

Unnecessary Hospital Readmissions Through Person-Centered Chronic Disease Care

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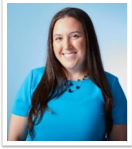
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### Our Panelists



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### Course Objectives

Upon completion of each session, participants should be able to:

- Identify common clinical and non-clinical drivers of avoidable hospital readmissions among older adults with chronic disease.
- Apply person-centered strategies to support disease self-management and early symptom recognition.
- Describe how tools such as INTERACT enhance communication and escalation across care settings.
- Explain how in-home care programs can support care transitions and reduce rehospitalization risk.

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**PATHWAY HEALTH**  
Right | Location | Knowledge

ComForCare  
HOME CARE

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## The Human Impact of Unnecessary Hospitalization

Readmissions | Why it Matters

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### Diagnosis – Medicare Hospitalizations

Common Drivers:

- Septicemia
- Heart Failure
- Respiratory Infections
- Kidney/UTI
- Pulmonary Edema
- Psychosis



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### Early Identification of Change in Condition Matters

Early identification prevents:

- Cognitive changes
- Acute exacerbations of a condition
- Sepsis progression
- HF escalation
- Respiratory failure
- Crisis transfers
- Psycho-social changes
- Change in function
- Regulatory deficiencies



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### Septicemia- Early Warning Signs

- General feeling of weakness and fatigue
- Loss of appetite
- A feeling of being cold or shivering
- Not acting like themselves
- Increased sleepiness




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### Pneumonia-Early Warning Signs

- Fatigue
- Loss of appetite
- Confusion
- Dry cough




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### Potentially Preventable Readmission Diagnoses

#### High-Frequency Diagnoses:

- Heart Failure
- COPD
- Pneumonia
- Diabetes Complications
- Sepsis
- UTI
- Kidney Disease
- Stroke Complications
- Mental Health Disorders
- Substance Use Disorders



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### Risk related to Hospitalization

- 59% developed hospital-associated complications including delirium, infection or falls
- Older adults spend less than one-hour out of bed while hospitalized
- Complications related to medication errors
- Experience clinical depression
- Higher rates of re-admission
- Post-hospital syndrome



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### Potential Impact of Hospitalizations

Unnecessary hospitalizations can lead to:

- Delirium and cognitive decline
- Hospital acquired infections
- Pressure injuries
- Functional decline
- Deconditioning
- Medication complications
- Emotional distress and anxiety
- Increased mortality risk



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### Potential Impact of Hospitalizations

Hospital transfers disrupt:

- Routine and environment
- Familiar care givers
- Medication stability
- Sleep cycles
- Emotion and reactions
- Care continuity
- Confidence, trust

Older adults are vulnerable to:

- Post hospital syndrome – high risk for complications
- Functional loss
- Loss of independence



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### Respiratory Assessment

- Inspection
- Auscultation
- Percussion
- Palpation
- Accurate vital signs
- Laboratory test interpretation
- Pulse oximetry



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### Accurate History



- Onset and duration of cough, fever,
- Recent exposure
- Vaccination
- Medication
- Any early recognition
- Capability of clinical decision making



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Person-Centered Care

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### Understanding-Goals and Preferences

- Make sure communication is simple, clear and culturally sensitive
- Explore the understanding of the condition
- Tailor education to the learning style
- Assess for deficits with hearing and vision



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### Relevant Education

- Break information into small steps
- Link information to daily routines
- Large print
- Plain language
- Repeat instructions



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### Adapt to Functional and Cognitive Abilities

- Easy to read pill bottles
- Modify home environment
- Provide adaptive equipment
- Use repetition and routines, visual aids
- Keep instructions short and concise
- Always support dignity



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### Strengthen Social Support

- Involve family, friends or community support
- Provide realistic healthy lifestyle behaviors
- Nutritional support, access to food and respect for cultural foods
- Sleep hygiene
- Smoking cessation
- Assessment of substance use disorder



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### English as a Second Language

- Clear, simple and culturally sensitive communication
- Incorporate interpreters and bilingual resources
- Visual, hands-on teaching methods
- Build trust through respect, patience and cultural awareness



