Adoration Home Health

Quality, Innovation, and High-Value Care at Home

A home health-focused white paper from Adoration Home Health, an affiliate of BrightSpring Health Services

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Executive Summary

Adoration Home Health delivers skilled, compassionate care in the home for patients recovering after acute illness, managing chronic conditions, or needing rehabilitation to restore strength, mobility, balance, endurance, self-care, and independence. Services also include medication reconciliation, patient and caregiver education, and care coordination. As part of BrightSpring Health Services, Adoration combines local home health teams with broader home and community-based infrastructure across home health and hospice, with private duty services available in select markets. [1-5]

2026 quality results demonstrate an operating model focused on timely access, functional recovery, patient experience, documentation discipline, and branch-level accountability. Home health reached 98.9% timely initiation of care (97.4% SHP national average), 86.1% discharge function (78.6% national), 86.5% patient satisfaction (81.0% national), and 93.2% of branches rated at least four stars (90% internal target). [6]

98.9%	86.1%	86.5%	93.2%
Timely initiation of care vs. 97.4% SHP avg.	**DC function** vs. 78.6% SHP avg.	**Patient satisfaction** vs. 81.0% SHP avg.	**HH branches ≥4 Stars** goal 90%

The same quality infrastructure also spurs areas of innovation. A continual focus and programming centered on disease-state management and reducing potentially preventable hospitalizations are embedded throughout the organization. Other ongoing initiatives include branch-level performance-improvement projects, after-hours triage, chart audits, OASIS documentation improvement, and education designed to identify clinical deterioration early while preserving appropriate escalation when a patient's condition requires it. [6,15]

Innovation strengthens this clinical model. BrightSpring's Vitality Therapy™ program brings a structured anti-frailty intervention into the home health episode, translating evidence on strength, gait speed, balance, independence, and frailty into a practical care pathway for older adults recovering at home. [7]

Scale and infrastructure support consistency. BrightSpring adds enterprise-level quality systems, clinical support capabilities, pharmacy and medication-management assets, workforce development, and data-driven operating disciplines that help local Adoration teams respond reliably to patient and referral-partner needs. [8-10]

Two BrightSpring family-of-brands integrations further differentiate Adoration from a stand-alone home health agency. Abode Care Partners provides home-based primary care for older adults and complex populations, while Continue CareRx adds pharmacy-enabled medication reconciliation, adherence packaging, synchronized home delivery, pharmacist review, virtual nursing support, and 24/7 medication access. Together, these capabilities address two common drivers of avoidable utilization after discharge – gaps in longitudinal primary care and medication-management failure – and help knit home health into a broader home-centered platform. [8-10]

Adoration's recent expansion, including the acquisition of more than 115 home health and hospice branches across 19 states as part of the UnitedHealth/Amedisys divestiture process, extends access and creates a larger platform for standardized quality, integrated transitions, and high-value care in the home. [11-13]

1. What Home Health Is

Home health care delivers skilled clinical services in a patient's residence – most often following a hospital discharge or during an exacerbation of a chronic condition, or when a new acute clinical need can be safely managed at home – so patients can recover safely at home, regain function, and avoid preventable utilization. For payers and health system partners, home health is a critical site-of-care option for post-acute recovery and longitudinal management that can improve outcomes while lowering total cost of care. [14,15]

1.1 Definition and Scope

Under the Medicare home health benefit, eligible patients may receive intermittent skilled nursing and therapy services (physical therapy, occupational therapy, and speech-language pathology), along with medically necessary supplies and, when appropriate, part-time home health aide and medical social services. Home health is intended for patients who are homebound and require skilled care under a physician-established plan of care. [14]

In practical terms, a home health episode typically includes:

- A clinician visit in the home to assess the patient, stabilize post-discharge needs, and provide ongoing skilled care.
- Rehabilitation therapy focused on functional recovery (mobility, self-care, safety, and strength).
- Medication reconciliation and education to reduce adverse drug events and preventable readmissions.
- Caregiver training and home safety interventions to support independence and reduce falls.

