups to instruct patient to call the day after hospital discharge, for a follow-up (f/u) appointment within 7 days (either telehealth or in person)

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PROVIDER GROUP'S KEYS TO SUCCESS

- Ensure that provider groups have available appointments for patients that need f/u within 7 days after hospital discharge
- To prevent readmission, remind patients to call clinic the next day after hospital discharge, to schedule f/u appointment to complete medication reconciliation and discuss discharge summary for understanding and home management
- Encourage providers to offer telehealth, telephone or virtual visits as an option, to ensure that the 7- day f/u is completed, if there is no in-person appointment spot available
- Ensure that providers have a process to receive hospital admission report and create an alert within EMR to flag these patients

Resources

- HEDIS Quick Reference Guide (page 25)