



Administrator Program

Monday, November 17, 2025

2:15pm-3:30pm

3b. A CASE STUDY: Unplanned Hospital Readmissions of Seniors – What We Have Learned and What the Future Holds

Presented by:

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Unplanned Hospital Readmissions of Seniors: What We Have Learned and What the Future Holds

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LEARNING OBJECTIVES FROM THIS PRESENTATION:

- *What are all the reasons that the U.S. healthcare system must continue to work on reducing unplanned hospital readmissions of seniors?*
- *What has research revealed about efforts to date to help reduce unplanned hospital readmissions of seniors?*
- *What is the role of home health agencies in this effort and what does the future hold that will help achieve the goal?*

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Current state of affairs with regards to the U.S. healthcare system:

- Aging of the Baby Boomer generation - 10,000 seniors a day turn 65, over 4 million alone in 2025, and this trend continues until 2030
- In 2030 there will be more 80+ year olds than at any time in our history
- U.S. spends approximately 18% of gross domestic product on healthcare, an all-time high in our history
- U.S. spends \$15 - \$20 billion annually on unplanned hospital readmissions

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Impact of an unplanned readmission:

Patient – physical/emotional drain on the patient and their family/caregivers; reduces confidence in the healthcare system

Financial – cost to the patient and their family; cost to the hospital; cost to the healthcare system

Healthcare resources – inefficient use of resources, detracts from care that could be provided to other patients



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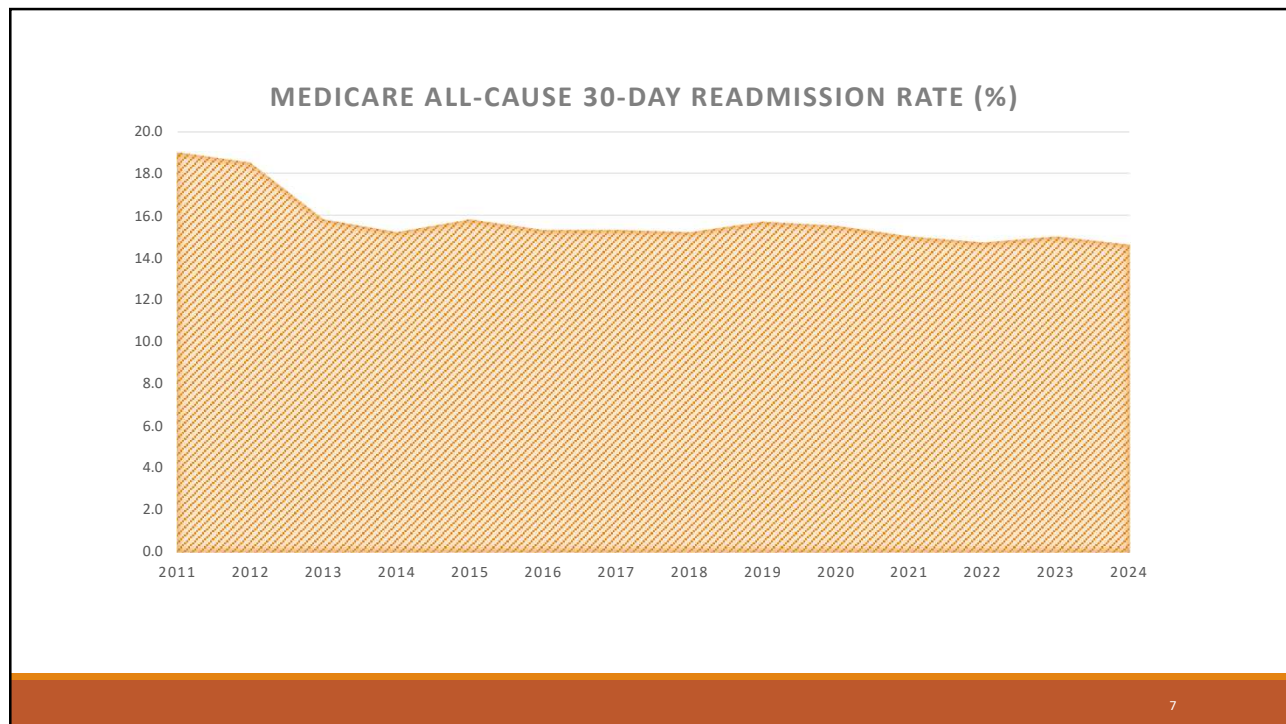
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U.S. response to unplanned hospital readmissions:

- Hospital Readmissions Reduction Program (HRRP) – part of the Affordable Care Act of 2010
- Started in 2012 and penalizes hospitals for readmission rates that exceed a unique target rate for AMI, COPD, HF, Pneumonia, CABG, and elective THA/TKA
- Result of HRRP – through 2023, 3,139 hospitals have been penalized \$2.5 billion; all cause readmission rate has declined from 17% to 14.6%;

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Impact of focus on unplanned readmissions on home health agencies:

- Medicare Home Health Compare – started in 2003, changed to include star ratings in 2015
 - Has historically included both ED use while on service and hospital readmission while on service

Current data reported on Medicare Home Health Compare:

Preventing unplanned hospital care

How often patients remained in the community after discharge from home health

How often patients were re-admitted to the hospital for a potentially-preventable condition after discharge from home health

How often patients were admitted to the hospital for a potentially preventable condition while receiving home health care

2025 - Home Health Value Based Purchasing (HHVBP) – ED/ACH – 35% of total score!

