AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Reducing All-Cause Readmissions Quick Reference Guide

2026

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PCP-LED READMISSION REDUCTION

Primary care practices can **reduce avoidable readmissions** by engaging before discharge, identifying high-risk patients quickly, and **coordinating one reliable transition plan** across the hospital, post-acute setting, pharmacy, specialists, patient, and caregiver.[1–3] The operating model **begins with real-time admission and discharge visibility** and ends only after the **patient is clinically stable in longitudinal care**.[4,5]

AAVBC PERSPECTIVE

*The PCP practice should function as the **longitudinal command center**.[6] **Pair automated admission-discharge-transfer alerts with**: a transitions team, early medication reconciliation, risk-stratified follow-up, high-performing inpatient and post-acute partners, and shared review of **every** clinically important return.*[1,4,7–9]

Core Operating Sequence

PHASE	PRIMARY ACTION[10,11]	VALUE PROTECTED[10,12]
Admission	**Receive alert**; **contact inpatient team**; **communicate**: baseline, medications, vulnerabilities, goals, prior workup, and previous hospital utilization	**Fewer information gaps** and **duplicate services**
First 48 hours	Contact patient or receiving facility; **verify**: medications, services, symptoms, and escalation plan	Early detection of **transition failure**
Days 3 to 7	Complete **high-acuity PCP or TCM evaluation** and **resolve root cause**: clinical, functional, and social barriers	Rapid **treatment correction** and plan reinforcement
Days 8 to 30	**Monitor high-risk conditions**; coordinate home or SNF care; respond through triage; complete **root-cause** learning	**Reduced avoidable deterioration** and repeat utilization
Discharge planning	**Apply objective risk score**; confirm stability; schedule follow-up; **reconcile medications**; secure **destination** and **services**	Executable transition **before** departure

ABBREVIATIONS: PCP = primary care physician; SNF = skilled nursing facility; TCM = transitional care management

Primary Outcomes

- **Lower 30-day all-cause readmission** and **avoidable emergency use**

- **Faster** discharge-summary and medication information transfer
- **Higher completion** of risk-appropriate PCP follow-up
- **Fewer**: Gaps, duplications, and conflicting treatment plans

CLINICAL PEARL: OWN THE TRANSITION BEFORE DISCHARGE

A follow-up appointment is most reliable when the inpatient team books it **before the patient leaves**, the **PCP receives the clinical plan**, and the patient knows exactly **whom to call** if recovery deviates.[5,13,14]

GOVERNANCE AND RISK STRATIFICATION

Reliable transitional care depends on **explicit role accountability** and **structured risk stratification**, so that each team member **owns a defined action** and the highest-risk patients receive the **earliest**, **most intensive support**.

Transitional Care Team Roles and Time-Sensitive Actions

ROLE	CORE ACCOUNTABILITY[7,15,16]	TIME-SENSITIVE ACTION[7,17,18]
Lead PCP	**Clinical ownership**, **hospitalist partnership**, escalation standards, and practice performance	Review **complex** or **unstable transitions** and **remove barriers to rapid access**
Lead care manager	Common census, outreach, scheduling, **SDOH**, patient and caregiver navigation, and **loop closure**	Act on **admission** and **discharge alerts**; complete first contact
Utilization management nurse	**Concurrent inpatient and post-acute review**, level-of-care alignment, and milestone tracking	Coordinate with hospital and PAC teams **while the patient is still admitted**
Pharmacist or trained medication reviewer	**Compare**: preadmission, inpatient, discharge, pharmacy, and current medication lists	Identify omissions, duplications, interactions, supply problems, and monitoring needs
Scheduling team	Protect **rapid TCM access** and **convert** discharge notices **into appointments**	Book the visit **before discharge** or **immediately after alert**
Data and quality lead	**Alert**: reliability, readmission dashboard, attribution, root-cause review **and resolution**, and feedback	Trend clinically meaningful patterns and **report failures**

