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Stars Measure C18 Plan All-cause Readmissions

Quick Reference Guide

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Stars Measure C18 Plan All-cause Readmissions — Quick Reference Guide

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Introduction

Value-based care in the United States is measured through performance metrics; there has been a decisive shift **from process-oriented reporting to** rigorous evaluation of **clinical outcomes.** At the center of this transformation is the Medicare Star Ratings program, specifically the C18 Plan All-Cause Readmissions (PCR) measure.

As of the 2025 Star Ratings cycle, the Centers for Medicare & Medicaid Services (CMS) has elevated this measure to **triple-weighted status**, underscoring the federal government's commitment to incentivizing hospital avoidance and seamless care transitions.[1]

For healthcare providers and Medicare Advantage (MA) organizations, the C18 measure is no longer merely one of many metrics; it is a primary driver of financial viability, brand reputation, and regulatory standing. The complexity of this measure requires an understanding of both its mathematical derivation and the clinical realities of the high-risk populations it serves.

1. MEASURE SNAPSHOT

Medicare PART C DOMAIN 2 - Managing Chronic (long-term) Conditions: C18 - Plan All-Cause Readmissions (PCR)

CMS Definition: For Medicare Advantage (MA) members aged 18 years and older, the percentage of acute inpatient and observation stay discharges that were followed by an unplanned acute readmission for any diagnosis within 30 days. The score is a risk-adjusted ratio of observed-to-expected (O/E) readmissions, multiplied by the national average observed rate.[1-4]

Measure Weight: Triple-weighted (3x) outcome measure for 2025 and 2026; accounts for approximately 10% of the total Part C rating.[1]

Exclusions: Members who died during the index stay, primary diagnosis of pregnancy or perinatal conditions, chemotherapy maintenance, rehabilitation stays, organ transplants, or potentially planned procedures without a principal acute diagnosis. Requires continuous enrollment 365 days before discharge through 30 days post-discharge. Excludes members in hospice or using hospice services any time during the measurement year. Further excludes contracts whose denominator was less than 150. **The complete set of exclusions is available in the NCQA HEDIS Measurement Year 2024 Technical Specifications Volume 2.**[4]

2025 Financial Impact: An estimated 2 million patients are readmitted each year, costing Medicare $26 billion. The Centers for Medicare & Medicaid Services estimate that $17 billion of that comes from avoidable readmissions.

CMS PCR Cut Points 2025:[1]

1 Star	2 Star	3 Star	4 Star	5 Star
>12%	>10% to less than or equal to 12%	>9% to less than or equal to 10%	>7% to less than or equal to 9%	Less than or equal to 7%

Current Industry Performance (2025 → 2026 Trend)[3,5]

- **National Average Star Rating:** The national average for C18 in 2026 is **2.9 stars**, consistent with 2025 and reflecting the measure's high difficulty
- **Market Stabilization:** While enrollment in 4+ star plans saw a historic decline between 2023 and 2025, it stabilized for 2026 at approximately 64% of enrollees, up slightly from 62% in 2025
- **5-Star Scarcity:** Achieving 5 stars remains rare. For 2026, only 18 MA-PD contracts nationwide earned a 5-star overall rating, though the percentage of members in 5-star plans increased slightly to 2.3%
- **Performance Volatility:** PCR is designated as a "poorer performing" measure in the 2026 cycle. Success is heavily dependent on its "lead measure," Transitions of Care (TRC), which emphasizes engagement and medication reconciliation post-discharge

Rating Impact & Revenue

Star Rating	Benchmark Bonus	Rebate	Marketing Rights
5 stars	5% increase + QBP	70%	Year-round enrollment
4.5 stars	5% increase + QBP	70%	Standard windows
4 stars	5% increase + eligible for QBP	65%	Standard windows
<4 stars	None	50-65%	Limited

2. HOW CMS MEASURES C18 — PCR

The **C18 Plan All-Cause Readmissions (PCR) measure** is an **outcome-based quality metric** derived from the Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by the National Committee for Quality Assurance (NCQA). CMS uses this measure to evaluate how effectively Medicare Advantage (MA) plans prevent **unplanned hospital readmissions within 30 days of discharge.**[1,3]

Unlike diagnosis-specific readmission metrics, C18 is “all cause” and intentionally broad. It captures **any unplanned acute inpatient readmission, regardless of diagnosis,** following an eligible hospital discharge. As a result, the measure reflects the **overall reliability of a plan’s care transitions, outpatient follow-up, medication management, and chronic disease stabilization.**

Eligible Index Events

An **index event** is defined as a discharge from:

- An acute inpatient hospital stay, or

- Observation stay for a Medicare Advantage member aged **18 years or older**

Each eligible discharge creates a **30-day measurement window** during which any unplanned acute readmission will be attributed to the plan. Importantly, the attribution does not depend on whether the readmission occurs at the same hospital or a different facility.[1,3]

Exclusions and Planned Readmissions

To ensure fairness and clinical relevance, CMS excludes certain events from the measure, including:[1,4]

- **Event-Level Exclusions (Planned Hospital Stays)**

  A hospital stay is considered "planned" and is excluded from the numerator (the count of readmissions) if it meets any of the following criteria on the discharge claim:

  - **Principal Diagnosis of Maintenance Chemotherapy:** Identified by specific ICD-10 codes (e.g., Z51.0, Z51.11, Z51.12)
  - **Principal Diagnosis of Rehabilitation:** Hospitalizations primarily for physical, occupational, or speech therapy
  - **Organ Transplants:** Stays with principal diagnoses related to organ transplantation (e.g., introduction of autologous pancreatic cells)
  - **Potentially Planned Procedures without an Acute Diagnosis:** Procedures that are typically elective and are not accompanied by a principal acute diagnosis code (e.g., certain orthopedic or elective cardiovascular procedures)

- **Stay-Level Exclusions**

  The following index hospital stays (denominator events) are excluded entirely:

  - **Pregnancy and Perinatal Conditions:** Beneficiaries with a principal diagnosis of pregnancy or conditions originating in the perinatal period on the discharge claim
  - **In-Hospital Mortality:** Members who died during the inpatient stay
  - **Direct Transfers:** For discharges followed by a direct transfer to another acute or non-acute facility within one calendar day, the stays are collapsed. The original admission date is kept as the Index Admission Date, but only the final discharge from the receiving facility is used as the Index Discharge Date

- **Member-Level Exclusions**
  - **Hospice Status:** Beneficiaries who received hospice care at any time during the measurement year are excluded from the denominator
  - **Outlier Status:** For Medicare and Medicaid populations, any member with four or more Index Hospital Stays (IHS) between January 1 and December 1 of the measurement year is classified as an "outlier" and removed from the calculation

These exclusions are applied algorithmically using diagnosis and procedure codes. Plans and providers **cannot manually override exclusions**, which reinforces the importance of accurate and specific coding during the index stay.

