



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Guide to Post-Acute Care Quick Reference Guide

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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}

- **Challenge a placement that does not match:** medical stability, skilled need, case complexity, therapy tolerance, or the home environment^{3,4}
- Confirm that the receiving setting **can provide the ordered services** at the required frequency and start time^{3,12}
- Remain engaged and connected with care plan until the patient **returns to stable longitudinal primary care**^{10,13}



CLINICAL PEARL: USE THE FULL APPROPRIATE LENGTH OF STAY TO DISCHARGE A STABLE PATIENT

Resisting pressure to discharge at the earliest DRG-permitted day, and instead using the **full clinically appropriate inpatient length of stay**, increases the likelihood the patient reaches **genuine medical stability, completes early rehabilitation, and progresses far enough in recovery** to step down to a **lower-acuity setting or home** rather than to a skilled nursing facility.^{14,15} Premature discharge to a setting that cannot meet the patient's needs frequently **forces re-escalation to a higher level of care** than would have been required at the appropriate time, increasing both readmission risk and total episode cost.^{14,15} The goal is not to minimize the index length of stay but to **optimize it**: a patient who leaves more fully recovered is more likely to be discharged home, less likely to bounce back, and **less likely to need prolonged institutional care**.^{14,16,17}



CLINICAL PEARL: PLACEMENT IS A CLINICAL PRESCRIPTION

A post-acute destination should specify the **required intensity, frequency, disciplines, monitoring, goals, and expected step-down conditions**.^{3,18} A facility name alone is **not** a care plan.^{3,19}

POST-ACUTE CARE CONTINUUM

The post-acute continuum is not a simple ladder from expensive to inexpensive. **Each setting serves a different clinical purpose.** Placement should be based on **what must be delivered safely and reliably**, then stepped down as soon as the patient can succeed at a lower level of care.

SETTING	CLINICAL GATEKEEPER ³	TYPICAL COURSE BENCHMARK ³	PRIMARY VALUE DRIVER ³
Long-term acute care hospital	Prolonged ventilation or weaning; multiple complex conditions; extended hospital-level treatment; expected prolonged stay	Often 25 or more days	Avoid prolonged ICU use; stabilize complex illness; wean ventilation; prevent secondary infection

SETTING	CLINICAL GATEKEEPER ³	TYPICAL COURSE BENCHMARK ³	PRIMARY VALUE DRIVER ³
Inpatient rehabilitation facility	Must be able to participate in 3 hours per day of intensive rehabilitation ; needs at least two therapy disciplines ; measurable functional goals ; physician oversight	Often 10 to 14 days	Maximize functional gain and direct community discharge
Skilled nursing facility	Needs daily skilled nursing or therapy ; medically stable; cannot tolerate intensive inpatient rehabilitation	Often 14 to 20 days	Safe subacute recovery ; prevent decline; shorten avoidable institutional time
Home with home health	Homebound; medically stable ; intermittent skilled service needed; safe environment and workable support between visits	Typically a time-limited home-health episode	Recover at home ; reinforce self-management; prevent emergency use
Home with outpatient care	Can leave home safely; no daily institutional skilled need ; reliable transportation and follow-up	Condition- and goal-specific	Lowest-intensity effective rehabilitation and medical follow-up

ABBREVIATIONS: ICU = intensive care unit

Four Questions Before Placement

- Is the patient **medically stable enough** to leave acute care?³
- What skilled medical or therapy service is **required**, and **how often** must it be delivered?³
- Can the patient **participate in and benefit from the proposed intensity**?^{3,20}
- Can the home, caregiver, transportation, equipment, and follow-up plan **safely support recovery**?³



MAKING CONNECTIONS

Consult the **AAVBC Reducing All-Cause Readmissions QRG** for the 48-hour outreach, medication reconciliation, risk-stratified follow-up, remote monitoring, and root-cause review processes that continue after the placement decision.



QUALITY OUTCOME: SAFE STEP-DOWN

High-value post-acute care moves the patient to a **less intensive** setting when **clinical milestones are achieved**, while **escalating promptly** when the **current setting cannot safely meet changing needs**.^{3,21,22}

PLACEMENT DECISION WORKFLOW

This section provides a structured, evidence-based framework for determining the **safest, lowest-acuity post-acute placement**, moving sequentially from confirming acute stability through selecting a setting and setting transition milestones, with specific physiologic thresholds and negotiation points to keep placement tied to clinical need rather than habit or bed availability.

Stepwise Placement Decision Workflow: Stability, Skilled Need, Function, and Setting

STEP	DECISION ^{3,23}	REQUIRED EVIDENCE ^{3,24,25}	OUTPUT ³
1 Confirm acute stability	Can the patient leave the hospital without predictable immediate deterioration	Vital signs , labs and oxygen trends ; active treatment; PT/OT/ST notes and duration each day, pending instability; if on ventilator , documented wean attempts: physician assessment	Stable for transfer or continued acute care
2 Define skilled need	What medical, nursing, rehabilitation, wound, infusion, respiratory, or monitoring service is required	Orders; IV medications including times administered per day; frequency; duration; disciplines; after-hours needs	Explicit service prescription
3 Assess function and participation	What can the patient do now , and what intensity can the patient tolerate	PT/OT/ST including daily duration , nursing, cognition, ADLs, falls, endurance	Therapy and assistance profile
4 Test home feasibility	Can care be executed safely between professional visits	Homebound status ; caregiver reliability; home safety; DME; transport; health literacy	Home pathway or documented barrier

STEP	DECISION ^{3,23}	REQUIRED EVIDENCE ^{3,24,25}	OUTPUT ³
5 Select setting and provider	Which available high-performing option meets all required capabilities	Quality; access; network; capability; location; patient preference	Named setting with backup
6 Set milestones and transition date	What must improve before step-down or discharge	Functional goals including what were baseline ADLs prior to hospitalization; medical targets; expected length; follow-up	Time-bound recovery plan

ABBREVIATIONS: PT = physical therapy; OT = occupational therapy; ADLs = activities of daily living; DME = durable medical equipment



QUALITY OUTCOME: BASELINE DOCUMENTATION ENABLES LOWER-ACUITY DISCHARGE

Excellent documentation of pre-episode baseline laboratory and functional values is one of the strongest enablers of **home or lower-acuity discharge**, and it is the PCP's responsibility, in coordination with the admitting team, to ensure those values are documented and available.^{26,27} Because the PCP holds the longitudinal record, **maintain up-to-date documentation** of each patient's own baseline (ambulatory status and ADLs, cognition, renal function, hemoglobin, oxygen saturation, and weight) and **actively communicate it to the inpatient team at admission**.²⁸ When discharge readiness is judged against that individualized baseline rather than a generic population threshold, **avoidable institutional placement is prevented** in patients who have simply returned to their own normal.^{27,29}

This is decisive for patients whose **chronic disease sets a baseline below conventional discharge cutoffs**:

