2024 Star Measure Tips

One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Plan All-Cause Readmissions (PCR)

Effectiveness of Care HEDIS® Measure

Measure description

The percentage of patients that were readmitted to the hospital within 30 days of discharge.

Measure population (denominator)

Patients 18 years and older who had an acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year.

- This measure is based on discharges.
- Patients may appear in the denominator more than once.
- Includes acute discharges from any type of facility.

Did you know?

- Unplanned readmissions are associated with increased mortality and higher health care costs.
- Readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.

Measure compliance (numerator)

The number of patients who had an unplanned acute readmission for any diagnosis within 30 days following an acute discharge.

Exclusions

- Diagnosed with pregnancy or a condition originating in the perinatal period
- Received hospice services anytime during the measurement year
- Deceased during the hospital stay

continued

Helpful HEDIS hints

- Keep open appointments so patients who are discharged from the hospital can be seen within seven days of discharge.
  - 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.
  - Request patients bring all prescriptions, over-the-counter medications and supplements to the post-discharge visit, and complete the medication reconciliation.
- Connect with your state's automated electronic admission, discharge and transfer (ADT) system to receive admission, discharge and transfer notifications for your patients. Michigan Health Information Network (MiHIN). **https://mihin.org/**
- Perform transitional care management for recently discharged patients.
- Consider implementing a post-discharge process to track, monitor and follow up with patients.
  - Obtain and review all discharge summaries.
  - Obtain any test results that were not available when patients were discharged and track tests that are still pending.
  - Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients or caregivers to describe their new medication regimen back to you.
- Document and date the medication reconciliation in the outpatient medical record.
- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Ask about barriers or issues 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 workups or other services. This could include physical therapy, home health care visits and obtaining durable medical equipment.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
  - Start as-needed or PRN medications
  - Call their doctor (during or after office hours)
  - Go to the emergency room

Tips for coding

- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period to be submitted on a claim.
- Document and date the medication reconciliation in the outpatient medical record.
  - Submit an 1111F claim as soon as the reconciliation is complete. It is not necessary to wait for all components of TCM or care planning services to be met.

Resources

1. Institute for Healthcare Improvement (IHI). 2009. "Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions." **ihi.org/resources/Pages/Changes/EffectiveInterventionstoReduceRehospitalizationsCompendium15PromisingInterventions.aspx**
2. Centers for Medicare and Medicaid Services (CMS). 2022. "Hospital Readmissions Reduction Program (HRRP)." **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program**