FHA Readmissions Focus Group
September 2025

Executive Summary

Florida Hospital Association
Mission to Care. Vision to Lead.

Readmissions continue to be a challenge for Florida hospitals, with most receiving a penalty under the Medicare Hospital Readmissions Reduction Program (HRRP) and no regions meeting the potentially preventable readmissions target under the Medicaid Directed Payment Program (DPP). Additionally, Medicare penalty amounts will likely increase when Medicare Advantage patients are included in the HRRP.

As a result, the FHA Quality and Patient Safety Committee and the FHA Board of Trustees has identified reducing readmissions as an association priority, charging staff to develop a comprehensive approach to support members. FHA is launching a readmissions collaborative in October to provide resources, tools, and training to support hospital efforts to reduce rehospitalizations.

To identify the priorities and design the collaborative, FHA hosted a Readmissions Focus Group to explore the biggest challenges, opportunities and initiatives currently underway. A one-day planning session was held on July 29, 2025, 10:00-3:00 p.m. ET at AdventHealth to gather feedback from hospital leaders across the state.

Findings

- Every hospital is struggling with readmissions
- The biggest challenges to overcome are:
    - Access to timely follow up appointments and primary care, in general
    - Patient and Caregiver understanding of the patient's condition, steps to recovery and medications
    - Medication reconciliation, adherence and access
    - Post acute care approvals and transitions
    - Health plan barriers to post-acute care and other necessary support
    - End of life decision making and leveraging palliative care
    - Social needs
- Opportunities included:
    - Leveraging EMRs, AI and other data tools to identify patients at risk for readmission
    - Closer partnerships with Skilled Nursing Facilities and leveraging technology to better share information.
    - Eliminating the three-day stay requirement for a SNF admission
    - Community partnerships
    - Improving the discharge process
    - Leveraging the state HIE and creating a bi-directional flow of key patient information
    - More timely, better data on readmissions

Next Steps

1. Reconvene the Readmissions Focus Group to review the findings and recommendations
2. Develop a 12-month plan for education, toolkit development and partner outreach
3. Launch by October 26, 2026

Florida Hospital Association Readmissions Focus Group

July 29, 2025
AdventHealth, Orlando, Florida
Prepared by Mirine Richey, DrPH, IBCLC

Framing the Challenge

Hospital readmissions continue to be a major challenge across Florida's healthcare systems, with a growing urgency as more patients present complex medical and social needs. To better understand the challenges facing hospitals and to identify opportunities for a statewide readmissions collaborative, , the Florida Hospital Association (FHA) convened a Readmissions Workgroup July 29, 2025, composed of a selected group of system leaders from care coordination, quality improvement, population health, and executive management.

To frame the conversation and ensure that workgroup priorities reflected frontline realities, FHA distributed a pre-session survey with the meeting registration. The survey asked for responses on 1) top three challenges, 2) top three opportunities, 3) if they have implemented anything in the past 18 months related to reducing readmissions, and if so, 4) to please briefly share what has been implemented (Appendix 1).

The survey captured a broad spectrum of challenges in discharge planning, medication reconciliation, post-acute coordination, data transparency, patient engagement, and social determinants of health (SDOH). These responses guided the structure of the in-person meeting, which was organized around five final key domains that were thematically identified in the survey responses, the existing literature, and previous issued identified by FHA:

- Care Transitions & Discharge Planning
- Patient & Family Engagement
- Social Determinants of Health
- Workforce Capacity, Training & Culture
- Data & Metrics

To guide this strategic discussion, the SOAR framework highlighting Strengths, Opportunities, Aspirations, and Results, was selected. Unlike deficit-based approaches that focus primarily on gaps or weaknesses, SOAR leverages a strengths-based, forward-looking lens. This model encourages innovation, engagement, and collaborative problem-solving by focusing on what systems do well, what is possible, and how those possibilities

can be translated into measurable improvements. Given the diversity of participating health systems and their varied starting points, SOAR provided a common language to identify priorities, build alignment, and chart a practical path forward.