- **Chronic hemiplegia or prior stroke**: baseline mobility, transfer dependence, and one-sided weakness may never meet a standard gait or ADL target; return to documented pre-admission function, not to "independent ambulation," is the correct discharge endpoint²⁶
- **Sickle cell disease**: baseline hemoglobin (**often 6 to 9 g/dL**) and chronic pain regimens fall well below transfusion or discharge hemoglobin thresholds used for other patients; discharge should track return to the patient's steady-state hemoglobin and baseline analgesic needs^{30,31}
- **Advanced COPD or interstitial lung disease**: baseline oxygen saturation on home O₂ (e.g., 88 to 90%) is the target, not 94% on room air^{32,33}
- **Advanced CKD**: baseline creatinine and eGFR anchor renal recovery expectations rather than a "normal" value^{34,35}
- **Chronic heart failure**: dry-weight and baseline functional capacity define euvolemia and readiness^{36,37}

Without a recorded baseline, these patients are frequently **held or routed to a higher-acuity setting for values that represent their chronic normal**.^{3,28} High-value post-acute care therefore moves the patient to a less intensive setting **once individualized clinical milestones are met**, while escalating promptly when the current setting cannot safely meet changing needs.^{3,4}

Vitals and Labs Preventing Discharge

The purpose of admission is **resolution of the acute problem**, or maximal stabilization within the limits of chronic disease, not the earliest moment a vital sign brushes a threshold. The clinically appropriate length of stay is the **time required to reach and sustain objective stability**; discharge should be timed to that endpoint, not to values that are merely "close enough." The inpatient benefit (DRG) is a **prepaid resource meant to be used for the full duration recovery requires**.

This is not academic. Discharge with even one physiologic instability raises risk-adjusted 30-day mortality and readmission in dose-dependent fashion. In 32,835 medicine discharges, death or readmission rose from **12.8% with none** to **16.9%, 21.2%, and 26.0%** with one, two, or three-plus instabilities, and any instability **roughly doubled adjusted odds of death**.³⁸ The same dose-response holds in pneumonia, where two or more instabilities carried roughly five-fold higher odds and instability within 24 hours of discharge nearly quadrupled 30-day mortality.^{39,40} The **2019 ACC Heart Failure pathway** states plainly that many patients are discharged too early, before meeting stability criteria, and that verifying the oral diuretic regimen for at least 24 hours after stopping IV diuretics was associated with **fewer 30- and 90-day readmissions**.³⁷ The unifying principle is stability-based discharge: discharge after verified, sustained recovery is safe; premature discharge is not.⁴¹

Discharge Red-Flag Thresholds: Reconsider Discharge When Present

CATEGORY	PARAMETER	RED-FLAG THRESHOLD	WHY IT SHOULD DELAY DISCHARGE ^{38,42–45}
Vital signs	Heart rate	>100 bpm	Discharge tachycardia independently predicts 30-day death and readmission; combined with tachypnea it raises early readmission risk
	Systolic blood pressure	<90 mmHg or >180 mmHg	Low SBP signals occult sepsis, hypovolemia, or shock and doubles odds of post-discharge admission; markedly high SBP suggests hypertensive crisis
	Respiratory rate	>20–24 breaths/min	Sensitive early marker of respiratory failure, fluid overload, or infection ; part of every clinical-stability standard
	Oxygen saturation	<90% on room air (or below chronic baseline)	Persistent hypoxia reflects incomplete respiratory recovery and predicts readmission
	Temperature	>38.0°C (100.4°F) or <36.0°C	Ongoing fever/hypothermia indicates active, unresolved infection or systemic inflammation
Laboratory	Serum creatinine	Rising trend from baseline	Signals evolving acute kidney injury or fluid imbalance not yet stabilized
	Potassium	<3.0 or >5.5 mEq/L	Risk of life-threatening cardiac arrhythmia ; near-critical values warrant correction before discharge
	Sodium	<130 mEq/L	Hyponatremia causes confusion, falls, and seizure risk , especially in older adults
	Hemoglobin	<7 g/dL (or rapidly falling)	Suggests active bleeding or severe anemia requiring source evaluation before discharge

CATEGORY	PARAMETER	RED-FLAG THRESHOLD	WHY IT SHOULD DELAY DISCHARGE ^{38,42–45}
Laboratory	White blood cell count	Rising or falling out of range	Indicates active, unmanaged infection or evolving sepsis
	Troponin/BNP	Elevated or rising	Points to ongoing myocardial injury or unstable/decompensated heart failure
	INR	Critically supratherapeutic	Confers extreme bleeding risk ; correct or verify plan before discharge

ABBREVIATIONS: PROMs = patient-reported outcome measures; ED = emergency department

These thresholds are decision aids that cut both ways. An abnormality reflecting the patient's documented baseline (chronic hypoxemia, steady-state anemia, chronically elevated creatinine) does not by itself justify prolonging the stay.³⁸ But a new, unresolved, worsening, or only transiently corrected instability signals that the acute illness **has not been adequately treated**, and discharge then is **incomplete care**, not efficient care. Two or more concurrent instabilities carry several-fold higher 30-day mortality risk and should trigger reassessment of readiness and destination.^{38,43}

Completing the appropriate course **does not mean holding a stable patient needlessly**. Once true stability is reached, **added inpatient days confer little benefit** and expose patients to deconditioning, delirium, and post-hospital syndrome.⁴⁶ Rather, **de-escalation to a lower-acuity setting** is appropriate after the acute problem is fully addressed and the patient is stable, and only when that setting can safely meet the patient's individualized needs. Skilled nursing and home-based post-acute care are designed for patients with a stable plan not requiring active titration or close monitoring; **matching level of care to actual need**, whether home support, skilled nursing, or rehabilitation, protects outcomes, whereas defaulting to the earliest possible discharge does not.³ **Use the full clinically indicated stay to reach durable stability**, then step the patient down to the individually matched setting.

Hospitalist and PCP Negotiation Points

- State the patient's **baseline function (ADLs) and cognition**; a **change from baseline** often determines whether institutional care is necessary^{3,47}
- Ask the team to **name the skilled service that cannot be delivered safely** in the proposed lower setting³
- If home is rejected, identify the exact environmental, caregiver, equipment, or access barrier and the **action needed to remove it**^{48,49}



CLINICAL PEARL: BEFORE ACCEPTING A VENTILATOR TRANSFER OR LIBERATION, CONFIRM THE PATIENT PASSES OBJECTIVE RESPIRATORY BENCHMARKS

Premature ventilator liberation, or transfer of a still-ventilated patient to a lower-capability setting, carries a **high risk of respiratory failure, reintubation, and death**; roughly **10-20%** of patients reintubated within 72 hours have **markedly higher mortality and ventilator-associated complications**.^{50,51} Liberation and transfer decisions should therefore rest on **documented, objective benchmarks** rather than a single stable snapshot. **Confirm daily spontaneous breathing trial (SBT) readiness before liberation.**

Standard weaning criteria that should be **met before an SBT include**: resolution or control of the cause of respiratory failure, manageable secretions, hemodynamic stability (no or low-dose vasopressors), adequate mentation, and adequate gas exchange without excessive effort.^{52,53} A **structured daily SBT** is the best predictor of successful liberation and **reduces ventilator duration**.^{53,54}

SBT-failure red flags that indicate the patient is not ready include **respiratory rate >35 breaths/min, SpO₂ persistently <90%, heart rate persistently >140 bpm, systolic BP <90 or >180 mmHg**, and any **visible distress** (accessory-muscle use, abdominal paradox, diaphoresis, cyanosis, agitation, or depressed mental status).⁵⁵ A rapid shallow breathing index (RSBI = RR/tidal volume in liters) **>105 signals rapid respiratory fatigue**, though it lacks reliable predictive value in isolation.^{54,56}

Gas-exchange and ventilator settings **incompatible with liberation or lower-acuity transfer**: FiO₂ >0.40, PEEP >8 cm H₂O, PaO₂/FiO₂ ≤150, PaO₂ <60 mmHg, or respiratory acidosis (rising PaCO₂ with pH <7.30).^{52,57} A patient requiring aggressive settings to maintain acceptable numbers **has not recovered enough to move**.