Home health is different from longer-duration private duty services, which may include skilled nursing or non-skilled assistance depending on patient need and program availability. Home health is time-limited, clinically directed, and anchored in intermittent skilled nursing and therapy needs, though it frequently coordinates with other community supports. [5,14]

1.2 How home health differs from other post-discharge care settings

Following an acute hospitalization, patients can transition to a range of post-acute settings. The right setting depends on clinical acuity, functional status, caregiver support, and patient goals. Home health is typically appropriate when the patient can be safely supported at home with intermittent skilled visits – while skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), or long-term care hospitals (LTCHs) may be needed for higher-intensity or facility-based care. [16-19]

Setting	Typical services & intensity	Common clinical use	Partner considerations
Home health (in the home)	Intermittent skilled nursing and therapy visits; remote monitoring/telephonic support may supplement in-person care.	Post-discharge stabilization, chronic disease management, rehabilitation, and safety in the home.	Lower-cost site of care; requires reliable start-of-care, escalation pathways, and strong care coordination.
Skilled nursing facility (SNF)	24/7 nursing oversight with rehab services delivered in a facility.	When patients need facility-based support for mobility, cognition, or medical complexity that exceeds safe home support.	Higher per-episode cost; may reduce caregiver burden but introduces transition risk and facility-related complications.
Inpatient rehabilitation facility (IRF)	Hospital-like rehab setting with intensive therapy.	Patients needing intensive multidisciplinary rehab after stroke, major orthopedic events, or significant functional impairment.	High resource intensity and cost; appropriate for a narrower clinical subset.
Long-term care hospital (LTCH)	Extended acute inpatient care for high-complexity patients.	Patients with complex medical needs (e.g., prolonged ventilation, complex wounds) requiring hospital-level care over longer stays.	Highest acuity and cost; not comparable for most routine post-acute recovery populations.
Outpatient/clinic-based therapy	Therapy delivered in a clinic setting; patient travels to care.	When patients are stable, mobile, and transportation is feasible.	Often complements home health or follows discharge from home health for continued progress.

1.3 Core components of a home health episode

High-performing home health programs share a common set of operational and clinical components that drive quality, safety, and reliable transitions:

- Referral & intake: Timely receipt of hospital discharge documentation or physician office visit information, medication lists, orders, and clinical history; rapid scheduling.
- Start of Care assessment: In-home assessment and standardized clinical documentation, including functional and risk evaluation.
- Plan of care: Physician collaboration, patient-specific goals, visit frequency, and interdisciplinary coordination.
- Skilled visits & education: Nursing and therapy visits focused on symptom control, function, home safety, and self-management.

- Escalation & care coordination: Protocols to identify deterioration early, coordinate with physicians, and prevent avoidable ED use.
- Discharge & transition: Graduated discharge planning, handoff to outpatient providers/community resources, and closeout of goals.

1.4 Accreditation, oversight, and quality measurement

Home health agencies operate in a highly regulated environment. Medicare-certified agencies must comply with CMS Conditions of Participation (CoPs) and are surveyed for quality and safety standards. Quality measurement is driven by standardized clinical assessment data (OASIS) and patient experience measurement (HHCAHPS), which feed public reporting and Star Ratings. Many home health providers also participate in value-based programs such as the Expanded Home Health Value-Based Purchasing (HHVBP) Model, which adjusts payment based on performance and seeks to reduce avoidable utilization. [15,20,21]

1.5 Payment model and why home health lowers total cost of care

Medicare reimburses home health under a prospective payment system that pays for 30-day periods of care using the Patient-Driven Groupings Model (PDGM). Payment is case-mix adjusted based on clinical and functional characteristics and includes adjustments for low-utilization periods and outlier cases. In 2024, the national standardized base payment amount was approximately $2,038 per 30-day period before case-mix and geographic adjustments. [16,22]

Because home health is delivered in the home and emphasizes early identification of deterioration, medication safety, functional recovery, and patient/caregiver education, it can reduce total cost of care through two complementary mechanisms:

- Site-of-care substitution: when clinically appropriate, home health replaces higher-cost institutional post-acute settings.
- Utilization avoidance: strong care transitions and early intervention reduce preventable ED visits, readmissions, and complications.

Evidence of total cost-of-care impact

A large retrospective cohort study found that patients discharged with home health care had lower total health care costs over 365 days (adjusted savings of $6,433 per patient) and lower hazards of both readmission (HR 0.82) and death (HR 0.80) compared with matched "self-care" discharges. [23]

In a national Medicare analysis of post-acute discharge decisions, patients discharged home with home health had lower total Medicare payments over 60 days (−$4,514) than similar patients discharged to a skilled nursing facility. [24]

CMS reports that the original Home Health Value-Based Purchasing demonstration improved quality and generated average annual savings to Medicare, with reductions in unplanned acute care hospitalizations and SNF stays – supporting the logic of performance-linked home health models. [15]

