POST-ACUTE CARE 2025

Service Line Trends

Post-Acute Care

Post-Acute Care Trends

- Overview
- Top Trends
- Action Steps
- What's Changed

Strategic Planning Resources for Specific Procedures

- Post-Acute Care Service Line
- Home Health Nurse Visits & Home Visits Other
- Skilled Nursing Facility Stays
- Hospice Stays and Home & Domiciliary Hospice Visits
- Home & Domiciliary Evaluation & Management Visits
- Home Infusions—Medications/Chemotherapy
- Home Physical Therapy/Occupational Therapy

QUICK TAKEAWAYS

POST-ACUTE CARE LANDSCAPE

The post-acute care landscape is undergoing significant transformation, driven by consumer preferences, policy changes and demographic shifts. Home-based care is experiencing substantial growth, with home nurse visits, physical and occupational therapy, and hospice care seeing increased demand due to an aging population and legislative support for care-at-home models.

Workforce pressures, including staffing shortages in skilled nursing and home health services, will influence patient distribution across care settings. Policy and payment shifts such as site neutrality payment proposals may increase the push toward home health but create financial challenges for skilled nursing facilities. Technology integration, including advances in virtual care, remote monitoring and home infusion safety protocols, are critical enablers of this transition.The post-acute sector is evolving toward a more home-centered, tech-enabled care model, with significant growth expected in home health services and alternative care models. However, operational and policy challenges will shape how quickly and effectively these shifts occur.

TOP TRENDS

Rising inpatient acuity continues, requiring organizations to leverage outpatient/ambulatory sites of care to manage an increasingly complex patient population. Home-based care options are often prioritized to alleviate capacity constraints.

While SNF stays have rebounded post-pandemic, policy changes and workforce shortages will put downward pressure on SNF utilization. Site neutrality payment reforms and staffing constraints may push more patients toward home health care.

Workforce challenges and staffing policies will shape how care is distributed across post-acute settings, with increased reliance on home health aides and non-nursing providers.

Reimbursement improvements for home-based medication infusions are boosting adoption. Enhanced safety protocols and monitoring are making home chemotherapy more viable, though specialized care will be required.

SNF = skilled nursing facility.

TOP TRENDS (Cont'd)

Families and patients overwhelmingly prefer home and domiciliary hospice stays over inpatient settings. Legislative support for home-based palliative care is expanding. A larger elderly population with multiple comorbidities will sustain demand for hospice care.

Fewer patients are qualifying for SNF stays, leading to greater reliance on home-based rehab. Digital PT/OT platforms and remote monitoring tools are increasingly used to enhance care delivery. Growth in home care staffing, including home health aides and therapists, is needed to meet rising demand for PT/OT services in the home.

SNF = skilled nursing facility.

Payment and Policy Changes Drive PAC Decision-making

POLICY	CONSIDERATIONS	EFFECT ON PAC SERVICES	WHY IT MATTERS
SNF Minimum Staffing Standards	In April 2024, CMS finalized staffing standards and increased reporting requirements for skilled nursing providers to improve quality of patient care. In July 2025, these standards were delayed through September 30, 2034.	No short-term effect on post-acute services unless further legislative or legal action occurs.	Organizations may want to remain aware of future developments related to long-term care staffing policy for strategic planning purposes, as the staffing standards could impact staffing, operations, and shift more patients to home-based care.
Hospital at Home and Virtual Health/Telehealth Waiver	The future of the telehealth waiver remains unclear past September 2025. The waiver would allow for the expansion of care delivery via telehealth and for acute care in the home.	If extended, systems can continue innovative care delivery across the care continuum, meeting patients where they want, when they need it. If terminated, many gaps in care will prevent patients from being treated. Capacity constraints in brick-and-mortar facilities will be exacerbated.	Care needs to move out of brick-and-mortar settings to accommodate the rising demand in acuity of services within the hospital walls. Telehealth enables care access, especially in rural and underserved areas, and can help scale services. These waivers enable care delivery innovation, patient preference alignment and cost-saving initiatives.
Immigration/ Deportation Executive Orders*	The Trump administration's executive orders target mass deportation of persons living in the US illegally.	Potential workforce shortages resulting from deportation could affect availability of home health aides, clinical nursing assistants and support staff, disproportionately impacting rural communities.	Policy shifts could exacerbate staffing shortages in PAC settings.
MedPAC Site-Neutral Proposal	CMS has proposed unifying disparate PAC payment systems into a single model that prioritizes patient acuity over location.	The proposal could shift patients from SNFs to home health and outpatient settings.	Reimbursement changes may favor lower-cost, home-based care options, financially impacting provider organizations. The workforce will need to be upskilled in preparation. Site neutrality remains on the horizon, though implementation timeline is still unclear.

*Proposed rulings that do not have finalized policy. MedPAC = Medicare Payment Advisory Commission; PAC = post-acute care; SNF= skilled nursing facility. **Sources:** CMS. *Medicare and Medicaid Programs: Minimum Staffing Standards for Long-term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule (CMS 3442-F).* April 22, 2024; One Big Beautiful Bill Act. HR 1. 119th Cong. 2025. Accessed August 2025; Telehealth.HHS. Telehealth policy updates. Accessed March 2025; Aramayo A et al. Recent White House actions on immigration. Congressional Research Service. February 10, 2025; MedPAC. Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities. In: *Report to the Congress: Medicare and the Health Care Delivery System*. June 2014; Sg2 Analysis, 2025.

ACTION STEPS

INCORPORATE

home health, nursing, therapy, hospice and infusions into home service options to expand offerings. Leverage tech-enabled solutions to support RPM and virtual health. Align with consumer preferences.

PARTNER

to enhance service delivery and efficiency by identifying strategic alliances in PAC. Collaborate with systems, payers, tech providers and community-based organizations. Build VBC arrangements to improve outcomes and costs.

INVEST

in digital infrastructure as a key priority, including RPM, telehealth and AI-driven analytics. Strengthen data integration across care settings to enhance continuity and reduce readmissions.

COORDINATE

care across the continuum by implementing strategies and utilizing RPM and transitional care models to optimize patient management to reduce readmissions. Adopt VBC principals to align financial incentives with outcomes.

INNOVATE

by rethinking workforce strategies to address staffing shortages in SNFs, home health and hospice. Leverage technology, automation and nontraditional care models to alleviate workforce bottlenecks. Enhance training programs for home health aides, therapists and skilled nursing staff.

SCALE

new services. Start with pilot programs in home health, telehealth and hospital at home models, then expand. Develop cross-specialty PAC programs, integrating primary care, rehabilitation and palliative care. Use data-driven insights to refine service offerings and improve patient management.

PAC = post-acute care; RPM = remote patient monitoring; SNF = skilled nursing facility; VBC = value-based care.

What's Changed: 2024 vs 2025 Post-Acute Care IoC Forecast

Procedure	2025 Story
Home Nurse Visits	Home nurse visits remain in demand due to population trends, consumer preference for home-based care and legislation shifting post-care into the home. • OP 2025 Forecast, 2025–2035: +22% • OP 2024 Forecast, 2024–2034: +20%
Skilled Nursing Facility Stays	SNF stays are experiencing downward pressure in the first half of the decade due to policy-driven staffing requirements. By decade's end, growing patient acuity, an aging population and workforce adaptation will stabilize volumes. • OP 2025 Forecast, 2025–2035: +1% • OP 2024 Forecast, 2024–2034: –2%
Hospice Stays	Complexity and late referrals will keep some patients in acute settings, while an aging population with multiple comorbidities will sustain a stable hospice population by decade's end. • OP 2025 Forecast, 2025–2035: +4% • OP 2024 Forecast, 2024–2034: +2%
Home & Domiciliary Hospice Visits	Substantial growth is expected later in the decade for home and domiciliary hospice visits as the aging population increasingly opts for home-based end-of-life care. • OP 2025 Forecast, 2025–2035: +43% • OP 2024 Forecast, 2024–2034: +36%

IoC = Impact of Change®; SNF = skilled nursing facility. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2024, 2025.

What's Changed: 2024 vs 2025 Post-Acute Care IoC Forecast (Cont'd)

Procedure	2025 Story
Home Visits Other	Growth in this procedure is driven by consumer preference, an aging population and the expanded use of the supporting provider workforce. • OP 2025 Forecast, 2025–2035: +30% • OP 2024 Forecast, 2024–2034: +27%
Home & Domiciliary Evaluation & Management Visits	Population drives growth in this procedure as patients opt for care in the home. This procedure encompasses both visits in the patient home as well as other domiciliary locations. • OP 2025 Forecast, 2025–2035: +33% • OP 2024 Forecast, 2024–2034: +34%
Home Infusion—Medication	The proven safety of home medication delivery encourages providers to shift care to this preferred site, easing the burden on other sites of care; however, policy changes are necessary to address sustainable reimbursement challenges. • OP 2025 Forecast, 2025–2035: +26% • OP 2024 Forecast, 2024–2034: +28%
Home Infusion—Chemotherapy	Consumers are not yet ready to receive chemotherapy in the home, keeping the procedure flat over the decade. • OP 2025 Forecast, 2025–2035: +2% • OP 2024 Forecast, 2024–2034: +0%

Note: 0% indicates the forecast is flat (less than ±1%). IoC = Impact of Change®. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2024, 2025.

What's Changed: 2024 vs 2025 Post-Acute Care IoC Forecast (Cont'd)

Procedure	2025 Story
Home Physical Therapy/ Occupational Therapy	As the procedural shift matures, home-based rehabilitation will expand because fewer patients will quality for SNF stays. Consumer preference, an aging population and the adoption of digital health systems will also drive growth. • OP 2025 Forecast, 2025–2035: +31% • OP 2024 Forecast, 2024–2034: +29%

IoC = Impact of Change®; SNF = skilled nursing facility. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2024, 2025.

Strategic Planning

Phases of the Strategic Planning Process

Assessment of Current State

Determination of Desired Future State

Road Map to Get There

Tools

- System of CARE curves
- Basic-to-comprehensive program offerings
- Forecasts
- Local market data (if available)

CARE = Clinical Alignment and Resource Effectiveness.

Post-Acute Care

Specific Procedures

- Post-Acute Care Service Line
- Home Health Nurse Visits & Home Visits Other
- Skilled Nursing Facility Stays
- Hospice Stays and Home & Domiciliary Hospice Visits
- Home & Domiciliary Evaluation & Management Visits
- Home Infusions—Medications/Chemotherapy
- Home Physical Therapy/Occupational Therapy

Strategic Planning Resources

- Overview
- Forecast Data
- Case Study

CARE = Clinical Alignment and Resource Effectiveness.

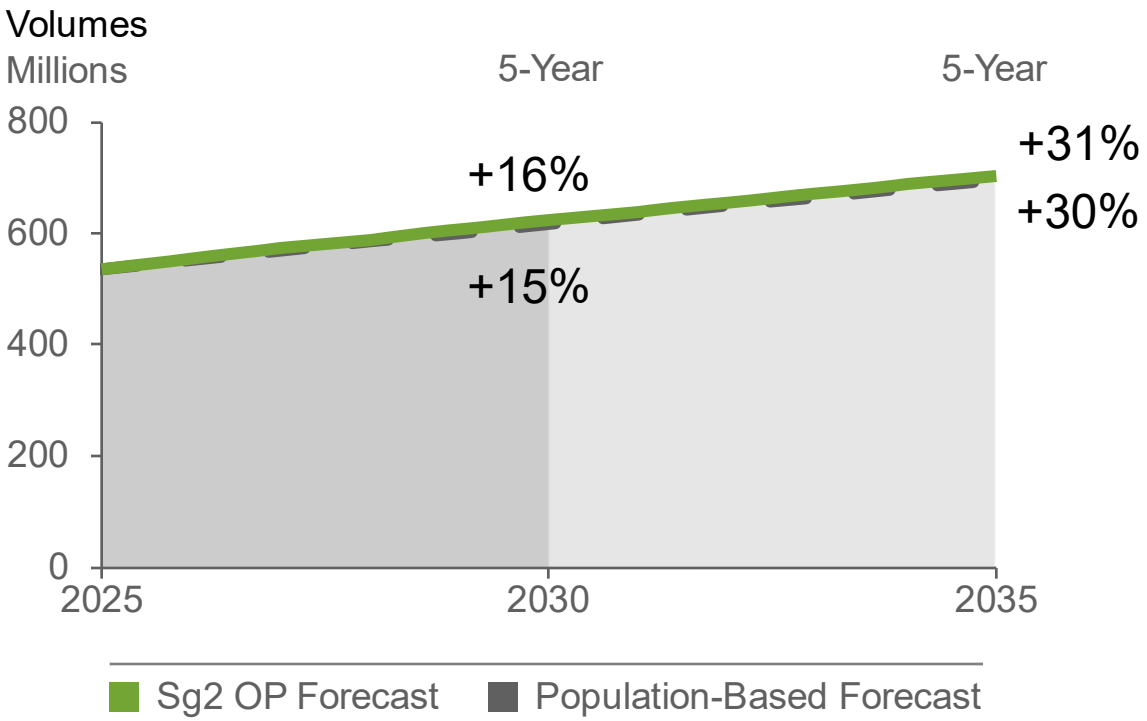
Post-Acute Care Service Line Overview

Sg2 defines the post-acute care service line via nine specific procedures:

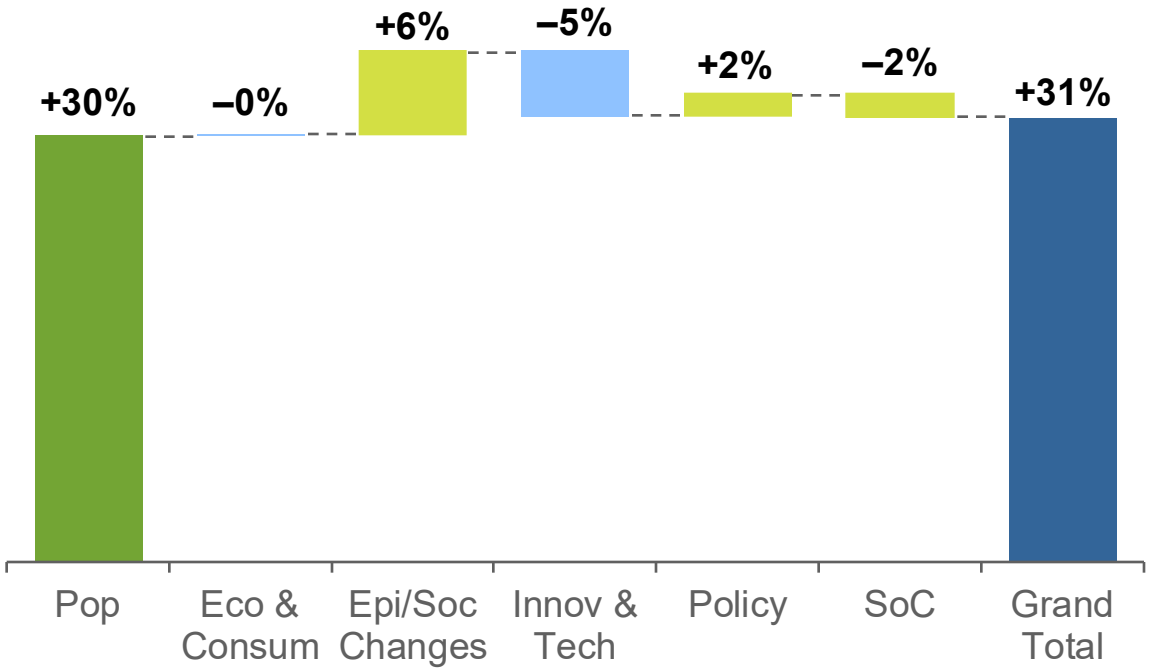
- Home Nurse Visits
- Home Visits Other
- Skilled Nursing Facility Stays
- Hospice Stays
- Home & Domiciliary Hospice Visits
- Home & Domiciliary Evaluation & Management Visits
- Home Infusions—Medications
- Home Infusions—Chemotherapy
- Home Physical Therapy/Occupational Therapy