Airway-protection and neurologic red flags persist even when the lungs are strong: altered mental status or inability to follow commands, weak cough or copious secretions (peak cough flow ≤60 L/min, suctioning more than every 2-3 hours), and a failed cuff-leak test (risk of post-extubation stridor from laryngeal edema).^{58,59} **Systemic steroids reduce reintubation and stridor rates** in patients who fail a cuff-leak test.⁵⁹

When any of these are present, the correct action is **continued ventilatory support or transfer only to a setting** (e.g., LTACH) **that can safely manage** an actively ventilated, high-risk patient with rescue capability, not liberation or step-down.^{56,60}

PAC RISK SCORING SYSTEM

Use the following **14-point operational risk score** to identify readmission, prolonged length-of-stay, and transition-failure risk.^{4,61} Calculate the score **when discharge planning begins**, then combine it with medical stability, skilled-service requirements, therapy tolerance, and home feasibility.^{4,61}

CATEGORY	RISK FACTOR ⁶¹⁻⁶³	POINTS
Prior utilization	At least one emergency department visit in the prior 90 days	1
Prior utilization	At least one inpatient admission in the prior 90 days	2
Clinical complexity	Nine or more active medications	1
Clinical complexity	High-risk diagnosis such as heart failure, COPD, end-stage kidney disease, or advanced diabetes	2
Clinical complexity	Moderate or severe dementia, delirium , or other cognitive impairment	1
Functional status	Total assistance required with at least two activities of daily living	2
Functional status	At least one fall in the prior six months	1
Social determinants	Lives alone without reliable family or caregiver support	2
Social determinants	Transportation, food, housing , or similar barrier to care	1
Care transition	History of: missed appointments, unfilled prescriptions, or other nonadherence	1

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease; ADL = activities of daily living



CLINICAL PEARL: A SCORE INFORMS PLACEMENT, IT DOES NOT DICTATE IT

A post-acute risk or acuity score is a **decision aid, not a placement order**.^{4,64} A higher score signals **greater transition-support needs but does not by itself establish medical necessity** for LTACH, rehabilitation, or SNF, just as a **low score does not make home safe** when the patient is unstable or lacks a feasible skilled-service plan.^{3,4} Reassess the score whenever cognition, function, caregiver support, or utilization changes, and let the **clinical trajectory, not a single number**, drive the final setting.^{61,65}



QUALITY OUTCOME: APPROPRIATE SCORE USE

Risk stratification determines the **intensity of transition management**. Level-of-care criteria **determine the destination**. Use both decisions together.^{4,66}

MATCHING POST-ACUTE SETTING TO RISK: THE PCP'S ROLE IN TIER-BASED ADVOCACY

The following framework links each discharge risk tier to the **least-intensive setting that safely meets the patient's needs** and to the **specific actions the PCP takes to champion that transition**. In every tier **the PCP's core levers are the same**: communicate the **patient's individualized baseline vitals** and labs, advocate against overplacement, and secure timely, reconciled, closed-loop follow-up.

SCORE	RISK TIER	LIKELY SETTING RANGE ^{3,21}	PCP ACTION AND ADVOCACY ^{9,67,68}
0 to 3	Low	Home; outpatient therapy; home health when eligibility and skilled need are present	Champion discharge to the lowest-acuity safe setting ; communicate the patient's documented baseline vitals and labs to the transition so recovery is judged against individualized norms ; supply reconciled medication list; confirm PCP follow-up within 14 days ; give clear return precautions
4 to 7	Moderate	Higher-intensity home health or SNF when clinical and functional criteria support it	Advocate for home health over facility placement when needs can be met at home ; when home nursing is used, front-load it (concentrate skilled visits in the first days after discharge when readmission risk peaks, rather than spreading them evenly); reconcile medications within 24 hours ; conduct PCP follow-up within 7 days; resolve transport and caregiver barriers
8 or more	High	SNF, inpatient rehabilitation, or LTACH only when setting-specific criteria are met; intensive home plan may remain appropriate for selected patients	Champion the least-intensive setting that safely meets individualized needs, using communicated baseline vitals and labs to prevent overplacement; enroll in transition management; front-load home nursing when an intensive home plan is chosen; consider remote monitoring; lead weekly interdisciplinary milestone review; establish a rapid escalation pathway

ABBREVIATIONS: PCP = primary care physician; SNF = skilled nursing facility; LTACH = long-term acute care hospital

Minimum Bundle for Every Tier

CONTROL	MINIMUM EXPECTATION ^{3,10,69}
Named accountable clinician	Identify who owns medical decisions during the post-acute episode and how the PCP will communicate with that clinician
Medication integrity	Send to PAC facility: the reconciled list, indications, duration, monitoring, discontinued drugs, and pending pharmacy issues
Functional baseline and goals	Document: pre-hospital function (ADLs), current assistance level, therapy tolerance, and measurable recovery objectives
Escalation plan	Define: urgent symptoms, who receives the first call, after-hours coverage, and when emergency transfer is required
Next transition	Set expected review and step-down dates from the first day of the episode

ABBREVIATIONS: PCP = primary care physician; ADLs = activities of daily living; POC= post acute care



MAKING CONNECTIONS

Use the **AAVBC Reducing All-Cause Readmissions QRG** to operationalize risk-stratified outreach, LACE scoring, TCM visits, disease-specific monitoring, and the 30-day feedback loop.