Insights from the Pre-Survey

The pre-survey identified core themes that informed these thematic areas:

- **Care Transitions & Discharge Planning:**
  - Gaps in timely follow-up visits, fragmented evaluations, high SNF turnover, and limited access to specialists were prominent. Participants emphasized the need for reliable risk tools and consistent discharge protocols.
- **Patient & Family Engagement:**
  - Providers noted frequent challenges with health literacy, refusal of services, and poor disease self-management. A lack of advance care planning and early goal-setting was also highlighted.
- **SDOH:**
  - Barriers such as housing instability, transportation gaps, and insurance constraints frequently led to unmet post-discharge needs. Respondents called for closed-loop systems and greater community integration.
- **Workforce Capacity & Culture:**
  - Turnover, clinical silos, and a lack of standardization (especially in early intervention protocols) were cited as risks to continuity. Respondents called for shared accountability between hospitals and PAC providers.
- **Data Systems:**
  - There was broad concern about a lack of real-time data across settings, variation in review practices, and insufficient tools for understanding why readmissions occur.

Key Themes from the Focus Group Discussion

The SOAR framework structured both the discussion questions and the organization of responses (see Appendix 2). While this provided a clear framework, the group devoted more time to certain topics as needed. Future sessions will allow for further exploration of specific opportunities and measurable results.

Strengths

- Established transition clinics, meds-to-beds programs, and daily huddles were cited as effective.
- Strategies and efforts that have been implemented include EMR-integrated risk flags, CarePort, REACH, and PACE programs.

- Family navigators, discharge lounges, and AI documentation tools (like Ambience AI) reflected ongoing innovation.

Opportunities

- Participants stressed the need for policy reforms (e.g., SNF 3-day rule elimination, prior authorization streamlining).
- Expanded multidisciplinary review protocols, standardized patient education, and AI-driven care planning were seen as key levers such as Palantier.
- Increased data sharing and SDOH integration through platforms like UniteUs and HMIS were high-priority.

Aspirations

- Systems envisioned closed-loop care from discharge to post-acute recovery.
- Broader deployment of teach-back methods, goals-of-care discussions, and real-time risk scoring tools.
- A statewide repository of toolkits, metrics dashboards, and shared implementation frameworks was suggested.

Results

- Institutions reported growing use of PowerBI, structured readmission reduction teams, and performance dashboards.
- Metrics such as 72-hour post-discharge follow-up, medication reconciliation completion, and PHOV scheduling were emerging as benchmarks.
- A suggestion for a statewide data subgroup to align measurement practices and promote continuous improvement was proposed.

Next Steps

Based on the focus group results, FHA will take the following steps:

1. Disseminate the meeting report, to be circulated for participant confirmation in August 2025.
2. Convene a follow-up virtual Zoom session to review and validate priority areas and refine strategic direction.
3. Develop an implementation roadmap to launch coordinated work in October.
4. Gather and disseminate tools and resources aligned with the SOAR domains for broader use.
5. Present to the FHA Quality Committee in September, followed by FHA Board review and adoption in October.

Attachments:

Appendix 1. Pre-session Survey, Questions and Results
Appendix 2. Focus Group Questions and Responses
Appendix 3: Focus Group Meeting Agenda
Appendix 4. Attendees and Affiliations

Appendix 1. Pre-session Survey, Questions and Results

Group	Challenge
Care Transitions & Discharge Planning	**Medication reconciliation** and getting correct prescriptions to appropriate pharmacy
	Patients understanding their diagnosis and having goals of care
	Readmission from home within the **first seven days**
	Post Acute: **SNFs and HHA** care for secondary diagnosis
	Post Acute providers/ Transitional services through other providers
	Lack of post discharge **access to specialists** in timely manner.
	Costs and staffing challenges associated with Post Discharge Care Management Clinic and Critical Access Clinics for **uninsured**, underserved and **charity patient populations**
	High **SNF Leadership Turnover** and Program Inconsistency: Frequent administrator and DON turnover disrupts continuity of care programs and quality initiatives like care pathways or readmission **reduction efforts often lose momentum when leadership changes**.
	Securing timely **follow-up/ post-hospital office visits** (PHOV)
	Fragmented evaluations with narrow scope.
	Provider access in the community, having a **reliable readmission risk tool that takes SDOH into consideration**
	Health plan barriers authorization delays/ network inadequacy(non-acceptance from , PAC facilities
	Hemodialysis
	Understanding why patients are returning. Is it mindset that when patients call providers the **provider says "go to the ED"?**
	Is **high hospital census** causing **early discharges** which can lead to readmissions?
	Lack of use of community **Palliative care**
Patient & Family Engagement	**Patient compliance** with treatment regimen accompanied by their refusal of services or **family unwilling** to assist- patient/family acceptance of prognosis
	Limited Health Literacy and health planning for their life course
	Providing patients with **disease management programs after hospital dc** that specialize in their disease processes
Social Determinants of Health	Barriers to care: lack of resources, insurance constraints. **Patient Nonadherence** and **Unmet Social Needs in Home Health**