Ten-Year Post-Acute Forecast

Outpatient Post-Acute Forecast
US Market, 2025–2035



Outpatient Post-Acute Forecast Impact Factors
US Market, 2025–2035



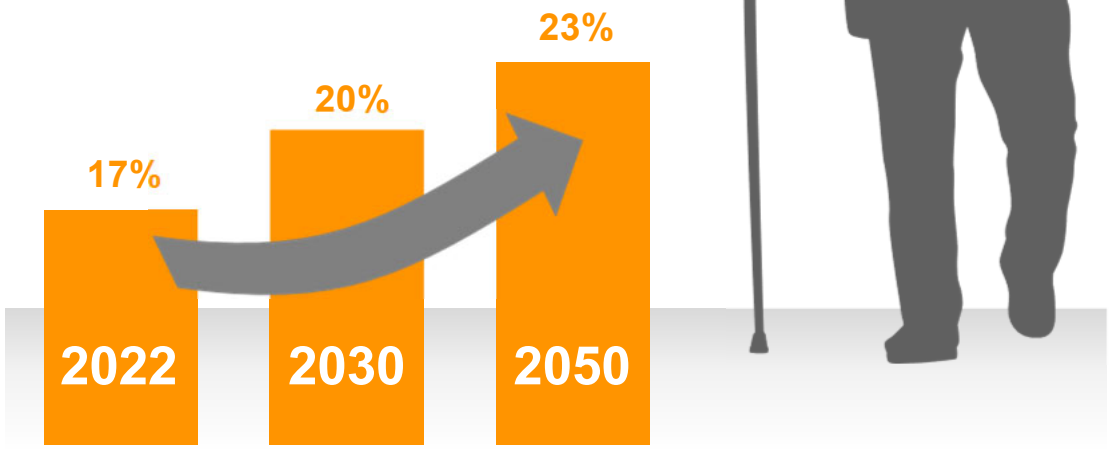
Note: Analysis excludes 0–17 age group. 0% indicates the forecast is flat (less than ±1%). Includes the following nine procedures: post-acute procedures: home and domiciliary hospice visits; post-acute services: home nurse visits; post-acute services: home visits other; post-acute services: hospice stays; post-acute services: SNF stays; procedures—minor: home infusion—chemotherapy; procedures—minor: home infusion—medications; rehab: home physical therapy/occupational therapy treatments; visits—evaluation and management: home and domiciliary evaluation and management visits. CARE = Clinical Alignment and Resource Effectiveness; Eco & Consum = Economy and Consumerism; Epi/Soc = Epidemiology/Sociocultural; Innov & Tech = Innovation and Technology; Pop = Population; SoC = Systems of CARE. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

The Silver Tsunami Is Here

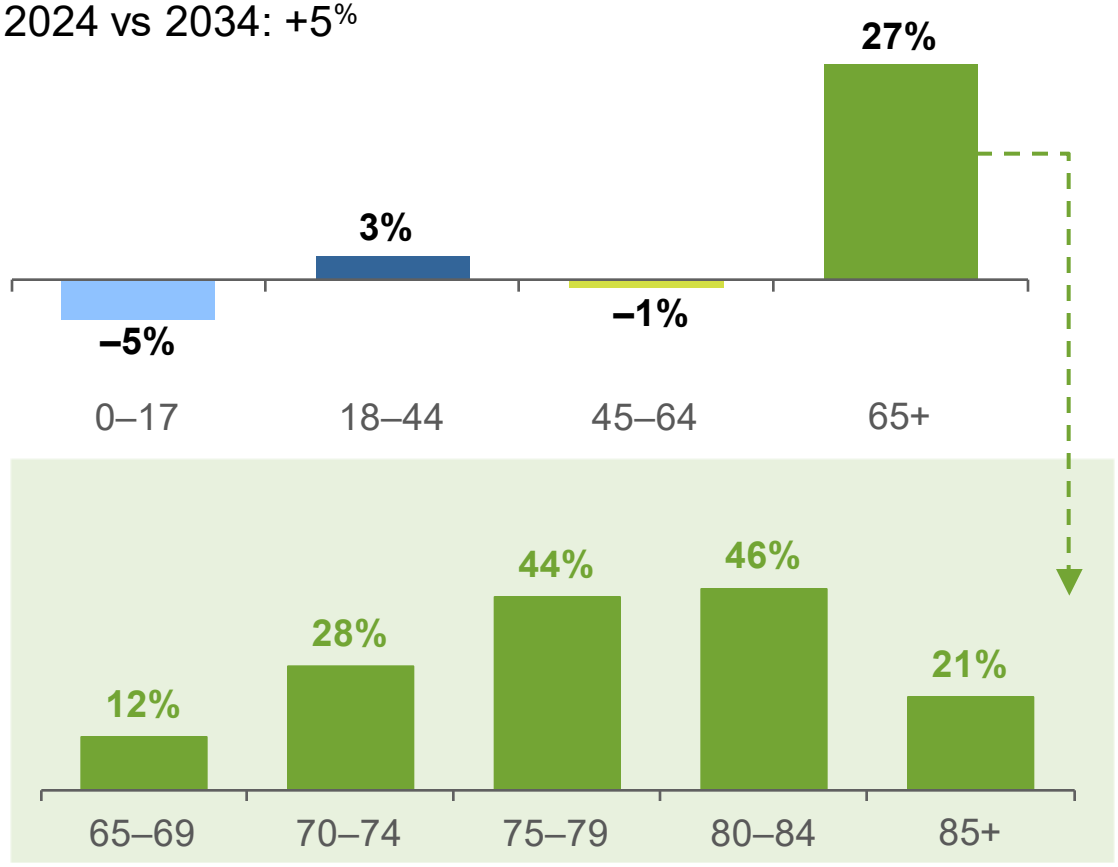
4.1 million Americans turned 65 in 2024.

—US Census Bureau

Americans Aged 65 or Older as Proportion of Population

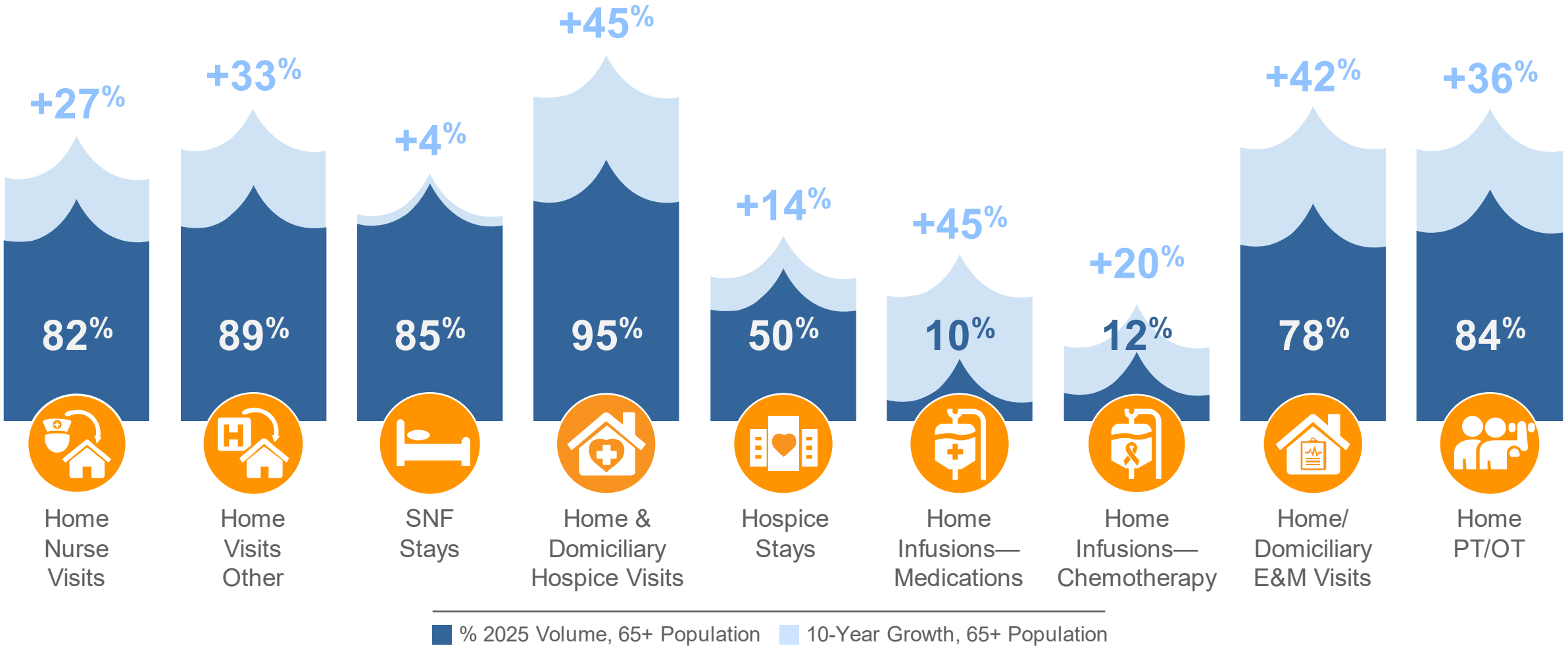


Population Forecast, 2024–2034
2024 vs 2034: +5%



Sources: US Census Bureau. *2023 National Population Projections Tables: Main Series.* Accessed May 2024; Claritas Pop-Facts®, 2024; Sg2 Analysis, 2024.

The Sea Level Is Rising: Prevalence of PAC Needs in the 65+ Age Group Is Growing



Note: Analysis excludes 0–17 age group. E&M = evaluation and management; PAC = post-acute care; SNF = skilled nursing facility. **Sources:** Impact of Change®, 2025; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2021. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Growing Demand Requires Decisions

+27%
Age 65+

Growing aging population, epidemiological forecasts and increasing acuity will require thoughtful decision-making from leaders.

OP: +31% Data-driven decisions help guide planning and alleviate capacity and open access.

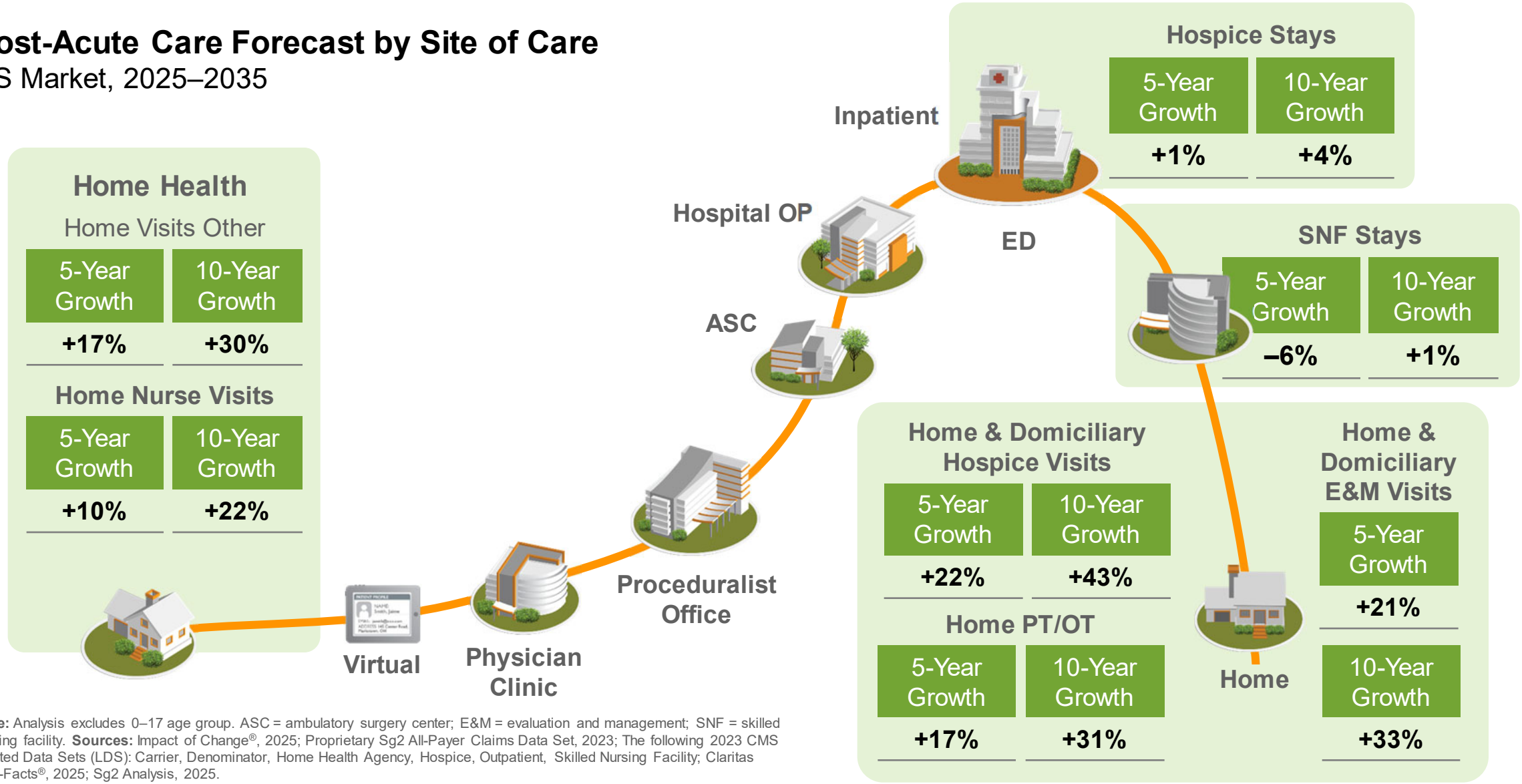
Think broadly about your decisions—innovation, multidisciplinary care and care redesign will be critical in designing your future strategies.