What Is Counted

The measure evaluates the **percentage of index discharges** that result in:

- An **unplanned acute inpatient readmission**
- For **any diagnosis**
- Within **30 days of discharge**

Because the measure is "all-cause," it captures failures across multiple domains, including:

- Inadequate discharge planning
- Delayed or absent outpatient follow-up
- Medication errors or non-adherence
- Poor chronic disease control
- Unaddressed social or functional barriers

This design intentionally shifts accountability away from hospitals alone and toward the **entire care continuum**.

The Observed-to-Expected (O/E) Framework

C18 performance is calculated using an **Observed-to-Expected (O/E) ratio**, which compares:

- **Observed**: the actual number of unplanned 30-day readmissions
- **Expected**: the number of readmissions predicted based on patient risk factors

The formula is:

$$O/E\ Ratio\ = \frac{Observed\ 30{-}Day\ Readmissions}{Expected\ 30{-}Day\ Readmissions}$$

An O/E ratio:

- **Below 1.0** indicates better-than-expected performance
- **Equal to 1.0** indicates expected performance
- **Above 1.0** indicates worse-than-expected performance

For Star Ratings purposes, CMS **inverts the scoring** so that **lower O/E ratios result in higher Star Ratings**.

Why This Matters Operationally

Because C18 is risk-adjusted, **clinical documentation directly affects the** measure denominator. If patient complexity is under-documented:

- The **expected** readmission count is artificially low
- Even average performance can appear poor
- Plans are penalized for caring for complex populations

This makes **accurate diagnosis capture during the index stay and post-discharge visits just as important as the clinical intervention itself**.

Minimum Denominator Requirements

The C18 PCR measure requires a substantial denominator to be considered valid for a Star Rating. While many HEDIS measures have a minimum denominator of 30, the C18 PCR measure requires at least 150 index hospital stays.[11] This higher threshold ensures statistical reliability but also means that smaller contracts may not receive a rating for this measure, potentially shifting the weight of their overall score to other, less impactful metrics.[4]

Unlike many HEDIS measures, C18 requires a **minimum of 150 eligible index discharges** for a contract to receive a Star Rating score. This higher threshold:

- Improves statistical reliability
- Disadvantages smaller contracts or newer plans
- Shifts performance pressure onto large, high-volume provider networks

Plans that fail to meet the denominator do not receive a score, increasing reliance on other measures that may carry less weight.

Measure Components at a Glance[1]

Component	Description
Target Population	MA members aged ≥18 years
Index Event	Acute inpatient or observation discharge
Exclusions	Planned readmissions and transfers
Measurement Window	30 days post-discharge
Risk Adjustment	Age, sex, diagnosis, procedures, HCCs
Scoring Unit	Observed-to-Expected (O/E) Ratio
Star Weighting	Triple-weighted outcome measure

3. RISK ADJUSTMENT, HCC, AND THE TUKEY EFFECT

Why Accurate Documentation Now Determines Star Survival

The C18 Plan All-Cause Readmissions (PCR) measure is not evaluated on raw readmission rates alone. CMS applies a risk-adjustment methodology designed to account for patient complexity and ensure plans are compared fairly. In practice, however, this methodology introduces a critical operational reality:

> If patient complexity is under-documented, performance will appear worse than it truly is — even when clinical care is appropriate.

For value-based organizations, risk adjustment is no longer a coding function in the background. It is a frontline determinant of Star Ratings performance and financial viability

How Risk Adjustment Works in C18

The "Expected" readmission count in the O/E ratio is generated using a multivariable model that incorporates:

- Age and sex
- Principal diagnosis from the index hospitalization
- Surgical vs medical admission status
- Hierarchical Condition Categories (HCCs) derived from claims data
- Prior utilization patterns

This model is designed and validated by CMS and NCQA to ensure plans caring for sicker populations are not unfairly penalized.[1-4]

However, the model can only adjust for what is documented and submitted.

The Hidden Risk: Under-Documentation Lowers the Denominator

If a chronic condition is **present but not coded**, it is **invisible to the risk-adjustment model**. The result is:

- A **lower Expected Readmission Count**
- A **higher O/E ratio**
- A **worse Star Rating**, even if care quality is strong

This is especially damaging for plans serving:

- Dual-eligible beneficiaries
- Members with multiple chronic diseases
- Special Needs Plan (SNP) populations

In these populations, missing even **one high-impact diagnosis** (e.g., CKD, morbid obesity, COPD, heart failure) can materially distort expected utilization.

Why the Index Stay Matters More Than You Think

Risk adjustment for C18 draws heavily from:

- Diagnoses coded **during the index hospitalization**
- Diagnoses made in the **12 months prior**

If chronic conditions are omitted during the index stay:

- The hospitalization appears lower-acuity than reality
- The predicted risk of readmission is underestimated
- Subsequent readmissions are more likely to be judged "excess"

Key implication:
Hospitalists, inpatient coders, and outpatient clinicians are all influencing the same Star metric — whether they realize it or not.

Common High-Impact Diagnoses That Are Frequently Missed

The following conditions frequently go under-documented but carry substantial weight in risk adjustment:

- Chronic kidney disease (with stage specificity)
- Morbid obesity (BMI ≥40)
- Diabetes with complications
- COPD and chronic respiratory failure
- Heart failure (with preserved vs reduced EF)
- Malnutrition
- Major depressive disorder
- Substance use disorders

Failure to make or document these diagnoses during face-to-face encounters may **artificially suppress expected readmissions**.

The Tukey Outlier Deletion Effect: Why "Average" Is No Longer Safe

Beginning in the 2025–2026 Star Ratings cycles, CMS implemented **Tukey outlier deletion** when establishing Star cut points.[2]

Under this approach:

- Extreme low-performing outliers are removed from the distribution
- Remaining plan performance shifts upward
- Cut points for 4- and 5-star ratings become more stringent

What this means operationally:

- Maintaining the same O/E ratio year-over-year may still result in a Star drop
- "Good enough" performance is no longer sufficient
- Plans must **outperform peers**, not simply meet historical benchmarks

Risk-adjustment errors become more punitive in this environment because **there is less margin for error** once outliers are removed.