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RESEARCH – GOVERNMENTAL, ACADEMIC, PRIVATE



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Four primary areas of recent research:

“Big data (large dataset)” analysis identifies trends for modeling purposes to identify patients at-risk for readmission during the index hospitalization

Transition of care best practices as the patient is being discharged from the hospital are key to reducing unplanned readmissions

Post-discharge studies that identify successful interventions outside of the acute care setting are key to reducing readmissions

“Data’s Big Three” includes health learning systems, predictive analytics, and artificial intelligence (AI) assist medical practitioners with diagnosis and treatment to prevent readmissions

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“Big Data” Research



Characteristics of “Big Data” Research

- Retrospective review of claims
- Normally involves thousands of claims and some studies involve millions of claims
- Goal of these studies is to find trends that help identify patients with specific attributes that are at risk for an unplanned readmission

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Results from “Big Data” research

- *Development of machine learning algorithms*
 - *HOSPITAL, LACE, LACE+, mLACE+, et al.*
- *Programs that hospitals use to predict readmission risk once a patient has been admitted*
- *Studies indicate that all of these methods are approximately 70% accurate in predicting readmission risk*
- *Drawback to this method is that treatment decisions do not always align with risk of readmission*

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Characteristics of TOC Research

- Identify best practices to reduce unplanned hospital readmissions upon discharge
- Initial best practices as recommended by CMS included:
 - Comprehensive discharge planning
 - Timely communication – in-hospital and post-discharge
 - Medication reconciliation
 - Education of patient/caregiver – “teach back method”
 - Follow-up visit with PCP

Transitions of Care (“TOC”) Research



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Results from Transition of Care Research

Innovation within hospitals

- Involvement of multiple departments in discharge process
- Models such as SOAR – Supporting Older Adults at Risk – 24 tasks to discharge
- VA Hospitals – 20 tasks to discharge
- Increased involvement of pharmacist in discharge process
- Focus on health literacy – use of interpreters

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Results from interviews of patients discharged from the hospital

- Ineffective communication – Number one complaint of discharged patients – “talking to patient/caregiver” versus communicating
- System pressure to discharge – administration directive to open beds
- Poor medication management – lack of understanding and access
- Health literacy – inability to navigate the healthcare system
- Poor understanding of illness and treatment plan
- Perceived lack of concern by hospital staff for post-discharge care

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Post-Discharge Research



Characteristics of Post-Discharge Research

- Type of post-discharge visit – PCP versus specialist
- Pro-active home visits by medical personnel working for the hospital
- Telephone call versus in-person visit
- Role of home health

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Results from Post-Discharge Research

- Follow-up visits with PCP versus specialist were more effective
- Community paramedicine visits to the home
- Premature discharge or sent home versus facility
- Home health is effective – front load visits

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“Data’s Big Three” Research

Characteristics of “Data’s Big Three” Research

- Health learning systems
- Predictive analytics
- Artificial Intelligence (AI)



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Results from “Data’s Big Three” Research

- Health learning systems – tools developed to assist medical practitioners at the point of care
- Predictive analytics – used upon admission and updated as plan of care is executed
- AI – used at bedside to assist with diagnosis and treatment

Notable quote: “It is a long-standing dream for physicians to have AI assistants observing care along with them and chiming in with predictions and advice.”

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What does the future hold with regards to unplanned readmissions?



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***Research shows that there is not one solution to the problem,
so where do we go from here?***

- **Healthcare system approach – ED, hospital admission, transition of care, hospital discharge, post-acute care, follow-up post-discharge**

Better triage in the ED – not a walk-in clinic; Identify known “frequent flyers”; Case manager in ED; “Educate” community medical providers

Identify patients at risk for readmission upon admission and communicate with medical team for appropriate treatment; follow TOC processes; **involve pharmacist in discharge process**; direct patient to the appropriate post-hospital care setting; in-person follow-up with patients that are discharged home without additional care

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- **Non-clinical factors – health literacy, social determinants of health**

Starts in the hospital at admission; provide appropriate education – interpreter, written material in native language, video

Involve social workers, community resources, identify non-clinical needs and seek solutions

- **Role of “Data’s Big Three”, particularly AI**

Embrace machine learning and AI as tools that can assist with identifying at-risk patients and providing appropriate treatment; educate patients and encourage acceptance of technology as a tool

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Risks of use of AI

- Patient privacy
- “Black box” stigma causes mistrust by patients
- Overreliance on AI by medical practitioners

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Center for Medicare and Medicaid Innovation (CMMI)

HHVBP – Home Health Value Based Purchasing
TEAM – Transforming Episode Accountability Model

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What is home health industry's role in the helping the healthcare system solve the problem of unplanned readmissions?

- More important than ever, first line of offense/defense
- Talk to patients – listen to what they have to say
- Hold clinicians accountable – at admission and while on service
- Engage with hospitals to find solutions
- Stay abreast of research and current best practices – Hospital at Home
- Adopt AI as a tool for clinicians
- Lobby Congress for expanded use of telehealth that is reimbursed
- Innovate, experiment, and share

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Potential practical solutions that could help your home health agency reduce unplanned readmissions:

- Encourage patients to go to walk-in clinic or free-standing ER versus the hospital ED - provide information at admission with options
- Revitalize or implement a “Call Me First” program
- Engage with staff and encourage involvement in the process
- Set a realistic goal for your agency and celebrate success
- If you need help, hire a consultant

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What if...



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Remember what our mission is...



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Questions?



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