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### Proactive – INTERACT

Readmissions | Proactive



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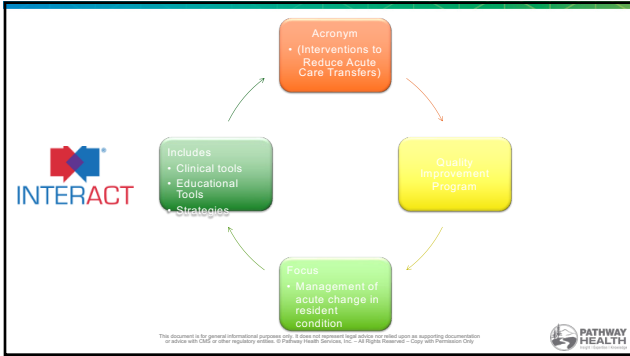
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**INTERACT**

- Is not a "tool"
- Is no longer a "toolkit"
- INTERACT 4.5 - All other versions are not supported
- INTERACT **IS** a QI Program

The goal of **INTERACT** is to improve care, not to prevent all hospital transfers

In fact, **INTERACT** can help with more rapid transfer of residents who need hospital care

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### Common Tools

**Decision Support Tool – Care Paths**

- Acute Mental Status Change
- Change in Behavior: New or Worsening Behavioral Symptoms
- Dehydration
- Fall
- Fever
- GI Symptoms
- Symptoms of Shortness of Breath (SOB)
- Symptoms of CHF
- Symptoms of Lower Respiratory Illness
- Symptoms of UTI

**CARE PATH Symptoms of Lower Respiratory Infection**

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### Common Tools - CoC File Cards

Vital Signs (report)	Laboratory Tests/Diag (report only the first or prior)	Signs and Symptoms S's																		
Blood Pressure Pulse Respiratory Rate Temperature	Complete Blood Count CBC Chemistry Chest X-ray Diagnosis ECG EKG Hemoglobin Hematocrit Urea Nitrogen Creatinine Sputum Urine Culture X-ray	<table border="1"> <thead> <tr> <th>Signs and Symptoms</th> <th>S's</th> </tr> </thead> <tbody> <tr> <td>Setback activity</td> <td>Any new onset setback activity, OR persistent setback in someone with known intermittent setback activity</td> </tr> <tr> <td>Altered onset of shortness of breath with pain, fever, or respiratory distress, or other progressive SOB criteria</td> <td>Accompanied by significant pain or bleeding</td> </tr> <tr> <td>Skin Tear</td> <td>Not applicable</td> </tr> <tr> <td>Sleep disturbance</td> <td>Not applicable</td> </tr> <tr> <td>Speech abnormality?</td> <td>Altered change in speech, with or without other focal neurological findings</td> </tr> <tr> <td>Sputum</td> <td>Altered to increased sputum, with OR accompanied by considerable pain or bleeding</td> </tr> <tr> <td>Syncope/presyncope</td> <td>Make a detailed patient history</td> </tr> <tr> <td>Swallowing difficulty</td> <td>With new onset or progressive choking, aspiration</td> </tr> </tbody> </table>	Signs and Symptoms	S's	Setback activity	Any new onset setback activity, OR persistent setback in someone with known intermittent setback activity	Altered onset of shortness of breath with pain, fever, or respiratory distress, or other progressive SOB criteria	Accompanied by significant pain or bleeding	Skin Tear	Not applicable	Sleep disturbance	Not applicable	Speech abnormality?	Altered change in speech, with or without other focal neurological findings	Sputum	Altered to increased sputum, with OR accompanied by considerable pain or bleeding	Syncope/presyncope	Make a detailed patient history	Swallowing difficulty	With new onset or progressive choking, aspiration
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### Many other tools - INTERACT

<b>Admission</b> <ul style="list-style-type: none"> <li>• Advance Care Planning tools</li> <li>• Medication Reconciliation</li> </ul>	<b>Communication</b> <ul style="list-style-type: none"> <li>• Stop and Watch</li> <li>• SBAR</li> <li>• Hospital Communication</li> <li>• Capabilities Checklist</li> <li>• D/C Tool</li> <li>• Transfer Checklist</li> <li>• Transfer Data List</li> </ul>	<b>Decision Support</b> <ul style="list-style-type: none"> <li>• Care Paths</li> <li>• Acute CoC File Cards</li> </ul>	<b>Quality Improvement</b> <ul style="list-style-type: none"> <li>• Hospital Rate Tracking Tool</li> <li>• QI Tool for Review of Acute Care Transfers</li> </ul>
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**Access INTERACT**

Includes evidence and expert-recommended clinical practice tools, strategies to implement them, and related educational resources

The basic program is located on the internet:  
<http://www.pathway-interact.com>



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**Reviewing Transfers**

After every transfer ask:

- Was this preventable?
- Was recognition timely?
- Was documentation complete?