LONG-TERM ACUTE CARE HOSPITAL

A **long-term acute care hospital (LTACH)** is intended for patients who remain **medically complex** and require **extended hospital-level services** after the short-term acute phase.^{3,70} **It is not a default rehabilitation destination** or a substitute for completing needed stabilization in the hospital.^{3,70}

APPROPRIATE INDICATORS ^{3,71}	NOT APPROPRIATE WHEN ^{3,70}	REQUIRED VALUE CONTROLS ^{3,71,72}
• Prolonged mechanical ventilation or active weaning needs • Multiple complex medical conditions • Severe organ dysfunction • Extensive wounds or burns • Expected prolonged hospital-level stay	• The patient is clinically stable with a single uncomplicated problem • The patient needs only routine wound care • The patient is ready for lower-intensity rehabilitation • The patient lacks a continuing hospital-level skilled need	• Begin discharge planning on day 1 • Track ventilator weaning and infection • Review medical milestones weekly • Step down promptly when hospital-level capability is no longer required

Placement Verification

- Confirm the current service **cannot be delivered safely** in a lower-acuity setting^{3,70}
- Ventilators: Ensure **three weaning attempts are conducted prior to any consideration of a LTACH transfer**
 - **Spontaneous Breathing Trials (SBTs):** The attempts must be **formal, documented SBTs** (such as putting the patient on a tracheostomy collar or low-pressure support) where the patient ultimately **did not meet tolerance criteria**
- Document **expected duration** and the **clinical milestones** supporting a prolonged course³
- **Review LTAC capabilities to match complexity of patient:** ventilator, respiratory therapy, laboratory, imaging, physician, wound, infusion, and rescue **capabilities as applicable**^{3,70}
- **Review recent instability** to avoid transferring a patient whose needs **still require short-term acute hospitalization**^{73,74}



CLINICAL PEARL: LTACH IS NOT EXTRA RECOVERY TIME

A prolonged stay alone **does not justify LTACH care**.⁷⁰ The patient must continue to **need hospital-level medical capability** that cannot be safely provided in a **SNF**, or **home** setting.^{3,70}

INPATIENT REHABILITATION FACILITY

Inpatient rehabilitation is appropriate when a patient **needs coordinated rehabilitation across multiple disciplines**, can **tolerate the intensity (three hours PT/OT/ST daily required)**, requires **rehabilitation physician oversight**, and has a reasonable expectation of **meaningful functional improvement**.^{3,23,75}

CLINICAL GATE	EVIDENCE TO DOCUMENT ^{3,23}	MISMATCH SIGNAL ^{3,76}
Therapy intensity	Ability to participate in about 3 hours daily on 5 days per week , or an equivalent intensive schedule over 7 days	Repeated inability to perform/tolerate 3 hours daily of PT/OT/ST without a new acute clinical change
Multiple disciplines	Active needs in at least two of PT/OT/ST	Single low-intensity therapy need
Functional potential	Measurable mobility, self-care, communication, swallowing , or cognitive goals	Maintenance-only or custodial objective
Medical oversight	Medical issues require coordinated rehabilitation nursing and physician management	Patient requires unstable acute care or only routine subacute monitoring
Participation capacity	Cognition, behavior, endurance, and pain control permit meaningful engagement	Severe impairment prevents learning or safe participation

Value-Based Review

- **Track:** standardized functional gain, therapy participation, complications, and progress toward community discharge^{77,78}
- **Reassess the plan promptly** if the patient cannot meet the intensive schedule **for several days**^{3,79}
- Do not use inpatient rehabilitation for **permanent placement** or **passive recovery**^{23,80}
- Coordinate the home, equipment, caregiver, and follow-up plan **before** the final days of the stay^{18,81}

Performance Signals to Monitor

MEASURE	ILLUSTRATIVE NETWORK TARGET
Discharge to community	Above 75 percent

MEASURE	ILLUSTRATIVE NETWORK TARGET
Section GG functional gain	More than 30 points
30-day readmission	Below 10 percent
ABBREVIATIONS: GG = Section GG (Functional Abilities and Goals), the standardized functional-status assessment items used across CMS post-acute care settings	



QUALITY OUTCOME: FUNCTIONAL RECOVERY

The central result is not **completion of therapy hours**.⁷⁸ It is **meaningful improvement** that allows the patient to **return safely to the community** at the highest practical level of independence.⁷⁸

SKILLED NURSING FACILITY

A skilled nursing facility is appropriate for **medically stable patients** who require **daily skilled nursing or rehabilitation** but cannot tolerate or benefit from inpatient rehabilitation intensity.^{3,75} It should be a **time-limited bridge toward home** whenever recovery potential and circumstances permit.^{3,75}

APPROPRIATE NEEDS ⁴⁰	INAPPROPRIATE NEEDS ⁴⁰	VALUE-BASED EXPECTATIONS ⁴⁰
• Daily skilled nursing • Complex IV medications • Advanced wound management • Moderate-intensity rehabilitation • Close monitoring of stable chronic illness • Safe environment during recovery	• Active ventilator weaning • Highly unstable illness requiring frequent physician intervention and immediate diagnostics • Independent patient needing only minor home changes • Custodial care without a qualifying skilled need	• Initial clinician evaluation with frequent rounding based on acuity • Weekly milestone and discharge review • INTERACT-style change-in-condition management • Early home planning and medication reconciliation • The PCP should communicate baseline ADLs and deficits so the SNFist can set realistic expectations for return to baseline



CLINICAL PEARL: PCP USE OF INTERACT TO REDUCE AVOIDABLE TRANSFERS FROM THE SNF

INTERACT (Interventions to Reduce Acute Care Transfers) is a quality-improvement program that equips SNF staff to recognize, document, and communicate early changes in condition, so that **treatable problems are managed in place rather than through a default emergency department transfer**.^{22,74} For the PCP, **reinforcing INTERACT tools** (such as the "Stop and Watch" early-warning tool, SBAR communication, and care-path guidance for common conditions) at the facilities where patients are placed **protects value by reducing avoidable transfers and readmissions** while keeping the PCP informed of change in condition.^{82,83} When communicating a **patient's individualized baseline vitals, labs, and ADLs** to the SNF, framing them within an INTERACT change-in-condition threshold gives nursing staff a concrete, **patient-specific trigger for when to call the PCP** versus when a finding simply represents that patient's chronic normal.^{84,85}

SNF-to-Hospital Transfer Controls

- Provide a live clinician or triage line for **non-life-threatening changes in condition before emergency transfer**.^{22,86}
- Do not delay emergency transport when **time-sensitive evaluation or treatment is required**.^{87,88}
- **Use current hospital and PCP records** to **avoid repeating** clinically adequate laboratory and imaging studies.^{12,89}
- Treat SNF discharge to home as a **new high-risk transition** with medication review and **prompt PCP contact**.^{90,91}

SNF Network Performance Targets

MEASURE	ILLUSTRATIVE NETWORK TARGET
30-day readmission	Below 15 percent
Length-of-stay variance	No more than 1.5 days above the governed benchmark
Antipsychotic use	Below 5 percent when used as a network learning target



CLINICAL PEARL: SNF IS A BRIDGE, NOT A DEFAULT DESTINATION

Define the skilled need, measurable goals, and anticipated home transition **at admission**.^{74,75} Without those elements, institutional care **can extend without producing added clinical value**.^{4,6}

HOME HEALTH AND OUTPATIENT RECOVERY

Home is often the **most patient-centered** and **efficient recovery setting for medically stable patients** who do not need continuous institutional monitoring.^{3,6} Home health requires both **eligibility** and a **skilled intermittent service**; outpatient care is more appropriate when the patient **can leave home safely and reliably**.^{3,25}

