

July 2026 Vol. 29

Predictive Intelligence Improves Inpatient Quality, Revenue, and Rankings

Every day, care teams make critical decisions without a complete picture of patient risk. Important conditions can go undocumented, high-risk patients may not be identified early enough, and valuable clinical data often remains buried in the EHR instead of appearing when and where it's needed.

HealthVision™ changes that. Outcome-specific predictive models surface directly within existing EHR workflows. Care teams receive rank-ordered risk lists, condition-specific insights and AI-generated patient summaries that complement their clinical judgement *when they need them most*.

Readmission Prevention

Readmissions are lower when high-risk patients are seen within 14 days of discharge. But strapped for time, care teams often rely on clinical judgment and expediency to decide who to prioritize. Our platform identifies patients at highest risk of 30-day readmission before they leave the hospital and, importantly, surfaces the drivers of that risk. Condition-specific models for cardiac, pulmonary, surgical and other service lines find the impactable patients where interventions are most likely to keep patients safely at home, ensuring optimized allocation of your busy staff and resources.

***Houston Methodist** dropped readmission rates from 18.1% to 16.2% across eight hospitals while acuity remained flat.*



18.1% → 16.2%

Readmission rate achieved

Identify patients at the highest risk of 30-day readmission at the point of discharge. Condition-specific models for cardiac, pulmonary, and surgical populations surface the interventions most likely to keep patients safely at home.

- ✓ Condition-specific readmission risk at the point of discharge
- ✓ 7-day and 30-day follow-up scheduling prioritized by risk level
- ✓ Top contributing factors surfaced for each patient
- ✓ Service line targeting across medical and surgical populations
- ✓ Post-discharge mortality risk for highest-acuity patients
- ✓ Embedded directly within the EHR

Discharge Planning & Transitions

Effective discharge planning depends on knowing where patients are likely to go next and what support they'll need after they leave the hospital. Our predictive models estimate discharge destination and post-acute care needs, with specific risk thresholds guiding enrollment of eligible patients into TCM, CCM, and RPM programs to support continuity after discharge.

1M+ post-acute outcomes benchmarks power smarter discharge decisions.



1M+

Post-acute outcome benchmarks for network optimization

Predict discharge destination, expected length of stay, and post-acute care needs earlier in the admission process to support proactive discharge planning.

- ✓ Discharge destination prediction—home, SNF, rehab, LTACH
- ✓ Expected length of stay with daily updates
- ✓ Post-acute resource matching based on patient needs
- ✓ Risk-stratified post-discharge follow-up scheduling
- ✓ SNF performance benchmarking for referral patterns

Advanced Illness Identification

Many patients are first identified for advance care planning during a crisis, when families are overwhelmed, patient goals of care are buried in the chart, and treatment options have narrowed. HealthVision's 90-day hospice and mortality risk models identify patients with serious illness before a crisis forces the conversation. AI-generated summaries surface each patient's expressed wishes, fears, and understanding of their prognosis so care teams can engage earlier and provide patient-centric, goal concordant care.

\$2,935 lower inpatient costs per enrolled patient at Houston Methodist Coordinated Care, with earlier hospice referrals and higher patient and family satisfaction.



\$2,935

Lower cost of care per patient in AIC program

Identify patients approaching advanced illness before a turning point forces reactive decision-making, giving care teams time to initiate goals-of-care conversations that reflect patient wishes.

- ✓ Predictive identification of patients approaching end-of-life milestones
- ✓ AI-powered clinical summaries for personalized goals-of-care conversations
- ✓ Trigger-based alerts for palliative care and hospice referral
- ✓ Prioritization by actionability, not severity alone

Every day counts when identifying patients who need additional support. If you'd like to see how **HealthVision** fits into your existing workflow, please reach out for a demo.

[Learn more](#)

What we've been up to.....

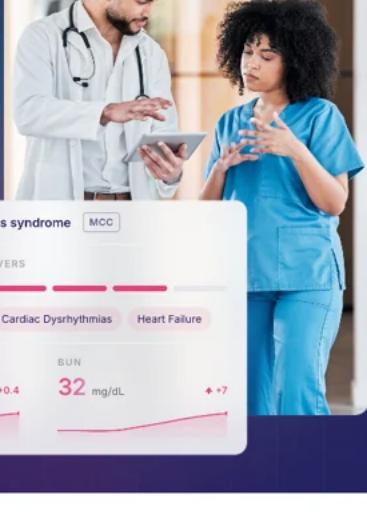


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Upstream Intelligence. Downstream Impact.

Your clinicians already deliver exceptional care. HealthVision™ uses the latest in predictive and generative AI technology to help convert their excellent work into measurable improvements in readmissions, mortality, and revenue capture.

[Request a Demo](#)






HDAI's New Website is Live!

HDAI's new [website](#) launched last week! It better reflects our platform, our partnerships, and the work we do every day to help health systems move from reactive care to using predictive intelligence that supports more proactive care.

Whether you're new to HDAI or a longtime partner, we hope you'll explore our new site.

[Check it out](#)

What's coming up next.....



Conference Season Is Around the Corner

After a summer breather, the fall conference calendar picks up quickly and the HDAI team will be out in force.

With 10 speaking engagements through the remainder of 2026, our clinical and analytics leaders will be crossing the country presenting on topics like [predictive AI in clinical care](#), [readmission and mortality reduction](#), and [improving quality and revenue](#).

If your organization is planning an event, hosting a panel, or looking for thought leadership speakers in the healthcare AI and value-based care space, we'd love to talk. Our speakers share real-world implementation experience, measurable outcomes, and practical lessons from health systems already using predictive AI in clinical workflows.

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News we're following



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Health tech's next big question

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