4. CRITICAL BARRIERS & EVIDENCE-BASED SOLUTIONS

Primary Drivers of C18 Failure

Unplanned 30-day readmissions are rarely random events. Evidence suggests that they arise from **predictable clinical vulnerabilities and system-level breakdowns**, most of which occur **after discharge**, not during the index hospitalization.[6-8]

For the C18 measure, this distinction is critical. Because attribution is plan-level and all-cause, **any unresolved post-discharge failure whether it be clinical, operational, or social could potentially convert a successful hospitalization into a Star Ratings liability**.

High-Risk Clinical Conditions Driving Readmissions

National claims-based analyses confirm that **30-day readmissions are highly concentrated among a small number of clinical conditions**, many of which are common in Medicare Advantage populations. According to the **AHRQ Healthcare Cost and Utilization Project (HCUP) National Readmissions Database**, medical conditions account for the majority of readmissions and drive the highest aggregate readmission burden in the U.S. healthcare system.[6]

Top 20 Conditions by Number of 30-Day All-Cause Readmissions in 2020

Principal Diagnosis at Index Admission	30-Day Readmissions	% of All Readmissions
1. Septicemia	317,200	9.3%
2. Heart failure	202,200	5.9%
3. Diabetes mellitus with complication	115,400	3.4%
4. Acute & unspecified renal failure	82,300	2.4%
5. Schizophrenia spectrum & other psychotic disorders	80,500	2.4%
6. Pneumonia (except tuberculosis)	80,500	2.4%
7. COVID-19	75,900	2.2%
8. Cardiac dysrhythmias	68,500	2.0%
9. COPD & bronchiectasis	64,600	1.9%
10. Respiratory failure/insufficiency/arrest	63,100	1.8%
11. Acute myocardial infarction	61,000	1.8%
12. Alcohol-related disorders	60,600	1.8%
13. Urinary tract infections	58,400	1.7%
14. Fluid & electrolyte disorders	57,600	1.7%
15. Complications of surgical or medical care	53,100	1.6%

Principal Diagnosis at Index Admission	30-Day Readmissions	% of All Readmissions
16. Cerebral infarction (ischemic stroke)	50,700	1.5%
17. Depressive disorders	46,200	1.4%
18. Gastrointestinal hemorrhage	45,100	1.3%
19. Skin & subcutaneous tissue infections	44,900	1.3%
20. Chronic kidney disease	42,900	1.3%

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Readmissions Database (NRD), 2020. Released 2024.

Why These Conditions Matter for C18 Performance

These diagnoses share several high-risk characteristics that directly undermine post-discharge stability:

- Rapid physiologic deterioration after discharge
- Heavy reliance on medication titration and self-management
- Sensitivity to missed follow-up or delayed intervention
- Strong interaction with social determinants of health

From a C18 perspective, these are not “hospital problems.” They are care transition failures that become visible only after the patient returns to the community.

Take away:
Readmissions Are Highly Concentrated:

- Top 20 combined: ≈60% of all adult 30-day readmissions
- Three diagnoses alone (sepsis, HF, diabetes w/ complications) account for ~19% of all readmissions
- Medical (not surgical) admissions dominate the list
- Behavioral health is a major driver — schizophrenia, depression, and alcohol-related disorders together represent ~5.6% of all readmissions
- These patients are systematically underserved by traditional discharge workflows

These conditions share common features: rapid clinical deterioration, medication sensitivity, and dependence on patient self-management after discharge.

The Follow-Up Gap: The Single Largest Driver of Readmissions

The most consistently cited contributor to 30-day readmissions is the **absence of timely outpatient follow-up**.[6-9]

Seminal analyses of Medicare readmissions have shown that **more than half of patients readmitted within 30 days had no documented physician visit between discharge and readmission.**[7]

This gap persists despite decades of policy focus and remains the most actionable failure point for MA plans.

Operationally, delayed follow-up leads to:

- Missed early signs of clinical decompensation
- Unaddressed medication changes or adverse effects
- Failure to reinforce discharge instructions
- Inability to intervene before deterioration requires rehospitalization

For C18 performance, **speed matters more than volume**. A single visit within the first 7 days is more protective than multiple contacts later in the month.

Timing of Readmissions Reveals the Root Cause

The timing of readmission provides insight into the underlying failure:

- **Days 1–8:** Most often reflect complications related to the index hospitalization, including incomplete stabilization, early medication toxicity, or unresolved infection
- **Days 9–30:** More commonly driven by poor care coordination, delayed follow-up, medication mismanagement, or progression of chronic disease

This temporal pattern reinforces the need for a two-phase intervention strategy:

1. Immediate stabilization (first week post-discharge)
2. Sustained outpatient management through day 30

Plans that focus exclusively on discharge-day interventions consistently underperform on C18.

Medication Mismanagement and Polypharmacy

Medication-related adverse events are among the **most preventable causes of readmission**. Nearly **one in five patients experiences an adverse drug event after discharge**, most commonly due to reconciliation errors or unclear instructions.[7,9,10]

Common failure modes include:

- Duplicate therapies (brand and generic overlap)
- Dose confusion after inpatient titration
- Restarting medications intentionally discontinued in the hospital
- Lack of monitoring for high-risk drugs (e.g., anticoagulants, insulin, diuretics)
- Medication discrepancies are widespread, occurring in **30–70% of hospital discharges**

Risk is highest among patients with:

- Polypharmacy (≥5 medications)
- Cognitive impairment

- Limited caregiver or social support

Importantly, **pharmacist-led medication reconciliation and post-discharge monitoring reduce readmissions by 30–40%**. This makes medication safety one of the **highest-impact, lowest-friction interventions** for improving C18 performance.[8,11]

Socioeconomic and Health Literacy Barriers

Clinical excellence alone is insufficient to prevent readmissions when social and functional barriers are unaddressed.[12]

Factors strongly associated with higher readmission risk include:

- Transportation insecurity
- Food insecurity
- Housing instability
- Low health literacy
- Limited caregiver support

Patients may understand what they are supposed to do, but lack the means or capacity to do it. These barriers disproportionately affect dual-eligible and SNP populations, amplifying their impact on C18 performance.

Health literacy deserves special emphasis. Patients who cannot accurately describe their diagnosis, medications, or warning signs are significantly more likely to be readmitted, even when discharge instructions are technically complete.[12]

Behavioral Patterns That Undermine Traditional Interventions

A substantial subset of patients driving readmissions exhibit low engagement with preventive care and delay seeking help until crisis occurs. Traditional education-heavy discharge approaches are often ineffective for these individuals.[12]

For this population, passive education must be replaced with active engagement, including:

- Teach-back methods
- Frequent early touchpoints
- Simplified care plans
- Proactive outreach rather than patient-initiated contact

Failing to adapt engagement strategies to patient behavior patterns results in repeated readmissions despite escalating resource use.