ROLE	CORE ACCOUNTABILITY[7,15,16]	TIME-SENSITIVE ACTION[7,17,18]

ABBREVIATIONS: PCP = primary care physician; SDOH = social determinants of health; PAC = post-acute care; TCM = transitional care management

Objective Risk Assessment

- Validated score such as **LACE** or a **governed hospital** or **payer risk model**[3]
- **Clinical instability**, **premature discharge**, frailty, cognition, function, falls, polypharmacy, and high-risk medication changes[19,20]
- Prior admissions, emergency visits, repeated transition failure, and post-acute placement[21]
- Caregiver capacity, **transportation**, medication affordability, food, housing, and health literacy[22]
- **Unresolved tests**, unclear ownership, difficult specialist access, or services that may not start on time[13]

QUALITY OUTCOME: RISK DETERMINES RESPONSE TIME

The highest-risk patients receive the **earliest outreach**, **visit**, **medication review**, and **monitoring**.[23] Risk classification should accelerate support **without delaying urgent or emergency evaluation**. Evaluate and complete clinical workup that **may not have been completed** during an acute hospitalization.

LACE INDEX

The LACE index combines **Length** of stay, admission **Acuity**, Charlson **Comorbidity**, and recent **Emergency** department utilization.[3] Calculate it **when the discharge alert arrives** or use a **validated score supplied by the hospital**. The score **supports triage** and **does not** replace clinical judgment.[3]

LACE Index: Length and Acuity

COMPONENT	CRITERION	POINTS
Length of stay	Less than 1 day	0
	1 day	1
	2 days	2
	3 days	3

COMPONENT	CRITERION	POINTS
Length of stay	4 to 6 days	4
	7 to 13 days	5
	14 or more days	7
Admission acuity	Elective admission	0
	Acute or non-elective admission	3

LACE Index: Charlson Comorbidity and ED Use

COMPONENT	CRITERION	POINTS
Comorbidity	Charlson Comorbidity Index 0	0
	Charlson Comorbidity Index 1	1
	Charlson Comorbidity Index 2	2
	Charlson Comorbidity Index 3	3
	Charlson Comorbidity Index 4 or more	5
ED use in prior 6 months	0 visits	0
	1 visit	1

ABBREVIATIONS: ED = emergency department

Charlson Comorbidity Weights

Use the governed Charlson definition and score **only the highest tier within the same disease category**.[24] Confirm that diagnoses are **active** or **historically relevant** according to the scoring method:

WEIGHT	REPRESENTATIVE CONDITIONS[24,25]
1 point	Myocardial infarction; heart failure; peripheral vascular or cerebrovascular disease; dementia; chronic pulmonary disease; connective tissue disease; ulcer disease; mild liver disease; **diabetes without organ damage**
2 points	**Diabetes with organ damage**; hemiplegia or paraplegia; moderate or severe kidney disease; nonmetastatic tumor; leukemia; lymphoma

WEIGHT	REPRESENTATIVE CONDITIONS[24,25]
3 points	Moderate or severe liver disease
6 points	Metastatic solid tumor; AIDS

ABBREVIATIONS: AIDS = acquired immunodeficiency syndrome

Risk Tiers and Intervention Bundles

RISK TIER	CONTACT AND VISIT[12,27]	MEDICATION AND SERVICES[1,28,29]	MONITORING AND ESCALATION[1,3]
Low: LACE 0 to 4	Outreach **within 48 hours**; PCP evaluation **within 7 days** when clinically indicated and within the governed transition standard	**Confirm**: discharge list, pharmacy access, appointments, and **patient understanding**	Clear return precautions and **routine follow-up**
Moderate: LACE 5 to 9	Outreach **within 48 hours**; PCP or TCM **visit within 7 days**	**Medication reconciliation**; home-health or community linkage as indicated; **resolve SDOH barriers**	Condition-specific checks and **proactive second contact**
High: LACE 10 or more	Prioritize outreach **within 48 to 72 hours** and aim for **intensive clinical follow-up** within about **72 hours** or 3 to 5 days when feasible	**Pharmacist review**; home health or SNF coordination; caregiver training; equipment; **specialist handoff**	**Remote monitoring when actionable**; 24/7 triage; **low threshold** for same-day reassessment

