Preventing Avoidable Hospitalizations and ED Visits: A National Practice Module

Preventing avoidable hospital stays and emergency visits among home care clients.

Why this module matters. Medicare home health is measured on hospital and emergency use, hospitals are penalized for readmissions, and new payment models hold hospitals accountable for 30 days after discharge. Home care staff are the early warning system.

About this module

This module gives teams a shared, evidence-based approach to preventing avoidable hospital stays and emergency visits among home care clients. It draws on current federal rules and national guidance, and it ends with a checklist that agencies, clinicians, and families anywhere in the United States can adopt.

Item	Details
Who it is for	Agency leaders, nurses, supervisors, aides, and partner clinicians
Format	7 units, case scenarios, a knowledge check, and a national checklist
Time	About 2 hours as training
How to use it	Aides focus on Units 3 and 4. Nurses and leaders use all units. Pair with the Hospital-to-Home Transition module.

Learning objectives

After completing this module, learners will be able to:

1. Explain the scale and cost of avoidable hospital use.
2. Describe how national programs measure it.
3. Recognize early changes with Stop and Watch.
4. Report condition-specific red flags.
5. Build agency systems that respond quickly.
6. Choose alternatives to the ED when safe.
7. Track hospital use.

Scope. Aides and family caregivers observe, support, and report. Clinical assessments, medication changes, and treatment decisions belong to licensed clinicians. Follow your state scope-of-practice rules and agency policies.

Unit 1. Why avoidable hospital use matters

Many hospital stays and emergency visits by older adults living at home can be prevented when changes are caught early and managed with the clinician. Home care staff see clients more often than anyone else on the care team, so they are the early warning system.

Measure	Figure	Source
Adult 30-day readmissions	About 3.85 million (2020)	AHRQ HCUP
Medicare 30-day readmission rate	17.0 per 100 hospital stays (2020)	AHRQ HCUP
Average cost of a readmission	$16,300 (2020)	AHRQ HCUP
Emergency department visits for older adult falls	About 4.5 million (2024)	CDC
Older patients with a medication error or misunderstanding after discharge	81%	Ziaeian et al., 2012

Unit 2. How national programs measure it

Program	What is measured
Medicare home health quality reporting	Acute care hospitalization and ED use without hospitalization during the first 60 days, potentially preventable hospitalization during the stay, potentially preventable readmission within 30 days after discharge, and discharge to community. Lower is better for hospital use.
Home Health Value-Based Purchasing	Ties Medicare home health payments to quality, including hospital use measures.
Hospital Readmissions Reduction Program	Reduces Medicare payments to hospitals with high readmissions; a sepsis readmission measure is being added.
TEAM model (2026 to 2030)	Hospitals accountable for 30 days after certain surgeries, including hip fracture.
Medicaid HCBS Quality Measure Set	Includes health and safety measures; states report from 2028.

Even private-pay agencies benefit: hospitals and health plans increasingly choose partners that can show lower hospital use.

Unit 3. Catching change early

Most avoidable hospital stays follow a change that was visible days earlier. INTERACT's Stop and Watch tool lists changes any caregiver can spot:

Change	Examples
Seems different than usual	Less talkative, less engaged
Talks or communicates less	Shorter answers, quieter
Overall needs more help	Needs help with tasks they did alone
Pain new or worse	Grimacing, guarding
Ate less	Skipped meals
No bowel movement in 3 days, or diarrhea	Constipation or loose stools
Drank less	Refused fluids, dry mouth
Weight change	Clothes looser or tighter; swelling
Agitated or nervous	Restless, anxious
Tired, weak, confused, or drowsy	Sleeping more, new confusion
Change in skin color or condition	Pale, flushed, sores
Help with walking, transferring, or toileting more than usual	Unsteady, near falls, accidents

Report any change the same day using SBAR: Situation, Background, Assessment, Request.

Unit 4. Condition-specific red flags

Condition	Report the same day	Call 911
Heart failure	Weight up 2 to 3 lb in a day or 5 lb in a week, more swelling, more breathless lying flat	Severe breathlessness, chest pain
COPD	More breathless, change in mucus, fever	Cannot speak in full sentences, blue lips
Diabetes	Repeated high or low readings, not eating	Unresponsive, seizure
Urinary infection	Burning, fever, new confusion, new incontinence	Very high fever with confusion and low blood pressure (possible sepsis)
Dementia	Sudden worse confusion (possible delirium), refusing food or fluids	Unresponsive
After a fall	New pain, bruising, change in walking	Head strike on a blood thinner, cannot get up, deformity

Personal plans first. Follow each client's specific instructions from their clinician. The thresholds above are common examples.