2. Adoration Home Health at a Glance

Adoration Home Health & Hospice was founded in the Middle Tennessee area with the aim of building a world-class home health and hospice organization rooted in the communities it serves. In 2018, Adoration joined the BrightSpring Health Services family of brands to expand its reach and bring its model of compassionate care to more people and more homes across the United States. [2]

2.1 Services and care team

Adoration provides home health and hospice services across its broader footprint, as well as private duty services in select Tennessee markets. Home health focuses on patients recovering from illness or injury who have difficulty leaving home; hospice supports individuals with life-limiting illness; and private duty services may include skilled nursing or non-skilled assistance and companionship for patients who need longer-duration help at home. [1,5]

Within home health, Adoration's interdisciplinary care teams include clinical managers, registered nurses (RNs), licensed practical nurses (LPNs), medical social workers, and occupational, physical, and speech therapists, working with a Medical Director to evaluate care and drive continuous improvement. [4]

2.2 Clinical capabilities and common conditions served

Adoration's home health teams provide specialized nursing care (e.g., medication management, wound care, chronic disease education), therapy services to restore function and reduce fall risk, and social services to connect patients with community resources and support. [4]

Common conditions addressed in the home setting include congestive heart failure (CHF), COPD, diabetes, hypertension, chronic kidney disease, stroke recovery, Parkinson's disease, Alzheimer's & dementia, arthritis, post-surgical rehabilitation, respiratory infections, complex wound care, and cancer treatment support. [4]

In select Tennessee markets, Adoration's private duty services provide longer- or short-term support that may range from skilled nursing care to assistance with activities of daily living, based on an individualized plan of care. [5]

2.3 Geographic footprint and access

Adoration serves patients in many states and continues to expand its footprint. The locations directory provides a state-by-state listing of offices and services offered; phone calls are answered 24/7/365. [3]

Figure 1 maps Adoration home health locations by state. [25]

