2024 PCR
Plan All Cause Readmission

Plan All Cause Readmission (PCR)

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A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination.

Unplanned readmissions are associated with increased mortality and higher health care costs.

Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.

This measure information can also be used to decrease pediatric readmissions.

This is an administrative only measure. Supplemental data may not be used for this measure, except to prove exclusion criteria.

An acute discharge can be from any type of facility, including behavioral health facilities.

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Measure Description

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

A lower rate indicates a better score.

For Medicaid and Commercial patients – The included age range is 18–64 only.

This measure is based on the number of discharges, not patients. A patient may fall into this measure *several* times in the current performance year.

Medicare: 18 years of age and older

Medicaid: 18-64 years of age

Commercial: 18-64 years of age

The number of acute inpatient or observation stays followed by an unplanned readmission within 30 days in the current performance year.

X3

Triple Weighted Star Measure

Measure Steward: National Committee for Quality Assurance (NCQA)

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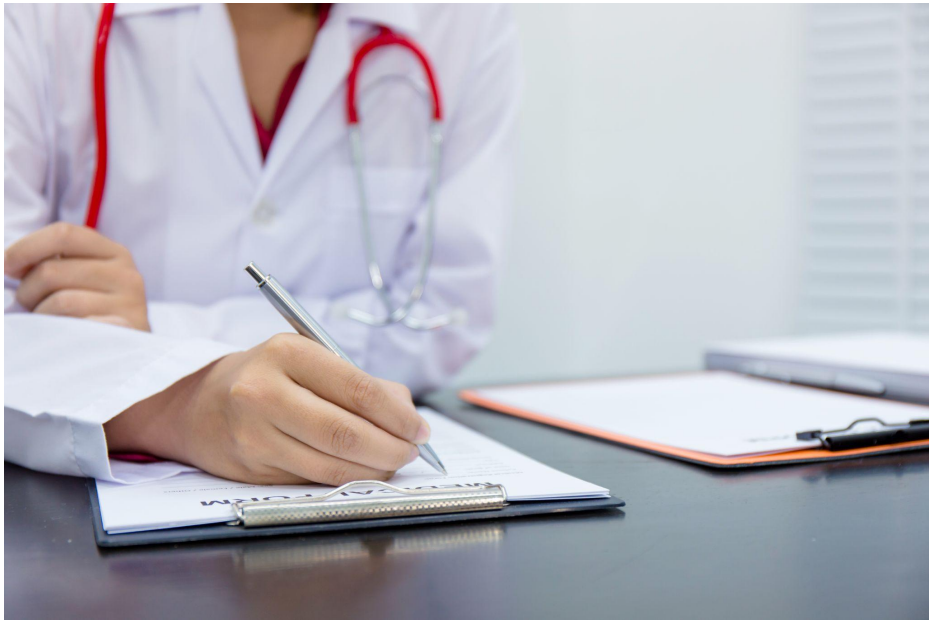
Required Exclusions

These exclusions can be verified via claims **or** supplemental data submissions.

- **Hospice or palliative care services** anytime during the current performance year
- Patients who **passed away** during the inpatient stay
- Principle diagnosis of **pregnancy on the discharge claim**
- Principal diagnosis of a **condition originating in the perinatal period** on the discharge claim
- Patients who were **admitted and discharged the same day**
- Acute hospitalizations where the discharge claims has a diagnosis for:
  - **Chemotherapy maintenance**
  - **Principle diagnosis of rehabilitation**
  - **Organ transplant**
  - **Potentially planned procedure without a principal acute diagnosis**



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Best Practices

- **Remember: A lower readmission rate and comprehensive diagnosis documentation will drive better scores for this measure.**
- Patients with multiple comorbidities are expected to return post inpatient or observation discharge at a higher rate. Ensure all suspect conditions are appropriately identified in the patient's medical record and claims.
- Encourage patients to engage in palliative care or hospice programs as appropriate to drive lower readmissions for high risk patients to reduce hospitalizations.
- Remember to document Transition of Care Indicators, including **medication reconciliation (CPT II Code 111F)**
- Be aware of the high utilizers and those at high risk for readmissions.
- Partner with hospitals to aid in care management services and receive copies of discharge summaries
- Develop a process to identify patients who have been discharged from acute facilities using daily discharge census or reporting from health plan/partners.
- Make plan to see discharged patients within a week of discharge.
- If the patient is a planned admission, make it practice to pre-schedule the follow up appointment prior to admission.
- Ensure patients have access to all medications. Address medication barriers.
- Express the importance of keeping PCP appointments.
- Educate the patients on choosing the correct access of care: PCP, Urgent Care, ED.

Knowledge Check

1. **The PCR measure looks at unplanned acute readmissions within _____ days of discharge.**

A. 30
B. 60
C. 90
D. 120

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A. 30
B. 60
C. 90
D. 120

Rationale: PCR measures unplanned acute readmissions within 30 days of discharge.

2. This measure is based on the number of discharges, not patients. A patient may fall into this measure several times in 2024. True or False.

A. True
B. False

2. **This measure is based on the number of discharges, not patients. A patient may fall into this measure several times in 2024. True or False.**

A. True
B. False

Rationale: A patient can fall into this measure each time they are discharged from an inpatient facility stay.

3. Which of the following acute hospitalization diagnosis claims will exclude the patient from the PCR denominator? Choose all that apply.

A. Congestive heart failure exacerbation
B. Rehabilitation
C. Chemotherapy maintenance
D. Organ Transplant
E. All of the above

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A. Congestive heart failure exacerbation
B. Rehabilitation
C. Chemotherapy maintenance
D. Organ Transplant
E. All of the above

Rationale: Rehabilitation, chemotherapy maintenance, organ transplant or a planned procedure without a principal acute diagnosis will exclude the patient from the PCR measure.

4. **You are reviewing the patient's medical record and see that the patient used hospice services in 2024. You can copy this information and submit it to the payer to remove the patient from the measure denominator. True or False.**

A. True
B. False

4. **You are reviewing the patient's medical record and see that the patient has utilized hospice services in 2024. You can copy this information and submit it to the payer to remove the patient from the measure denominator. True or False.**

A. True
B. False

Rationale: This measure is based on claims and encounters, but supplemental data may be submitted to verify exclusion criteria.

5. Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management. True or False.

A. True
B. False

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A. True
B. False

Rationale: Providing follow-up care with the patient and ensuring patient support is given post-discharge is proven to prevent unplanned readmissions.

Thank You!