BlueCross BlueShield Nebraska

Plan All-cause Readmissions (PCR)

Risk-Adjusted Utilization HEDIS® Measure

HEDIS MEASURE DEFINITION

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

EXCLUSIONS FROM THE HEDIS MEASURE

Patients are excluded if they:

- Received hospice care during the measurement year
- Died during the hospital stay
- Diagnosed with pregnancy or a condition originating in the perinatal period

GENERAL TIPS

- Keep open appointments so patients who are discharged from the hospital can be seen within seven days of their discharge.
- When scheduling the post-discharge visit, ask patients to bring in all their prescription medications and over-the-counter medications and supplements so medication reconciliation can be performed.
- Obtain and review the patient's discharge summary.
- Obtain any test results that were not available when patients were discharged and track tests that are still pending.
- Connect with your state's automated electronic admission, discharge and transfer, or ADT system to receive admission, discharge and transfer notifications for your patients.
- If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed.
- Consider implementing:
    - A post-discharge process to track, monitor and follow up with patients
    - Transitional care management for recently discharged patients

STEPS TO SUPPORT CARE GAP CLOSURE

Document the reconciliation in the patients' medical record and submit a claim with CPT® II code 1111F (discharge medications reconciled with the current medication list in the outpatient medical record).

TIPS FOR TALKING WITH PATIENTS

- Discuss the discharge instructions with patients and ask if they understand the instructions and filled their new prescriptions.
- Complete a thorough medication reconciliation and ask patients and/or caregivers to describe their new medication regimen back to you.
- Provide the patient with a current list of medications.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
    - Start PRN medications.
    - Call their doctor (during after office hours).
    - Go to the emergency room.
- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Ask about barriers that might have contributed to patients' hospitalization and discuss how to prevent them in the future.
- Ask patients if they completed or scheduled prescribed outpatient services. This could include physical therapy, home health care visits and obtaining durable medical equipment.

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