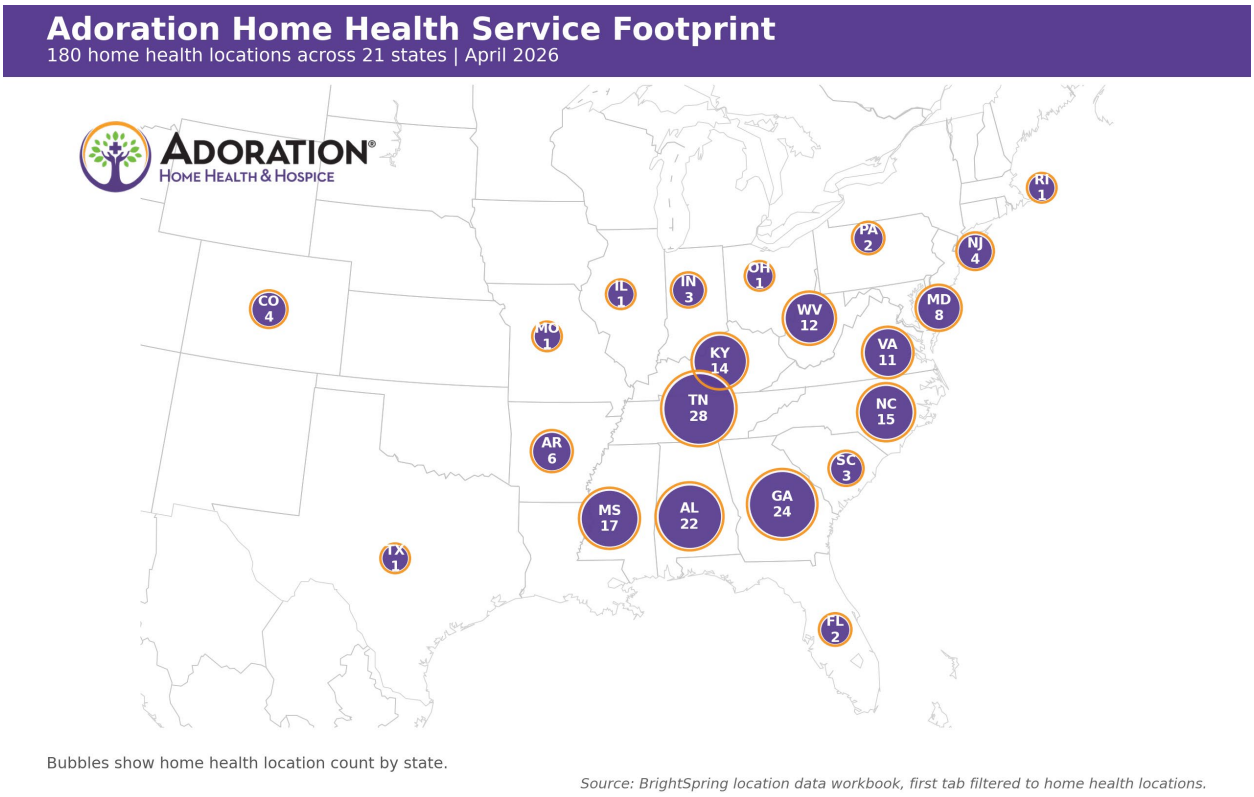

Figure 1. Adoration Home Health service footprint (home health locations by state, April 2026).

3. Why Home Health Matters Now

Home health is a critical component of the healthcare continuum, enabling clinically appropriate care in the home while supporting patient preference for receiving services where they live. Medicare covers certain home health services for eligible beneficiaries who need part-time or intermittent skilled services and meet “homebound” requirements. [14]

At the same time, payment and transparency models increasingly link reimbursement to quality. CMS reports on home health Quality of Patient Care Star Ratings on Care Compare, summarizing performance across process and outcome measures. [21] The Expanded Home Health Value-Based Purchasing (HHVBP) Model is a nationwide program designed to improve the quality and efficiency of home health care and strengthen outcomes such as patient experience and physical function. [15]

Against this backdrop, Adoration’s focus is to deliver high-quality care, reduce potentially preventable hospitalizations and other avoidable acute utilization, and improve functional independence – supported by standardized clinical pathways, data-driven improvement, and ongoing workforce development. [4,6,9,10,15]

4. Clinical Model and Programs

4.1 Care planning and physician collaboration

Adoration clinicians collaborate with the patient’s physician(s) to create and maintain an individualized plan of care, and the care team reviews and revises that plan as needs evolve. Patients receive a copy of the current plan of care. [4]

4.2 Condition-focused pathways: examples

Adoration uses structured, condition-relevant interventions to help patients stabilize clinically and regain function. These examples reflect common referral patterns and care opportunities for patients with complex chronic and post-acute needs. [25,26]

Diabetes

- Skilled nursing support for diabetes education, medication review, and monitoring for complications. [25,26]
- Assessment of nutrition and resources, with reinforcement of self-management behaviors. [25,26]
- Therapy services as indicated to improve endurance, mobility, and safety at home. [25,26]

Congestive Heart Failure

- Vital sign and symptom monitoring, medication reconciliation, and reinforcement of diet/fluid guidance. [25,26]
- Fall risk and home safety assessment; therapy interventions to improve endurance and mobility. [25,26]
- Early identification of decompensation to avoid preventable ED visits and hospitalization. [25,26]

Alzheimer’s & dementia

- Timely home health referral when cognitive decline begins to impact safety, independence, medication adherence, and caregiver burden. [25-27]

- Interdisciplinary support spanning nursing, therapy (balance and ADLs), and caregiver education to reduce fall risk and improve daily functioning. [25-27]

4.3 Patient and family experience

In addition to clinical outcomes, Adoration emphasizes patient and family experience. Branch feedback highlights professionalism, responsiveness, and compassionate support across nursing and therapy disciplines. [25,26]

Example (paraphrased) patient feedback includes appreciation for therapists and nurses who explain care clearly, provide encouragement, and help patients feel safe and supported at home. [26]

Patient voices (selected testimonials)

Murfreesboro, TN **"Adoration Home Health has cared for me for almost two years…My nurse, Taimi, goes above and beyond with compassion and dedication. The entire staff is friendly and attentive." [26]**	**Winston-Salem, NC** **"After my left total shoulder arthroplasty, Ray (Occupational Therapist) helped start my road to recovery – very professional and supportive." [26]**
West Virginia "Lora is such a blessing…always going above and beyond to help take care of me and keep my husband and I as healthy as possible." [25]	**Shelbyville, TN** "The therapy Mike provides my mom (Parkinson's) has made a huge difference in her day-to-day life…we highly recommend the team." [25]

5. Quality Outcomes and Performance

Adoration and BrightSpring manage home health quality through CMS-facing measures, branch scorecards, survey activity, value-based purchasing metrics, hospitalization trends, visit reliability, patient experience, OASIS documentation, and rapid branch-level performance management. In Q2 2026, the 60-day hospitalization rate improved to 15.8% (16.9% in Q1) versus a 15.6% SHP national average; potentially preventable hospitalizations improved to 12.7% (13.5% in Q1) versus 10.1% nationally. Both remain focused priorities. [6,15]

