Bridging the Gap: How Home Care Agencies and Hospital Discharge Planners Can Use ALBERTai to Transform the Journey from Hospital to Home

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There is a moment in every patient's hospital stay that carries more risk than almost any other point in their care. It isn't the surgery, the diagnosis, or the acute crisis that brought them to the hospital in the first place. It is the moment they walk out the front doors and head home. For discharge planners and home care agencies alike, that moment represents both the culmination of careful clinical work and the beginning of a period during which visibility into the patient's condition all but disappears.

The discharge instructions have been reviewed, the medications reconciled, the follow-up appointment scheduled. And yet, once that patient crosses the threshold into their own home, the health system's ability to see what happens next effectively ends. What unfolds in the days and weeks that follow, whether the patient is sleeping well, eating enough, moving safely, taking medications as prescribed, or beginning to show the subtle signs of decline that so often precede a fall or a return trip to the emergency department, remains largely invisible until something goes wrong.

This is the exact gap that ALBERTai, the artificial intelligence platform developed by Unity Global Care Inc., was built to close, and it is a gap that home care agencies and hospital discharge planners are uniquely positioned to close together. When these two parts of the care continuum, the hospital system responsible for a safe discharge and the home care agency responsible for what comes after, are connected through a shared intelligence layer rather than operating as disconnected handoffs, the entire trajectory of a patient's recovery changes.

For hospital discharge planners, the value of partnering with home care agencies powered by ALBERTai begins with something discharge teams have long wanted but rarely had: a genuine extension of clinical oversight beyond the walls of the facility. Rather than releasing a patient into an environment that offers no feedback loop, discharge planners gain access to a continuously updated picture of how that patient is actually functioning at home.

Sleep patterns, mobility, appetite, cognitive function, medication adherence, mood, balance, and strength are all captured and synthesized into a single, evolving portrait of the patient's condition. This is not a static report generated days after the fact. It is a living, longitudinal record that reflects how a patient is trending, whether toward stability and recovery or toward the kind of quiet deterioration that so often precedes a readmission. For a discharge planner accountable not just for getting a patient safely out the door but for what happens to that patient in the thirty days that follow, this kind of visibility is transformative. It means a decline in a patient's condition can be identified and acted upon while there is still time to intervene, rather than being discovered only after an ambulance has already been called.

For home care agencies, the opportunity is equally significant, though it manifests differently. Most agencies today operate with an abundance of data and a scarcity of insight. Caregivers document visits, monitoring devices track vitals, medication reminders log adherence, and yet all of this information tends to live in disconnected silos, reviewed individually rather than understood as a whole. ALBERTai changes that by integrating every one of these data streams into a single intelligence layer that does not simply store information but interprets it, learns from it, and translates it into clear guidance that reaches caregivers, care coordinators, and clinical partners at the moment it matters most.

An agency that can say to a hospital discharge planner, with confidence and data to support it, that a client's functional trajectory is stable or improving is offering something categorically different from an agency that can only report that a visit occurred and a task was completed. That difference becomes the foundation of a genuine partnership between hospital and home, one built on shared visibility rather than a one-way handoff followed by silence.

At the center of this shared visibility is the patent pending ALBERTai Aging-in-Place Score®, a continuously updated composite indicator that draws on physical health biomarkers, cognitive function, mobility and strength, sleep quality, appetite, medication adherence, and overall functional stability to produce a single, clinically meaningful number. Unlike a discharge summary or a one-time home safety assessment, which capture a patient's condition at a single moment, the ALBERTai Aging-in-Place Score® reflects a trajectory over time. For a discharge planner following up on a recently released patient, or a home care agency managing a caseload of aging clients, this score offers an early warning system that did not previously exist in any practical, scalable form. A patient whose score begins to soften in the weeks after discharge is signaling a need for attention well before that decline shows up as a fall, an infection, or a trip back to the emergency department.

Caught early, that signal can trigger a medication review, a nursing visit, a call to the family, or a conversation with the physician, all of which are far less costly and far less traumatic for the patient than the alternative.