PATHWAY	BEST FIT ^{3,25}	CORE CONTROLS ^{18,92,93}	MISMATCH SIGNAL ^{3,74}
Home health	Homebound patient needing: intermittent skilled nursing, physical therapy, or speech-language pathology	First visit promptly after discharge; front-load visits for higher risk; 24/7 triage; medication review; home safety; caregiver plan	Needs continuous care, active hospital-level rescue, or more therapy intensity than home services can deliver; patient is not homebound and able to travel to office and therapy centers
Home with outpatient therapy	Medically stable patient who can travel and does not meet homebound criteria	Appointment scheduled before discharge; transportation; equipment; written home program; PCP follow-up	Travel is unsafe, no reliable transport, or required care is too frequent
Home without skilled PAC	Independent or caregiver-supported patient whose needs can be managed through routine PCP and community care	Medication access; patient education on escalation/red flags; follow-up; preventive services; social support	Unrecognized/undelivered need for skilled nursing, rehabilitation, wound, infusion, or monitoring need

ABBREVIATIONS: PCP = primary care physician; PAC = post-acute care

High-Risk Home Bundle

- **Front-load** approximately three nursing contacts in the first week when ordered and operationally appropriate^{94,95}
- Provide **round-the-clock telephone triage** and a **clear first-call pathway**¹⁰
- Use **remote monitoring for selected chronic conditions** when the team can review and act on the data^{96,97}
- Confirm **PCP follow-up within 7 days** and medication reconciliation **within 24 hours**⁶⁹



CLINICAL PEARL: HOME WHEN SAFE

Home-first does not mean home-only. Choose home when **required services can be delivered reliably** and the **patient can remain safe between visits**; escalate when those conditions are not met.^{3,6}

TRANSITION AND DISCHARGE CONTROLS

Strong transitions reduce early return to acute care.^{67,81} Discharge planning **begins on admission** and is revised as the patient's medical course, function, therapy tolerance, caregiver availability, and goals change.⁸¹

TIMING	REQUIRED ACTION ^{3,18,98}	ACCOUNTABLE CONNECTION ^{3,90}
At acute admission	Capture: baseline function (ADLs), cognition, living situation, caregiver capacity, goals, medications, and prior services	PCP and hospitalist or inpatient team
Before placement	Complete therapy assessment; define skilled needs; verify stability; test home feasibility; identify preferred and backup providers	Hospital team, PCP, utilization management, patient and caregiver
At transfer	Send: diagnoses, medication list, pending tests, treatment plan, functional status, wounds, equipment, goals, and escalation instructions	Sending clinician to receiving clinician
Within 4 hours	Make the care plan and key clinical information electronically available when the receiving workflow supports it	Health information exchange or EHR connection
Within 24 hours	Complete medication reconciliation and resolve omissions, duplications, substitutions, access, and monitoring issues	Pharmacist, receiving clinician, and PCP team
During episode	Conduct interdisciplinary milestone reviews and revise the expected transition date	PAC team with PCP visibility
At community discharge	Confirm: home safety, DME, medication supply, appointments, caregiver understanding, and first-call instructions	PAC team to PCP and home-care team

ABBREVIATIONS: PCP = primary care physician; EHR = electronic health record; PAC = post-acute care; DME = durable medical equipment

Warm Handoff Minimum

- Name the **clinician accepting responsibility** and **confirm receipt** of the transfer packet¹⁰
- Identify pending results and **who will act on them**^{3,89}
- State the expected **clinical** and **functional milestones for step-down**³
- Document what would require **urgent reassessment** or **emergency transfer**²²



MAKING CONNECTIONS

The **AAVBC Reducing All-Cause Readmissions QRG** provides the companion post-discharge sequence for ADT alerts, 48-hour outreach, TCM scheduling, disease-specific monitoring, and 30-day review.

HOME READINESS AND CAREGIVER SUPPORT

A home disposition is only **as safe as the environment** and **support between professional visits**.^{3,99} Screen the home early enough to **correct barriers before discharge**, and distinguish skilled home health from ongoing custodial assistance.^{49,100}

DOMAIN	READINESS QUESTIONS ^{49,101}	TYPICAL ACTION ^{101,102}
Access and entry	Step-free route; secure railings; lighting; doorway width; safe transport into the home	Ramp, alternate entrance, transport plan, or short-term alternative setting
Floors and mobility	Clear walkways; no loose rugs or cords; stable surfaces; night lighting; walker or wheelchair clearance	Remove hazards; install lighting; arrange mobility equipment
Bedroom	First-floor option; safe bed height; stable support; phone, water, medications, and light within reach	Temporary first-floor setup or hospital bed when covered and needed
Bathroom	Safe shower or tub transfer; nonslip surface; toilet height; grab bars; ability to toilet safely	Shower chair, transfer bench, raised seat, commode, or grab bars
Support network	Named caregiver; coverage schedule; emergency contacts; pharmacy pickup; ability to perform required tasks	Training, rotation plan, delivery services, home aide resources, or different level of care

Patient and Family Discussion

- Explain the benefits of familiar surroundings, mobility, sleep, privacy, and lower exposure to facility-acquired complications **when home is clinically appropriate**^{103,104}
- Describe what home health **will** and **will not provide**, including the time between visits³
- Review potential facility cost sharing and benefit-day use **without presenting cost as the reason to reject medically necessary care**^{3,74}
- Use **teach-back** to confirm red flags, medication changes, equipment, appointments, and whom to call first^{105,106}



CLINICAL PEARL: HOME SAFETY IS MODIFIABLE

Do not treat every stair, missing grab bar, or transportation problem **as an automatic reason for institutional care**. Identify the barrier early, assign an owner, and determine whether equipment, home modification, transport, or caregiver training **can resolve it safely**.^{48,49}

CONCURRENT REVIEW AND LENGTH OF STAY

Expected length-of-stay benchmarks support planning and utilization review, but they **do not determine when a patient is ready to move**.³ The safe transition date follows **medical stability, functional progress, skilled need, home readiness, and service availability**.^{3,107}

REVIEW DOMAIN	WEEKLY QUESTION ^{3,18,23}	ACTION WHEN OFF TRAJECTORY ^{3,18}
Medical stability	Are oxygen, infection, wounds, laboratory trends, nutrition, pain, and chronic disease control improving ?	Escalate treatment , reassess setting capability, or transfer when medically necessary
Skilled need	Does the patient still require the current frequency and capability ?	Step down when services can be delivered safely at lower intensity
Function	Is the patient gaining : mobility, self-care, communication, swallowing, or endurance as expected ? Has the patient returned to baseline ADLs ? Has the patient's progress ceased and is no longer benefiting from skilled services and should be considered for Custodial Care status ?	Revise : goals, technique, intensity, equipment, or setting

REVIEW DOMAIN	WEEKLY QUESTION ^{3,18,23}	ACTION WHEN OFF TRAJECTORY ^{3,18}
Participation	Can the patient engage in the ordered therapy schedule?	Evaluate: medical, cognitive, behavioral, pain, and fatigue barriers → If unable to progress/discharge home, consider Custodial Care status
Discharge readiness	Are the home, caregiver, DME, medications, and follow-up ready?	Assign unresolved items with deadlines and backups
Length-of-stay variance	Is the difference from the governed benchmark clinically justified ?	Document reasons; remove operational delay; avoid premature discharge