Sources: Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Post-Acute Demand Forecast Reflects Shifting Sites of Care

Post-Acute Care Forecast by Site of Care

US Market, 2025–2035



Note: Analysis excludes 0–17 age group. ASC = ambulatory surgery center; E&M = evaluation and management; SNF = skilled nursing facility. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Strong Foundations Influence Home-Based Care Portfolio

ON-DEMAND CARE AT HOME

- Lab at home
- Direct-to-consumer testing
- Urgent care at home

ACUTE CARE AT HOME

- Hospital at home
- Observation at home

CHRONIC CARE AT HOME

- Primary care at home
- Mobile integrated health
- Oncology at home
- Dialysis at home
- Infusion at home

CONTINUING CARE AT HOME

- SNF at home
- Rehab at home
- Hospice at home
- Palliative care at home

Low Acuity — High Acuity

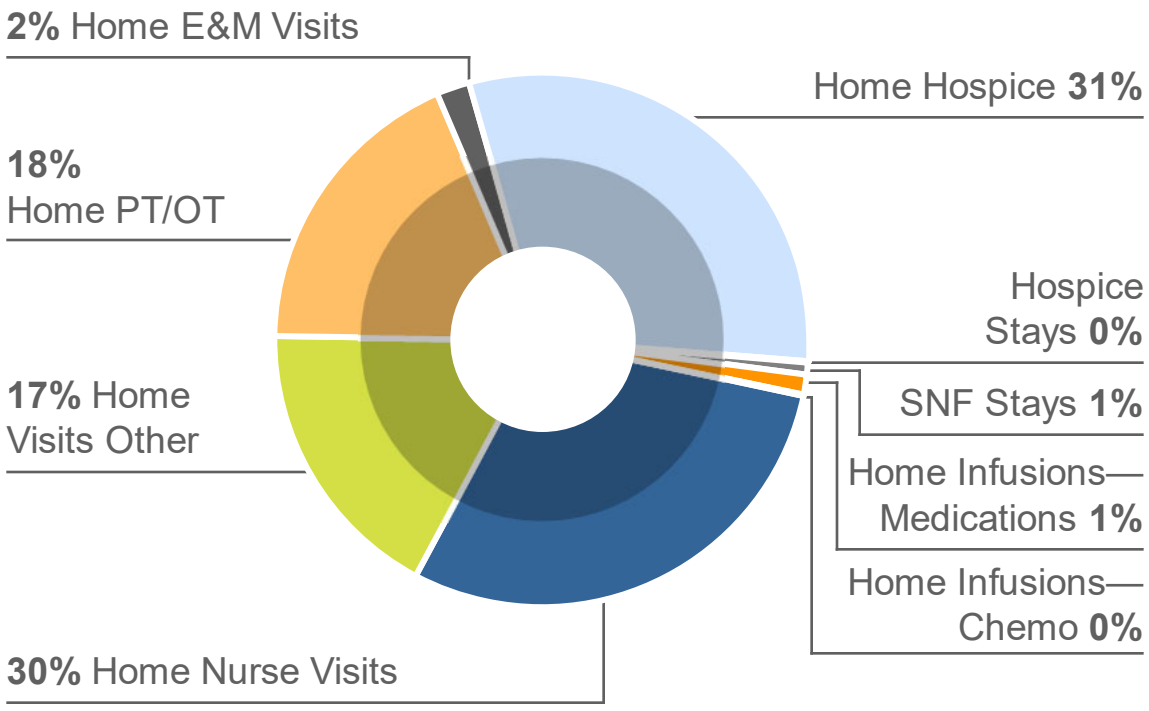
HOME HEALTH (eg, home nursing and home visits other services—CNAs, social workers, nonclinical support)

DIGITAL PLATFORM FOUNDATION (eg, virtual triage, virtual visits, remote monitoring)

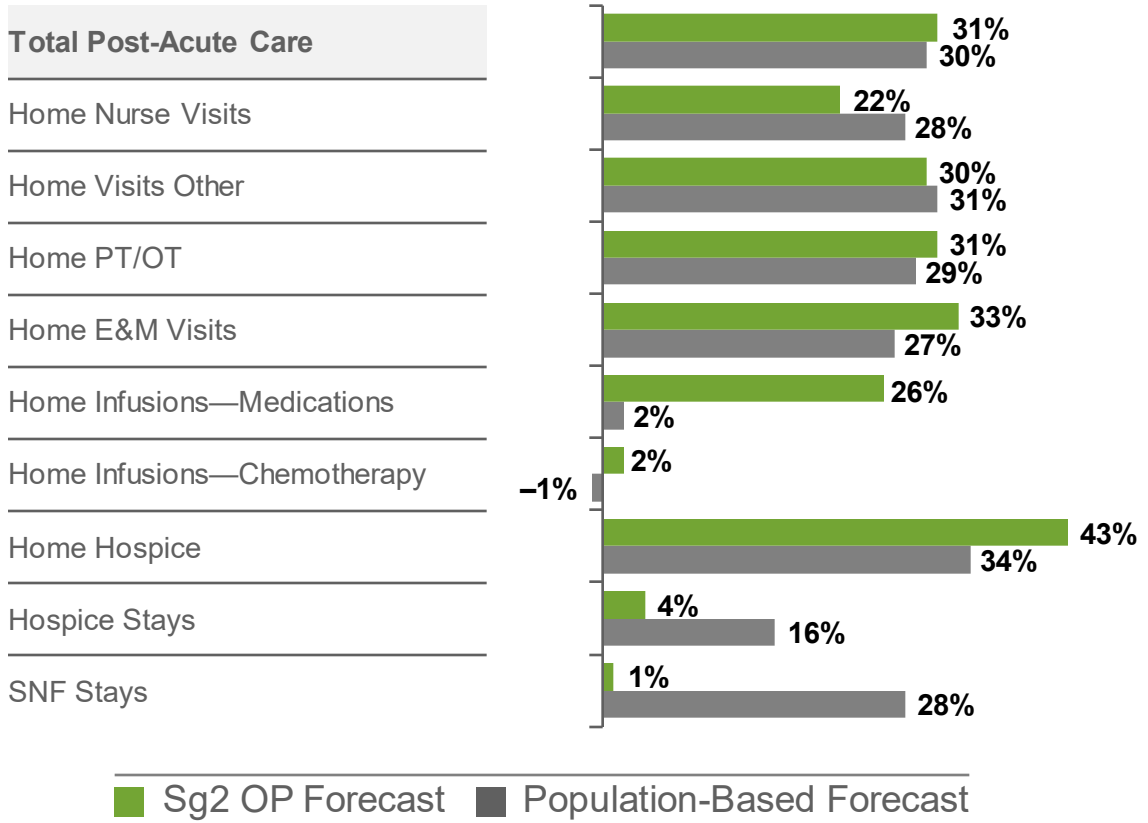
Note: Sg2 defines home health as home nurse visits and home visits other. CNA = certified nursing assistant; SNF = skilled nursing facility.

Post-Acute Care Landscape by Volume and Growth Potential

OP Post-Acute Care Volumes
US Market, 2025; Total Volume: 537M



OP Post-Acute Care Forecast, Select Procedures
US Market, 2025–2035



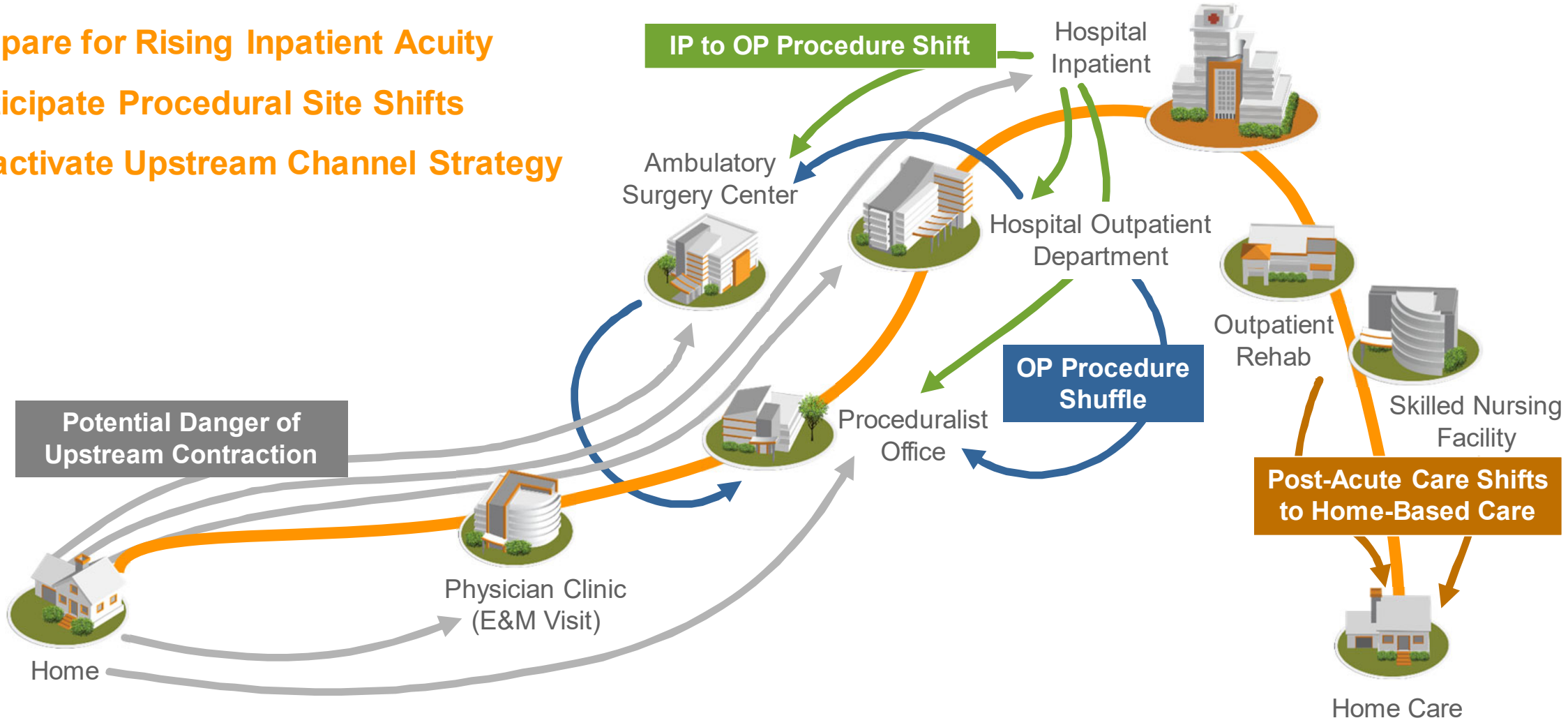
Note: Analysis excludes 0–17 age group. 0% indicates the forecast is flat (less than ±1%). Percentages may not add to 100% due to rounding. Chemo = chemotherapy; E&M = evaluation and management; SNF = skilled nursing facility.
Sources: Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Health Care Is a Function, Not a Place: Evolve Your System of CARE

Prepare for Rising Inpatient Acuity

Anticipate Procedural Site Shifts

Reactivate Upstream Channel Strategy



CARE = Clinical Alignment and Resource Effectiveness; E&M = evaluation and management. **Source:** Sg2 Analysis, 2025.

QUICK TAKEAWAYS

Home Health Overview

GROWTH AT A GLANCE

Five- and Ten-Year Total Growth

5-YEAR: **+13%** 10-YEAR: **+25%**

Key Areas of Opportunity

Discharge disposition	Digital health platform	Workforce retention

The Sg2 home health procedure encompasses two procedures: home nurse visits and home visits other. These visits occur in a patient's domiciliary setting, which may include their home, a skilled nursing facility, an assisted living facility, etc.

Demand for home health continues to rise, driven by consumer preferences and recent legislative changes that facilitate the transition of care from other post-acute settings to the home (where appropriate).

Note: Five- and ten-year forecast projections for home health include the combination of two procedures: home nurse visits and home visits other. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

The Future of Home Health: Growth Projections and Strategic Considerations

Outpatient Home Health Forecast
US Market, 2025–2035

	5-Year	10-Year
Home Health	+13%	+25%
Home Nurse Visits	+10%	+22%
Home Visits Other	+17%	+30%

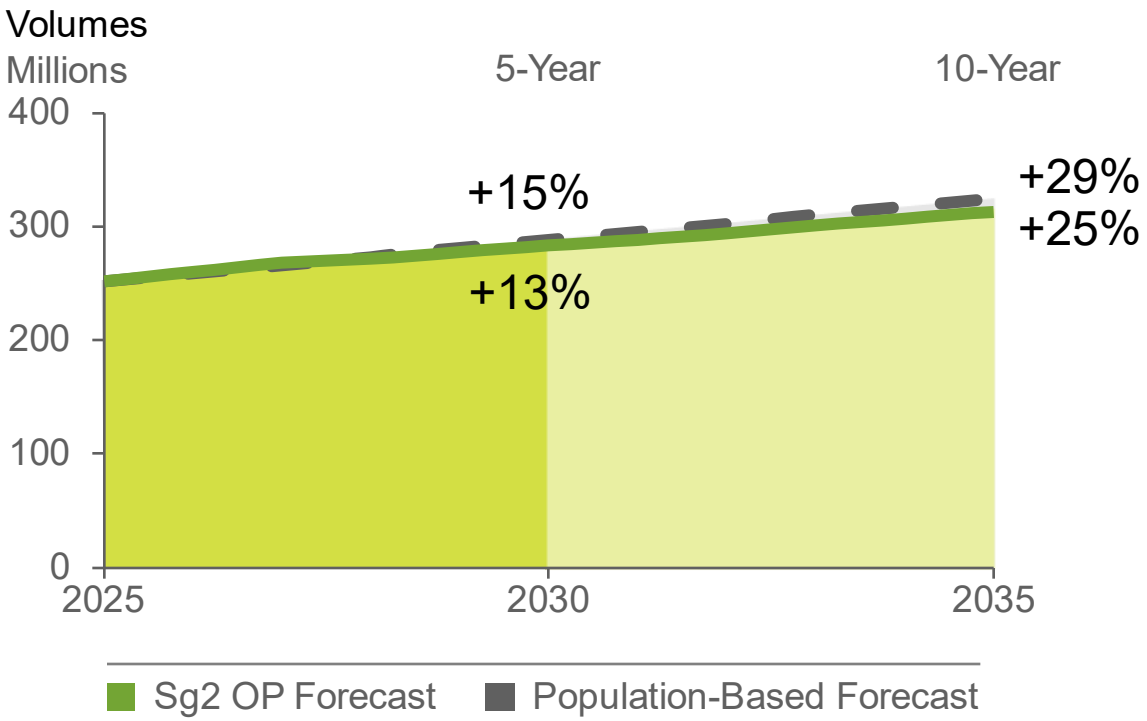
Considerations for capitalizing on home health growth:

- Maintain workforce recruitment and retention by upskilling and implementing specialized training support.
- Expand RPM capabilities via AI-powered monitoring for chronic disease management and early interventions.
- Align with systems, payers and ACOs to ensure seamless patient transitions to the home.
- Expand home visits from CNAs, social workers and community health workers to address food security, transportation and housing. Integrate mental health screenings and support into home-based services.