Unit 5. Agency systems that prevent hospital use

System	What it looks like
Risk identification	Flag clients with recent hospital stays, heart failure, COPD, diabetes, dementia, or falls
Early warning reporting	Every caregiver trained on Stop and Watch and SBAR
24/7 clinical access	An on-call nurse or clinician line for caregivers and families
Rapid response	Same-day nurse call or visit for reported changes
Clinician partnerships	A direct line to primary care offices for urgent same-day visits
Medication safety	Regular reviews and reconciliation after every hospital stay
Advance care planning	Goals of care and wishes recorded, so care fits what the person wants
Transition support	Contact within 2 business days of discharge and follow-up within 7 to 14 days

Unit 6. Alternatives to the emergency department

When a change is not an emergency, the right setting may be faster and safer:

- A same-day or telehealth visit with the primary care clinician.
- A nurse home visit, or home health if eligible.
- An urgent care clinic for minor injuries.
- Hospital-at-home or community paramedicine programs, where available.
- Palliative care or hospice support for people with serious illness who prefer care at home.

Emergencies. Never delay 911 for chest pain, signs of stroke, severe breathing trouble, heavy bleeding, or unresponsiveness.

Unit 7. Measures to track

Measure	How to calculate
Hospital admission rate	Admissions ÷ client days × 1,000
ED visits without admission	ED visits ÷ client days × 1,000
30-day readmission rate	Readmissions within 30 days ÷ discharges home
Same-day response to reported changes	Responded the same day ÷ reports
Clients with a documented goals-of-care conversation	Documented ÷ high-risk clients

Case scenarios

Case 1. Quiet change

An aide notices Mrs. G, who has COPD, is talking less and needs more rest between tasks.

- Which Stop and Watch signs apply?
- What should happen next?

Discussion: Talks less and needs more help. The aide reports with SBAR; the nurse calls or visits the same day and contacts the clinician, who may adjust treatment before a crisis.

Case 2. After-hours worry

At 9 p.m. a daughter calls the agency because her father is more confused.

- Why does a 24/7 line matter?
- What might the nurse advise?

Discussion: Without it, families often go straight to the ED. The on-call nurse can assess by phone, check for delirium causes, and advise a same-night visit, urgent clinician contact, or 911 if needed.

Knowledge check

1. Which Medicare home health measures track hospital use? *(Acute care hospitalization, ED use without hospitalization, potentially preventable hospitalization and readmission)*
2. Name four Stop and Watch changes. *(Seems different, talks less, eats less, more tired or confused, and others)*
3. What is the heart failure weight warning sign? *(2 to 3 lb in a day or 5 lb in a week)*
4. Name two alternatives to the ED for non-emergencies. *(Same-day clinician visit, nurse visit, telehealth, urgent care)*
5. Why record goals of care? *(So care, including hospital use, fits what the person wants)*

National Avoidable Hospitalization and ED Visit Prevention Checklist

This checklist turns national quality measures and early warning practices into one tool any agency can adopt. The "National basis" column shows where each item comes from. Adapt it to your state rules and policies.

Name or ID	Date	Completed by and role
Agency or organization	Reviewed by	Next review date

A. Identify risk

Action	National basis	Done	Notes
High-risk clients flagged (recent stay, heart failure, COPD, diabetes, dementia, falls)	Best practice	☐	
Medicines reviewed and reconciled after every hospital stay	Medicare TCM; CTI	☐	
Goals of care and advance directive recorded	Age-Friendly 4Ms	☐	

B. Catch change early

Action	National basis	Done	Notes
All caregivers trained on Stop and Watch and SBAR	INTERACT	☐	
Condition-specific red flags in each high-risk plan	Best practice	☐	
Changes reported the same day	Best practice	☐	

C. Respond

Action	National basis	Done	Notes
24/7 nurse or clinician line for caregivers and families	Best practice	☐	
Same-day nurse follow-up for reported changes	Best practice	☐	
Direct line to primary care for urgent visits	Best practice	☐	
Alternatives to the ED known and listed	Best practice	☐	

D. After discharge

Action	National basis	Done	Notes
Contact within 2 business days	Medicare TCM	☐	
Follow-up visit within 7 to 14 days	Medicare TCM	☐	
Fall risk rechecked	CDC STEADI	☐	

E. Measure

Action	National basis	Done	Notes
Admission, ED, and readmission rates tracked quarterly	Medicare home health measures	☐	
Same-day response rate tracked	Best practice	☐	

Completed by: signature	Printed name and title	Date
Reviewed by: signature	Printed name and title	Date

Sources and further reading

CMS: Home Health Quality Measures (cms.gov)
AHRQ HCUP Statistical Brief 304 (hcup-us.ahrq.gov)
INTERACT Stop and Watch Early Warning Tool (secure.in.gov)
CMS: FY 2027 IPPS Final Rule fact sheet (cms.gov)
AAPM&R: TEAM model (aapmr.org)
ACP: Transitional Care Management fact sheet (acponline.org)
CDC: Facts About Older Adult Falls (cdc.gov)
Ziaeian et al., 2012 (pmc.ncbi.nlm.nih.gov)

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