ABBREVIATIONS: LACE = length of stay, acuity of admission, comorbidities, and emergency department visits; PCP = primary care physician; TCM = transitional care management; SDOH = social determinants of health; SNF = skilled nursing facility

Operational Use

- **Automate scoring** or route the hospital-provided score **into the care-management queue** when feasible[17]
- **Display the component values** so staff can validate the total rather than accepting a black-box flag[3]
- **Escalate based on the whole patient** when the **numeric score understates**: frailty, cognitive impairment, medication risk, or home instability[19,20]
- **Reassess support needs** when discharge destination or clinical status changes[26]

CLINICAL PEARL: SCORE THE PATIENT, THEN LOOK BEYOND THE SCORE

LACE captures **important utilization and disease burden**, but it **does not fully represent**: function, cognition, caregiver capacity, medication complexity, or whether the discharge plan **can actually be carried out**.[3,19]

Universal Discharge Controls

CONTROL	MINIMUM EXPECTATION[13,14,26]
Information	**Discharge summary**, final diagnoses, **medication changes**, pending results, appointments, and destination are **available to the PCP**
Medication	New, continued, stopped, held, and time-limited drugs are **reconciled with supply** and **monitoring confirmed**
Services	Home health, SNF, infusion, therapy, DME, transportation, and caregiver tasks have **named start dates and owners**
Access	The patient has a **first-call route**, **after-hours help**, and an **appointment** within the required clinical window
Understanding	**Patient and caregiver can explain**: the diagnosis, plan, red flags, medications, and next contacts

ABBREVIATIONS: PCP = primary care physician; SNF = skilled nursing facility; DME = durable medical equipment

↔ MAKING CONNECTIONS

Consult the **AAVBC Post-Acute Care Utilization QRG** for setting-specific criteria, home readiness, LTACH, inpatient rehabilitation, SNF and home-health selection, milestone review, and overuse or underuse examples.

POST-DISCHARGE CARE COORDINATION: DAYS 0-30

The first 30 days after discharge carry the **highest risk of readmission**, **adverse drug events**, and **preventable deterioration**, so this section lays out a structured, time-sequenced coordination model that assigns explicit triggers, actions, and owners across three phases: **inpatient coordination** (days 0 to 2), the **transitional care management visit** (days 3 to 7), and **longitudinal support** (days 8 to 30). Each phase is designed to **close the loop** on medications, pending results, function, and social barriers while **keeping the practice the default first point of contact** for non-emergent concerns and preserving an unobstructed path to emergency care.

Inpatient Coordination: Days 0 to 2

TRIGGER	PCP PRACTICE ACTION[5,6,12]	HOSPITAL CONNECTION[6,12,30]
Admission alert	**Add patient to common census ideally using HIE automation**; assign care manager; **verify**: facility, unit, diagnosis, and attending team	Send **baseline summary** and **direct contact information to hospitalist**
Within 24 hours	**Review**: prior medications, function, cognition, goals, specialists, and recent utilization	Conduct **concurrent review** with hospitalist or discharge planner
Within 48 hours	**Call the patient or receiving facility**; assess symptoms, medications, services, and plan execution	Escalate discrepancies to **hospitalist** or **PAC clinician**
Discharge planning begins	**Apply risk score**; identify **likely destination**; surface social and caregiver barriers	Align on objective **discharge and post-acute criteria**
Before discharge	**Reserve rapid PCP access**; **confirm**: pharmacy, DME, transport, services, and patient contact information	Have hospital planner book the appointment **before departure**
Discharge event	**Obtain summary and final medication list**; route high-risk patients to priority workflow	Receive **warm handoff** and **unresolved-item list**