	(economic stability, **(housing)** education, healthcare access,(**uninsured)** neighborhood and built environment (**transportation),** and social (**family)** and community context **(linkages)**
	ED physician's: utilizing **Community Resources/ lack of wrap-around, no closed loop systems**
	The multi-visit patient- readmitters at **end of life and with chronic diseases**
	Medicare guidelines on homebound status and 3 midnight stay
Workforce Capacity, Training & Culture	**Making this a priority for collaboration for all involved**: hospital nursing, physician and ancillary teams - post-acute partners such as SNFs, HHCs and PCP offices.
	Ownership: Quality VS Case Management.
	Gaps in Early Intervention and Clinical Standardization: Failure to recognize early warning signs of decline leads to preventable hospitalizations along with **lack of standardized clinical protocols** that align with the hospital, such as sepsis.
Data	Lack of **real-time data** and transparency/ **data throughout continuum of care** (prior to admission, internal post-acute care/ services, SNF)
	Variation in review processes across facilities and departments.

Group	Opportunity
Post-acute partnerships	Managed care plans doing their part in managing the patients
	Stronger alignment with outpatient services - engaging PCPs so they are not sending patients to ED/ direct admitting for items that can be managed outpatient.
	Increase availability of TOC team
	Pharmacy needs to be more involved with medication reconciliation
	Post discharge monitoring system for high-risk readmissions
	Education on secondary diagnosis
	ED U-Turns
	Discharge excellence
	Transitions
	High risk readmissions with RSI >20 and multi visit are 1.5% of our discharge volumes but account for 25% of our readmissions.
	Lack of accountability of post discharge facilities and home healthcare agencies in care transitions, GDMT adherence and readmissions.

	Systematic multidisciplinary patient/family conferences for high-risk patients
	Proactive scheduling of timely PHOV for high-risk patients
	Further collaboration and shared ownership with PAC facilities
	High SNF Leadership Turnover and Program Inconsistency: Frequent administrator and DON turnover disrupts continuity of care programs and quality initiatives like care pathways or readmission reduction efforts often lose momentum when leadership changes.
	Gaps in Early Intervention and Clinical Standardization: Failure to recognize early warning signs of decline leads to preventable hospitalizations along with lack of standardized clinical protocols that align with the hospital, such as sepsis.
	Patient Nonadherence and Unmet Social Needs in Home Health: Patients may decline visits, unable/can't follow medication recommendations as well as the SDOH issues like lack of transportation, etc. can cause readmissions.
	Medication reconciliation by PCP/hospitalist
	Early intervention by Case Management for pt's with identified SDOH concerns.
	opportunities for building relationships with PAC providers/ facilities as well as for evaluation of systems that will allow for a wider view of discharged pts EMR/ on-going care.
	Enhanced care coordination
	Increased medication reconciliation
	Enhanced Transitional Care
	Medication Reconciliation
	Looped into support systems -Managed Plan/PCP offices
	Creation of a pathway for surgical/procedural services to have patients evaluated quickly outside of the ED.
	Limited collaboration with post-acute care facilities: ALF, SNF, even LTC. They are resistant (afraid?) to let us work with them and help them help.
	Lack of follow up care
	Med to bed program to ensure the patient has medications prior to discharge and the pharmacists has explained the medications to them.
	Getting doctor appointments within first week of dc rather than waiting 4-6 weeks to have patient seen after hospitalization.
Increasing patient engagement	Medication compliance
	Patient education