ABBREVIATIONS: DME = durable medical equipment

Milestone Review Cadence

- **Start discharge planning on day 1** in every institutional setting⁸¹
- Conduct **at least weekly interdisciplinary reviews** and more often when the patient is unstable or progress stalls^{108,109}
- Trend **standardized functional measures** such as **Section GG**, **CARE**, or **AM-PAC** when applicable¹¹⁰
- Treat avoidable days and premature step-down as **separate quality failures**^{73,111}



QUALITY OUTCOME: BALANCING PRINCIPLE

A benchmark is a **planning tool**, not a discharge order. High value means **removing avoidable delay** while keeping the patient in the current setting until the **next setting can safely deliver the needed care**.^{3,73}



CLINICAL PEARL: PCP USE OF SECTION GG TO TRACK FUNCTIONAL RECOVERY ACROSS POST-ACUTE CARE

Section GG is the CMS-mandated, cross-setting measure of **self-care** and **mobility** collected at admission and discharge in **every skilled nursing facility, inpatient rehabilitation facility, home health agency, and LTCH**, where each task is scored on a **6-point scale of assistance needed** (**1** = dependent, helper does all the effort, up to **6** = independent, no helper) across **7 self-care items** (eating, oral hygiene, toileting hygiene, bathing, dressing, footwear) and 15 scored mobility items (bed mobility, sit-to-stand, transfers, walking distances, stairs). Mandated by the **IMPACT Act**, it replaced the FIM in IRFs and Section G in SNFs and now **drives payment** (PDPM, IRF-PAI) **and quality reporting**, so the **same functional language follows a patient through every post-acute setting**. For the PCP, the actionable concept is "**functional gain**" (the admission-to-discharge change in the summed Section GG score) which reflects whether a patient referred to a SNF or IRF is **actually regaining independence, predicts discharge to community** and length of stay, and should **prompt a care-plan review** when the trajectory plateaus or declines. **One caveat worth knowing when interpreting a discharge score**: Section GG discriminates best at the independent end and shows ceiling effects, so it is **less sensitive once a patient is already near-independent**.

PREFERRED PAC NETWORK PERFORMANCE

Preferred networks should be built from **transparent capability** and **performance criteria**.³ The PCP team should **maintain clinically appropriate alternatives** when the preferred provider lacks a bed, cannot start services in time, is geographically inaccessible, or cannot meet a patient-specific need.^{3,111}

SETTING	PERFORMANCE SIGNALS ^{5,78,112,113}	OPERATIONAL EXPECTATION ^{3,114}
LTACH	Readmission ; ventilator weaning; central-line infection; step-down rate ; mortality; risk-adjusted length	Day-1 discharge plan ; weekly clinical review; transparent ventilator and infection outcomes
Inpatient rehabilitation	Functional gain ; therapy participation; community discharge; readmission; complications	Accurate preadmission screen; measurable goals; early home and caregiver plan
SNF	Readmission ; emergency transfers ; length; community discharge; functional gain; antipsychotic use	Rapid clinician assessment ; skilled seven-day services when needed; pre-transfer triage; weekly step-down review
Home health	Timely first visit ; hospitalization; emergency use; medication reconciliation; goal completion	Weekend intake ; front-loaded high-risk support; 24/7 triage; prompt note exchange

SETTING	PERFORMANCE SIGNALS ^{5,78,112,113}	OPERATIONAL EXPECTATION ^{3,114}
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ABBREVIATIONS: LTACH = long-term acute care hospital; SNF = skilled nursing facility

Selection Checklist

- Capability and staffing **match the specific clinical prescription**^{3,22}
- Quality and utilization results are **risk-adjusted, current**, and based on a **credible denominator**^{22,115}
- The provider participates in the **patient's exact network** and **benefit**³
- Geoaccess, transportation, language, accessibility, and caregiver logistics are **workable**²²
- Records, daily or weekly updates, and discharge notes **can move bidirectionally**¹²



MAKING CONNECTIONS

Consult the **AAVBC Referral Management: Cost-Efficient and Clinically Effective Specialist Selection QRG** for a companion quality-first method to compare clinical effectiveness, total episode cost, access, geoaccess, network status, and patient fit.



QUALITY OUTCOME: ACCESS IS PART OF EFFECTIVENESS

A clinically capable PAC provider is **not a high-value option** if it **cannot admit in the required window** or the **patient cannot** reasonably **reach, enter, communicate with, or use the service**.^{3,115}

BARRIERS TO THE LOWEST SAFE SETTING

Reaching the lowest safe level of care is often **blocked by non-clinical barriers**, and the following section organizes those barriers, along with matched value-based responses, so the **PCP can anticipate and correct them** before they force a higher-acuity placement.

Barriers to the Lowest Safe Setting and Value-Based Responses

BARRIER CATEGORY	COMMON BARRIER ^{3,12,111}	VALUE-BASED RESPONSE ^{111,116,117}
Clinical	Subjective screening ; family pressure; inaccurate estimate of therapy tolerance	Use an objective multidisciplinary screen ; perform therapy trials ; counsel on benefits, risks, and realistic support needs

BARRIER CATEGORY	COMMON BARRIER ^{3,12,111}	VALUE-BASED RESPONSE ^{111,116,117}
Operational	Weekend home-health gap; delayed DME; difficulty locating a preferred bed	Contract for timely intake; order equipment about 72 hours before expected discharge; use a transition coordinator and backup providers
Payer and financial	Slow authorization; payment that rewards long stays; limited support for nonmedical needs	Streamline authorization for trusted providers; use episode or shared-savings incentives; deploy permitted flexible supports
Social	Lives alone; unsafe home; transportation barrier; food insecurity	Use monitoring and calls; rapid home modifications; caregiver training; meal and transportation benefits
Information	Incomplete transfer record; inaccessible prior tests; unclear medication changes	Use bidirectional EHR or HIE exchange; reconcile medications; assign pending-result ownership
ABBREVIATIONS: DME = durable medical equipment; EHR = electronic health record; HIE = health information exchange		

Avoid Two False Choices

FALSE CHOICE	BETTER APPROACH ^{3,73,118}
Institutional placement or unsafe home discharge	Build a higher-support home plan, correct the barrier, or use a time-limited appropriate setting with explicit step-down criteria
Meet a length target or keep the patient indefinitely	Use clinical milestones and remove operational delays without discharging before the next setting is ready

Escalation for Unresolved Barriers

- **Name:** the barrier, risk, owner, due time, backup, and decision-maker^{3,91}
- Escalate **capacity** or **authorization problems** early enough to preserve a safe discharge date¹¹⁹
- Document why a **higher level is temporarily necessary** when social or operational barriers cannot be corrected in time^{3,73}



CLINICAL PEARL: CAPACITY FAILURE IS NOT A CLINICAL INDICATION

When the **preferred lower setting is unavailable**, document the capacity barrier separately from the patient's medical need and **continue working toward the least intensive safe alternative**.^{3,119}