ABBREVIATIONS: PCP = primary care physician; PAC = post-acute care; DME = durable medical equipment; HIE = health information exchange

48 Hour Outreach Questions

- Do you **have** and **understand** the discharge instructions?
- Were all **new prescriptions obtained**, and were **discontinued drugs removed**?
- Are any red-flag symptoms **present now**?
- Did home health, SNF, infusion, therapy, or DME services **start as planned**?
- Can you **attend the scheduled PCP visit**, and what barrier could prevent it?
- Do you know **whom to call** before using the emergency department **for a non-emergent concern**? **Emphasize**: “Call Us First” principle

QUALITY OUTCOME: COMPLETE THE FIRST LOOP

The first outreach is successful only when the **team verifies the plan**, **resolves discrepancies**, and **assigns unresolved problems**.[31] A documented attempted call without clinical closure is not the same result.[31]

CLINICAL PEARL: CALL US FIRST PRINCIPLE

Every patient leaving the hospital should know that **the practice is the first point of contact for any new**, **worsening**, or **confusing symptom** that is **not an emergency**, and should be given a specific number that reaches the care team during and after business hours.[1,22] Reaching the team first allows same-day triage, medication clarification, and rapid-access visits that resolve most post-discharge concerns before they escalate, **redirecting avoidable emergency department use** toward **faster**, **lower-cost**, **better-coordinated care**.[32,33]

This principle does not delay emergency care: patients must be told explicitly which red-flag symptoms (for example, chest pain, difficulty breathing, stroke signs, or uncontrolled bleeding) warrant calling emergency services or going to the emergency department immediately, without calling first.[1,34] The goal is to **make the practice the default route for non-emergent needs** while keeping the path to emergency care unobstructed.[35]

TCM Visit: Days 3 to 7

Schedule a face-to-face or appropriate high-acuity telehealth visit **within 7 days**, aiming for **3 to 5 days or sooner** for high-risk patients.[23,36] Confirm **current Transitional Care Management requirements before billing** and document the communication and medical decision-making needed for the applicable service.[18]

VISIT DOMAIN	REQUIRED REVIEW[19,37,38]	OUTPUT[37–39]
Hospital cause and trajectory	Why admission occurred including root cause; treatment response; current symptoms; unresolved diagnostic questions	Updated **problem list** and **recovery plan**
Physical assessment	Volume status; respiratory status; wound; infection; pain; mobility; cognition; nutrition; condition-specific findings	**Stability decision** and **treatment adjustment**
Medication reconciliation	Preadmission, discharge, current use, fills, affordability, adherence, interactions, monitoring, and duration	**One reconciled list with accountable prescribers**
Pending care	Laboratory, imaging, pathology, cultures, referrals, therapy, home health, equipment, and follow-up	**Named owner** and **completion date**
Function and safety	ADLs, falls, gait, delirium, caregiver workload, home environment, and driving	Therapy, DME, support, or placement adjustment

VISIT DOMAIN	REQUIRED REVIEW[19,37,38]	OUTPUT[37–39]
Social determinants	Transport, food, housing, language, literacy, finances, pharmacy, and technology	**Barrier-specific intervention**
Escalation	Red flags, first-call route, same-day access, and emergency indications	**Written** and **teach-back-confirmed response plan**

ABBREVIATIONS: ADLs = activities of daily living; DME = durable medical equipment

Close the Visit

- Set the **next contact** and **laboratory or monitoring date** before the patient leaves[5]
- **Send updated orders and medication changes to**: home health, SNF, pharmacy, specialists, and caregiver as applicable[40,41]
- Document **who owns each outstanding result** and when lack of improvement **should trigger escalation**[13]

CLINICAL PEARL: RECONCILE THE PLAN, NOT ONLY THE LIST

Medication reconciliation should **connect every drug to**: its indication, dose, duration, monitoring, access, and prescriber.[7,39] A matching list can still fail when the patient **cannot obtain**, **understand**, or **safely use the regimen**.[7,39]

