

Measure at a Glance

CBE #5575: Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes

Measure Summary (Where does this measure seek to improve care?)

This measure looks at how many days patients spend in acute care within 30 days after being discharged from the hospital for diabetes. The measure adds up all days spent in emergency department visits, observation stays, and unplanned readmissions to show how often patients need more care after discharge.

The measure includes patients who are 65 years or older, have Medicare, and were treated in a hospital for diabetes. The results adjust for age, other health conditions, and how long patients are alive during the 30-day period. The measure compares predicted days (what actually happens to patients at a hospital) to expected days (what would usually happen for similar patients at an average hospital), and reports the difference as excess days per 100 discharges to show whether patients needed more or fewer days of care than expected,

This measure focuses on hospital-level performance. It shows how hospitals compare based on how many days their patients spend in acute care after discharge. A lower score shows fewer days in acute care than expected (meaning better performance). A higher score means patients spent more days in acute care than expected.

Meaningfulness (Why does this matter to patients, and how could it improve their care?)

This measure reflects the impact of care after a hospital stay for diabetes, including how often patients need to return to the hospital. The developers report that returning to acute care can be difficult for patients and caregivers. It may increase stress, lead to higher costs, and raise the risk of complications such as infections.

The developer gathered patient and caregiver input. Interviews described experiences such as confusion after discharge, problems with medications, and poor communication with providers.

The developers also conducted a review with a technical expert panel that included patients and caregivers. All patient and caregiver participants agreed that the measure is meaningful and provides useful information for care decisions.

Usability (How will providers use this measure to improve care delivery?)

This measure combines different types of care, such as emergency department visits, observation stays, and readmissions, into one result. By showing total days in acute care, the measure may help show patterns across hospitals. The Centers for Medicare & Medicaid Services (CMS) reports the results at the hospital level, which allow patients, families, hospitals and providers to compare performance across hospitals. Hospitals also may use the results to identify differences in post-discharge care.

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Because CMS calculates the results using existing claims data, hospitals can use the measure consistently.

Feasibility (How can this measure be implemented without adding burden for providers and patients while still improving care?)

This measure uses claims data, which are billing records created during routine health care services. The data come from Medicare fee-for-service (FFS) claims and Medicare Advantage (MA) encounter data, along with other Medicare administrative data. All of these data are stored in structured electronic systems and are already collected as part of routine care and payment processes.

CMS calculates the measure using existing data, so hospitals and clinicians do not need to submit additional information. The data include details needed to define the patient group and count days in acute care, such as hospital stays, emergency department visits, and observation stays. Because the measure relies only on existing claims data, it does not require manual chart review or new data collection. Therefore, no additional costs or workflow changes are required to report this measure.

There are also no additional concerns about patient privacy, because the measure uses data already within CMS systems for billing and reporting.

Impact (How will using this measure improve patient experiences and outcomes?)

This measure focuses on the 30 days after a hospital stay for diabetes, when patients may have a higher risk of complications. Days spent in acute care, such as emergency visits, observation stays, and readmissions, can reflect the quality of care transitions after discharge.

The developers cite evidence that actions such as medication review, patient education, and timely follow-up care may help reduce the need for additional hospital-based care after discharge. Studies and clinical guidelines show that these types of interventions result in lower use of emergency services and readmissions for patients with diabetes.

Diabetes-related hospital care is common and costly. The developers report that diabetes is associated with high rates of hospital use and significant health care spending, including billions of dollars spent on readmissions. By combining multiple types of acute care use into a single result, the measure provides a more complete view of patient outcomes after discharge.

Performance Gap (Based on current performance, where and how much care can improve?)

This measure shows differences in how many days patients spend in acute care after leaving the hospital for diabetes.

Testing data are from January 1, 2022, to December 31, 2023. The analysis includes 4,193 hospitals (facilities) and 370,594 patient admissions.

Measure scores represent excess days in acute care per 100 discharges. A negative score means better performance, because patients spent fewer days in acute care than expected. A positive score means worse performance, because patients spent more days than expected.

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When results are grouped into 10 equal groups (deciles), scores ranged from about -55.1 at the 10th percentile to about 87.7 at the 90th percentile. This shows a difference of about 143 excess days per 100 discharges between lower- and higher-performing hospitals. Using percentiles helps show how results vary across hospitals without focusing on very low or very high values.

Disclaimer: Battelle used generative artificial intelligence in the initial drafting of this document. Actual humans with relevant expertise subsequently validated and revised the content.