The financial stakes behind this kind of coordination are substantial and well documented. Approximately one in five Medicare patients is readmitted to the hospital within thirty days of discharge, at an average cost of between fifteen thousand and twenty-five thousand dollars per episode, with the Medicare program spending more than twenty-six billion dollars annually on hospital readmissions. Falls compound this burden significantly, with roughly thirty-six million falls occurring among older adults each year, resulting in more than three million emergency department visits and direct medical costs exceeding fifty billion dollars annually.

These are precisely the outcomes that a well-coordinated hospital-to-home transition, supported by continuous intelligence rather than episodic check-ins, is capable of preventing. For hospitals operating under the Hospital Readmissions Reduction Program and value-based purchasing arrangements, every readmission avoided through better post-discharge visibility is not just a better outcome for the patient, it is a direct reduction in financial penalty exposure. For home care agencies, the ability to demonstrate measurable improvement in client outcomes becomes a powerful differentiator in an increasingly competitive referral landscape, one that hospital systems are learning to prioritize when selecting post-acute partners.

Perhaps most importantly, this kind of coordinated, intelligence-driven transition changes the experience of recovery itself for patients and their families. An older adult discharged home after a hip fracture or a cardiac event is often frightened, and so is their family. Family caregivers, more than fifty million of them nationally, already carry an extraordinary burden, and much of that burden stems from uncertainty: not knowing whether a parent's confusion is a normal part of recovery or the

beginning of something more serious, not knowing whether a missed meal or a restless night is meaningful or incidental. When home care agencies and discharge planners are working from the same continuously updated picture of a patient's condition, families are no longer left to interpret these signals alone. They become part of a coordinated team that includes the hospital, the home care agency, and the technology quietly working in the background to catch what human observation alone might miss.

The path from hospital bed to home has always been treated as an endpoint, the final step in an episode of care rather than the beginning of an ongoing one. ALBERTai offers hospital discharge planners and home care agencies the opportunity to treat it instead as a continuation, a bridge sustained by shared data, shared visibility, and shared accountability for what happens next. For health systems facing mounting pressure to reduce readmissions and demonstrate real-world outcomes, and for home care agencies seeking to prove their value as genuine clinical partners rather than simple service providers, this kind of collaboration represents not just an operational improvement but a fundamentally better way of caring for the millions of aging adults who deserve to remain safely, healthily, and independently in the homes they love.

About the Authors
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Dr. Thomas Gill is a physician at Yale who specializes in caring for older adults and studying how to help people stay healthy and independent as they age. For more than 30 years, his research has focused on understanding why older individuals develop difficulties with everyday activities and, importantly, how to prevent or delay those changes.

He leads major research programs at Yale that follow people over time and test new approaches to maintain strength, mobility, and quality of life. His work has helped shape how doctors and scientists think about aging, disability, and independence.

Dr. Gill has published extensively and received many honors for his contributions. At Yale, he also directs key programs devoted to aging research and the health of older adults. Dr. Gill has led and contributed to groundbreaking epidemiologic research, clinical trials and other aging initiatives. His work has been widely recognized with prestigious awards and leadership roles across Yale and the broader aging research community.

David S. DuPlay, Co-Founder & CEO Unity Global Care Inc.

Dave brings a uniquely informed perspective to the conversation around aging, technology, and compassionate care. A patient advocate, entrepreneur, and seasoned healthcare strategist with more than 30 years of experience working alongside medical professionals, research organizations, and patient communities across virtually every disease area, Dave has dedicated his career to aligning the goals of all healthcare stakeholders in service of better patient outcomes. As Chairman of Vital Options International, a global health foundation founded in 1983 and committed to health education, advocacy, and financial assistance for patients in minority and underserved communities worldwide, Dave understands firsthand the human stakes embedded in every healthcare decision.

A recognized author and speaker on the challenges facing vulnerable populations, Dave is a passionate believer that technology, when thoughtfully applied, has the power to close gaps in care, amplify the voices of those too often left behind, and preserve the dignity of aging individuals and the families who love them. It is through this lens that Dave Co-Founded Unity Global Care Inc., to bring the ALBERTai eco-system to families and providers, not merely as tools of convenience, but as meaningful instruments of empowerment for some of the most emotionally complex moments families will ever face.