Longitudinal Support: Days 8 to 30

SUPPORT	BEST USE[15,42,43]	OPERATIONAL REQUIREMENT[38,44,45]
Remote patient monitoring	**Selected**: heart failure, COPD, hypertension, diabetes, or other high-risk patients	**Defined data thresholds**; daily review process; named responder; escalation pathway; patient ability to use device
Home health	**Homebound patients** needing **intermittent** skilled nursing or therapy	**Timely first visit**; medication verification; shared notes; **24/7 contact**; PCP notification of change
Care-manager follow-up	**Moderate- and high-risk patients**; unresolved barriers or complex service plans	Scheduled contacts; symptom screen; appointment and service tracking; **closure documentation**

SUPPORT	BEST USE[15,42,43]	OPERATIONAL REQUIREMENT[38,44,45]
24/7 clinical access	New or worsening symptoms that may be safely assessed **outside** the emergency department	**Live triage**; same-day clinician pathway; clear emergency exception
Specialist connection	Condition-specific **instability**, **unresolved diagnostic need**, or **high-risk therapy**	**Warm handoff**; response window; shared medication and monitoring ownership
Caregiver support	Cognitive, functional, language, sensory, or self-management limitation	**Teach-back**; written plan; task assignment; backup and respite resources

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease; PCP = primary care physician

Longitudinal Contact Priorities

- **Confirm** clinical trajectory and adherence **after any treatment change**[37]
- Review monitoring data only **when the practice can respond to actionable trends**[42]
- **In older adults**, **watch for and address common complications**: deconditioning, delirium, falls, caregiver strain, and medication adverse effects in older adults[19,20]
- Treat a SNF-to-home discharge as a **second high-risk transition**[46]

QUALITY OUTCOME: BALANCING PRINCIPLE

A **triage line** and **remote monitoring should create faster appropriate care**, not a barrier to emergency treatment.[42] RPM alerts addressed early by the physician and their team can often **prevent further deterioration** that may necessitate an ER visit. Direct the patient to emergency services **immediately** whenever an alert signals that the condition has reached a **critical level**.[42]

DISEASE PATHWAY CONSIDERATIONS

Condition-specific transitions require targeted attention because the **drivers of readmission**, the **interventions that prevent it**, and the **red flags that warrant escalation differ substantially by disease**. This section adapts the general days 0 to 30 coordination model to the **highest-volume**, **highest-risk discharge diagnoses** (heart failure, sepsis and serious infection, COPD, pneumonia, diabetes with complications, and kidney or urinary disease), pairing common return drivers with concrete interventions, disease-specific transition checklists, and escalation criteria. The recurring theme across all pathways is that **a written plan**, **reconciled medications**, **confirmed device** and **supply access**, and a **named owner for every pending result** are what convert a discharge order into **safe**, **coordinated recovery**.

Heart Failure and Sepsis

CONDITION	COMMON RETURN DRIVERS[47,48]	TARGETED INTERVENTION[47–49]	ESCALATION FOCUS[50,51]
Heart failure	**Residual congestion**; **medication confusion** or **nonadherence**; missed weight or symptom change; kidney or blood-pressure instability	**Daily weights**; blood pressure when useful; sodium and fluid plan; early medication and laboratory review; PCP or cardiology visit **within 7 days**	Rapid weight gain; **worsening dyspnea or edema**; syncope; chest pain; hypotension; severe kidney or electrolyte change
Sepsis or serious infection	**Incomplete antimicrobial course**; source-control failure; line or wound complication; delayed recognition of **recurrent infection**	**Confirm**: antibiotic, duration, route, cultures, line plan, source follow-up, home infusion, and temperature or symptom monitoring	**Fever or hypothermia**; confusion; hypotension; worsening wound or respiratory symptoms; **inability to take treatment**