	Understanding wrap around services in the community
	Medications: reconciliation issues, access to meds, compliance.
	Quality patient education and involving them in the care. Nursing caseloads not conducive to provide high-quality patient education.
	Early Identification/Mitigation of Barriers
	Many readmissions occur because patients leave the hospital without a clear understanding of their care plan, medications, or follow-up needs.
	Patients may not fill prescriptions, miss follow-up appointments, or misunderstand warning signs.
	Enforcement of teach back.
	Encouraging use of the teach back program to ensure patients are educated appropriately prior to discharge.
	Medication compliance and patients needing goals of care conversations early on in disease process so they can make informed decisions about their healthcare as they progress thru the disease/lack of community support for goals of care discussions, advance directive discussions and planning ahead.
Resource, policy, or regulatory improvements	Community health worker referral capability through the Heartland Rural CHW Program.
	Funding for Outpatient opportunities
	Lack of access to healthcare for underserved creating over utilization of EDs and admits.
	Transportation
Leadership partnerships and motivators	Cross collaboration
	Stronger focus on advanced care planning initiatives.
	Leveraging hospitalist scorecards to strengthen accountability initiatives.
Data sharing, technology access, tools	Comprehensive information campaign delivering updates across the system.
	EHR tools to notify providers if their patient is readmitted.
	Need for discreet data to collect data on reason for readmission.

Current Strategies

Grouped	Strategy Responses
ED-Based Triage and Gatekeeper Strategies	**ED Gate Keepers**, daily call to action **huddles** to discuss opportunities with the C-Suites
	Strategies around discharge excellence, transitional care, ED gatekeepers. **24/7 hotline.**
	A formal pause/**huddle in ED** before inpatient admission with the whole care team (CM, RN, MD) to determine if a safe outpatient plan can be initiated (for non-clinically urgent cases).
	ED Pause Care Management process stood up to establish a multi stakeholder review prior to readmission.
Transition of Care Teams and Clinics	Initiated a transition of care team including a **Care Line number** for follow up post discharge
	Automatic consultation to transition of care clinic for any emergency room patient and inpatient that **do not have a PCP**
Post-Acute and High-Risk Care Management	Stood up **Post Acute Management Clinic (PAM) and Critical Access Teams (CAT)** to manage high risk readmissions within 72 hours of discharge to bridge to TCM visit.
	Nurse navigators for COPD and Heart Failure post discharge care coordination with EMMI journeys.
	Program called **Enhanced Home Health**; Serious Illness Conversation **training for SNF**; weekly calls with SNF's that have high readmissions; starting to work on standard process for Sepsis patients going to SNF
Readmission Risk Tools and EHR Innovations	Readmission reduction program that includes **systematic identification** and daily dissemination of high readmit risk patients, high readmit risk interdisciplinary rounding tool, end of life care index scoring to initiate palliative care consultation discussion with the attending provider, case management/social work working on improving patient/family conferences and securing post-hospital office visits for high readmit risk patients.
	Implementation of RUR Version 2 within **Epic,** High Utilizer Care Conference
	Transitioned to **new EMR that identifies readmission risk**
Other Unique Interventions	Assess post discharge for needs and solve for issues before the readmission occurs
	System-wide Readmissions task force.
	Medication Reconciliation Technicians
	The **med to bed** program. The pharmacists will visit new patients and attempt to encourage them to obtain their prescriptions prior to discharge.

Appendix 2. Focus Group Questions and Responses

Table 1: Care Transitions & Discharge Planning

SOAR Area	Prompt	Response
Strengths	What is working well in discharge planning and follow-up care?	• Transitions care clinic w/ hospital • post-acute care resources, virtual tele visits, bridging to PCP, home care. Care Port referral program. SME to determine skill for care. Lower 20-25 care ratios kept low. • Education process of care mgmt., education foundational to care mgrs., bedside conversations strong emphasis on pt educator's accountability & leadership • meds to beds program, interface with EPIC, identify safety gaps and tech solutions • escalation points, conflicts care team, SDOH triggers for SW team, team meetings for closed loop. Technology improvements- Aidin system and Care Port include post-acute authorizations/ various payors • Senior leadership accountability, priority setting , daily meeting/huddles, team meetings, presentation, discharge excellence definitions • Serious Illness Management & Advocacy (SIMA) team , previous outreach, adv care coord, adv care planning. NP to assist with the bedside and home visit • engagement and assessments to engage in quality, low ratio for staff • Palantier system for f/u care and goal setting • "discharge lounge" with dedicated focus, medication tiered process with pharmacy, interface with any transportation needs EPIC BPA to risk assess and f/u care timing • REACH program identify and prioritize "VIP" higher risk and provide focused intervention/escalation points (MSW precept site). Starts with MyChart screening. • partnerships with local partners, diabetic/CHF team partners for education • Telephone f/u to continue care plan,
Aspirations	What would an ideal discharge and care transition process look like?	• Risk for unplanned scoring, new system in planning • Define and clarify what ever pt needs to know and leave with (f/u care, PCP, etc) • Built out an EPIC add-on to look for readmission risk • Outpatient AI summaries • new AI tech improvements • Risk scoring, RUR system in EPIC (v2)

