HEDIS® Tip Sheet

Risk Adjusted Utilization Measures

health net

Plan All-Cause Readmissions (PCR)

Learn how to improve your PCR HEDIS[1] rates by using this tip sheet for key details about the PCR measure, exclusions, and best practices.

Measure

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

- For Commercial and Medicaid population, the measure applies to patients 18–64 years of age.
- For Medicare population, the measure applies to patients 18 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 who meet any of the following criteria are excluded from the measure:

- In hospice or using hospice services any time during the measurement year.
- Died during the inpatient stay.
- 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.
- Acute hospitalizations where the discharge claims have a diagnosis for:
  - Chemotherapy maintenance.
  - Primary diagnosis of rehabilitation.
  - Organ transplant.
  - Potentially planned procedure without a principal acute diagnosis.

1 HEDIS – Healthcare Effectiveness Data and Information Set.

(continued)

Best practices

- Connect with Cozeva® to receive timely admission, discharge, transfer (ADT) data from Health Net.
- Request discharge summaries from hospitals prior to the appointment or remind patients to bring their discharge papers to their appointment.
- Keep some open appointments so patients who are discharged from the hospital can be seen within 7 days of discharge. Consider telehealth post-discharge visits and remote patient monitoring solutions for patients at greater risk of readmissions if there are barriers preventing in-person follow-up in a timely manner.
- Identify high-risk patients, refer to appropriate complex care management programs, and ensure frequent communication across the whole care team.
- Conduct a post-discharge phone call to assess patient condition and understanding of their discharge plan and medications. Use techniques such as the teach-back method to reinforce patient education and adherence.
- Assess potential barriers to follow-up (e.g., need for family/caregiver support, transportation challenges, language barriers) and provide support and referrals as needed.
- Ensure patients obtain durable medical equipment, physical therapy, home health services, and community-based resources when needed.
- Reconcile medications on discharge instructions with those on the list of patients' outpatient medications.
- Inform patients of their available care options including urgent, emergent and postoperative care. Provide phone numbers and addresses for patients.

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