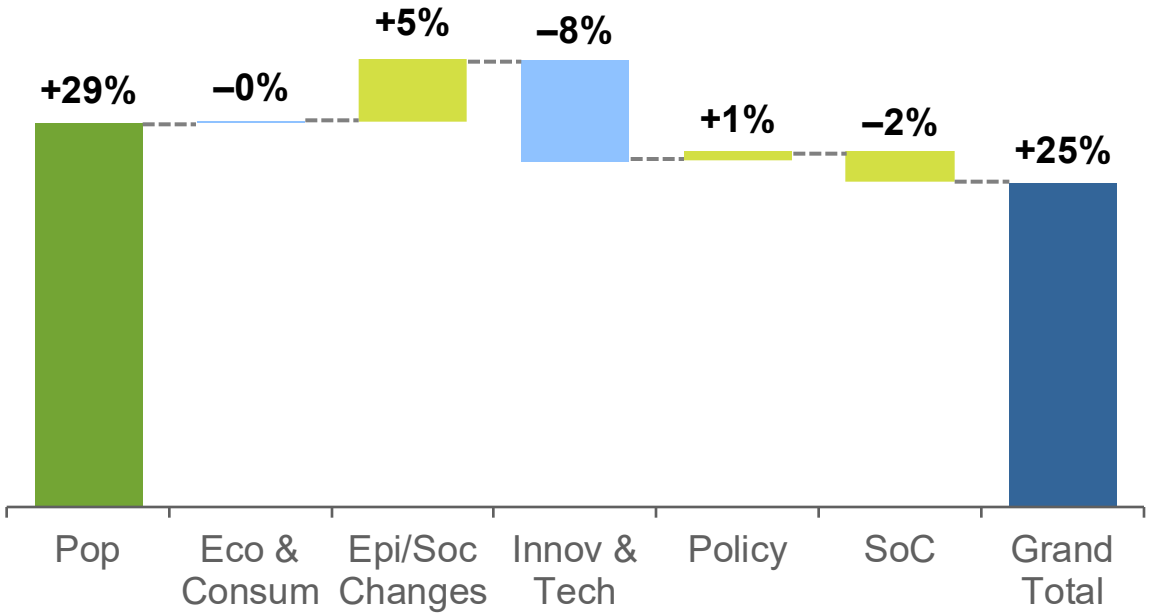
Note: Analysis excludes 0–17 age group. ACO = accountable care organization; CNA = certified nurse aide; RPM = remote patient monitoring. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Ten-Year Home Health Forecast

Outpatient Home Health Forecast
US Market, 2025–2035



Outpatient Home Health Forecast Impact Factors
US Market, 2025–2035



Note: Analysis excludes 0–17 age group. 0% indicates the forecast is flat (less than ±1%). Home health forecast includes the combination of two procedures: home nurse visits and home visits other. CARE = Clinical Alignment and Resource Effectiveness; Eco & Consum = Economy and Consumerism; Epi/Soc = Epidemiology/Sociocultural; Innov & Tech = Innovation and Technology; Pop = Population; SoC = Systems of CARE. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

CASE STUDY

Cost Savings and Patient Satisfaction for High-Acuity Care in the Home

DISPATCHHEALTH & MULTICARE PARTNERSHIP

OBJECTIVE: Create a cohesive patient journey to close gap in the care continuum and save costs for at-risk populations

PROGRAM

DispatchHealth worked with MultiCare to integrate services through:

- Nurse consult lines
- Care management
- Physician alignment and EHR integration
- Direct-to-consumer outreach
- Senior communities and home health agencies

RESULTS

- 65% ED diversion
- 2% IP admission diversion
- $1.5K average savings per patient
- $1.5M in medical cost savings

WHAT'S NEXT

- Expand market throughout Pacific Northwest.
- Enter markets where they have no physical location.
- Prioritize addressing SDOH.

CASE EXAMPLE

- A patient in need of after-hours acute medical attention reached out via a direct-to-consumer referral channel.
- The patient reported a red/swollen leg and had a medical history of diabetes, hypertension and high cholesterol.

ACTION TAKEN

- A DispatchHealth medical director provided an on-scene consultation and prescribed medication.
- The patient was referred to a PCP and offered help to schedule an appointment.
- DispatchHealth planned to return in five days to check the patient's labs if no PCP follow-up had occurred.

PCP = primary care physician; SDOH = social determinants of health. **Source:** DispatchHealth. MultiCare case study: Reimagining the way healthcare is delivered. Accessed February 2025.

CASE STUDY

Unique Partnerships Help Scale At-Home Care

UC DAVIS HEALTH AND BEST BUY HEALTH PARTNER TO INCREASE ACCESS AND REDUCE READMISSIONS

THE CHALLENGE

~50% of adults in the US have hypertension,
resulting in 145 million ED visits per year.

"So, the goal of this remote patient monitoring program is to create a holistic approach to chronic disease management. Where we are not only changing medications but creating a patient and physician alliance and creating a team who are reaching out to patients and helping them understand their blood pressure."

– Dr Vimal Mishra, Associate Chief Medical Officer, UC Davis Health

THE PROGRAM

- The blood pressure RPM program lasts 90 days. Devices (BP cuffs, scales) are connected via the Best Buy Current Health platform.
- All readings are accessible in real time by the UC Davis Health Connected Care Center.
- Patients are offered 1:1 coaching, medication support and group classes.

THE CARE TEAM

Physician, pharmacist, registered nurse and medical assistant

WHAT'S NEXT

- UC Davis Health hopes to expand its collaboration to address additional chronic conditions.
- UC Davis Health plans to integrate AI technologies into a unified Digital Davis platform.

BP = blood pressure; RPM = remote patient monitoring. **Sources:** Connolly L. New at-home monitoring program for patients with high blood pressure. UC Davis Health. June 20, 2024; Diaz N. UC Davis Health, Best Buy Health team up for 'holistic' care. *Becker's Health IT*. July 1, 2024.

QUICK TAKEAWAYS

Skilled Nursing Facility Stays Overview

GROWTH AT A GLANCE

Five- and Ten-Year Total Growth

5-YEAR: **–6%**

10-YEAR: **+1%**

Key Areas of Opportunity

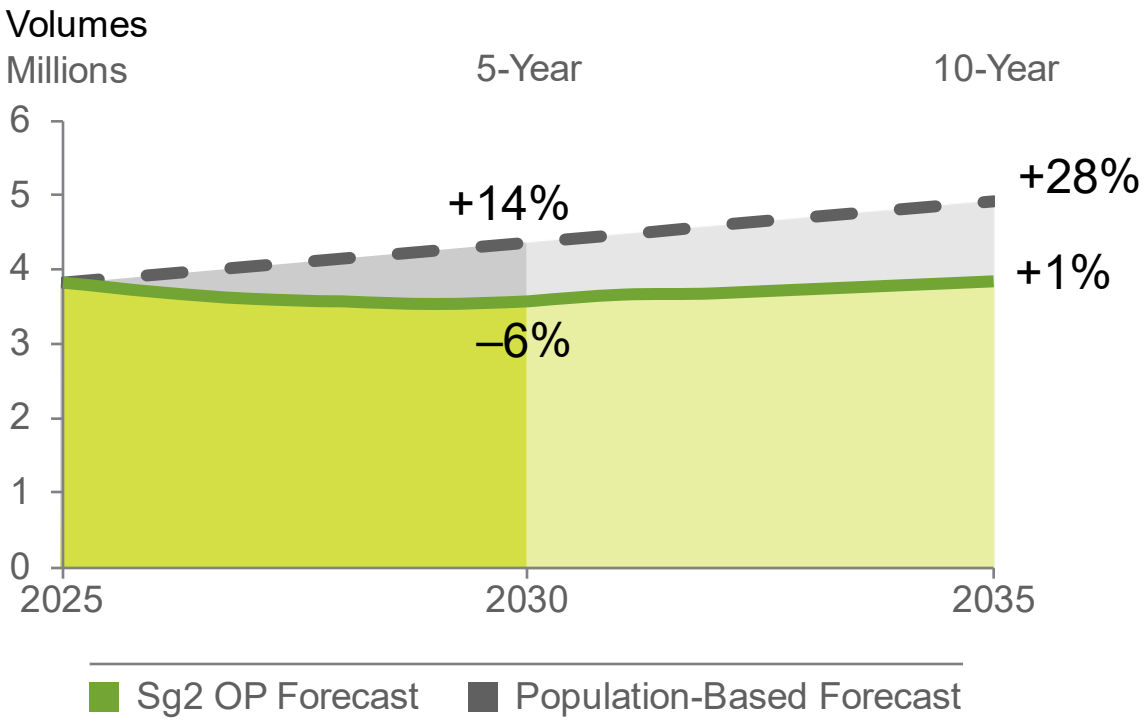
- Innovative workforce models
- AI integration for administrative tasks
- Transitions of care

Skilled nursing volumes represent stays within a skilled nursing facility, captured as overall episodes rather than length of stay. Although discharges to SNFs remain strong, staffing policy changes impose downward pressure on SNF operations in the short term. By the decade's end, SNF volumes are expected to rebound as a result of rising inpatient acuity, the aging population and organizational adjustments to policy shifts. Pending legislation around site neutrality of post-acute sites of care will need to be closely monitored to better understand long-term impacts.

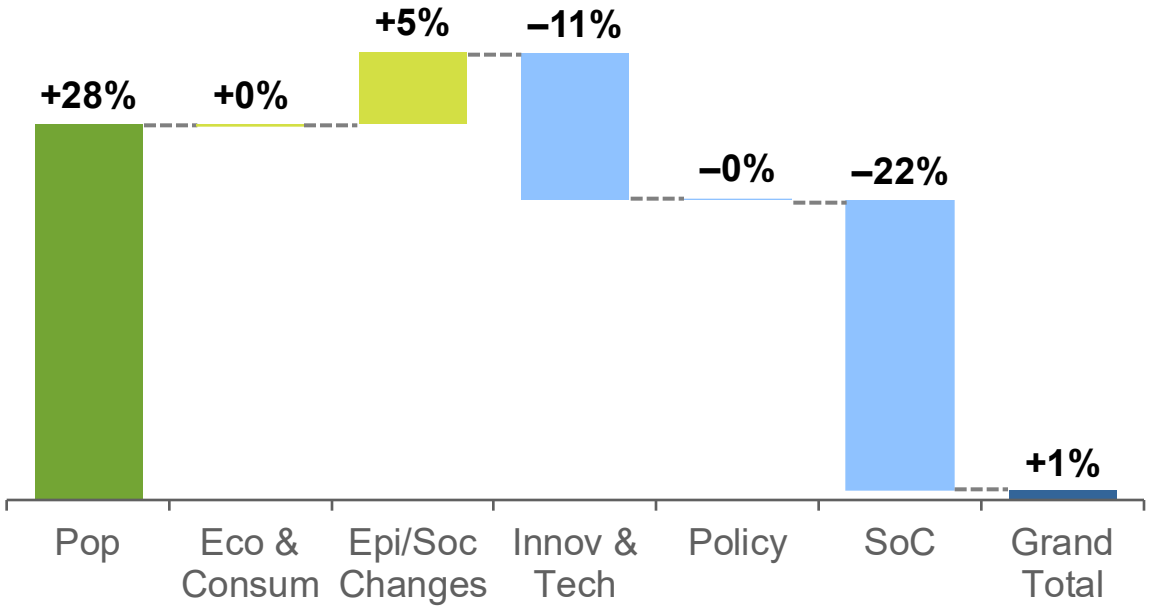
SNF = skilled nursing facility. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Ten-Year SNF Stays Forecast

Outpatient SNF Stays Forecast
US Market, 2025–2035



Outpatient SNF Stays Forecast Impact Factors
US Market, 2025–2035



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CASE STUDY

Reducing SNF-to-Hospital Readmissions Through Virtual Care and Partnerships: OSF Healthcare's Success Story

OSF HEALTHCARE, PEORIA, IL

CHALLENGE

High rate of hospital readmits from SNF

SOLUTION

Enhanced care coordination and virtual care management system implementation

- Focused SNF partnerships
- Physiatry-led model
- Real-time data tracking

RESULTS

Reduced readmission rate from **29%** to **<9%**

Proactively monitor **1,000** patients

STRATEGIC CONSIDERATIONS FOR PARTNERSHIP

1. **Scenario plan** to assess partnership impacts on strategic goals, patient care and services.
2. **Consider** multiple provider **partnerships,** prioritizing quality of care, acuity capabilities and mission alignment.
3. **Establish** a meeting cadence to review **key metrics** and ensure clear communication with partners.
4. **Pilot** program with a select patient cohort; **scale** from there.
5. Select technology that **integrates seamlessly** with EHR and is user-friendly for providers and patients.

SNF = skilled nursing facility. **Sources:** Siwicki B. OSF deploys care transition program, reduces readmission rate from 29% to 9%. *Healthcare IT News*. June 24, 2024; Sg2 Analysis, 2025.

QUICK TAKEAWAYS

Hospice Stays and Home & Domiciliary Hospice Visits Overview

GROWTH AT A GLANCE

Five- and Ten-Year Total Growth

5-YEAR: **+22%** 10-YEAR: **+43%**

Key Areas of Opportunity

Integrative care coordination	Patient and provider education	Emerging technologies

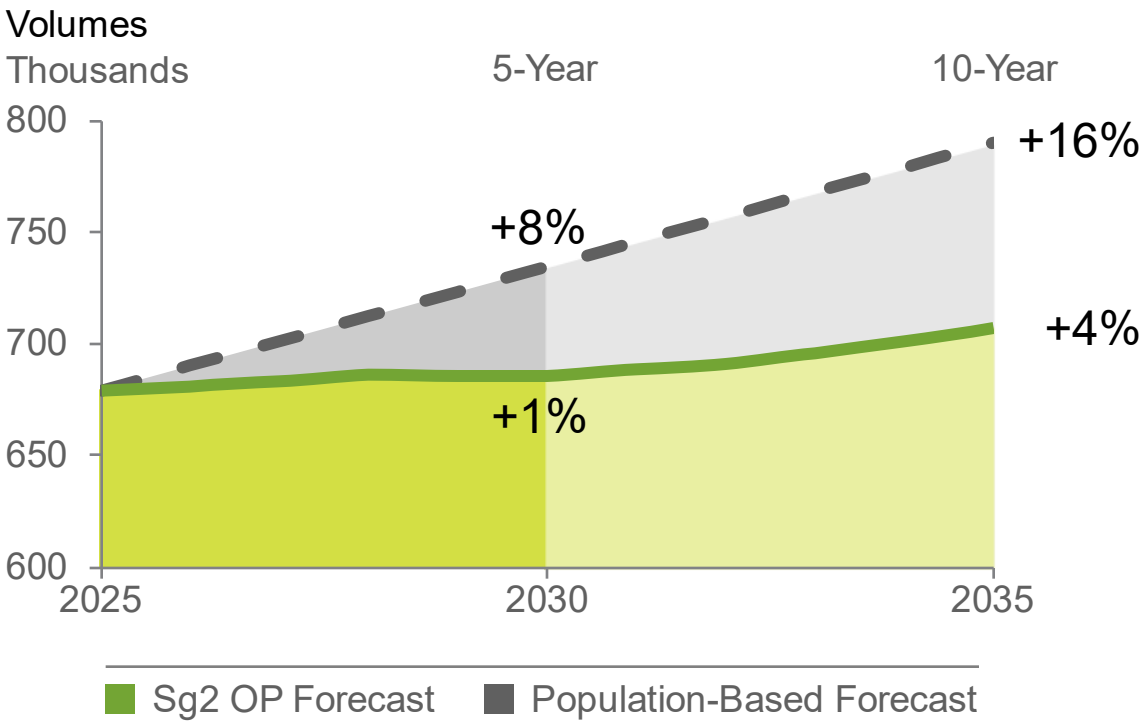
Home and domiciliary hospice visits include community-based hospice care in the patient's domiciliary location: home, nursing home or subacute facility. Alternatively, hospice stays refer to patients meeting strict admission criteria within the hospital setting only, where admissions often originate from inpatient settings or the emergency department.