5. HIGH-YIELD STRATEGIES TO IMPROVE PCR PERFORMANCE

To move the needle on the C18 measure, value-based organizations should implement multifaceted, interdisciplinary interventions that have been rigorously tested and validated. The literature consistently demonstrates that no single intervention is effective on its own; instead, success is found in "bundles" of care that span the transition from the hospital to the community.

High-performing Medicare Advantage organizations focus on **speed, targeting, and accountability**, rather than volume-based outreach.

1. Early Post-Discharge Follow-Up (≤7 Days)

Why it matters

Early outpatient follow-up is the **strongest single protective factor** against readmission. Patients seen within 7 days of discharge have significantly lower readmission risk compared with those seen later or not at all.

High-impact actions

- Schedule PCP or advanced practice follow-up **before discharge**
- Prioritize **Top 20 high-risk diagnoses** (Section 4)
- Use transportation benefits proactively to ensure visit completion

C18 relevance

- Prevents early clinical deterioration
- Identifies medication issues before adverse events occur
- Aligns with CMS emphasis on early care transitions

2. Transitional Care Management (TCM) Services

In the outpatient setting, the most effective high-yield intervention is the formal provision of TCM services, billed under CPT codes 99495 and 99496. These services are specifically designed to bridge the gap between hospital discharge and the return to the community. Evidence indicates that patients who receive TCM services have a significantly lower chance of readmission compared to those who do not.[13]

CPT Code	Requirement
99495 (moderate complexity)	**Initial Contact:** Reach the patient or caregiver via phone, email, or in person within **2 business days** of discharge **Decision Complexity:** Provide at least **moderate complexity** medical decision-making during the 30-day period **Office Visit:** Complete a **face-to-face visit** within **14 calendar days** of discharge
99496 (high complexity)	**Initial Contact:** Contact the patient or caregiver (phone, email, or in person) within **2 business days** of discharge

CPT Code	Requirement
	Decision Complexity: Perform **high-complexity** medical decision-making throughout the 30-day service period **Face-to-Face Visit:** Conduct a physical office visit within **7 calendar days** of discharge
1111F (medication reconciliation)	**Clinical Action:** Discharge medications are reconciled with the current outpatient medication list **Documentation:** The medical record must explicitly show a **discharge medication list was reconciled** with the patient's pre-admission list by a prescribing practitioner or pharmacist **Timing:** Typically performed during the face-to-face visit of the TCM period (Days 7–14)

Note: You can provide CPT codes 99495 and 99496 through telehealth.

TCM requires a multifaceted approach, including non-face-to-face services such as reviewing the discharge summary, identifying needed community resources, and educating the patient or caregiver on symptom management. For MA plans, incentivizing providers to prioritize TCM visits ensures that the clinical follow-up gap is addressed.

Transitional Care Management (TCM) + Medication Reconciliation + Nurse Transition Support[11-15]

Care Component	Responsible Role	Timing Standard	Actions	Why It Matters for C18
Risk Stratification	Hospital team/ Nurse Transition Coach	During inpatient stay	Identify high-risk patients using evidence based tool-kits and analytics	Ensures resources focus on patients driving readmissions
Pre-Discharge Engagement	Nurse Transition Coach	≤2 days before discharge	Introduce role; assess caregiver support; review discharge plan at high level	Reduces confusion at discharge; improves follow-through
PCP TCM Visit	Primary Care Provider	≤7 days post-discharge	Review discharge summary, inpatient studies, procedures, consults, and new diagnoses	Early follow-up is the strongest modifiable readmission reducer
Root Cause Analysis	Primary Care Provider	During TCM visit	Identify why admission occurred and what failed prior to hospitalization	Prevents recurrence of the same admission
Medication Reconciliation	PCP (with Pharmacist support when indicated)	During or immediately after TCM visit	Reconcile meds started, stopped, or dose-changed; update EMR; communicate final list to patient	Prevents early medication-related readmissions
Pharmacist Escalation	Clinical Pharmacist	≤48–72 hours post-discharge (if triggered)	Perform medication sweep; verify fills; resolve discrepancies; educate patient	Reduces ADE-driven readmissions by up to 30–40%

Care Component	Responsible Role	Timing Standard	Actions	Why It Matters for C18
Goals-of-Care Discussion	Primary Care Provider	During TCM visit	Discuss palliative or hospice care for advanced or terminal illness	Prevents non-beneficial readmissions
Post-Discharge Check-In	Nurse Transition Coach	≤2 days after discharge	Confirm PCP visit scheduled; reinforce meds; assess early symptoms	Catches early instability
Ongoing Follow-Up	Nurse Transition Coach	3 contacts within first 30 days	Ensure visits completed; monitor adherence; reinforce action plans	Sustains stability through the 30-day window
Self-Care & Monitoring Education	Nurse Transition Coach	Throughout 30 days	Teach symptom monitoring, escalation steps, and fall prevention	Empowers patients to avoid crisis care
SDOH Support	Nurse Transition Coach/Care Management	As needed	Address transportation, food, caregiver, and home safety needs	Prevents non-clinical readmissions

C18 readmissions are lowest when PCP TCM, medication reconciliation, and nurse transition support are delivered as one coordinated workflow within the first 7 days.

3. Pharmacist-Led Medication Reconciliation

Why it matters
Medication-related adverse events account for a large share of early readmissions and are **highly preventable**. Pharmacist involvement consistently reduces discrepancies and readmissions.

High-risk triggers

- ≥5 chronic medications
- New anticoagulants, insulin, diuretics, or opioids
- CKD, heart failure, or cognitive impairment

High-impact actions

- Post-discharge medication “sweep” within 72 hours
- Verification of fills and dosing
- Patient or caregiver education using teach-back

4. Structured Discharge Education Using Teach-Back

Why it matters
Many readmissions occur because patients **do not understand** their diagnosis, medications, or warning signs — even when instructions were technically provided.

High-impact actions

- Replace passive education with **teach-back**
- Focus on:
  - What changed
  - What symptoms require action
  - Who to call and when

5. Address Social and Functional Barriers Early

Why it matters
Clinical care alone cannot overcome barriers such as transportation insecurity, food insecurity, or lack of caregiver support.

