

## What the Measures Reward, and What the Evidence Supports

Companion to The Standard, Article 20. Every component of the transitions of care and emergency follow-up measures, set against the strength of evidence behind it. Build the measure, and know what it does and does not buy you.

| MEASURE COMPONENT                               | WHAT IT REQUIRES                                                                                                       | WHAT THE EVIDENCE SHOWS                                                                                                                                                                                                                                                                           |
|-------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Notification of inpatient admission</b>      | Documented receipt of notification on the day of admission through two days after.                                     | Not tested independently as a readmission intervention. It is a necessary condition for any timely response, and worth measuring as process.                                                                                                                                                      |
| <b>Receipt of discharge information</b>         | Documented receipt of discharge information on the day of discharge through two days after.                            | Not tested independently. Same reasoning. Without it, nothing downstream can be sequenced.                                                                                                                                                                                                        |
| <b>Patient engagement after discharge</b>       | An office visit, home visit, or telehealth encounter within thirty days of discharge.                                  | Benefit is concentrated in the highest risk patients. Across 65,000 discharges, the absolute reduction in thirty day readmissions ranged from 1.5 percentage points in the lowest risk group to 19.1 points in the highest. Follow-up within three days was not significant in any group but one. |
| <b>Medication reconciliation post-discharge</b> | Documented reconciliation from the date of discharge through thirty days after.                                        | Pooled readmission risk ratio of 0.91, confidence interval 0.66 to 1.25. No readmission reduction demonstrated. It does reliably identify and resolve medication discrepancies, which is a genuine safety benefit. CMS retired the standalone Star measure for 2027.                              |
| <b>Follow-up after emergency visit</b>          | Follow-up within seven days of an emergency visit, for members with two or more of eight high risk chronic conditions. | Same risk stratification caveat as the thirty day visit. Worth noting that the average Star rating on this measure has fallen from 3.0 in 2024 to 2.5 in 2027, so performance is moving the wrong way.                                                                                            |

### Strongest evidence, and not in the measure set

| INTERVENTION                        | WHAT WAS TESTED                                                            | RESULT                                                                                                                                                                          |
|-------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Home visiting</b>                | Heart failure, fifteen randomized trials, outcomes at three to six months. | All cause readmission risk ratio 0.75, number needed to treat 9. Rated high strength of evidence.                                                                               |
| <b>Multidisciplinary clinics</b>    | Heart failure, seven randomized trials, same window.                       | All cause readmission risk ratio 0.70, number needed to treat 8. Rated high strength of evidence.                                                                               |
| <b>Multicomponent interventions</b> | Forty two randomized trials, thirty day readmission.                       | Pooled risk ratio 0.82. Larger effect where the intervention supported the patient's own capacity for self care. Note the effect has attenuated in trials published after 2002. |

| INTERVENTION                         | WHAT WAS TESTED                                        | RESULT                                                                                                                                                           |
|--------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Structured discharge planning</b> | Thirty three trials, 12,242 participants.              | Readmission risk ratio 0.89 at about three months, moderate certainty. Length of stay shorter by 0.73 days. No mortality difference.                             |
| <b>Transition coaching</b>           | Single site randomized trial, 750 adults 65 and older. | Thirty day rehospitalization 8.3 percent against 11.9 percent, odds ratio 0.59, confidence interval 0.35 to 1.00. Real but fragile, and not replicated at scale. |

## Two facts about timing

**Risk does not end at day thirty.** In the Medicare rehospitalization data, 19.6 percent of patients were readmitted within thirty days and 34.0 percent within ninety. By arithmetic, roughly 42 percent of the readmissions inside ninety days occurred after the thirty day window closed. Measuring only to day thirty manages the measure rather than the member.

**Early and late readmissions are different problems.** Across ten academic medical centers, 36.2 percent of readmissions within seven days were judged preventable, against 23.0 percent in days eight through thirty. Preventability also shifted location: hospital setting 47.2 percent early against 25.5 percent late, outpatient setting 15.2 percent against 6.6 percent. The first week is a hospital and placement problem. The rest of the window is an ambulatory problem.

## How to use this

Report the measures, because they are required and because three of the five are necessary conditions for anything else to work. Do not fund them as a readmission strategy. Put the incremental dollar where the evidence is: risk stratify at discharge, concentrate intensive follow-up on the high risk tier, and build toward home based and multidisciplinary models for the conditions that carry the readmission burden.

### SOURCES

Measure specifications: National Committee for Quality Assurance, Transitions of Care and Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions. Star Ratings weights and measure changes: Centers for Medicare and Medicaid Services, 2027 Star Ratings measures and fact sheet, October 2026.

Evidence: McNab and colleagues, BMJ Quality and Safety, 2018, pharmacist led medication reconciliation. Jackson and colleagues, Annals of Family Medicine, 2015, timeliness of outpatient follow-up. Feltner and colleagues, AHRQ Comparative Effectiveness Review, 2014, transitional care interventions in heart failure. Leppin and colleagues, JAMA Internal Medicine, 2014, preventing thirty day readmissions. Goncalves-Bradley and colleagues, Cochrane Database of Systematic Reviews, 2022, discharge planning from hospital. Coleman and colleagues, Archives of Internal Medicine, 2006, the Care Transitions Intervention. Graham and colleagues, Annals of Internal Medicine, 2018, preventability of early versus late readmissions. Jencks, Williams and Coleman, New England Journal of Medicine, 2009, rehospitalizations in Medicare fee for service.

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