As the aging population increasingly opts for home-based services, significant growth is projected for home and domiciliary hospice visits, particularly later in the decade. Projected growth in hospice stays remains flat, largely due to the matured shift to community-based hospice programming. Continued patient education on hospice program benefits will prevent delays in care and referrals.

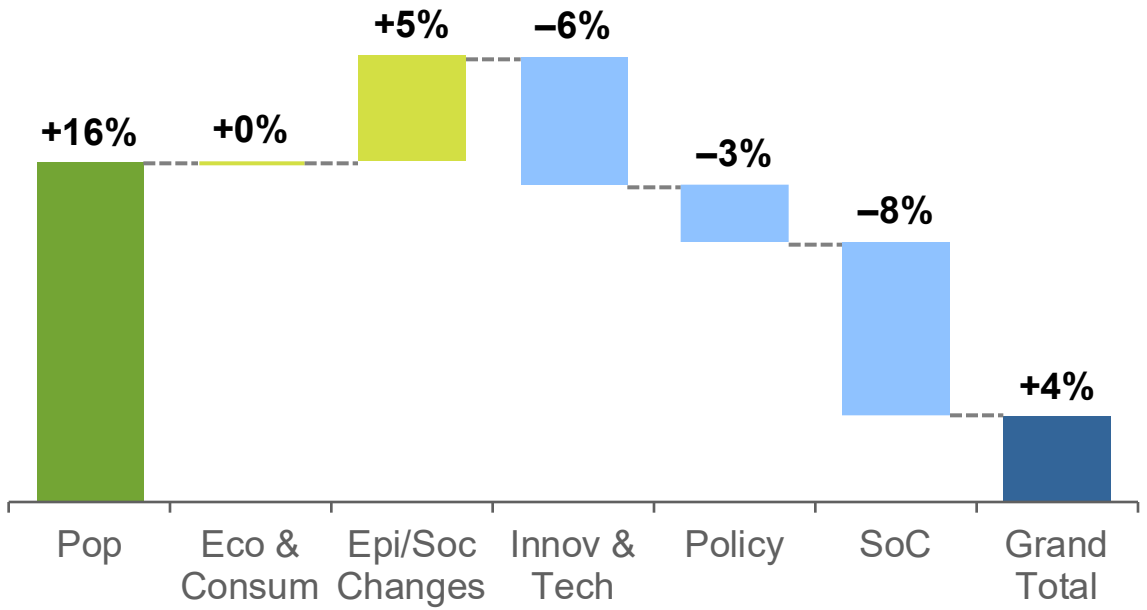
Note: Five- and 10-year forecast projections include the combination of two procedures: hospice stays and home and domiciliary hospice visits. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Ten-Year Hospice Stays Forecast

Outpatient Hospice Stays Forecast
US Market, 2025–2035



Outpatient Hospice Stays Forecast Impact Factors
US Market, 2025–2035



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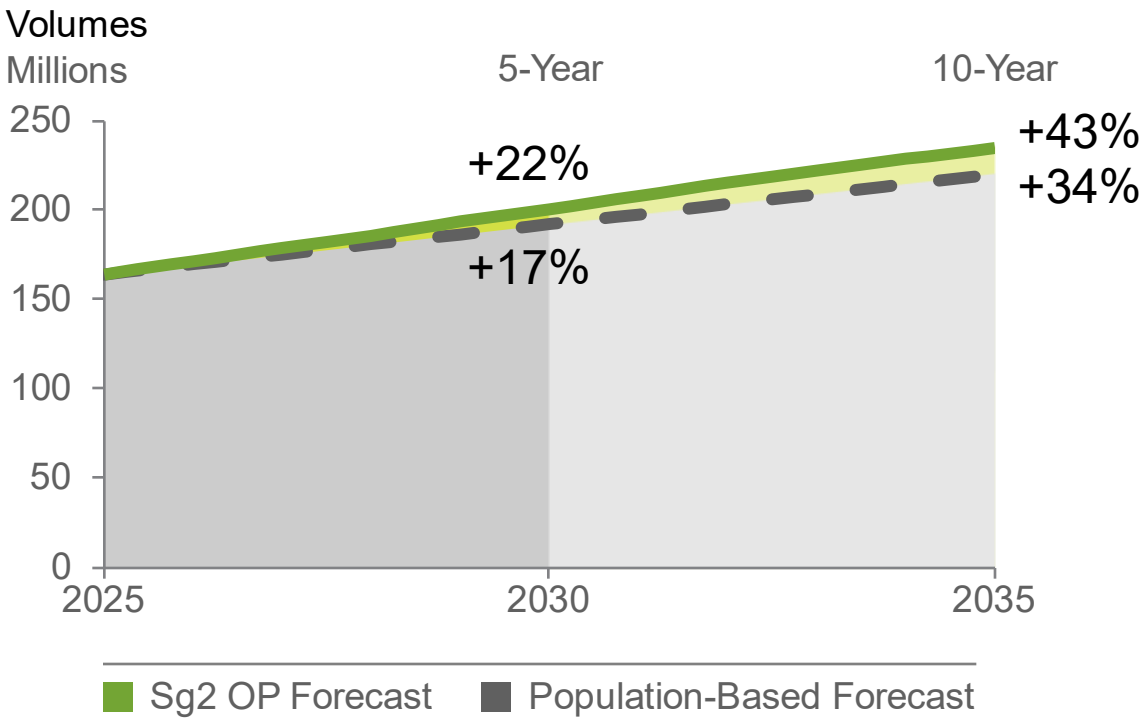
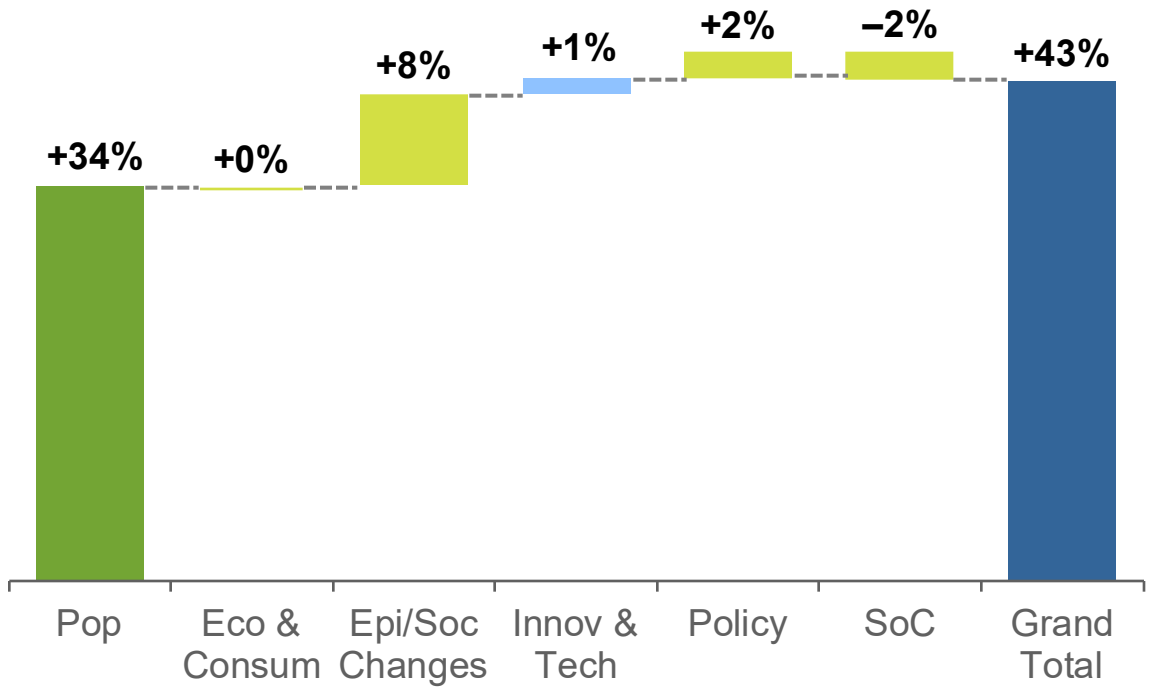
Ten-Year Home & Domiciliary Hospice Visits Forecast

Outpatient Home & Domiciliary Hospice Visits Forecast
US Market, 2025–2035



Outpatient Home & Domiciliary Hospice Visits Forecast Impact Factors, US Market, 2025–2035



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CASE STUDY

Hospice Programming Shifts Based on Community Need

PENN MEDICINE, PHILADELPHIA

BACKGROUND

Penn Medicine offered an inpatient hospice program for 15 years. In response to local market trends, it recently transitioned to hospice in the home.

- Previously, the inpatient program served patients at The Penn Hospice at Rittenhouse, an off-site, freestanding inpatient unit.
  - Patients with acute hospice care needs came from Penn Medicine and nearby health systems.
- Penn Homecare and Hospice Services is an outpatient, home-based palliative and hospice program.
  - This program serves a diverse patient pool from Philadelphia and surrounding counties.

SERVICES

- Specialized care plans crafted by an interdisciplinary team
- Physician home visits for complex symptom management
- 24-hour triage available for home care and visits
- A full range of home health services, including home infusion therapy

OUTCOMES

Penn Medicine won the American Hospital Association Circle of Life Award for expanding the reach of innovative palliative and end-of-life care to the community.

A proactive approach allowed Penn Medicine to identify and track readmission rates and activity in payment bundles to share in cost savings.

Sources: Penn Medicine. Penn Medicine hospice services. Accessed November 2023; University of Pennsylvania Health System. Penn Medicine's home care and hospice services: alignment, collaboration and innovation across the care continuum. Presented November 2018.

QUICK TAKEAWAYS

Home and Domiciliary Evaluation & Management Visits Overview

GROWTH AT A GLANCE

Five- and Ten-Year Total Growth

5-YEAR: **+21%** 10-YEAR: **+33%**

Key Areas of Opportunity

- Digital health platform
- Scheduling and logistics partnerships
- Integration of offerings

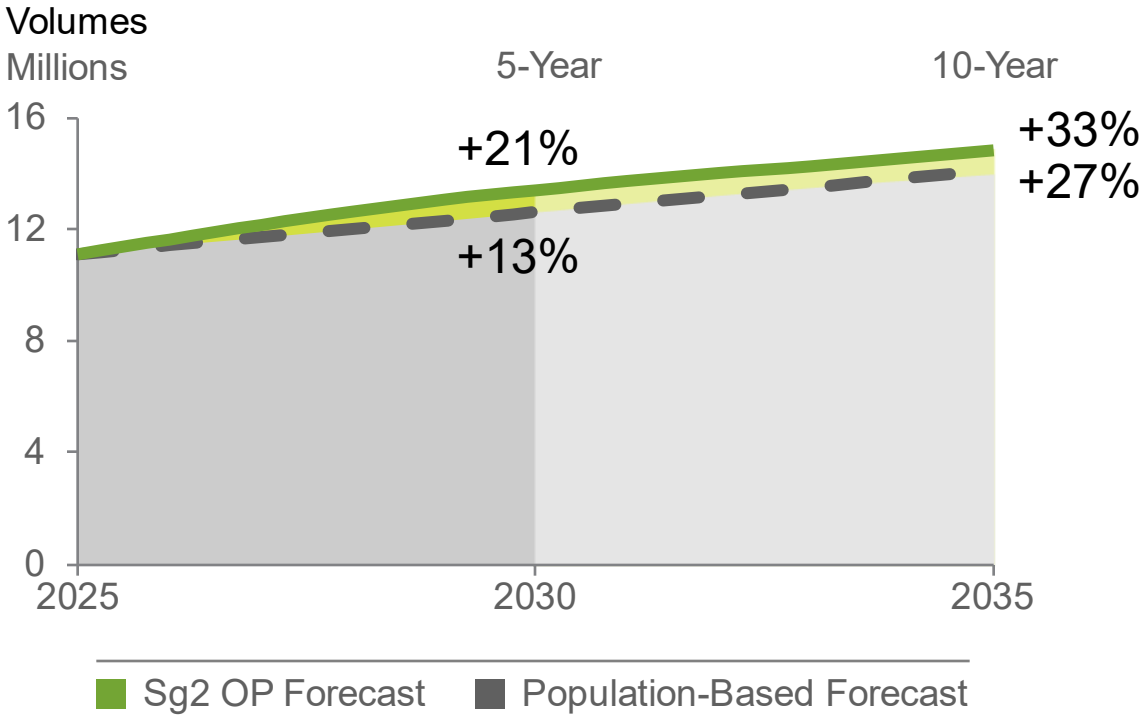
Home and domiciliary evaluation and management visits involve physicians or advanced practitioners (nurse practitioners, physician assistants, etc) providing in-person care, traditionally in subacute care settings like SNFs and assisted living facilities. However, home-based E&M visits remain underutilized in comparison to its E&M counterparts, as much of this care still happens in clinics or facility-based settings. Patient demand for at-home services is increasing, particularly among elderly and chronically ill patients. Of the volumes that occur in this space, a majority are in the domiciliary setting.

E&M visits at home are often underutilized, but they are crucial for high-risk patients in accountable care organizations and VBC models, as they help reduce hospitalizations. E&M visits can be a touchpoint for coordinating care between primary care, specialists, home health services, and SDOH initiatives.