MAKING CONNECTIONS: Also consult VBC-focused coding QRGs on **heart failure**, as well as the utilization management QRG on **heart failure medications**

ABBREVIATIONS: PCP = primary care physician; VBC = value-based care; QRG = quick reference guide

Heart Failure Transition Checklist

- Record **discharge weight** and **clinically defined target** or dry-weight context[47]
- **Reconcile**: diuretics, renin-angiotensin system therapy, beta blocker, mineralocorticoid receptor antagonist, SGLT2 inhibitor, potassium, and held medications as applicable[37,47]
- Schedule **kidney function** and **electrolyte monitoring** according to the regimen and clinical change[47]
- **Provide a written action plan for**: weight, swelling, breathing, blood pressure, and medication concerns[37,47]

Infection Transition Checklist

- **Name**: the infection source, final cultures, antibiotic stop date, and clinician monitoring response[48]
- **Confirm**: line care, infusion delivery, laboratory schedule, and who removes the line[48]
- **Teach the patient and caregiver to recognize**: fever, confusion, weakness, wound change, and poor intake[14,51]

↔ MAKING CONNECTIONS

Use the **AAVBC Value-Based Care Specialist Management QRG** to define PCP, cardiology, infectious-disease, pharmacy, and home-infusion ownership when ongoing co-management is required.

COPD and Pneumonia

CONDITION	COMMON RETURN DRIVERS[52–55]	TARGETED INTERVENTION[52,56,57]	ESCALATION FOCUS[52,54,58]
COPD	**Incorrect inhaler use**; medication access; DME delivery including nebulizer and oxygen; oxygen use confusion; environmental trigger; missed symptom progression; absent pulmonary rehabilitation	**Observe inhaler teach-back**; **reconcile maintenance and rescue therapy**; verify oxygen order and equipment; consider pulse-oximetry trends when actionable; **schedule rehabilitation and follow-up**	**Worsening breathlessness**; altered mental status; cyanosis; **severe oxygen decline** relative to plan; chest pain; inability to use treatment
Pneumonia	**Premature discharge**; **secondary infection**; medication nonadherence; aspiration; frailty; deconditioning	**Meds-to-beds** or **confirmed pharmacy access**; vaccine review; swallowing assessment when indicated; mobility and nutrition plan; **early clinical reassessment**	**Increasing work of breathing**; confusion; fever recurrence; **hypotension**; poor intake; oxygen deterioration

MAKING CONNECTIONS: Also consult the VBC-focused coding QRG on **COPD**, as well as the utilization management QRG on **COPD medications**

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease; VBC = value-based care; QRG = quick reference guide

Respiratory Transition Controls

- Have the patient **demonstrate each inhaler** rather than simply confirm understanding[52,58]
- Write the **oxygen flow**, **duration**, **target context**, **equipment supplier**, and **backup plan clearly**[52]
- **Provide a written, individualized green/yellow/red action plan** and teach what to do at each stage:
  - **Green** (baseline) = maintenance inhalers
  - **Yellow** (worsening dyspnea, cough, or sputum purulence) = start rescue medications (short-acting bronchodilator, plus self-initiated steroid/antibiotic if prescribed) and call the named contact

  - **Red** (severe rest dyspnea, chest pain, confusion, or cyanosis) = **emergency care immediately**[58–60]

- **Confirm antimicrobial duration** and whether symptoms **should be improving** by the first follow-up[54]
- **Assess**: aspiration risk, oral intake, frailty, mobility, and home support **before discharge**[19]
- **Schedule pulmonary rehabilitation or therapy** rather than leaving it as an unscheduled recommendation[52,57]

CLINICAL PEARL: DEVICE ACCESS IS PART OF THE PRESCRIPTION

A correct inhaler, oxygen, or monitoring plan **fails if the patient cannot operate the device**, **hear instructions**, **afford supplies**, **obtain replacements**, or **receive caregiver help**.[58,61] Verify function **with demonstration**.[58,61]