Quality outcomes snapshot (Q2 2026 selected highlights)

98.9%	86.1%	86.5%	93.2%
Timely initiation of care	**DC function**	**Patient satisfaction**	**HH branches ≥4 Stars**
vs. 97.4% SHP avg.	vs. 78.6% SHP avg.	vs. 81.0% SHP avg.	goal 90%

5.1 CMS Star Ratings and branch-level performance

BrightSpring continued to exceed its home health star-rating stretch goal. In Q2 2026, 93.2% of home health branches were rated four stars or higher, up from 91.4% in Q1 and above the 90% internal target. Weekly focus calls continue for branches below the four-star threshold. [6]

External recognition reinforces this quality direction. In March 2026, 65 Adoration home health locations earned the “High Performing” rating in U.S. News & World Report’s Best Home Health rankings. The rankings evaluate Medicare-certified home health agencies across quality-of-care indicators and patient experience. [28]

Adoration also expanded its clinical coding and documentation advisory partnership with WellSky to support quality, compliance, and consistency across additional locations. The expanded partnership supports coding, documentation, OASIS accuracy, and quality-program performance as Adoration scales. [29]

5.2 Timely initiation, functional outcomes, and patient experience

Access, functional outcomes, and patient experience remained strengths in Q2 2026. Timely initiation was 98.9% (99.2% in Q1), above the 97.4% SHP national average; discharge function improved to 86.1% (85.0%) versus 78.6% nationally; and patient satisfaction rose to 86.5% (79.4%) versus 81.0% nationally. [6]

Table 1. Selected BrightSpring Home Health quality outcomes (Q2 2026). [6]

Metric	Q2 2026 result	Benchmark / target	Interpretation
Timely initiation of care	98.9%	97.4% SHP national	Above SHP national average
Discharge function	86.1%	78.6% SHP national	Above benchmark; improved from Q1
Patient satisfaction score	86.5%	81.0% SHP national	Above benchmark; improved from Q1
Home health branches rated ≥4 Stars	93.2%	90% internal target	Above target; improved from Q1

Source: BrightSpring Q2 2026 Clinical Quality Summary.

6. Innovation and Continuous Improvement

6.1 Vitality Therapy™: a novel anti-frailty program delivered in home health

BrightSpring launched Vitality Therapy™ (VT) in 2023 to identify frailty using evidence-based definitions and engage patients in a structured exercise program during a home health episode. The program's core elements include strength training, aerobic exercise, balance training, and flexibility maneuvers. [7]

Program evaluation found that Vitality Therapy™ was associated with improvements in strength, gait speed, balance, independence, and frailty scores among frail older adults. BrightSpring presented the program outcomes at the International Conference on Frailty and Sarcopenia Research (ICFSR), and the study was published in Home Health Care Management & Practice. [7]

6.2 Clinical support and care transitions

Centralized clinical support strengthens safety and reliability across the home-based continuum. BrightSpring uses clinical hub support for on-call triage and outreach to high-risk home health patients following discharge; separate clinical quality and compliance audit processes use chart review and targeted education to identify improvement opportunities early in an episode of care. [6,9]

6.3 Training and workforce development

Clinical consistency at scale depends on training and competency development. Targeted clinical education and OASIS training support standardized practice, documentation accuracy, and readiness for value-based models. [6,9,10]

7. Integrated BrightSpring Differentiators: Primary Care and Medication Management

A core advantage of Adoration Home Health is its connection to BrightSpring's broader home and community-based healthcare platform. Home health is often the right clinical setting after discharge, but avoidable utilization frequently stems from two problems that extend beyond the episode itself: insufficient longitudinal medical management and medication complexity. BrightSpring's family of

brands gives Adoration a practical way to address both issues through integration with Abode Care Partners and Continue CareRx. [8-10]

The model is not merely referral adjacency. It is an operating philosophy: local home health teams supported by primary care, pharmacy, nurse triage, medication packaging, prescriber coordination, and enterprise quality infrastructure. For patients, the result is simpler and safer care at home. For hospitals, physicians, and payers, the result is a more complete home-based platform for reducing avoidable escalation while supporting recovery, function, and quality of life.