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**Leadership Ownership**

Leaders:

- Review data monthly
- Standardize expectations
- Audit documentation
- Engage providers
- Engage staff
- Incorporate INTERACT in your day-to-day processes!



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**Staff Training for Care Transitions and Reducing Rehospitalization Risk**

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### Foster a Culture of Person-Centered Care

#### Training to Support Safe Care Transitions to Home

- **Build shared accountability for successful care transitions** by embedding person-centered care principles into onboarding and ongoing education, reinforcing that every team member plays a role in preventing avoidable rehospitalizations.
- **Align person-centered care training** so staff understand not only what actions to take during transitions, but why individualized planning, communication, and relationship-centered practices matter for clients, families, and interdisciplinary teams.
- **Use practical, real-world care transition scenarios** to help staff confidently apply person-centered approaches in daily practice (e.g., recognizing subtle changes in condition, honoring client preferences, and ensuring clear handoffs across settings).
- **Strengthen competency through interdisciplinary case reviews**, and timely feedback, supporting staff in identifying early warning signs, escalating concerns appropriately to reduce risk of complications and unnecessary hospital readmissions.
- **Co-design training with input from frontline caregivers, clinical leaders, and care partners** to ensure content reflects real workflows, common transition gaps, and value-based care expectations, ultimately creating smoother transitions and safer outcomes for those served.





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### Strengthening Care Transitions

#### Training with Collaborative Partners

- **Foster shared accountability** by aligning transition-of-care education across partners, ensuring leaders and staff understand how every discipline contributes to safe discharges, continuity of care, and prevention of avoidable readmissions.
- **Use interdisciplinary training to reinforce the why behind coordinated care transition practices**, supporting clear communication, consistent messaging, and early identification of changes in condition across providers and settings.
- **Leverage technology** to deliver standardized, evidence-based education and real-time updates across partner organizations (e.g., virtual training platforms, digital communication tools that close gaps during handoffs).
- **Co-develop shared care protocols, escalation pathways, and risk-stratification strategies** through collaborative training sessions that support rapid response to post-discharge concerns.
- **Promote a unified person-centered transition-to-home approach** that respects each partner's role, reduces fragmentation and duplication, and strengthens collective responsibility for care outcomes, and safer recovery at home.





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### Training In Action – Care Transitions in Practice

**Client/Patient Example:**

- Client condition
- Client situation
- Client impact
- Support tools utilized



**Professional Care Team Training:**

- How is training provided?
- How are skills tested/maintained?
- What is gained in a long-term program?

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### Helpful Resources

- [The Centers for Medicare and Medicaid Services \(CMS\) HHRP \(Hospital Readmission Reduction Program\)](#)
- [Hospital Readmissions Reduction Program](#)
- [CMS – Skilled Nursing Facility Value Based Purchasing Program](#)
- [CMS SNF VBP Confidential Feedback Reports](#)
- [CMS SNF VBP Frequently Asked Questions](#)
- [Skilled Nursing Facility Within-Stay Potentially Preventable Readmission \(SNF WS PPR\) Measure for the Skilled Nursing Facility Value-Based Purchasing \(SNF VBP\) Program](#)
- [AHRQ Hospital Guide to Reducing Medicaid Readmissions](#)
- [Quality Improvement Organizations](#)
- [The risks of hospital stays: A guide to safe recovery and returning home for older adults \(Mayo Clinic\)](#)
- [Pneumonia - Symptoms and causes \(Mayo Clinic\)](#)
- [Reducing Hospital Readmissions \(ComForCare\)](#)

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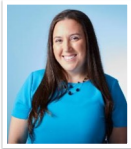
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