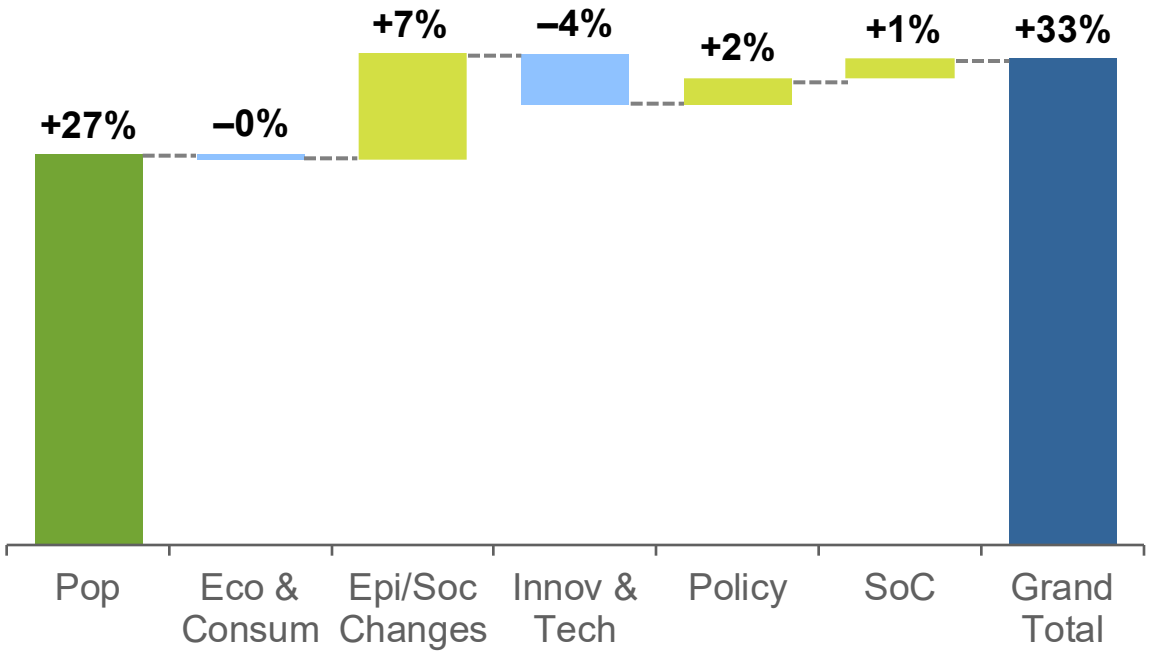
E&M = evaluation and management; SDOH = social determinants of health; SNF = skilled nursing facility; VBC = value-based care. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Ten-Year Home and Domiciliary Evaluation & Management Visits Forecast

Outpatient Home and Domiciliary Evaluation & Management Visits Forecast, US Market, 2025–2035



Outpatient Home and Domiciliary Evaluation & Management Visits Forecast Impact Factors, US Market, 2025–2035



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CASE STUDY

ChristianaCare Increases Access to Disease Management With Chronic Care at Home

PRIMARY CARE AT HOME, CHRISTIANACARE

Wilmington, DE

CHRONIC AND COMPLEX DISEASE MANAGEMENT FOR THE HOMEBOUND

- Initiated with house call programs for seniors and an expansion of the geriatrics program
- Participated in CMS Independence at Home Demonstration, transitioning to the CMS Primary Care First Demonstration

CARE TEAM

- Six clinical teams; each includes a physician, nurse practitioner, nurse, LCSW and administrator.
- LCSW is a key team member, securing social support for patient.
- Home health aides* are the biggest cost saver, helping to keep individuals out of the hospital, but require approval through the state Medicaid Waiver program.
- Clinical teams manage approximately 150 patients each.
- Adjustments to the care team are anticipated as data through the Primary Care First Demonstration program become available.

PATIENT SELECTION

- Homebound
- Multiple chronic conditions
- Often in the last 18 months to two years of life
- May be on waiting list for two to three months

*Home health aides are not part of the team, but they are a resource that ChristianaCare tries to secure for the patient through the state Medicaid Waiver program. LCSW = licensed clinical social worker. **Sources:** ChristianaCare. Primary care at home. Accessed September 2022; Sg2 Interview With ChristianaCare, 2022.

Home Infusions Overview

GROWTH AT A GLANCE

Five- and Ten-Year Total Growth

5-YEAR: **+14%** 10-YEAR: **+26%**

Key Areas of Opportunity

Care delivery expansion	Workforce upskilling and training	Advocacy for payment reform/ incentive

Home infusions—both chemotherapy and nonchemotherapy medications—are experiencing growing interest from patients, providers and pharmaceutical companies. However, adoption is limited by payment disparities, safety concerns and operational challenges.

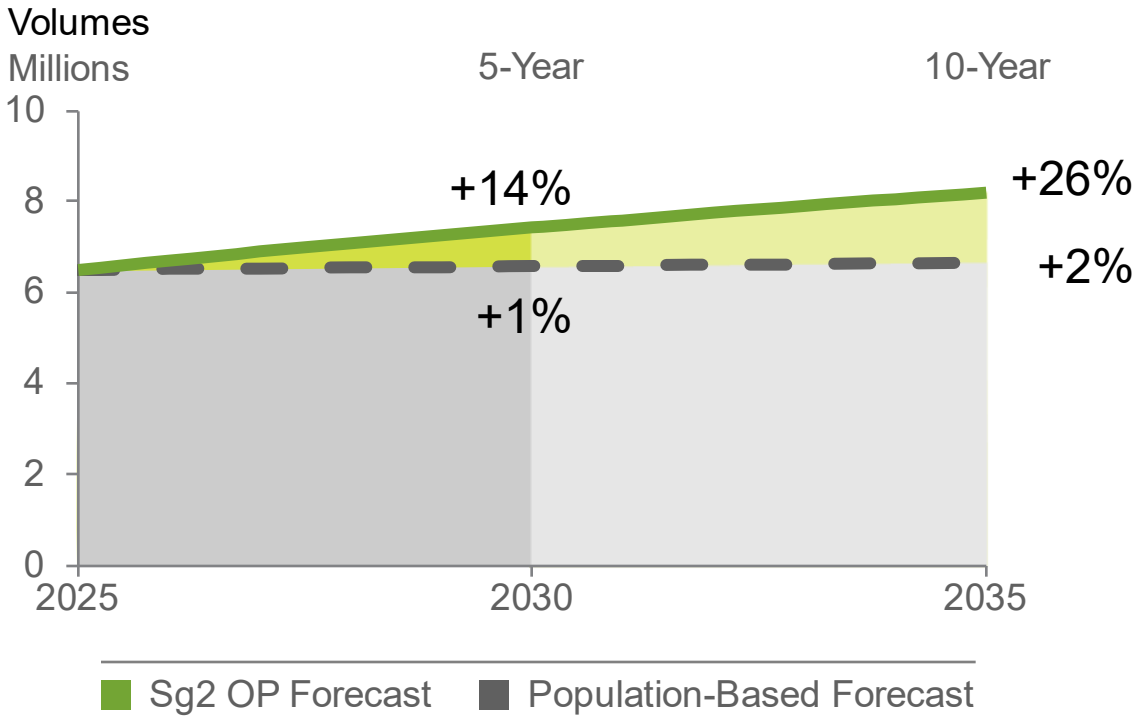
Home infusions—medications (nonchemotherapy specialty drugs and blood products) are expected to grow significantly as reimbursement policies evolve and home health infrastructure expands.

Home infusions—chemotherapy adoption remains limited due to safety concerns and regulatory challenges, though technological and clinical innovations may accelerate acceptance in the future.

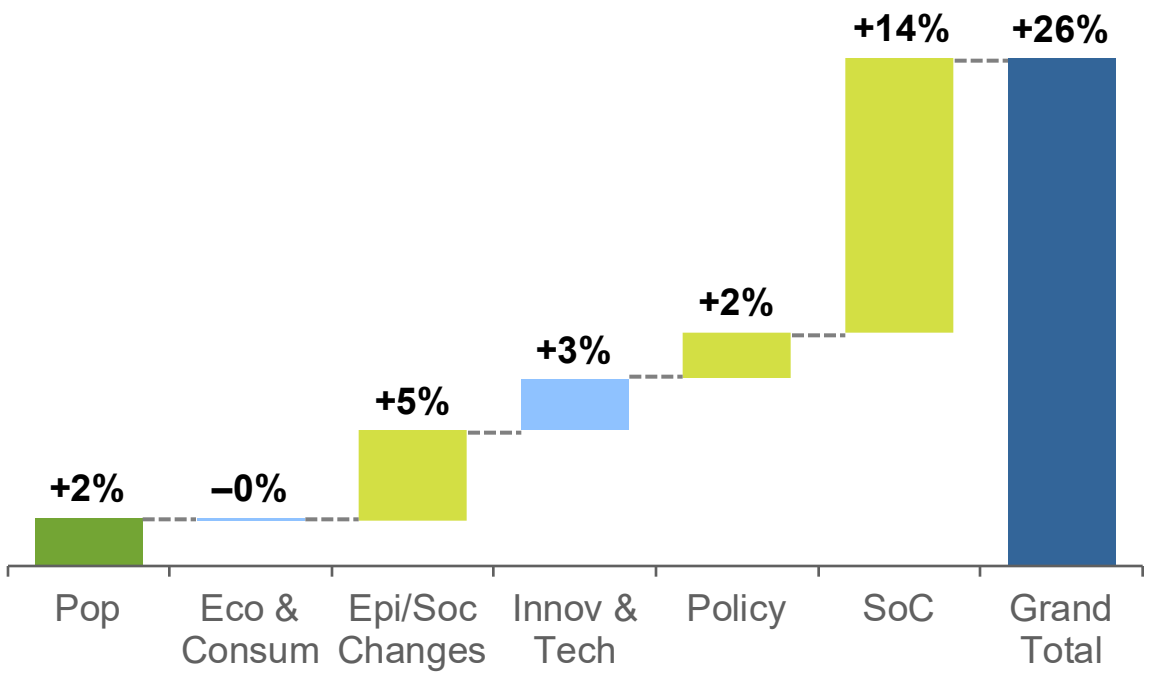
Note: Five- and ten-year forecast projections include the combination of two procedures: home infusions—medications and home infusions—chemotherapy. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Ten-Year Home Infusions—Medications Forecast

Outpatient Home Infusions—Medications Forecast
US Market, 2025–2035



Outpatient Home Infusions—Medications Forecast Impact Factors, US Market, 2025–2035



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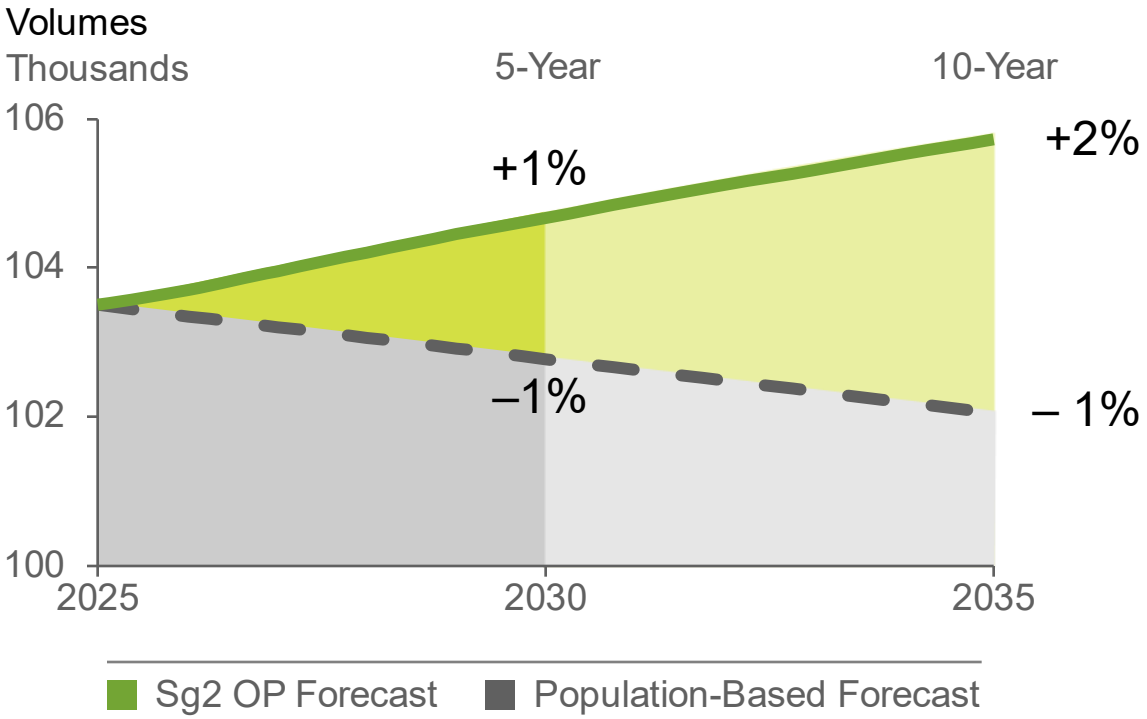
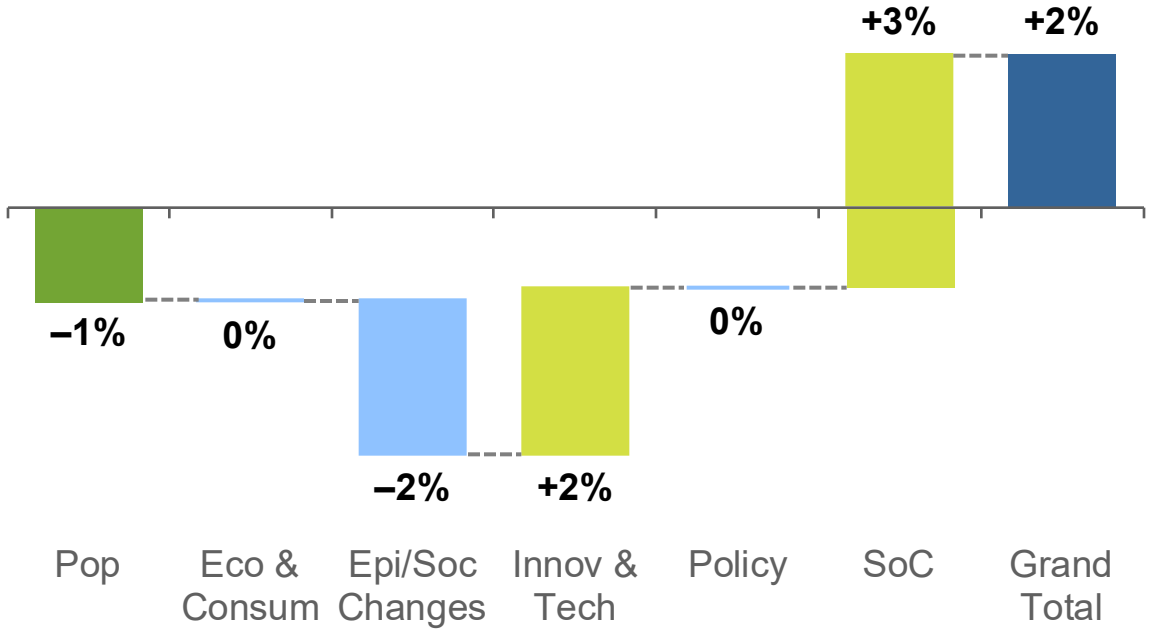
Ten-Year Home Infusions—Chemotherapy Forecast

Outpatient Home Infusions—Chemotherapy Forecast
US Market, 2025–2035



Outpatient Home Infusions—Chemotherapy Forecast Impact Factors, US Market, 2025–2035



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Innovations in Cancer and Specialty Care Expand Home Infusion Care, but Reimbursement Challenges Remain

Is Home-Based Treatment the Future of Cancer Care?