7.1 Home-based primary care: Abode Care Partners

Home-based primary care (HBPC) brings physician and advanced-practice provider services to older adults and medically complex patients where they live. Abode Care Partners delivers primary care, urgent care, and specialty care services to older adults in senior living communities, continuing care retirement communities, skilled nursing facilities, and private homes, with dedicated on-site nurse practitioners, 24/7 nurse triage support, and a model focused on chronic and complex conditions. Abode reports service reach across more than 650 locations, more than 35,000 patients annually, and 11 states. [30]

The clinical scope of HBPC is complementary to home health. Abode's services include physician and nurse practitioner visits, annual wellness visits, 24/7/365 care coverage, chronic disease management, palliative care, education, coordination of care, medication optimization, care-management support, cognitive support, wound care, fall-prevention assistance, remote patient monitoring, and value-based medical director support. Its value-based care model emphasizes proactive, preventive care and responsive urgent care to reduce unnecessary hospitalization and improve quality of life. [31]

BrightSpring's published HBPC evidence demonstrates the potential value of bringing primary care to high-need populations. In a JAMDA study of individuals with intellectual and/or developmental disability, home-based primary care was associated with a hospitalization rate of 329 per 1,000 patient-years compared with 619 per 1,000 patient-years under a traditional office-based model – a 47% lower rate. Although the study population differs from a typical Medicare home health cohort, the finding supports the same operating principle that matters after discharge: proactive, relationship-based medical care delivered where the patient lives can reduce avoidable acute utilization. [32]

For Adoration, Abode Care Partners can extend the home health model when geography, patient needs, coverage, and regulatory requirements align. A home health nurse or therapist may identify worsening chronic disease, recurring medication confusion, caregiver strain, unsafe mobility, or frequent emergency department use during an episode. In markets where Abode is available, the broader BrightSpring platform can help connect those patients to longitudinal primary care and urgent care support while Adoration continues skilled nursing, therapy, education, and care-plan execution in the home. [8,10,30-32]

7.2 Continue CareRx: pharmacy-enabled medication management at home

Medication failure is one of the most common and preventable causes of poor outcomes after discharge. Continue CareRx is PharMerica's comprehensive at-home medication management and

support program. The service combines prescription fulfillment, home delivery, virtual nursing, pharmacist support, pre-sorted multi-dose packaging marked by day and time, medication optimization reviews by consultant pharmacists, automatic monthly refills, monthly virtual nurse check-ins, and 24/7 access to pharmacists and nursing consults. [33]

The published Continue CareRx study is directly relevant to home health. In a JAMDA cohort study, the program combined adherence packaging, prescription synchronization, pharmacist review, medication reconciliation, clinician education, registered nurse care-management check-ins, and 24/7 clinical call-center access. Home health recipients enrolled in Continue CareRx had 21 hospitalizations during 23,622 managed days, compared with 7,015 hospitalizations during 2,128,738 managed days in matched controls. These results translated to 324 versus 1,203 hospitalizations per 1,000 patients per year, or a 73.1% lower hospitalization rate among enrolled patients. [34]

Continue CareRx also fits naturally into Adoration's home health workflow. The home health start-of-care assessment already identifies medication-management barriers, including patients who need individual doses prepared in advance, reminders or drug diaries, and patients with polypharmacy risk. The home health nurse's medication reconciliation can activate a broader medication operating model: pharmacist review, prescriber validation, synchronized dispensing, labeled multi-dose pouch packaging, home delivery, monthly nurse-hub validation, and urgent coordination with prescribers when a condition changes or medications are running low. [34]

For payers and health systems, this integration turns medication management from a discharge instruction into a managed process. It helps address adherence, reconciliation, refill timing, interaction risk, caregiver burden, and after-hours uncertainty – all of which can drive avoidable emergency department visits, readmissions, and patient frustration. [33,34]

Integration outcomes and capabilities snapshot

650+ **Abode locations** Communities & facilities [30]	**35,000+** **patients annually** Abode reported reach [30]	**47%** **lower hospitalization** HBPC vs. office-based model [32]	**24/7** **nurse triage** Abode care support [30,31]
73.1% **lower hospitalization** CCRx enrolled HH recipients [34]	**324 vs. 1,203** **hosp./1,000/yr** CCRx vs. matched controls [34]	**Monthly** **nurse check-ins** education & regimen validation [33,34]	**24/7/365** **medication support** pharmacist/nurse access [33]

Source: Abode Care Partners website; Continue CareRx website; BrightSpring published HBPC and CCRx studies. [30-34]