		• REACH program identify and prioritize "VIP" higher risk and provide focused intervention/escalation points (MSW precept site). Starts with MyChart screening. • Community paramedics to assist with transitions • new tech- Ambience AI as a scribe tool for summary and translation
Results	How could we measure improvements in discharge success and continuity of care?	• Decrease lag of the time-limited "72 hours" responses, propose 24 hours • Data: Explore MCO to show days and time frames • Policy: Elimination the 3-day inpatient qual for SNF • Policy: Eliminate prior auth elimination

Table 2: Patient & Family Engagement

SOAR Area	Prompt	Response
Strengths	What programs or protocols help manage high-risk conditions effectively?	• Point Click Care (PAC man) under acute care side, but involving home health data, multi-site monitoring- includes med rec/discharge data, f/u data to a 30-day care transition team • Family navigators at the clinics • Low-risk identification and assessments Remote pt. monitoring and home care kits • PACE program (Program for all-inclusive care for the elderly) nursing home level of care in the community /home (payor and provider) integrating PACE into care teams • Appropriate family helpers, SIMA program helpers • SNF visitation and care planning prior to DC planning • Family navigators specific conditions/care coord/education • in the EHR chart at bedside for discussions • Diabetes support, 24/7 hotline on a bracelet. • Post Acute Collaborative as partners for team alignment to help with metrics and measurements
Aspirations	What would optimal care coordination for high-risk patients look like?	• Value based approaches and new leadership • Continuous care loop regarding the DC plan • Building PAC man teams that interface with the SNF in real-time and track perf measures and safety nets for monitoring • Leverage PACE program (Program for all-inclusive care for the elderly) Fla PACE Provider Map and website • Family navigators specific conditions/ diabetes Early pt engagement and family conversations/family meetings

		• All complex pt assigned an advocate • Family conversations around Advanced directives/living will/ collaboration with PCP in primary settings
Results	What metrics would track impact for specific populations?	• Data: Understand the baseline data for Florida and Medicare Adv RA combined • Medicaid complaint form information and what data does it collect in the portal

Table 3: Social Determinants of Health

SOAR Area	Prompt	Response
Strengths	What resources or partnerships are helping address social needs?	• Home health, food bank partnerships • Seamless Transition option in the EHR for org PCPs • Community benefits dept for basic needs ie: cell phones Pathways to Care for specific populations (homeless, oncology) • Internal system food bank • EMR/EPIC screenings/ alerts • Find Hope website , Partnership with Feeding Tampa Bay (food, healing bags,) • Senior Resource Alliance for follow-ups and resources
Aspirations	How might we integrate SDOH screening and referral into routine care?	• Closed loop referral and use systems especially for the majority of the lower risk/med risk pt • more behavioral health to address health behaviors • UniteUs community care system • Limits of BA and other holds for care • Checklist to assess and referral sources but hard to reach populations • Food pharmacy for Feeding programs with specific dietary rest. (CHF, Diabetes, homeless) • PCP conversations around SDOH early • EMR that incorporates continuance of care and verifications of services
Results	What indicators or outcomes would show effective SDOH integration?	• Leverage HIE , HMIS (homeless mgmt. Information system), UniteUs enrollments for hospitals • Limits of BA and other holds for care • Partnerships with local legal services allowing them to meet pt onsite • SDOH- Increase home health providers who take Medicaid • Sharing best practice, emerging or promising practices around the state • Practice: Provide tool kits- change packages that

		could be implemented that may integrate with EHR • Increase facilitation and communication with SDOH resources (transportation, etc)

