Plan All-Cause Readmissions (PCR)

HEDIS measure overview

Coordination of care, including a post-discharge visit, has always been critical to patient health outcomes. Beginning with measurement year 2019, the National Committee for Quality Assurance (NCQA) implemented changes to the current Plan All-Cause Readmissions (PCR) Healthcare Effectiveness Data and Information Set (HEDIS®) measure that will likely increase the number of patient events reported.

Please note: Information in this flyer is based on HEDIS technical specifications. It is not meant to preclude clinical judgment. Treatment decisions should always be based on the physician’s or clinician’s clinical judgment.

Who is included in the PCR measure?
Medicare Advantage patients 18 years old and older who have had an acute inpatient or observation stay through Dec. 1 of the measurement year (denominator) and a subsequent unplanned acute readmission or observation stay for any diagnosis within 30 days (numerator) are eligible for this measure.

Exclusions
- Stays with discharge dates of Dec. 2–31
- Planned admissions for chemotherapy, rehabilitation,† transplant, etc.
- For acute to acute direct transfers, the subsequent admission’s discharge date is the relevant date for the measure.
- Pregnancy-related admission
- Patients in hospice
- Patients with four or more stays during the measurement year (known as outliers; added with draft 2020 measure)

† Rehabilitation exclusions are limited to fitting and adjustment of prosthesis and other medical devices, such as infusion pumps, neuropacemakers, etc.

What does it mean for PCR to be a risk-adjusted utilization HEDIS measure?
This means that after measure performance is determined using the numerator and denominator, the observed admission rate is compared with the expected readmission rate for the eligible population. The expected value is based on each patient’s known clinical history at the time of discharge and is calculated for each event. This ensures population rates are adjusted for patients who have a higher risk of unplanned readmissions. The risk calculation takes into account the following:
- Comorbidities such as diabetes, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD)
- Surgeries – procedures performed prior to and during the current event
- Discharge condition – diagnoses made prior to and during the current event
- Age and gender – men have a higher risk that increases with age
Service needed for PCR measure compliance

While there is no particular service needed for compliance, practices can have a process in place to identify patients who have been discharged from acute facilities using daily discharge reporting. Outreaches to these patients to schedule follow-up care and medication reconciliation may reduce the risk of readmission. Research on improving the rate of readmissions has indicated programs that include nurse-led care planning before discharge and pharmacist-led medication reconciliation after discharge observed significantly fewer readmissions.1, 2

Why is it important to perform well on the PCR measure?

It can prevent patients from returning to a hospital shortly after being discharged, which can be costly and often avoidable. Hospital readmissions are used to measure quality of care in a healthcare system. Common avoidable reasons for hospital readmission include:

- Patient confusion about dosing frequency of prescribed medications
- Important information, such as test results not communicated to the primary care physician
- Inadequate follow-up care after release

What is a good PCR performance rate?

PCR is one example of an inverse measure, which CMS defines as: “... a lower calculated performance rate for measures, which indicates better clinical care or control.” For an inverse measure, the desired performance rate is 0%. Better clinical care or control will produce a performance rate that trends closer to 0% as quality increases.

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<thead>
<tr>
<th>PCR Star measure cut points</th>
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<td>Cut points for compliance percentages that determine the measure-level Star rating</td>
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Measure best practices

- Promote health plan services (e.g., transition of care, care coordination, home health, etc.).
- Be aware of the daily discharge census.
- When possible, manage scheduling capacity to ensure discharged patients can be seen within seven days.
- Conduct medication reconciliation during the first post-discharge visit with the patient.
- Have a discussion with patients to determine if they have issues accessing the resources necessary to prevent a readmission (e.g., ability to get the medications prescribed at discharge, transportation for follow-up appointments, family or community support)
- Connect patients to community resources and/or health plan care management services to help remove barriers to care and/or access to resources.