High-impact actions

- Screen for SDOH at discharge
- Deploy non-clinical navigators
- Arrange transportation, meals, or home support **before discharge**

Evidence-Based Resources & Tool Kits

Project RED (Re-Engineered Discharge)

Project RED, developed by Boston University Medical Center and funded by the Agency for Healthcare Research and Quality, is one of the most extensively validated discharge redesign models. Implementation studies demonstrate a ~30% reduction in 30-day readmissions and emergency department visits. The core insight of Project RED is that discharge is a clinical event, not an administrative one. Failures at discharge disproportionately drive early (days 1–7) readmissions, which are especially damaging in the C18 measure.[14]

Project BOOST (Better Outcomes by Optimizing Safe Transitions)

While Project RED focuses on how discharge is executed, Project BOOST, developed by the Society of Hospital Medicine, focuses on who is most likely to fail a transition and why.[15]

Project BOOST is a mentored implementation program that embeds risk stratification early in the hospital stay, allowing teams to proactively deploy targeted resources rather than reacting after discharge.

Project BOOST identifies patients at the highest risk for readmission based on eight domains:

- **Prior hospitalizations**
- **Polypharmacy**
- **Problem medications** (e.g., anticoagulants, insulin, opioids)
- **Psychological conditions** (e.g., depression)
- **Principal diagnosis** (high-risk medical conditions)
- **Physical limitations**
- **Poor health literacy**
- **Patient support** (absence of caregiver)

Patients with multiple "P" factors are flagged for **intensified transitional interventions**.

6. WORKFLOW OPTIMIZATION AND REAL-TIME CARE COORDINATION

For a value-based provider, the difference between a high-performing and low-performing C18 rating is often found in the "latency" of their data. If a primary care provider (PCP) does not know their patient was discharged until 10 days after the event, the opportunity for a high-impact intervention has already passed. Workflow optimization must therefore center on real-time data exchange and clearly defined team roles.

Real-Time Admission, Discharge, and Transfer (ADT) Notifications

Admission, Discharge, and Transfer (ADT) messages function as the "central nervous system" of healthcare interoperability, acting as electronic notifications generated by a hospital's EMR whenever a patient's status changes. These messages flow through regional Health Information Exchanges (HIEs) as HL7 messages to identify and alert the patient's assigned care team in real-time.

In modern clinical workflows, ADT feeds serve as the primary trigger for the "Golden 48 Hours," initiating interactive contact for Transitional Care Management (TCM) billing and prompting pharmacists to conduct medication reconciliation using tools like the Project BOOST® 8P Tool. High-performing organizations now utilize machine learning to analyze these ADT messages alongside nursing data for predictive triage and centralized coordination through Discharge Care Centers to ensure patients successfully transition with a personalized After Hospital Care Plan (AHCP).[13-18]

Build a "Risk Engine" Operating System for Readmission Risk

C18 performance fails primarily because of **latency**: the care team learns about discharge too late, high-risk patients are not triaged early, and follow-up steps are not completed.

Organizations can solve this by combining:

Day 0 Trigger: ADT Discharge Event → Automatic Activation

Operational standard

- ADT discharge notice triggers:
  - Transition workqueue entry
  - Nurse transition outreach assignment
  - Pharmacy reconciliation trigger if high-risk
  - PCP TCM scheduling

This prevents the most common C18 failure mode: **"we didn't know they were discharged."**

Risk Stratification at Admission or by Day 1

BOOST 8P tool = bedside triage. LACE = rapid score. ML = optional enhancement.

Required minimum (choose one and standardize):

- BOOST 8P: Prior hospitalization, Polypharmacy, Problem meds, Psychological, Principal diagnosis, Physical limitations, Poor health literacy, Patient support[15]
- LACE (Length of stay, Acuity, Comorbidity, ED visits) to tier low/moderate/high risk. Damery & Combes evaluated LACE and found a score threshold can separate higher vs lower-risk groups, but many readmissions still occur outside "high-risk," supporting a tiered workflow rather than a single cutoff[16]
- Optional: ML-enhanced models using nursing data can support earlier and more comprehensive risk assessment (e.g., models using early hospitalization + nursing data for high-risk disease groups)[17]

AAVBC Tip: Risk scoring is only useful if it changes the workflow within 24 hours.

Standardized Discharge Execution (Project RED "Hardwiring")

Project RED contains evidence backed discharge redesign models that standardizes discharge into repeatable components, including a dedicated discharge education function, a patient-facing care plan (AHCP), and structured follow-up contact.[14]

Minimum RED elements to operationalize for C18:

- **Patient-facing After Hospital Care Plan (AHCP)** (plain language, structured "what changed" plan)
- **Confirmed follow-up appointments** (PCP + specialty) before discharge
- **Post-discharge follow-up call** using a standardized script (commonly within ~72 hours)

C18 lens: RED protects the first 72 hours, when medication errors and confusion drive rapid readmissions.

A Hospital-Wide Discharge "Care Center" Model for Scale

If your system needs a centralized operating model (especially across multiple service lines), a **patient- and risk-focused discharge care center** approach can reduce readmissions by providing **standardized discharge coordination at enterprise scale** (e.g., a hospital-wide Discharge Care Center model described in NEJM Catalyst).[18]

QRG takeaway: Centralization improves reliability when unit-level variation is the root problem.

Multidisciplinary "Team-Based" Transition Model

C18 performance requires **shared accountability across settings**. High-performing models replace siloed roles with a **defined transition team**:

- **PCP:** Leads clinical decision-making, root-cause analysis, goals-of-care alignment
- **Nurse Transition Coach:** Manages continuity, follow-up completion, education, and escalation
- **Clinical Pharmacist:** Owns medication reconciliation and high-risk drug monitoring
- **Care Manager/Navigator:** Resolves access, transportation, and SDOH barriers

AAVBC rule: No single role can prevent readmissions alone.

Day 0–2 Required Actions (Closed-Loop)

Within 48 hours of discharge, these actions should be completed:

Action	Owner	Completion Standard
Patient outreach	Nurse transition coach/care manager	Contact made or documented barrier + retry plan
PCP TCM scheduled	Practice scheduling	Appointment ≤7 days for high-risk
Med reconciliation triggered	Pharmacy/PCP team	Completed within 48–72 hours if high-risk
Discharge summary obtained	Transition team	In PCP chart before TCM visit
SDOH barriers addressed	Navigator/coach	Transportation, food, caregiver plan confirmed

Day 3–30: Follow-Through Tracking

Preventing Readmissions by Eliminating "Completion Gaps"

A defining strength of an effective risk engine is its ability to avoid completion gaps within 30 days, not just risk identification alone at discharge. This can be achieved by enforcing closed-loop follow-through during the high-risk post-discharge window (days 3–30) — when patients appear stable but frequently disengage from care.

