Plan All-Cause Readmissions (PCR)

Description of Measure

The number of acute inpatient and observation stays for patients 18 years of age and older between January 1st and December 1st, followed by an acute readmission, for any diagnosis, within 30 days of discharge and the predicted probability of an acute readmission.

Note: This measure is based on discharges, not patients, and includes behavioral health facilities.

Exclusions

Patients are excluded if they:

- Elected or using hospice services anytime during the measurement year (MY)
- Members who died during the the hospital stay
- Members with primary diagnosis of pregnancy on the discharge claim
- Members with a principal diagnosis of a condition originating in the perinatal period
- The Index Admission Date is the same as the Index Discharge Date
- A planned hospital stay using any of the following:
  - Principle diagnosis of maintenance chemotherapy
  - Principal diagnosis of rehabilitation
  - An organ transplant
  - A potentially planned procedure without a principle acute diagnosis

Tips for Success

- Please help members avoid readmission by:
  - Following up with them within 1 week of their discharge.
  - Making sure they filled their new prescriptions post-discharge.
  - Implementing a robust, safe discharge plan that includes a post-discharge plan that includes a phone call to discuss these questions:
    - Do you completely understand all the instructions you were given at discharge?
    - Do you complete understand the medications and your medication instructions? Have you filled all your medications?
    - Have you made your follow-up appointments? Do you need help scheduling them?
    - Do you have transportation to the appointment and/or do you need help arranging transportation?
    - Do you have any questions?
- Implement an appointment frequency protocol for patients at high-risk for admission.
- Utilize telehealth appoints for patients who are not able to come to the office for appointments.
- Obtain any test results that were not available when patients were discharged.

- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future.
- Consider outreach calls to members that are prone to readmission.
- Educate patients that are non-adherent to treatment plans on the risk to hospitalization, as appropriate.
- Educate patients to call their PCP prior to going to the emergency/ hospital, if appropriate.
- 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 members to engage in palliative care or hospice programs as appropriate.
- Promote regular PCP visits and follow-up appointments for chronic condition management. Members can find care at **secure.arkansasbluecross.com/Findcare/Default.aspx#/ChooseNetwork** if they don't have a PCP.
- Speak with an Arkansas Blue Cross case manager by calling **800-225-1891** to help manage chronic conditions between provider visits to stay out of the hospital. Learn more by visiting **arkbluecross.com/casemanagement**.
- Telehealth is an easy way to follow-up with a provider at home in between PCP visits. For ARHOME members, view virtual care options like Teladoc on Blueprint Portal (**blueprintportal.com/login**) or go to **myvirtualhealth.com** to create an account and schedule a virtual visit.
- *ARHOME members can earn Blue Wellness Rewards by completing PCP visits or follow-up appointments for chronic conditions and behavioral health conditions. Visit **BlueWellnessRewards.Healthmine.com** and register or login or call 800-800-4298 to sign up with a customer service representative to see what rewards are recommended.

Resources

I. National Committee for Quality Assurance, HEDIS® Measurement Year 2025 Volume 2 Technical Specifications for Health Plans