STEERING, CONFLICTS, AND AUDIT FLAGS

Claims, referral patterns, clinical records, and patient interviews can **identify placements that warrant review**.^{3,120} A flag is not proof of misconduct or inappropriate care; it is a prompt for **patient-level clinical assessment** and **fair due process**.^{22,115}

AUDIT SIGNAL	POTENTIAL CONCERN ^{20,73,121}	CLINICAL VALIDATION QUESTION ^{3,4}
Transfer well before acute length benchmark	Premature discharge or throughput pressure	Was the patient medically stable and was the receiving setting capable of managing foreseeable needs ?
High referral concentration to one LTACH or rehabilitation facility	Financial relationship, marketing influence, or habitual routing	Does concentration reflect quality , access, capability, patient choice, or an undisclosed conflict ?
Repeated failure to meet rehabilitation intensity	Inpatient rehabilitation used for a SNF-level patient	Was tolerance assessed before transfer and did an acute change explain the shortfall ?
Return to acute care within 72 hours	Unstable transfer, incomplete handoff, or receiving capability gap	What changed, what warning signs existed , and could the event have been prevented ?
Placement conflicts with objective screen	Gatekeeping override	Was the variance clinically justified and documented ?
Friday or pre-holiday discharge without services ready	Operational timing prioritized over execution	Were home health, DME, pharmacy, transport, and caregiver coverage confirmed?
Facility marketing influenced family choice	Decision made without balanced clinical options	Did the patient receive neutral information and a clinically appropriate choice set ?

ABBREVIATIONS: LTACH = long-term acute care hospital; SNF = skilled nursing facility; DME = durable medical equipment

Patient-Level Review

- **Review:** vital, oxygen, laboratory, therapy, and nursing trends near transfer^{3,122}
- Compare the ordered services with the destination's **actual capabilities and start times**³
- Confirm the patient and caregiver **understood the choices and financial implications**³
- Assess hospital, physician, facility, or payer relationships that **could bias routing**¹²³



QUALITY OUTCOME: CLINICAL FIT BEFORE STEERING

Use preferred networks to facilitate **high-quality, timely care**. Never allow a **financial relationship, census target, or throughput goal** to override the setting that can **safely meet the patient's needs**.^{120,123}

AUDIT SCORECARD AND REMEDIATION

The following scorecard identifies monthly measures that **flag potential overplacement or transition failure**, with guidance on interpretation and root-cause remediation; **a flag signals the need for review**, not proof of inappropriate care.

Monthly Post-Acute Placement Audit Measures and Interpretation

MONTHLY MEASURE	WHAT TO COUNT ^{20,111,121}	INTERPRETATION ^{22,111,121}
Flagged LTACH or rehabilitation placements	Cases meeting one or more defined audit signals	Review: rate, case mix, origin, setting, and preventability; do not assume every flag is inappropriate
Early post-transfer return	Hospital return within 72 hours of PAC arrival	Examine: stability, handoff, medication, capability, and response to change
Therapy-intensity variance	Rehabilitation days below the expected intensity without documented medical reason	Test screening accuracy and clinical change
Referral concentration	Share of placements by discharging group and receiving provider	Compare: quality, access, capability, geography, and relationships
Length variance	Days above or below the governed benchmark	Separate medical necessity from: authorization, capacity, DME, and caregiver delay

MONTHLY MEASURE	WHAT TO COUNT ^{20,111,121}	INTERPRETATION ^{22,111,121}
Estimated cost variance	Difference between reviewed placement and clinically appropriate alternative	Use only after confirming comparable need and outcome expectations
ABBREVIATIONS: LTACH = long-term acute care hospital; PAC = post-acute care; DME = durable medical equipment		

Remediation by Root Cause

ROOT CAUSE	CORRECTIVE ACTION ^{3,20,22,121}
Concentrated or conflicted routing	Use independent clinical review ; disclose relationships ; suspend streamlined routing if validated concerns persist ; preserve urgent access
Premature acute discharge	Add a discharge-stability checkpoint and escalation to physician leadership for unresolved instability
Rehabilitation tolerance mismatch	Require timely PT, OT, and speech assessment and document actual participation capacity before transfer
Lower-setting capacity gap	Expand: backup networks, weekend intake, DME pathways, transport, and home-support options
Poor transition execution	Standardize: warm handoff, medication reconciliation, pending-result ownership, and first-call instructions
ABBREVIATIONS: PT = physical therapy; OT = occupational therapy; DME = durable medical equipment	

CASE VIGNETTES

Appropriate Placement

SUCCESS: INTENSIVE REHABILITATION MATCH

SCENARIO

A 76-year-old man is medically stable after an ischemic stroke. He **needs physical and occupational therapy** plus speech-language treatment, **can participate for about three hours daily** with rest breaks, follows commands, and has a **realistic goal of returning home with his spouse**.

Decision: Inpatient rehabilitation facility with measurable mobility, self-care, swallowing, and communication goals; rehabilitation physician oversight; caregiver training; home and DME planning from admission.

Why it fits: The patient **needs multiple disciplines, can tolerate intensive therapy**, and has **clear functional potential**. A SNF would underdeliver intensity, while LTACH would add hospital-level resources that are not required.

Expected Outcome: Functional gain, safe oral intake, caregiver competence, and direct community discharge within the governed recovery window.

SUCCESS: HIGH-SUPPORT HOME RECOVERY

SCENARIO

An 82-year-old woman with heart failure is stable after diuresis. She walks short household distances **with a walker**, is homebound, has an **attentive daughter nearby**, and needs medication review, weight monitoring, nursing assessment, and **short-term physical therapy**.

Decision: Home with home health; **first visit promptly after discharge**; three early nursing contacts when available; medication reconciliation **within 24 hours**; daily weights with an actionable threshold; **PCP follow-up within 7 days**; 24/7 triage.

Why it fits: Her needs are **intermittent** and **can be delivered safely at home**. She does not require daily institutional skilled care or intensive inpatient rehabilitation.

Expected Outcome: Stable symptoms, correct medication use, improved mobility, fewer emergency visits, and **transition to routine outpatient management**.

Documentation Pattern

State: current stability, baseline and current function, skilled needs, therapy tolerance, home and caregiver conditions, selected setting, specific services and timing, escalation criteria, and the milestone that will trigger the next transition.

Overprescribed Care

PITFALL: LTACH FOR ROUTINE WOUND CARE

SCENARIO

A 79-year-old woman is afebrile, hemodynamically stable, breathing room air, eating, and walking with supervision after abdominal surgery. She needs a **daily dressing change for a healing wound** and **modest physical therapy**. A LTACH bed is offered because it is immediately available.

Why it is inappropriate: She has no prolonged ventilation, multi-organ instability, or continuing hospital-level treatment need. **LTACH care adds unnecessary intensity, infection exposure, and cost**.

Better plan: Use **SNF** only if daily skilled care and the home environment **require it**; otherwise **arrange home health** nursing and therapy with rapid follow-up and clear wound red flags.