Most readmissions in this period do not occur because care was unavailable. They occur because critical steps were never completed, and no one was accountable for confirming completion.

Closed-Loop Care: What "Done" Actually Means

In a closed-loop model, documentation of outreach is insufficient. Each transition step must reach a verifiable endpoint, with escalation if it does not.

Rules to follow:

- A task is not complete when it is attempted
- A task is complete only when the intended outcome occurs or an active escalation is documented

For every high-risk discharge, the care team must be able to answer **yes or no** — with evidence — to the following:

Critical Step	Closed-Loop Completion Standard	Escalation if Not Completed
PCP TCM visit	Visit completed within required timeframe (≤7 days for high risk)	Same-week rescheduling + nurse or PCP outreach

Critical Step	Closed-Loop Completion Standard	Escalation if Not Completed
Medication reconciliation	Reconciliation documented **and** patient demonstrates understanding	Pharmacist escalation + caregiver involvement
Symptom monitoring	Patient can verbalize warning signs and action plan	Nurse coaching + revised education
Specialty follow-up	Visit scheduled and attended, or clinical reason documented	Direct scheduling support or alternative plan
Ordered labs/tests	Labs completed and results reviewed	Reminder + provider notification
SDOH needs addressed	Transportation, food, or caregiver support confirmed	Navigator or social work referral

Ownership Model: One Patient, One Accountable Role

Closed-loop care fails when responsibility is diffuse.[15]

Best practice:

- Assign one primary owner (typically the nurse transition coach) per patient
- Owner is responsible for:
  - Tracking completion status: Initiating re-outreach and escalating unresolved gaps to clinical leadership

QRG rule: If everyone owns the transition, no one owns the outcome.

Standardized Re-Engagement Cadence

To prevent silent drop-off, high-risk patients should receive scheduled, structured contacts, not ad-hoc calls:

- **Day 2 post-discharge:** confirm PCP TCM scheduled and meds obtained
- **Week 1:** verify TCM completion and medication understanding
- **Week 2–3:** confirm symptom stability, labs, and specialty follow-up
- **Week 4:** final check for unresolved issues before day 30 closes

Each contact must explicitly answer: What was supposed to happen? Did it happen? If not, what is the next action?

7. DOCUMENTATION REQUIREMENTS

Documentation is the bridge between clinical action and Star Ratings performance. In the world of HEDIS and Medicare Stars, "if it wasn't documented, it didn't happen."

AAVBC principle: C18 performance requires clearly, timely, and specific documentation

Why Documentation Is Structurally Linked to C18

C18 performance is calculated using a **risk-adjusted Observed-to-Expected (O/E) ratio**. The **Expected** readmission denominator is driven entirely by **claims-based diagnoses**, not narrative intent.

This creates two high-risk failure modes:

- **Under-documentation of chronic disease → artificially low expected readmissions**
- **Incomplete transition documentation → Chronic conditions may not be reflected in expected rate**

Both result in worse Star Ratings despite appropriate care. Because the model relies on coded conditions, the clinical record plays an important structural role. When documentation fully reflects the patient's active chronic conditions, the expected rate more accurately mirrors the individual's true medical risk.

HCC Documentation: What Should Be Reflected at Each Encounter

To ensure accurate risk adjustment, **all active, clinically relevant chronic conditions** must be documented during **face-to-face encounters**, including the **PCP TCM visit**.

Incomplete vs Complete Documentation with RAF Impact

Condition	Poor Documentation	Correct Documentation	RAF/C18 Impact
Chronic Kidney Disease	"History of CKD."	"CKD stage 3b (eGFR 38), stable since discharge. Renal labs reviewed; ACE-I continued with BMP in 2 weeks."	Stage-specific CKD increases expected utilization; missing stage **artificially lowers expected readmissions**
Heart Failure	"CHF."	"Chronic systolic heart failure (HFrEF), NYHA II, recent exacerbation causing admission. Weight stable; diuretic dose reviewed."	HF subtype + acuity materially increases RAF; generic CHF coded incomplete
COPD	"COPD."	"Moderate COPD with recent exacerbation requiring hospitalization. Inhalers reconciled; technique reviewed."	Exacerbation status drives higher risk; omission depresses denominator
Diabetes	"Type 2 diabetes."	"Type 2 diabetes with diabetic CKD. A1c 8.4% inpatient; insulin regimen adjusted and reviewed."	Complicated diabetes carries higher RAF than uncomplicated DM
Morbid Obesity	"Obese."	"Morbid obesity (BMI 42), contributing to HF symptoms and limited mobility. Counseling provided."	BMI ≥40 is a high-impact HCC; vague terms **do not count**
Malnutrition	"Poor appetite."	"Moderate protein-calorie malnutrition diagnosed inpatient. Nutrition plan reviewed; supplements continued."	Malnutrition significantly increases risk; often **missed post-discharge**
Major Depressive Disorder	"Depression."	"Major depressive disorder, recurrent, moderate. PHQ-9 reviewed; stable on sertraline."	Psychiatric HCCs meaningfully raise expected utilization

Condition	Poor Documentation	Correct Documentation	RAF/C18 Impact
Substance Use Disorder	"History of alcohol use."	"Alcohol use disorder, moderate, contributing to admission. Counseling provided; follow-up arranged."	Active SUD increases readmission risk; "history of" may be excluded
Chronic Respiratory Failure	"On oxygen."	"Chronic hypoxic respiratory failure on 2L home O_2; stable since discharge."	Respiratory failure is high RAF; device use alone is insufficient
Anemia	"Anemia."	"Anemia of CKD; Hgb 9.6 reviewed, no transfusion indicated."	Etiology-linked anemia protects RAF; nonspecific anemia often down-coded

Documentation vs Coding: Why Specificity Matters

For CMS risk adjustment and C18 performance, **only ICD-10-CM codes submitted on claims are recognized.** Clinicians are not required to list ICD-10 codes in their notes; however, **clinical documentation must be written with sufficient specificity to allow coders to assign the correct ICD-10-CM code without interpretation.** Vague or historical language (e.g., "history of CKD" or "CHF") often results in non-HCC or downgraded codes, reducing expected readmissions and worsening observed-to-expected ratios.

MEAT Framework Applied to C18 Transitions

All chronic conditions relevant to the admission or readmission risk must meet **MEAT**:

MEAT Element	What Auditors Look For
Monitor	Labs, vitals, symptoms, or functional status
Evaluate	Clinical interpretation or stability assessment
Assess	Condition status (stable, worsening, uncontrolled)
Treat	Medications, referrals, counseling, or monitoring plan

A diagnosis listed without MEAT support may be disallowed during audit, reducing the expected readmission denominator.