Table 4: Workforce Capacity, Training & Culture

SOAR Area	Prompt	Response
Strengths	What training or staffing practices support readmission reduction?	• EPIC code/icon for those at risk for readmission to trigger recommendations/ notifications to complete a RA assessment • ED social work staff with care planning • iRounds tool for discharge teaching for anticipatory guidance • Pt list that shows risk for readmission and shown at clinical care huddles and rounds, create a template with questions/items • Use of readmission code (Code R) to keep leadership in the loop • Continue to have education on finding / communication skills • Specific dx education teaching for teach back Complex cases sim-labs • Teach -back part of education for nurses, relating to medications and transition to home care • Education with the secondary dx that may lead to readmissions • Prevention strategies and evaluation of coding
Aspirations	What kind of work environment fosters consistent quality improvement?	• Collaborative care journey cards with all staff names and touchpoints • looking at prevention of RA of Medicare 65 pts before a 30-day RA • Smart-rooms that are pt specific/age specific • Sharing the dx of high risk across teams with automation • Use of iPad in rooms for pt education when appropriate • Progress notes on education and milestones met
Opportunities	Where are staff capacity or knowledge gaps evident?	• Staff to teach pt on any tech or educational materials and knowledge/ comprehension • tool for readmissions questions • Family conversations around Advanced directives/living will/ collaboration with PCP in primary settings

Table 5: Data and Metrics

SOAR Area	Prompt	Response
Strengths	What data systems or reports support decision-making?	• Internal readmissions data, limited to internal/org
Opportunities	What additional data or tools are needed?	• Use of PowerBI in MS to capture the data points • Build DC plans with quant/qual measures and data points • Need for a data-subgroup • Coding of pt data for appropriate hx risk and status
Aspirations	What would a high-functioning feedback and learning system loop include?	• intervention grid within the EHR with data points to be easier to assess data • adding a readmissions questions tab in EHR for discrete capture
Results	What performance indicators should we regularly monitor to drive improvement?	• use of AI to help review chart and data and summarize Palantier is one example • HQI solutions, QIO for data access • Policy: Direct SNF admits • Practice: Streamline AHCA complaint form and provide education • Portability of outside directives from other providers • Data from AHCA/ CMS • Create a education/ training/tool/repository on mutual/universal resources

Appendix 3: Focus Group Meeting Agenda

Appendix 4. Attendees and Affiliations

Name	Title	Organization
Kerry-Ann Farrow	Executive Director Nursing: Readmissions	Advent Health
Kelli Burba	Executive Director Care Transitions	AdventHealth
Sara Juilleret-Moore	Regional Director of Care Coordination	AdventHealth East Florida Division
Sheila Richards	Population Health: Manager Post Acute and Readmissions	Ascension Florida Gulf Coast
Sandra Jenkins	Director of Post-Acute Care	Baptist Health
Suzanne Rodriguez	Regional Director	Baptist Health South Florida
Russ Lee	Director, Hospital Care Coordination	BayCare
Sonya Pease, MD, MBA	Chief Safety, Quality and Patient Experience Officer	Cleveland Clinic Florida Market
Michele Munzner	Social Work Case Manager	DeSoto Memorial Hospital
Leslie Yadi	Associate Vice President, Case Management and Utilization Review	Lakeland Regional Health
Britt Knapp	Post Acute Care Director	Lee Health
Nancy O'Keefe	Quality Manager	Mayo Clinic
Jonathan Brewster	Manager, Quality Improvement	Memorial Healthcare System
Anthony Stewart	Director of Corporate Quality	Memorial Healthcare System
Lynda Barcelo	VP, Managed Care & Population Health	Mount Sinai Medical Center
Jessica Fauci	Senior Director, Care Management	Orlando Health
Julie Haile	Director Transition Services	Orlando Health
Marcia Washington, MSW, MNM	Director, Care Management-REACH	Orlando Health
Agnes Kelly	Director of Disease Specific Programs	Sarasota Memorial HealthCare System
Stephanie Ott	Manager, Post-Acute Access	Sarasota Memorial Hospital
Heather Duggan	Director of Case Management	Tampa General Hospital Brooksville & Spring Hill
Shanna Miller	Director Case Management	TGH Crystal River
Kim Streit	Senior Vice President	FHA
Sean MacNeill	Community Outreach coordinator	FHA
Mirine Richey, DrPH	Facilitator	FHA