7.3 How integration creates value for home health partners

Adoration's home health episode remains the center of skilled post-acute recovery: nursing assessment, therapy, education, wound care, medication reconciliation, caregiver teaching, and physician collaboration. Abode Care Partners and Continue CareRx strengthen that episode by closing gaps around longitudinal medical management and medication execution. This creates a differentiated model for patients who are clinically appropriate for home health but remain at high risk because of multimorbidity, frailty, cognitive impairment, polypharmacy, or limited caregiver capacity. [8,10,30-34]

Patient or partner need	BrightSpring integration	Home health value
Frequent exacerbations, weak primary-care access, or high ED use	Abode Care Partners home-based primary care, urgent care, chronic disease management, and 24/7 nurse triage	More continuous medical oversight while Adoration executes skilled nursing, therapy, and care plan education at home.
Polypharmacy, unsafe self-administration, poor refill synchronization, or medication confusion	Continue CareRx medication reconciliation, pharmacist review, multi-dose packaging, home delivery, nurse check-ins, and 24/7 support	Lower medication friction during the home health episode and a stronger pathway to prevent medication-related escalation.
Payer or health system need to manage total cost of care after discharge	Integrated home health + primary care + pharmacy infrastructure	A broader home-centered alternative to fragmented post-discharge care, with outcomes measurement and escalation pathways across the platform.

Note: Integrated service availability depends on geography, patient eligibility, payer coverage, clinical appropriateness, and applicable regulatory requirements.

8. Growth, Scale, and the BrightSpring Platform

8.1 BrightSpring at a glance

BrightSpring Health Services is an integrated provider of home and community-based healthcare and pharmacy services for complex populations, serving more than 485,000 patients daily through more than 1,000 locations and delivering more than 120 million hours of care annually, primarily in lower cost home settings. [8]

This platform enables Adoration to connect home health services with adjacent capabilities – such as pharmacy solutions and clinical support – supporting safer care transitions, medication management, and continuity across settings. [8-10]

8.2 Acquisition-driven expansion: UnitedHealth/Amedisys divestiture

The UnitedHealth Group/Amedisys transaction created a significant scale-expansion opportunity in home health. To address competition concerns, the U.S. Department of Justice required divestiture of at least 164 home health and hospice locations across 19 states, representing approximately $528 million in annual revenue. [11]

BrightSpring closed on the acquisition of more than 115 home health and hospice branches in 19 states from UnitedHealth and Amedisys as part of this divestiture. [12,13]

For Adoration and BrightSpring, this acquisition underscores the ability to absorb and integrate large, multi-state home health platforms while scaling a standardized quality management system, evidence-based clinical pathways, and central support functions (clinical education, analytics, compliance, and payer contracting) across a broader network.

Integration priorities include continuity of patient care, clinician retention, and rapid deployment of BrightSpring's home health operating model, with emphasis on timely start of care, functional improvement, hospitalization avoidance, and patient experience.

9. Partnering with Adoration

9.1 Referral, responsiveness, and continuity

Adoration's locations directory supports partner and patient access to local branch information and notes that phone calls are answered 24/7/365. [3] For physicians, hospitals, and payers, reliable access and consistent care coordination are critical to successful home health utilization and avoidance of preventable acute care.

9.2 Value for health systems and payers

Adoration's model is designed to align with value-based priorities, including timely start of care, functional improvement, patient experience, and reduction of potentially preventable hospitalizations. [6,15] BrightSpring's broader platform also enables integration of clinical support and pharmacy capabilities that can enhance medication safety and post-discharge stabilization. [8-10]

BrightSpring integration broadens the value proposition. When home health is paired with home-based primary care and pharmacy-enabled medication management for selected high-risk patients, partners can address the post-discharge factors that commonly drive avoidable utilization: delayed follow up, condition changes that are not escalated early, polypharmacy, medication nonadherence, refill gaps, drug-interaction concerns, and caregiver confusion. [30-34]

ROI and site-of-care economics

For payers and health systems, home health creates value through both price and outcomes. When the patient can be safely supported at home, a home health episode is typically far less expensive than institutional post-acute settings – and high-quality care transitions can also reduce downstream utilization (ED visits and readmissions). [16-19,23,24]