Mayo Clinic's Cancer Care Beyond Walls program has provided more than 200 chemotherapy infusions in patients' homes since 2023.

Fairview Health Provides Home Infusion for Adults and Children

Offers a range of medications from routine antibiotics to biologics, to chemotherapy across 13 states

Huntsman at Home Offers Infusion Therapies for Cancer Patients

In one year, treated 350 patients within 20 miles of HCI, providing infusion therapies (IV and chemo), medication titration and more.

While Home Infusion Is the Next Big Thing in Home-Based Care, Barriers Remain

Many insurance providers cover the cost of home infusion therapy, but gaps remain in Medicaid and Medicare coverage.

Chemo = chemotherapy; HCI = Huntsman Cancer Institute. **Sources:** Mayo Clinic. Is home-based treatment the future of cancer care? January 16, 2025; Fairview Health Services. Fairview home infusion. Accessed February 2025; *ASCO Post*. Results from an oncology hospital-at-home evaluation. June 5, 2020; Martin A. While home infusion is the next big thing in home-based care, barriers remain. *Home Health Care News*. November 8, 2024; Sg2 Analysis, 2025.

QUICK TAKEAWAYS

Home Physical Therapy/Occupational Therapy Overview

GROWTH AT A GLANCE

Five- and Ten-Year Total Growth

5-YEAR: **+17%** 10-YEAR: **+31%**

Key Areas of Opportunity

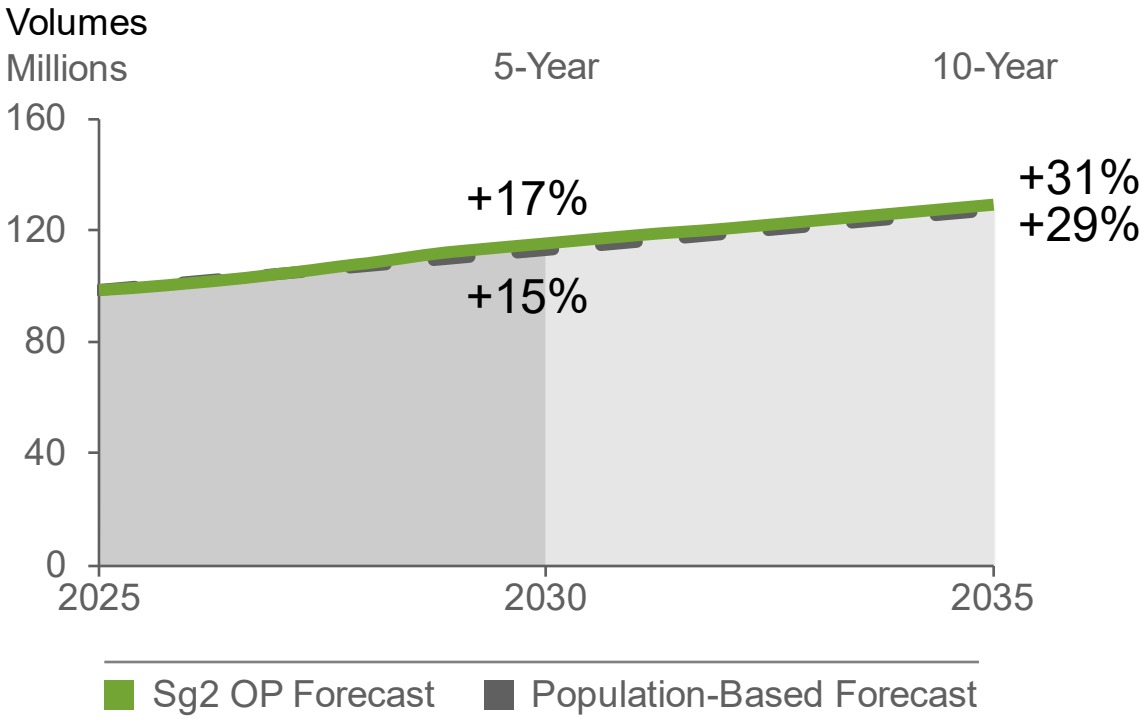
Enhance workforce strategies by leveraging digital tools.	Develop hybrid PT/OT models using telerehab, AI monitoring and virtual coaching.	Align with VBC and PAC networks.

Home-based PT and OT services are gaining traction as post-acute care shifts toward home settings. This growth is driven by aging demographics, policy shifts and technology adoption, but virtual rehabilitation and reimbursement challenges may temper expansion. An aging population and procedural shifts (eg, fewer patients qualifying for SNF stays) increase demand for home-based rehabilitation. Digital health and telerehabilitation are expanding, offering alternatives to in-person home visits. Consumer preferences for in-home recovery remain strong, but logistical and workforce constraints pose challenges.

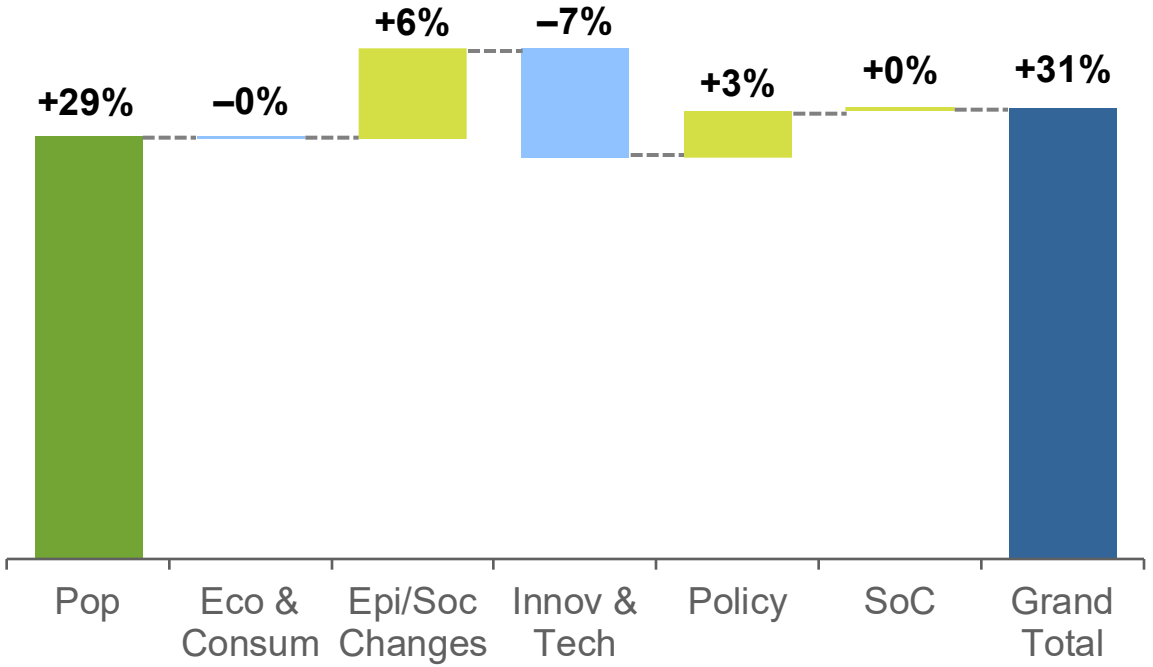
PAC = post-acute care; SNF = skilled nursing facility; VBC = value-based care. **Sources:** Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

Ten-Year Home PT/OT Forecast

Outpatient Home PT/OT Forecast
US Market, 2025–2035



Outpatient Home PT/OT Forecast Impact Factors
US Market, 2025–2035



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CASE STUDY

MedStar Health Home Care Provides Individualized PT/OT Offerings

MEDSTAR HEALTH

Washington, DC; Baltimore; Northern Virginia

BACKGROUND

MedStar's Home Care clinical experts create personalized treatment plans to align with each patient's healing journey.

Physical Therapy

- Designs customized home-based movement and strength programs
- Focuses on restoring mobility and reducing fall risk
- Enhances confidence through guided skill-building
- Advises on supportive tools and safety adjustments

Occupational Therapy

- Evaluates functional needs within the home environment
- Identifies adaptive strategies to support daily living
- Builds capacity for independence and overall safety
- Develops targeted exercises to reinforce physical capabilities

The home care program, which includes PT/OT services, **supports 22,000+ patients** per year across the region, with an ADC of 2,400.

Industry Recognition: Ranked among the top 25% as a **HomeCare Elite agency** for 10 consecutive years

Scope of Care:

Alzheimer disease, cancer care, behavioral health, COPD, diabetes, heart failure, heart surgery, hemorrhagic stroke, orthopedic injuries and postsurgical services, spinal cord injury rehab, joint replacement, wound care

ADC = average daily census; COPD = chronic obstructive pulmonary disease. **Source:** MedStar Health. MedStar Health home care. Accessed July 2025.

Appendix

Equipment and Supplies Need to Be Easy for Providers and Family Caregivers to Use in the Home Environment

Examples	On Demand	Chronic	Acute	Continuing
Durable Medical Equipment	Limited need	For support of chronic conditions and activities of daily living • Adaptive equipment (wheelchairs, walkers, etc) • Oxygen • Nebulizers • Monitoring equipment, including glucose • Pumps (infusion, suction) • Patient lifts • Scales (digital and other)	For treatment and monitoring • Hospital beds (sometimes) • Oxygen • Nebulizers • Monitoring equipment, including glucose, oxygen saturation, respiratory, mobility, etc • Pumps (infusion, suction) • Patient lifts • Medication safe box	For rehab and recovery management • Adaptive equipment (wheelchairs, walkers, etc) • Oxygen • Nebulizers • Monitoring equipment, including glucose • Pumps (infusion, suction) • Patient lifts • Traction and rehab equipment
Supplies	• Blood draw kits • Point-of-care testing	For assessment and management of chronic conditions • Wound management • Disease monitoring (blood sugar, etc) • Dialysis • Infusion	For treatment and monitoring • IV drug delivery • Infusion • Medications and medication dispensing • Point-of-care testing	For rehab and recovery management • Wound management • Disease monitoring (blood sugar, etc) • Pain management

The more complex the care, the greater the risk of user error.

REDUCE THE RISK

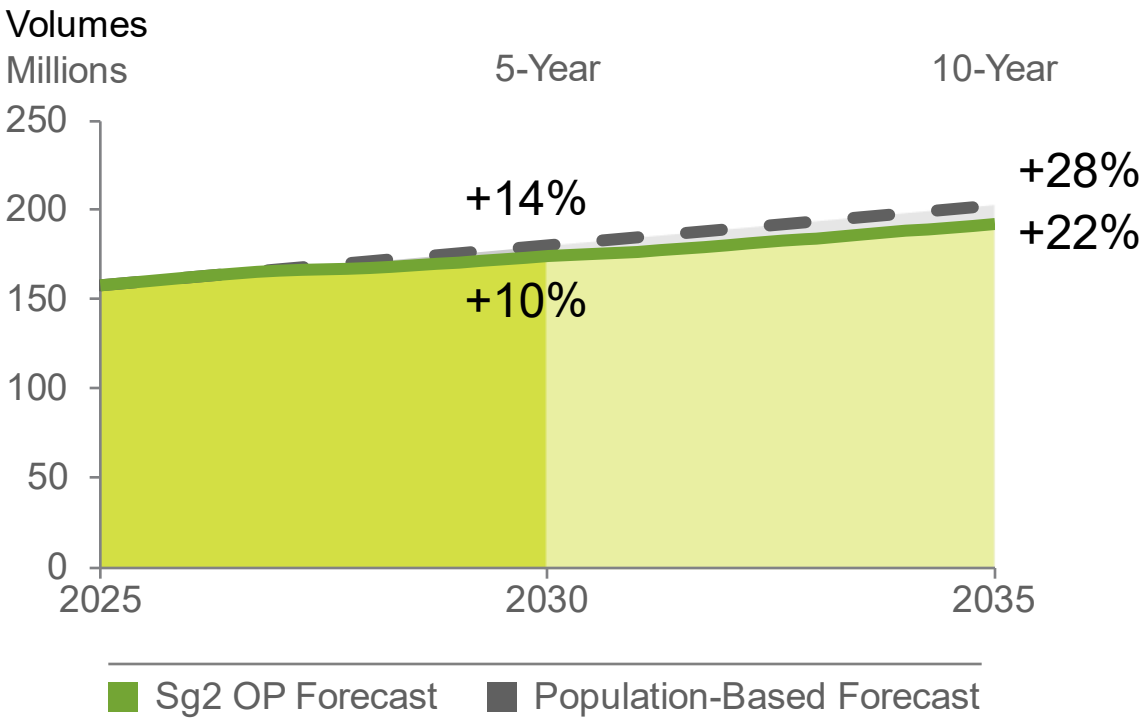
Simplify supplies and devices.

Ensure compatibility with other devices and supplies.

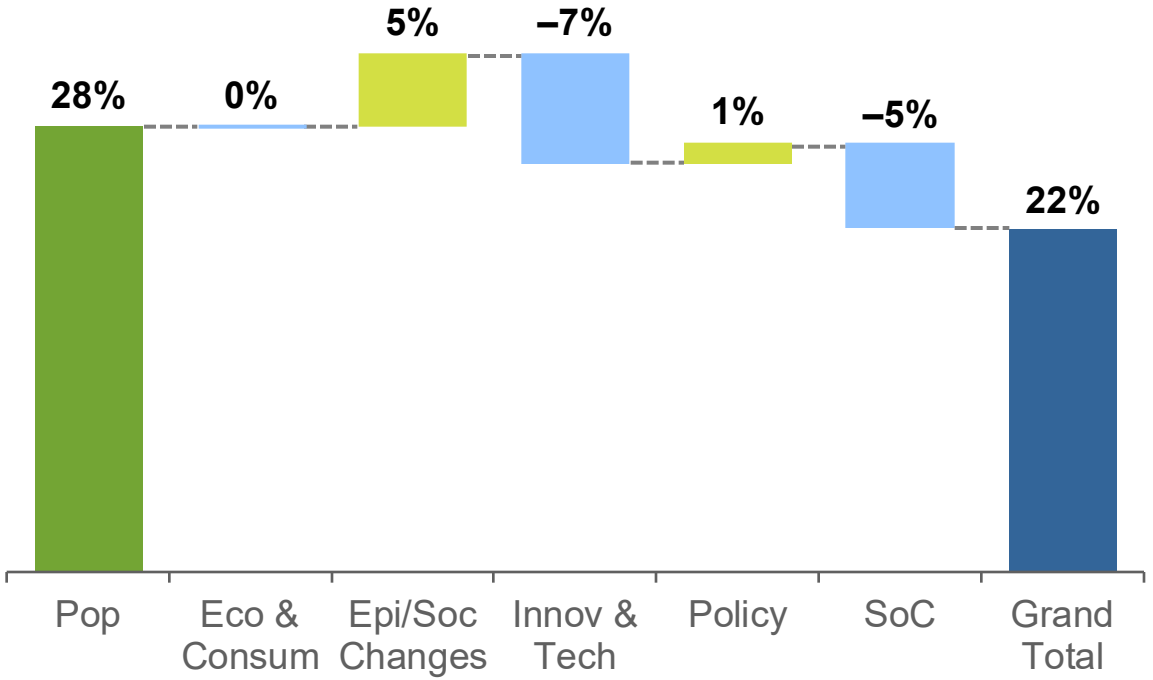
Provide easy-to-understand education.

