

Provider Bulletin

HEDIS® News You Can Use

Plan All-Cause Readmissions (PCR)



Importance of the PCR measure

Hospital readmissions within 30 days of discharge are often preventable and can result in serious consequences, including complications, increased stress, and a higher risk of mortality.

This bulletin offers information on any measure changes, best practice suggestions, and free resources.



Measure requirements

The measure assesses, for persons 18 and older, the number of unplanned acute **readmissions** for any diagnosis **within 30 days** of an initial acute inpatient or observation stay.

For more detailed measure info, go to [MC Gap Closure Reference Guide](#)



Readmission statistics

Nationally the overall 30-day all-cause readmission rate is 13.5%. For Medicare patients about 20% are readmitted within 30 days of discharge.



Common reasons for readmissions

1. Clinical conditions: Heart failure, sepsis, COPD, pneumonia, diabetes with complications, renal failure.
2. Care transition issues: Suboptimal discharge planning, missed follow-up, medication related issues.
3. Social factors: Inadequate home support, limited transportation, improper diet.
4. Post-discharge risks: Falls, hospital acquired infections, procedural complications.

For members assigned but choosing not to establish care, go to [MC PCP Change Request Form](#)



How Mercy Care helps

Proactive discharge planning by Utilization Management (UM) in collaboration with assigned facilities, ICM (Integrated Care Management) Support Coordinators, and outpatient (OP) teams ensuring:

- Notification of admission, discharge
- Appropriate referrals of ICM and recovery agencies prior to discharge.
- Collaboration at weekly inpatient rounds to help identify discharge and readmission risk.
- Mom's Meals referrals for meals post-discharge.



Great resources

[Care Management For Our Members October 22, 2025](#)

**Thank you for the care you provide
to our members**



Best Practices Tips to improve results

1. **Track transitions:** Ensure discharge summaries are accessible for review in the outpatient medical record.
2. **Follow-up/monitor:** Reach out within 48-72 hours post-discharge; use remote monitoring for chronic conditions.
3. **Educate patients:** Discuss an action plan for chronic conditions: warning signs and when to seek help.
4. **Support/access:** Offer 24/7 nurse advice lines, telehealth; offer home visits for high-risk patients when feasible.
5. **Medication management:** Reconcile medications, check understanding, access, and adherence.