Illustrative Medicare payment comparisons by post-acute setting

Post-acute setting	Illustrative payment level (typical base/median)	Notes
Home health (PDGM, 30-day period)	$2,038 base payment per 30-day period (CY2024)	Episodes often include 1–2 periods; case-mix and geographic adjustments apply. [16,22]
Skilled nursing facility (SNF)	$23,797 median Medicare payment per stay (MedPAC; 2021 data)	Per-stay cost varies widely by length of stay and case mix. [19]
Inpatient rehabilitation facility (IRF)	$18,907 base payment per discharge (FY2025)	Higher-intensity rehab; narrower clinical eligibility. [17]
Long-term care hospital (LTCH)	$49,383 standard federal payment rate (FY2025)	High-acuity population; not comparable for routine post-acute recovery. [18]

Illustrative ROI scenario: if 100 clinically appropriate post-acute discharges shift from a SNF stay to two 30-day home health periods, the difference in post-acute Medicare payments alone can exceed $1.9 million ([$23,797 − $4,076] × 100), before considering additional benefits from reduced complications or improved patient satisfaction. Actual savings will vary by case mix, episode length, local wage indices, and readmission patterns. [16,19]

Importantly, published evidence suggests that the lower cost of home health is not solely a price effect. In a national Medicare analysis, patients discharged home with home health had lower total Medicare payments over the 60-day post-discharge window than similar patients discharged to a SNF (−$4,514), reflecting the combined effect of post-acute spending and subsequent utilization. [24]

Home health can also reduce avoidable utilization relative to “self-care” discharges. In a large cohort study, patients discharged with home health care had lower hazards of readmission and death, with adjusted cost savings over 365 days. [23]

A practical framework for payer/health system ROI analysis includes:

- Identify clinically appropriate cohorts for home health (e.g., post-orthopedic, CHF/COPD, post-sepsis, frailty/falls risk).
- Measure baseline utilization (readmissions, ED visits, SNF days, and total cost) in the 30/60/90-day post-discharge window.
- Estimate the expected shift in site-of-care mix and the incremental quality improvements achievable with standardized pathways.
- Apply unit costs (payer-specific allowed amounts) to quantify expected savings; validate via pilot cohorts and continuous monitoring.

9.3 Suggested partnership use cases

- Hospital discharge programs focused on reducing readmissions for CHF, COPD, and complex medical patients. [4-6]

- Orthopedic and post-surgical recovery pathways requiring rapid therapy initiation and home safety support. [4-6]
- Dementia care support, including caregiver education and fall prevention, when cognitive decline impacts safety. [4-6]
- High-risk medication management coordination for patients with polypharmacy and frequent care transitions. [4-6]
- Integrated home health and home-based primary care pathways for high-risk older adults or complex patients who need longitudinal medical management in addition to a skilled home health episode. [30-32]
- Medication-management partnerships using Continue CareRx for patients with polypharmacy, self-administration barriers, refill complexity, or high risk of medication-related hospitalization. [33,34]
- Longer-duration in-home support through private duty services in select Tennessee markets, including skilled nursing or non-skilled assistance as appropriate to patient need and program availability. [5]

10. Conclusion

Adoration Home Health combines a compassionate, community-rooted care model with BrightSpring's scale, clinical infrastructure, and innovation focus. By delivering interdisciplinary care in the home, investing in measurable quality outcomes, integrating with BrightSpring family-of-brands capabilities such as Abode Care Partners and Continue CareRx, and expanding responsibly through strategic acquisitions, Adoration is positioned to be a high-performing partner for health systems, physicians, and payers seeking high-quality home-based care at scale. [1-13,15,30-34]

Appendix A – Abbreviations

- ADL – Activities of Daily Living
- APR – Annual Performance Report (HHVBP)
- CCRx – Continue CareRx
- CMS – Centers for Medicare & Medicaid Services
- CHF – Congestive Heart Failure
- COPD – Chronic Obstructive Pulmonary Disease
- DC – Discharge
- ED – Emergency Department
- EHR – Electronic Health Record
- HHA – Home Health Agency
- HBPC – Home-Based Primary Care
- HHCAHPS – Home Health Consumer Assessment of Healthcare Providers and Systems
- HHVBP – Home Health Value-Based Purchasing
- ICFSR – International Conference on Frailty and Sarcopenia Research
- LPN – Licensed Practical Nurse
- MPR – Medication Possession Ratio
- NPS – Net Promoter Score
- OASIS – Outcome and Assessment Information Set
- OT – Occupational Therapy
- PBM – Pharmacy Benefit Manager
- PT – Physical Therapy
- RN – Registered Nurse
- SHP – Strategic Healthcare Programs (industry benchmarking reference in internal reports)
- SLP – Speech-Language Pathology
- TIOC – Timely Initiation of Care
- VT – Vitality Therapy™

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