TCM Documentation: Minimum Standard

For every TCM episode, documentation must clearly show:

Element	Required Documentation
Discharge date	Date patient left inpatient or observation setting
Interactive contact	Date, mode, and content (≤2 business days)
Face-to-face visit	Date (≤7 or 14 days depending on complexity)
Medication reconciliation	Explicit statement that reconciliation occurred

Root-cause analysis	Why admission occurred and mitigation plan
Medical decision-making	Moderate or high complexity supported
Follow-up plan	Labs, referrals, monitoring, and escalation

Closed-Loop Documentation (Proving Completion)

In a C18-aligned workflow, documentation must prove **completion**, not effort.

Required closed-loop proof points:

- PCP TCM visit **completed**, not just scheduled
- Medication reconciliation **completed and understood**
- Specialist visits **attended or rescheduled**
- Labs **completed and reviewed**
- SDOH interventions **resolved or actively managed**

Closed-loop documentation should explicitly state:

1. What was done
2. What was found
3. What changed, and
4. What happens next — with dates and ownership

Example language to use:

Medication reconciliation completed on [date]. Discharge medication list compared against outpatient EMR list and pharmacy fill history. Duplicate lisinopril entry discontinued; furosemide dose clarified to 40 mg daily per discharge summary. Patient able to correctly state current medications and dosing using teach-back.

Heart failure: Chronic systolic heart failure (HFrEF), NYHA class II, recent exacerbation prompting admission. Weight stable since discharge; no dyspnea or edema today. Diuretic regimen reviewed and continued.

Chronic kidney disease: CKD stage 3b (eGFR 38 on [date]). Renal function reviewed; ACE inhibitor continued with plan for repeat BMP in 2 weeks.

Follow-up: Cardiology visit scheduled for [date]; labs ordered and patient instructed on completion. Transportation confirmed.

Assessment: Patient clinically stable post-discharge with completed medication reconciliation and follow-up plan in place to reduce risk of readmission.

Common Documentation Errors That Depress C18 Performance

Avoid these high-impact mistakes:

- Copy-forward remembering old diagnoses without MEAT
- Listing CKD or HF without stage/type
- Documenting “meds reviewed” without reconciliation language
- Failing to link social barriers to care plans
- Omitting palliative or hospice discussions in advanced disease

Each error can **lower expected readmissions**, worsen O/E ratios, and weaken audit defense.

8. PERFORMANCE MANAGEMENT, MONITORING, AND CONTINUOUS IMPROVEMENT

Sustaining 4- and 5-Star C18 Performance Over Time

Achieving strong performance on the **C18 Plan All-Cause Readmissions** measure is not a one-time clinical project. It requires **ongoing performance management**, tight monitoring of **Observed-to-Expected (O/E) ratios**, and proactive adaptation to **Star Ratings cut-point volatility**.

High-performing Medicare Advantage organizations treat C18 as a **continuously managed risk metric**, not a retrospective scorecard.

1. Understand What You Are Actually Managing: The O/E Ratio

C18 performance is driven by the **Observed-to-Expected (O/E) readmission ratio**, not raw readmission counts.

- **Observed** = actual unplanned readmissions
- **Expected** = risk-adjusted readmissions based on coded diagnoses and patient characteristics

Critical insight:
You can worsen your Star score even while reducing raw readmissions if expected risk is under-captured.

Operational implication

- Clinical improvement **and** documentation accuracy must move together
- Any initiative that lowers Observed without protecting Expected will underperform

2. Dashboards That Matter (and Ones That Don’t)

Generic utilization dashboards are insufficient for C18. Effective dashboards must be **action-oriented and risk-aware**.

Minimum required C18 dashboard elements

- Rolling 30-day **Observed readmissions**
- Rolling **Expected readmissions**

- Real-time **O/E ratio trend**
- Readmissions by:
  - Diagnosis group (Top 20 drivers)
  - Timing (0–7 vs 8–30 days)
  - Risk tier (low/moderate/high)
- % of discharges with:
  - ≤7-day TCM completed
  - Medication reconciliation completed
  - Closed-loop follow-up completed

AAVBC rule: If a metric cannot drive a same-week intervention, it does not belong on the dashboard.

3. Managing Star Cut-Point Volatility

C18 cut-points change year to year based on **national performance distribution**, not absolute thresholds. This creates volatility even for stable organizations.

What this means

- "Holding steady" may still result in Star loss
- Small changes in O/E can shift Star tiers disproportionately

Best practice

- Manage to a **buffer zone**, not the minimum threshold
- Target performance comfortably above prior-year 4- or 5-Star cut-points

AAVBC rule of thumb: Aim to outperform the prior year's 4-Star cut-point by a meaningful margin to absorb volatility.

4. Leading Indicators vs Lagging Indicators

Waiting for final HEDIS or Stars results is too late.

Lagging indicators (too late to act)

- Annual Star score
- Final HEDIS rates

Leading indicators (actionable)

- % of high-risk discharges with ≤7-day TCM completed
- % of medication reconciliations completed within 72 hours
- % of discharges with unresolved closed-loop gaps
- Readmissions within first 7 days (early failure signal)

High performers review leading indicators **weekly**, not quarterly.

5. Root-Cause Reviews Improve Performance

Not all readmissions deserve the same level of review. Focus on **preventable signal events**.

High-yield readmission reviews:

- Readmissions within 7 days
- Readmissions after missed TCM visits
- Medication-related readmissions
- Repeat readmissions for the same patient

Each review should answer:

1. Was the patient identified as high-risk?
2. Did the workflow activate on time?
3. Was the intervention completed (closed-loop)?
4. Was documentation sufficient to support Expected risk?

Patterns, not anecdotes, should drive changes.

6. Continuous Improvement Cycle (Quarterly Cadence)

Sustained C18 performance requires a **formal improvement cycle**, not ad-hoc fixes.

Quarterly C18 cycle

1. Review O/E trends and Star positioning
2. Identify top failure modes (latency, missed follow-up, documentation gaps)
3. Adjust workflows or thresholds (e.g., expand pharmacist triggers)
4. Retrain targeted teams (PCPs, care managers, coders)
5. Re-measure within the next quarter

AAVBC principle: C18 improvement is iterative. Stability comes from disciplined repetition.