Diabetes and Kidney Disease

CONDITION	COMMON RETURN DRIVERS[62–64]	TARGETED INTERVENTION[62,65–67]	ESCALATION FOCUS[64,68,69]
Diabetes with complications	**Hypoglycemia** or **hyperglycemia**; complex insulin changes; **supply or technique error**; poor intake; foot or wound deterioration	**Simplify when appropriate**; confirm insulin device and glucose-monitor use; diabetes educator; CGM for selected patients; nutrition plan; podiatry or wound follow-up	Severe or recurrent low glucose; persistent marked hyperglycemia; ketosis symptoms; infection; **inability to self-administer safely**
Kidney or urinary disease	**Acute kidney injury**; dehydration or overload; medication restart error; electrolyte change; catheter complication; missed laboratory follow-up	**Reconcile renally cleared and held drugs**; set fluid guidance; schedule metabolic panel in about 3 to 5 days when indicated; catheter plan; nephrology handoff	**Falling urine output**; confusion; dyspnea; edema; hypotension; severe electrolyte symptoms; fever or catheter obstruction

Older Adult Medication Safeguards

- **Compare the pre-hospital regimen with**: new renal function, nutrition, cognition, dexterity, and caregiver capacity[19,20]
- **Remove**: duplicative insulin orders, obsolete sliding scales, nephrotoxic over-the-counter drugs, and medications the hospital intended to stop[65,67]

- **Confirm**: glucose meter, CGM, insulin, needles, catheter supplies, and other equipment are physically available[39,62]
- Use **written sick-day** and **hydration guidance** that is specific enough to act on but does not conflict across conditions[67,68]
- Assign every laboratory order **to a clinician** who will receive and act on the result[67]

↔ MAKING CONNECTIONS

Use the **AAVBC Insulin and Heart Failure Medication Utilization QRGs** for condition-specific medication initiation, monitoring, deintensification, and older-adult safety principles.

QUALITY OUTCOME: NO UNOWNED TESTS

Scheduling a post-discharge laboratory panel **does not** create safety **unless** the result reaches an accountable clinician who **can interpret it**, **contact the patient**, and **change the plan promptly**.[13,67]

DESIGNATED HOSPITALIST PARTNERSHIP

A preferred hospitalist relationship can reduce transition gaps when selection is based: on clinical effectiveness, timely communication, discharge quality, access, and total episode performance.[6,44] The relationship **should preserve patient choice**, **emergency access**, **hospital rules**, and **applicable legal requirements**.

PHASE	HOSPITALIST COMMITMENT[70–72]	PCP COMMITMENT[12,36,70]
Admission	**Notify the PCP team rapidly through HIE** or **direct communication** and review available longitudinal information	**Maintain**: current problems, medications, goals, and contact routes; send **baseline** and **vulnerability summary**
Inpatient stay	Use **objective discharge criteria** and communicate on complex or high-risk patients	Participate in **concurrent review** and clarify **baseline function** and **outpatient feasibility**
Before discharge	**Schedule the PCP or TCM visit**; reconcile key changes; **finalize destination and services**	Protect rapid appointment capacity and **resolve outpatient or home barriers**
Discharge	**Transmit a typed summary with**: diagnoses, medications, pending results, follow-up, and ownership within 24 hours	Complete **48-hour outreach**, medication review, and rapid clinical follow-up

PHASE	HOSPITALIST COMMITMENT[70–72]	PCP COMMITMENT[12,36,70]
Governance	Participate in **joint readmission** and process review	**Share outcomes** and **address system failures** across the continuum

ABBREVIATIONS: PCP = primary care physician; HIE = health information exchange; TCM = transition care management

Selection Criteria

- **Risk-adjusted readmission**, mortality, length of stay, complications, and **discharge stability**[9,37]
- **Timely**: admission notice, discharge-summary completion, and response to PCP communication[13,71]
- **Medication accuracy**, use of **prior records**, and **avoidance of duplicate testing**[7,73]
- **Ability to schedule direct PCP follow-up** and coordinate post-acute placement[5,26]
- Patient experience, access, network participation, and **clinically meaningful local outcomes**[28,31]

↔ MAKING CONNECTIONS

Consult the **AAVBC Referral Management: Cost-Efficient and Clinically Effective Specialist Selection QRG** for the quality gate, total episode cost, access, geoaccess, network, patient-fit, and performance-review framework used to select clinical partners.