Fix: Document the specific skilled frequency, home feasibility, and step-down goal; **choose the lowest setting that can execute the plan**.

PITFALL: INPATIENT REHABILITATION AS A SAFETY NET

SCENARIO

An 87-year-old man with advanced dementia and severe delirium after pneumonia cannot follow one-step commands or participate consistently in therapy. He **requires assistance with all ADLs**. Intensive rehabilitation is proposed to reduce readmission risk.

Why it is inappropriate: The patient currently **lacks the participation capacity** needed to benefit from intensive therapy. The placement uses a high-intensity rehabilitation bed **without a realistic functional pathway**.

Better plan: Complete medical and delirium evaluation; select **SNF-level skilled care** if daily nursing and lower-intensity rehabilitation are needed; establish goals, reassessment timing, and caregiver planning.

Fix: Reassess cognition and participation after reversible contributors are treated; escalate to inpatient rehabilitation **only if tolerance and measurable potential emerge**.



RED FLAG — OVERPRESCRIBING SIGNAL

Choosing a higher level solely because it is available, feels safer, or protects a narrow short-term metric **can increase complications** and **total cost without improving recovery**.^{3,70}

Underprescribed Care

PITFALL: HOME WITHOUT ADEQUATE SUPPORT

SCENARIO

An 84-year-old woman after hip fracture repair **needs two-person assistance for transfers, cannot climb the steps into her home**, has **fluctuating delirium**, and lives with a **spouse who cannot provide physical help**. A routine home discharge is proposed because she prefers home.

Why it is inappropriate: The home plan cannot safely support transfers, cognition, access, or care between intermittent visits. **Preference does not eliminate foreseeable fall, medication, and caregiver risks**.

Better plan: Use **SNF-level skilled nursing and rehabilitation** while delirium and mobility improve; begin home modification, caregiver training, and DME planning immediately.

Fix: Set explicit goals for one-person transfers, safe entry, caregiver readiness, and a scheduled home transition.

PITFALL: SNF FOR ACTIVE VENTILATOR WEANING

SCENARIO

A 70-year-old man remains ventilator dependent after severe pneumonia, has **repeated weaning failure, complex wounds**, and requires **frequent physician-led respiratory adjustments**. A standard SNF is selected to lower cost.

Why it is inappropriate: The patient requires **hospital-level respiratory, physician, laboratory, wound, and rescue capability** that the proposed SNF does not provide.

Better plan: Use an **appropriately capable LTACH** after confirming acute stability, expected prolonged need, ventilator program performance, infection controls, and a step-down plan.

Fix: **Do not** allow transactional price to substitute for capability. **Reassess weekly** and step down when active hospital-level needs resolve.



RED FLAG — UNDERPRESCRIBING SIGNAL

A lower-cost setting is lower value **when it cannot provide the necessary frequency, disciplines, monitoring, or emergency response.**^{4,6} Failed placement often converts avoided upfront cost into harm and readmission.^{4,73}

GOVERNANCE AND QUALITY OUTCOMES

Clear accountability across the transition is what makes **value-based post-acute care durable**, and this section **assigns each owner a core responsibility** with the evidence that confirms execution, then pairs each target quality outcome with the balancing measure that **guards against unintended harm** from pursuing it too aggressively.

Roles and Accountability in the Post-Acute Transition

OWNER	CORE RESPONSIBILITY ^{3,11,13,117}	EVIDENCE OF EXECUTION ^{3,117,124,125}
Hospitalist and acute team	Stabilize; assess function; define skilled needs; communicate with PCP; build a feasible disposition	Clinical trends; therapy notes; complete transfer packet; accepting provider
PCP and care transitions team	Supply baseline ADLs, core chronic diseases (including stages); review placement; reconcile longitudinal plan; provide rapid follow-up; monitor recovery	Bidirectional contact; medication review; appointments; closed-loop updates
PAC clinician and interdisciplinary team	Deliver prescribed care; track milestones; respond to change; plan step-down	Progress notes; functional trends; length review; escalation and discharge plan
Patient and caregiver	Participate in: setting choice, training, goals, medication plan, and symptom response	Teach-back; preference; barrier plan; caregiver readiness
ACO, payer, or network	Support: timely authorization, transparent performance, capacity, and fair incentives	Access; network quality; authorization time; outcome and cost review

OWNER	CORE RESPONSIBILITY ^{3,11,13,117}	EVIDENCE OF EXECUTION ^{3,117,124,125}
ABBREVIATIONS: PCP = primary care physician; PAC = post-acute care; ACO = accountable care organization		

Quality Outcomes to Review

OUTCOME	BALANCING MEASURE ^{6,21,73}
Lower 30-day readmission and emergency use	Mortality, delayed escalation, and patient harm
Shorter institutional length of stay	Premature transfer , 72-hour return, and failed home transition
Higher community discharge	Caregiver strain , home safety, and service start reliability
Greater functional gain	Therapy tolerance, patient goals, and meaningful independence
Lower total episode cost	Clinical outcome , access, patient burden, and equity

TEN KEY TAKEAWAYS FOR PCPS

1 Stay involved during hospitalization

The PCP contributes the baseline ADLs and stage of the patient's Core Chronic Disease which helps prevent a placement based only on the inpatient snapshot.

2 Confirm acute stability first

Post-acute care cannot compensate for a discharge that occurs before foreseeable instability is addressed.

3 Prescribe services, not a building

Name the intensity, frequency, disciplines, monitoring, goals, and rescue capability.

4 Use the lowest safe setting

Home is preferred when the plan is executable; institutional care remains appropriate when needs exceed home capability.

5 Separate risk from destination

Risk scores trigger support; setting-specific medical and functional criteria determine placement.

6 Match rehabilitation intensity

Use inpatient rehabilitation only when the patient can participate at least 3 hours per day and is expected to improve meaningfully.

7 Plan the next transition on day 1

Every institutional episode needs goals, milestones, and an expected step-down pathway.

8 Remove operational barriers early

Address DME, home safety, staffing, authorization, transportation, and caregiver training before discharge day.

9 Audit both overuse and underuse

High and low intensity can each be inappropriate when capability does not match need.

10 Measure balanced outcomes

Pair cost and length with function, readmission, complications, access, caregiver burden, and community discharge.

AAVBC SUMMARY AND CONCLUSION

AAVBC supports PCP-engaged, clinically matched post-acute care. The best placement is the **lowest-acuity setting** that can **safely** deliver the patient's required medical and rehabilitation services, support recovery between professional contacts, and respond promptly to deterioration.^{3,6}

That decision must incorporate medical stability, function, therapy tolerance, cognition, home conditions, caregiver capacity, access, network capability, and patient goals.^{24,49}

Value is produced when acute and post-acute teams exchange complete information, reconcile medications quickly, review milestones, remove avoidable delays, and **step patients down as soon as it is safe**.^{12,69} Preferred networks should **reward timely access, functional recovery, community discharge, low preventable readmission, and reliable coordination**.^{5,111} They should **not** turn a benchmark, bed, or financial incentive into a substitute for **patient-level clinical judgment**.^{4,125}

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