



Guide to Post-Acute Care

Quick Reference Guide

2026

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VALUE-BASED POST-ACUTE CARE

Primary care physicians should remain **actively engaged during hospitalization and recovery**.^{1,2} Direct collaboration with hospitalists, utilization management, therapists, post-acute clinicians, patients, and caregivers helps ensure that **placement reflects the patient's clinical trajectory and baseline function** rather than bed availability, institutional habit, or a single short-term utilization goal.^{3,4}



AAVBC PERSPECTIVE

Select the **lowest-acuity, highest-quality setting** that can **safely** deliver the required level and frequency of care.^{3,5} Avoid both premature hospital discharge to a setting that cannot meet the patient's care needs and unnecessary institutional placement when recovery at home is medically and operationally feasible.^{3,6} Discharging a patient before they are stable often **forces a subsequent escalation to a higher level of care** than would have been needed had discharge occurred at the appropriate time, increasing both risk and total cost.^{3,6}

Core Objectives

OBJECTIVE	OPERATIONAL MEANING ^{3,7,8}	VALUE PROTECTED ^{3,8,9}
Right care, right time	Match medical acuity, therapy tolerance, function, cognition, home safety, and caregiver capacity to the setting (when patient is medically stable for discharge)	Safer recovery without unnecessary intensity
Reduce readmissions	Use: stable transitions, medication reconciliation, early follow-up, clinical triage, and rapid response to change; avoid: premature hospital discharges	Fewer avoidable emergency visits and hospital returns
Optimize function	Set: measurable mobility, self-care, communication, and community-discharge goals	Independence, dignity, and quality of life
Control total cost	Track: the full episode, length of stay, complications, transfers, and downstream services	Resources follow patient need rather than facility census

PCP Role at the Transition Point

- Communicate the patient's **baseline cognition, functional status including ADLs, mobility, core chronic diseases, medication regimen, caregiver support, goals of care, and prior utilization** across the transition, ensuring both the inpatient team at admission and the receiving providers at discharge have these elements^{10,11}

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