Reducing Hospital Readmissions Among Older Adults:

Village membership matters!

Villages offer social connection, volunteer services, and transportation support, all of which may help reduce hospital readmissions for members.

What are hospital readmissions?

A hospital readmission occurs when a person is discharged from the hospital but then needs to *return* to the hospital for additional care. Medicare uses the excess readmission ratio (ERR), a measure of readmissions within 30 days of discharge, to assess hospital performance.[1] Readmissions within 30 days may be due to socioeconomic factors, individual health factors, healthcare access and utilization, and/or clinical factors.[2] Preventing hospital readmissions can have positive effects on patient well-being, reduce costs, and optimize healthcare resources.[3]

What evidence-informed strategies are commonly used to reduce hospital readmissions?

The top seven interventions to reduce hospital readmissions, as presented by the National Transitions of Care Coalition (NTOCC),[4] emphasize the systemic nature of patient success post-discharge. They are: 1) Medication management services and coordination, 2) Transition planning, 3) Patient and identified family caregiver engagement and education, 4) Information transfer, 5) Follow-up care, 6) Healthcare provider engagement and shared accountability, 7) Physical health, mental health, social determinants of health.

In addition to the NTOCC interventions at the hospital level, studies suggest that social support after hospitalization may *reduce* readmission rates,[5] whereas social isolation may *increase* the likelihood of readmission.[6] One study emphasized the importance of social interaction and community support. These researchers recommended that healthcare providers routinely assess the social support for all hospitalized individuals as standard health care practice.

Finally, a study conducted by Gallup indicates that patients with *high wellbeing* are less than half as likely as those with *low wellbeing* to be readmitted to a hospital within 30 days of initial discharge.[7] The authors recommend that wellbeing be measured and managed, with a focus on caring for the whole person, to reduce readmissions as well as future admissions.

> ***A care team was set up, and someone called me every day for the first week I was home."***
> - 2024 SURVEY RESPONDENT

> ***[My Village] visited me in rehab, brought flowers and incidentals, [and] provided emotional support."***
> - 2024 SURVEY RESPONDENT

> ***[My Village] gave useful information about post-surgery care."***
> - 2024 SURVEY RESPONDENT

IN THE SUMMER OF 2024, the 13 Villages in Washington DC surveyed their members about their experiences with hospitalization and readmission. Among respondents who had been hospitalized while they were a member (n=328), 36% reported having received direct support from the Village after their hospitalization. **The two most frequently mentioned supports were transportation to follow-up appointments and emotional support and reassurance.** Indirect support, for example assistance provided by friends made through the Village, was not measured in this survey.

Among survey respondents (n=328), **the self-reported rate of readmission after hospitalization was very low,** with only 1.8% reporting that they had been readmitted within 30 days for the same condition and 1.5% reporting that they had been readmitted within 30 days for a different condition. According to the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (H-CUP), the national rate of readmission for any condition between 2016 and 2020 was approximately 17 per 100 people receiving Medicare.[8] The self-reported readmission rate among Village members who had been hospitalized was much lower, with only 3 individuals per 100 admitted reporting readmission for any condition within one month of their hospitalization.[9]

How *can* and *do* Villages support reduced hospital readmissions?

Villages are neighborhood-based, non-profit organizations created by and for older adults that offer activities, companionship, practical support from neighbors, and volunteer opportunities. In Washington DC, while the 13 Villages currently in operation run independently and have different structures and membership sizes, each Village is an integral part of the aging services network. Many Villages have volunteers and/or staff members who provide **supportive services during and after hospitalizations,** including:

- Helping members and care partners understand medication protocols and discharge instructions
- Running errands and delivering necessities (e.g., groceries, medications)
- Performing in-home safety assessments and recommending vendors to install needed supports (e.g., grab bars or stair chairs)
- Providing rides to follow-up medical appointments

Several DC Villages offer **professional case management services,** which include assistance with handling medical bills and paperwork, identifying a home health aide, and providing a connection between medical services. Two DC Villages have a **nurse on staff** who assists with medication management, tracking blood pressure, explaining medication interactions, and looking at recovery in a holistic way. In addition, all of the DC Villages offer **significant social networks.**

Through these supports, Villages work to reduce hospital readmissions among members of their communities who choose to age in their own homes within the neighborhoods they know and love.

What are opportunities for further exploration and research?

Further exploration of the reason for the apparent differences between Village and national hospital readmission rates is warranted. Socioeconomic factors have been shown to play a role in the likelihood of readmissions and, on average, members of DC Villages are more likely than the general US population[10] to report higher income, have achieved higher levels of education, and identify as white.[11] It may be important to explore the specific contribution of these factors to hospital readmissions.

In addition to examining population differences and characteristics unique to Village members, researchers may want to explore the following questions:

1. **To what extent do Village services and/or programs reduce the risk of 30-day hospital readmissions?**
   If Villages can quantify the extent to which their offerings reduce hospital readmissions, they will be more readily able to explain their value to the community.