Ten-Year Home Nurse Visits Forecast

Outpatient Home Nurse Visits Forecast
US Market, 2025–2035



Outpatient Home Nurse Visits Forecast Impact Factors
US Market, 2025–2035



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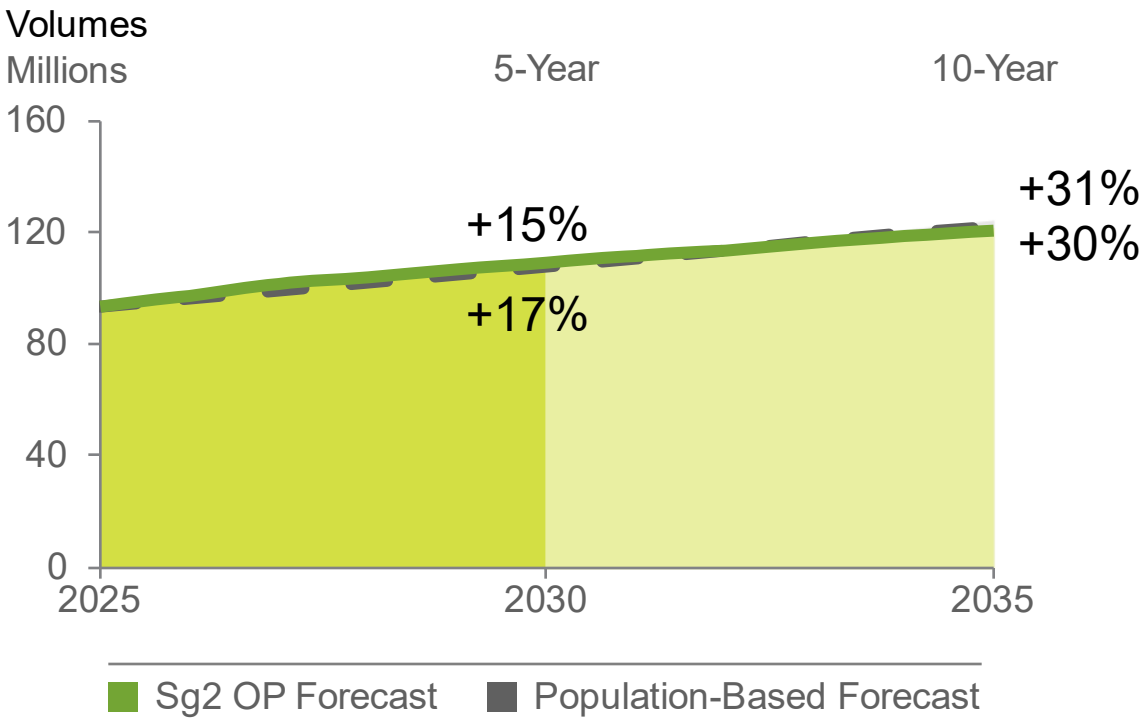
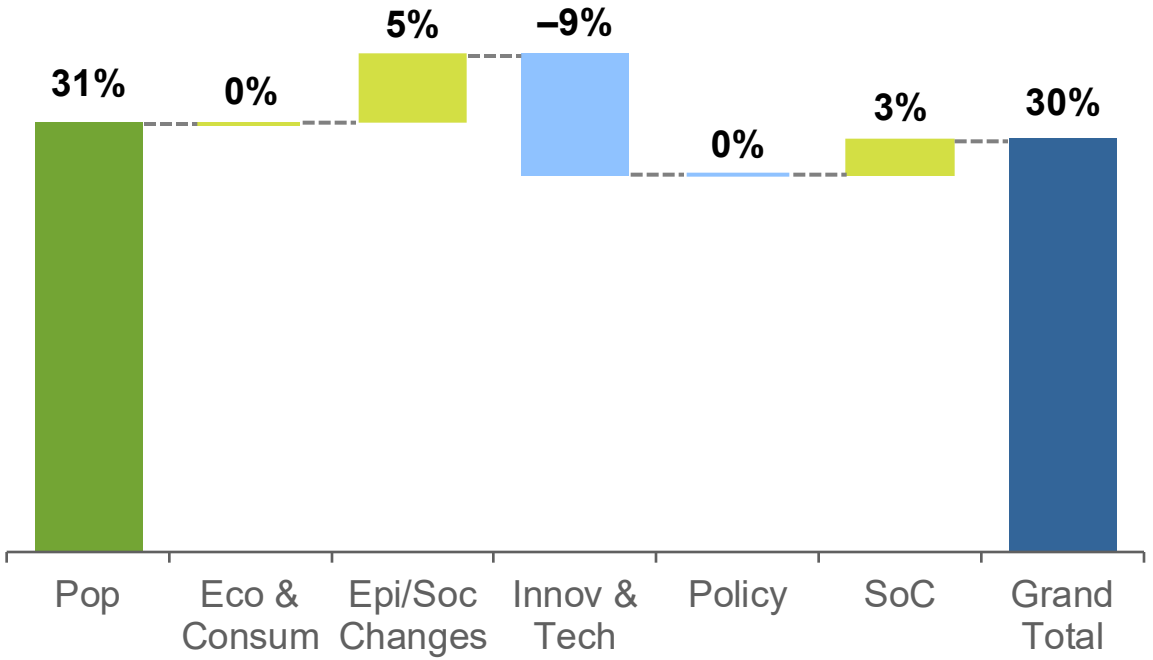
Ten-Year Home Visits Other Forecast

Outpatient Home Visits Other Forecast
US Market, 2025–2035



Outpatient Home Visits Other Forecast Impact Factors
US Market, 2025–2035



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CASE STUDY

UnityPoint Reduces Unnecessary Hospital Utilization With Primary Care at Home

CARE AT HOME CLINIC
UNITYPOINT HEALTH, DES MOINES, IA

LOW- TO HIGH-ACUITY, HOME-BASED PRIMARY CARE PROGRAM

- Primary care visits for patients with access issues to a traditional clinic
  - Proactive and preventive
  - Urgent and interventional
  - Serious-illness management
  - Post-acute, rehabilitative and recovery
- Activated by the patient's primary care physician, urgent care or the ED
- Responds to patient in their home within four hours
- Triages patient based on clinical need; referrals may include home health, hospice, hospital admission or hospital at home.

IMPACT

Reduces unnecessary ED, hospital IP and SNF utilization

Contributes to ability to flex services for other at-home services

SNF = skilled nursing facility. **Sources:** Raths D. UnityPoint Health pulls together suite of at-home services. *Healthcare Innovation*. October 4, 2021; Sg2 Interview With UnityPoint Health, 2022.

What Resources Do We Need for Acute Care at Home?

STAFFING

- Physician oversight
- Nurse
- Emergency response clinical team
- Phlebotomy
- PT/OT/SLP
- Community health worker
- IT support
- Home care aide

TECHNOLOGY

- Video visit
- Patient portal
- Remote patient monitoring

COMMAND CENTER

24/7 center for triaging urgent and/or emergent needs, monitoring patient vital signs

INFRASTRUCTURE

- Pharmacy
- DME
- Courier services
- Nutrition services
- Social services
- IT support
- Lab testing
- Mobile imaging
- Patient education
- Physician and nursing education

Note: All items span both hospital at home and observation at home. DME = durable medical equipment; SLP = speech-language pathology.

CASE STUDY

Acquisition Establishes One of Nation's Largest Hospital at Home Networks

DispatchHealth + Medically Home

Combined program components:

DH: offers skilled nursing, urgent care and HaH services directly to patients, at home

DH: partners with health systems and insurers

MH: supplies tech platform, logistical support and select staffing

MH: partners with health systems to aid in delivering HaH services

End-to-End HaH Solution

"This is really about scaling, integrating and delivering high-acuity care in the home in a way that has never been delivered before," DispatchHealth CEO Jennifer Webster said. **"DispatchHealth's clinical delivery model and Medically Home's enablement capabilities create an end-to-end solution which will create a platform for future opportunities."**

DH = DispatchHealth; HaH = hospital at home; MH = Medically Home. **Sources:** Eastabrook D. DispatchHealth to acquire Medically Home, create home care giant. *Modern Healthcare*. March 18, 2025; DispatchHealth website; Medically Home website; Sg2 Analysis, 2025. All websites accessed July 2025.

CASE STUDY

Hospital at Home Partnership

Two traditional competitors in hyper-competitive Florida team up to manage capacity and build capability to treat more patients at home.

Tampa General and Lakeland Regional

- ADC is 15 to 20; the goal is 100.
- Joint venture with specialty pharma company Shields
- Profitable enough to be self-sustaining
- Tampa General's readmission rate from the HaH program is 5.2%; cases with the same CMI that stayed in hospital had a readmission rate of 16%.
- Team member engagement is very high with low/zero turnover (all IP certified nurses).

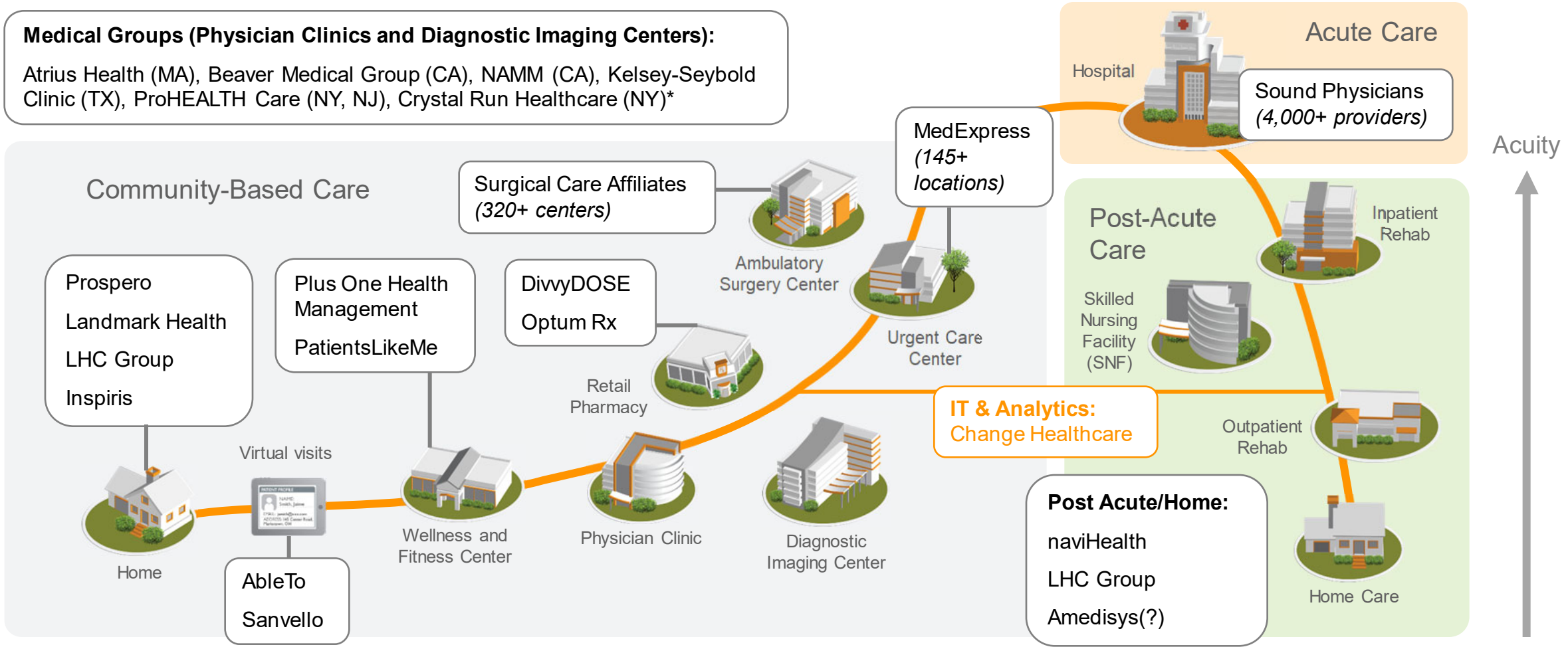
> "I wanted to unplug older patients who are getting so many tests ordered and aren't getting better in the hospitals and learn if their home environment will be better for recovery."
>
> – Dr Francisco Chebly, Lakeland Regional Health

ADC = average daily census; CMI = case mix index; HaH = hospital at home. **Source:** Sg2 Interviews With Lakeland Regional and Tampa General, April 2025; Sg2 Analysis, 2025.

Optum: Invested Across the Continuum

Medical Groups (Physician Clinics and Diagnostic Imaging Centers):

Atrius Health (MA), Beaver Medical Group (CA), NAMM (CA), Kelsey-Seybold Clinic (TX), ProHEALTH Care (NY, NJ), Crystal Run Healthcare (NY)*



*Additional medical groups: Southwest Medical (NV), WellMed (TX), ProHealth Physicians (CT), USMD ACO (TX), New West Physicians (CO), American Health Network (IN, OH), Reliant Medical Group (MA), DaVita Medical Group (CA, FL), The Everett Clinic (WA), The Polyclinic (WA), Unity Health Network ACO (OH), Oregon Medical Group (OR), GreenField Health (OR). **Note**: ACO = accountable care organization; PAC = post-acute care. **Sources**: UnitedHealth Group. Our family of businesses. Accessed April 2023; Gomez B. Crystal Run Healthcare sold to Optum. News 12 New York. April 12, 2023; Parker J. Prospero Health to merge with Landmark within UnitedHealth Group's Optum. *Hospice News*. March 8, 2023; Matthews A. UnitedHealth buys PatientsLikeMe after startup was forced to divest Chinese investment. *Wall Street Journal*. June 25, 2019; Sanborn BJ. OptumHealth and Summit Partners to acquire staffing firm Sound Inpatient Physician Holdings for $2.2 billion. *Healthcare Finance*. June 7, 2018; Donlan A. $5.4 billion LHC Group-Optum deal closes. *Home Health Care News*. February 22, 2023; Optum. Optum and Change Healthcare complete combination [press release]. October 3, 2022; Sg2 Analysis, 2025.

Determine What Type of Partnership Is Needed for Successful Care at Home Delivery

	Technology-based point solutions	Third-party care delivery partners	Comprehensive partners
Organization control	Organization drives utilization and manages interoperability	Organization drives use but can only influence quality of care	Control is shared and major decisions require agreement
Addressing gaps	Partners can fill one or more technology or infrastructure gaps	Service specific or more general and able to fill multiple care delivery gaps	Fill staffing, process and administrative gaps, including contracting
Strategic alignment	Invest in growth of the partner if aligned	Seek partners with aligned clinical quality and patient experience goals	Seek partners with an aligned vision for care at home
Exclusive arrangements	Limited exclusivity	Limited exclusivity	Exclusivity may be geographically defined

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