9. KEY TAKEAWAYS

Top 10 Takeaways: C18 Plan All-Cause Readmissions (PCR)

1. **C18 Is a Triple-Weighted Outcome Measure That Can Make or Break Star Ratings**
   As of the 2025–2026 Star cycles, C18 carries triple weight and accounts for ~10% of the Part C score. Small performance changes can have outsized financial and reputational impact.
2. **C18 Is Driven by the Observed-to-Expected (O/E) Ratio, Not Raw Readmission Counts**
   Reducing readmissions alone is insufficient. If patient complexity is under-documented, the Expected denominator is too low, making average performance appear poor.

3. **Accurate HCC/Documentation Is as Important as Clinical Intervention**
   CMS risk adjustment only recognizes ICD-10-CM codes submitted on claims. If chronic conditions are not clearly documented with sufficient specificity, they will not be coded—regardless of clinical reality.
4. **The Index Hospitalization Sets the Risk Baseline**
   Diagnoses coded during the index stay and prior 12 months heavily influence Expected readmissions. Missed diagnoses at this stage permanently disadvantage the plan for the full 30-day window.
5. **Readmissions Are Highly Concentrated and Predictable**
   Roughly 60% of readmissions are driven by 20 diagnoses, led by sepsis, heart failure, diabetes with complications, renal failure, COPD, and behavioral health conditions. These patients require targeted transition workflows.
6. **The Follow-Up Gap Is the Single Most Actionable Failure Point**
   More than half of readmitted patients have no outpatient visit between discharge and readmission. A single PCP visit within 7 days is more protective than multiple later contacts.
7. **TCM + Medication Reconciliation + Nurse Transition Support Works Best as a Bundle**
   Transitional Care Management, pharmacist-led medication reconciliation, and nurse transition coaching are most effective when deployed together within the first 7 days post-discharge.
8. **Medication Errors Are a Leading Cause of Early Readmissions—and Highly Preventable**
   Medication discrepancies occur in up to 70% of discharges. Pharmacist-led reconciliation and early follow-up reduce readmissions by 30–40% and should be prioritized for high-risk patients.
9. **Closed-Loop Execution Determines Success**
   Scheduling is not completion. Readmission prevention requires proof that key steps actually occurred—TCM visits completed, medications reconciled and understood, labs reviewed, and follow-up visits attended.
10. **Sustained C18 Performance Requires Continuous Management, Not One-Time Projects**
    High-performing organizations manage C18 with real-time dashboards, leading indicators, quarterly root-cause reviews, and a performance buffer to absorb Star cut-point volatility.

10. SAMPLE PATIENT COMMUNICATION

Effective patient communication employs these tactics

- Early
- Plain-language
- Repeated
- Closed-loop
- Focused on *when to call*, not just *what to do*

1. Day-of-Discharge Script (Nurse/Discharge Educator)

Goal: Reduce early (0–7 day) readmissions due to confusion.

“Before you leave today, I want to make sure we’re on the same page.

I’m going to explain three things, and then I’ll ask you to explain them back to me in your own words so I know I explained them clearly.

First, what changed during this hospital stay. Second, what medicines you should take when you get home. Third, who to call if something doesn't feel right."

(Pause, review After Hospital Care Plan)

"If you notice any of these warning signs—such as shortness of breath, swelling, fever, dizziness, or confusion — you should **call us right away**, not wait until things get worse.

You do not need to go back to the hospital unless we tell you to or it's an emergency."

2. 48–72 Hour Post-Discharge Call (Nurse Transition Coach)

Goal: Catch medication and follow-up failures early.

"Hi [Patient Name], this is [Name] calling to check in after your hospital stay.

I want to make sure everything is going smoothly since you got home."

Medication Check

"Can you tell me which medications you are taking right now and how you take them?

Were you able to pick them all up from the pharmacy?"

(If confusion or missing meds)

"Thank you for telling me. I'm going to help fix this today so it doesn't turn into a problem."

Follow-Up Check

"Do you have an appointment scheduled with your primary care doctor in the next week?"

"If transportation or cost is an issue, please tell me—we can help with that."

3. PCP Transitional Care Management (TCM) Visit Script

Goal: Prevent recurrence by addressing root cause.

"I want to talk about **why you ended up in the hospital**, not just what happened there.

From your perspective, what do you think led to this admission?"

(Listen, reflect)

"Based on what I'm seeing, here's what we're going to do differently so this doesn't happen again."

Medication Reconciliation (Plain Language)

"Some of your medicines changed in the hospital.

I'm going to read through what you should be taking now, and then I want you to tell me which ones you'll take when you get home."

"If something doesn't feel right with a medication, **call us before stopping it**."

4. High-Risk Patient Script (Polypharmacy/HF/CKD/COPD)

Goal: Reduce preventable deterioration.

"Because of your medical conditions, you're at higher risk of needing to come back to the hospital if problems aren't caught early.

That's why we're checking in more often—not because something is wrong, but to keep it from becoming wrong."

"Small changes can be warning signs. Calling early helps us fix things at home."

5. Symptom Escalation Script (Teach-Back)

Goal: Ensure the patient knows when and how to act.

"I want to make sure you know **when to call us** and **when to seek urgent care**."

"Can you tell me, in your own words, what symptoms would make you call our office?"

(If incorrect)

"That's a really common misunderstanding—thank you for saying that. Let me clarify."

6. Missed Appointment Re-Engagement Script

Goal: Close loop when follow-up fails.

"We noticed you weren't able to make your follow-up appointment.

This happens a lot, and it's not a problem—we just want to help you reschedule so small issues don't turn into big ones."

"What got in the way last time?"

(Offer solution)

"Let's fix that together today."

7. Medication Confusion/Non-Adherence Script (Pharmacist or Nurse)

Goal: Prevent medication-related readmissions.

"You're not alone — many people feel unsure about medications after a hospital stay.

My job is to make this simpler."

"Which medication feels the most confusing right now?"

(Normalize, simplify, teach-back)

8. Palliative/Hospice Introduction Script (When Appropriate)

Goal: Reduce non-beneficial readmissions.

"I want to talk about what matters most to you moving forward.

Some people in your situation choose care focused on comfort and quality of life, rather than returning to the hospital again and again."

"This doesn't mean we're giving up — it means we're aligning care with your goals."

9. Caregiver Engagement Script

Goal: Reduce readmissions in cognitively or functionally limited patients.

"We like to make sure a family member or caregiver understands the plan too.

Who helps you most at home?"

"Would it be okay if we reviewed the medication and warning signs together?"

10. Final 30-Day Close-Out Script

Goal: Prevent late (day 9–30) readmissions.

"You're coming up on one month since your hospital stay, which is great.

Before we wrap up, is there anything that still feels unclear or worrying?"

"If something comes up later, you don't have to wait until it becomes serious — just call us."

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