2. **Which Village activities and/or services offer the greatest protection against hospital readmissions?**
   It may be valuable to explore programs and services directly related to improved health outcomes as well as benefits of Village membership that may be more indirectly related.

3. **What services not currently offered may be valuable for Villages to add in support of reduced hospital readmissions?**
   An exploration of promising interventions and a crosswalk with Village services could reveal additional programs or services that Villages could offer to aid in an effort to reduce hospitalizations among members.

4. **What additional research might help Villages maximize the support they offer to their members?**
   This may include topics such as ways to help people stay as healthy as possible for as long as possible or the extent to which ageism – both internalized ageism and ageism among providers and in systems – might contribute to hospital readmissions.

Villages offer a community-driven solution for reducing hospitalization and readmission for older adults because they:

- ★ **Foster strong social connections** among members
- ★ **Support members' well-being** through Village programs and activities
- ★ **Provide professional and volunteer services** that support member needs before, during, and after hospitalizations (e.g., case management, volunteer transportation)

5. **What lessons can be learned from Village experiences and applied more broadly or in communities without Villages?**
   While Villages are looking to the research to ensure their programs and services are doing everything possible to reduce hospitalizations, there may also be an opportunity for researchers to collect universal practices that could be recommended to healthcare providers, community organizations, and local governments in an effort to reduce readmissions overall.

> ***"Staff and volunteers were invaluable when I was recovering from … surgery last year in many different ways. Supplying transportation to physical therapy while I was still using a walker probably most important but they helped in small ways like removing items from utility closet when I … couldn't yet bend from waist."***
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> - 2024 SURVEY RESPONDENT

[1] Centers for Medicare and Medicaid Services. (September 2024) Hospital Readmissions Reduction Program (HRRP) https://www.cms.gov/medicare/quality/value-based-programs/hospital-readmissions. The ERR tracks readmissions within 30 days for six specific conditions: acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), heart failure (HF), pneumonia, coronary artery bypass graft (CABG) surgery, elective primary total hip arthroplasty and/or total knee arthroplasty (THA, TKA).

[2] Cilla, F., Sabione, I., & D'Amelio, P. (2023). Risk Factors for Early Hospital Readmission in Geriatric Patients: A Systematic Review. International journal of environmental research and public health, 20(3), 1674. https://doi.org/10.3390/ijerph20031674

[3] Dhaliwal JS, Dang AK. Reducing Hospital Readmissions. [Updated 2024 Jun 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK606114/

[4] National Transitions of Care Coalition. (March 2022). Care Transition Bundle Seven Essential Intervention Categories. https://static1.squarespace.com/static/5d48b6eb75823b00016db708/t/66c37ae7a2d20e77089df4ce/1724087015931/VE+EDITS+Revised+Care+Transitions+Bundle+4.2022+%283%29+PLay.pdf

[5] Schultz, B. E., et al. (2022). Scoping review: Social support impacts hospital readmission rates. Journal of clinical nursing, 31(19-20), 2691–2705. https://doi.org/10.1111/jocn.16143

[6] Longman, J., et al. (2013). The role of social isolation in frequent and/or avoidable hospitalisation: rural community-based service providers' perspectives. Australian health review : a publication of the Australian Hospital Association, 37(2), 223–231. https://doi.org/10.1071/AH12152

[7] Witters, D. and Agrawal, S. (February 20, 2023) Patient Wellbeing Closely Linked to 30-Day Readmission Rates. Gallup News. Available at https://news.gallup.com/poll/470603/patient-wellbeing-closely-linked-day-readmission-rates.aspx

[8] Bailey, M. K., et al. (2019). Characteristics of 30-Day All-Cause Hospital Readmissions, 2010–2016. In Healthcare Cost and Utilization Project (HCUP) Statistical Briefs. Agency for Healthcare Research and Quality (US).

[9] This finding is supported by a pilot program outside of DC, reported by the RAND Corporation, where a hospital paid for three months of a Village membership upon hospital discharge in an effort to reduce readmissions among older adults. A focus group participant reported, "In the three years this project has been running, the numbers of readmissions within 30 days and emergency room visits is almost negligible." (See Palimaru, A.I., et al. (2024) Insights on Developing Research Capacity for Healthy Aging with Villages. RAND Research Report, p. 8. https://www.rand.org/pubs/research_reports/RRA3208-1.html)

[10] Administration for Community Living. (May 2024). 2023 Profile of Older Americans. U.S. Department of Health and Human Services, Administration for Community Living. https://acl.gov/sites/default/files/Profile%20of%20OA/ACL_ProfileOlderAmericans2023_508.pdf

[11] More than two-thirds of DC Village members reported annual household income of $75,000 or more while the median income of people 65+ years old in the US was $29,740. Most DC Village members (89%) reported having a bachelor's degree or higher, compared to 33% of those aged 65+ in the general population. Additionally, 87% of DC Village members identified as white, non-Hispanic compared to 75% of those aged 65+ in the general population. DC Villages data from 2024 multi-Village member survey; US data from Ibid.

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