QUALITY OUTCOME: PARTNERSHIP IMPROVES ACCESS

A **clinically effective**, **cost-efficient hospitalist partner** recognizes discharge risk early, communicates promptly, and connects the patient to the next service **within the required window**.[5,13]

HEALTH INFORMATION EXCHANGE: ALERTS AND DATA RECONCILIATION

CAPABILITY	WORKFLOW[40,74,75]	VALUE[40,73,75]
Real-time ADT feeds	**Push**: admission, emergency, observation, transfer, and discharge events **into a care-management work queue**	PCP team learns about events **early enough to act**

CAPABILITY	WORKFLOW[40,74,75]	VALUE[40,73,75]
Accurate patient roster	Submit current attributed Medicare, ACO, and Medicare Advantage panels **at least monthly**	**Higher alert match** and **fewer missed patients**
Tiered routing	Send acute events to the **care-transitions team** rather than a general inbox, care-transition team establishes routes to appropriate health providers	**Clear ownership** and faster response
Aggregated clinical documents	Pull consolidated hospital information **before the TCM visit** when the summary is delayed	More complete clinical reconstruction
Pharmacy history	**Compare** discharge instructions with available dispense or fill information	Detect **unfilled prescriptions** and **unexpected continued use**
Diagnostic reuse	Review current hospital laboratory, CT, radiograph, and other results **before ordering outpatient repeats**	**Fewer duplicative tests** and lower patient burden
Bidirectional care plans	Make goals, limitations, medication context, and outpatient plans **visible to emergency** and **hospital teams**	**Continuity** on the next acute encounter

ABBREVIATIONS: ADT = admission, discharge, transfer; PCP = primary care physician; ACO = accountable care organization; TCM = transition care management; CT = computed tomography

Operational Guardrails

- **Route alerts to named teams** with response windows and backup coverage[74]
- Suppress duplicate technical messages **without** suppressing clinically distinct events[4]
- Regularly reconcile **patient-matching identifiers** (name, date of birth, MRN, plan/member ID) and refresh the attributed panel as patients enter and leave the roster, so **alerts match the right patient** and **no attributed patient is missed**[4]
- Limit access to the **minimum necessary** and follow **applicable privacy and security requirements**

CLINICAL PEARL: AN ALERT IS NOT AN INTERVENTION

Real-time data creates value **only when it enters an owned workflow with**: a response time, clinical action, documentation standard, and escalation path.[74]

AUTOMATED COMMON CENSUS

A common census **combines HIE events for attributed patients across payers** so the practice can prioritize current utilization rather than search separate portals.[4,74] The dashboard should show only information **necessary for clinical routing** and **transition work**.

DATA FIELD	TYPICAL EVENT SOURCE[4]	OPERATIONAL USE[4]
Patient and contract	Patient identification and roster match	Identify the patient and **applicable value-based population**
Encounter class	Emergency, observation, inpatient, or transfer status	**Set urgency** and the correct workflow
Facility and unit	Assigned location	Reach the inpatient or emergency team **directly**
Admitting diagnosis	Diagnosis field or clinical message	Trigger **condition-specific pathway** and clinical prioritization
Discharge destination	Disposition field	**Route to**: home, home-health, SNF, rehabilitation, LTACH, or other transition workflow
Event time	ADT timestamp	**Measure alert** and **response latency**
Owner and status	Care-management workflow	Prevent **unassigned alerts** and **document closure**

ABBREVIATIONS: SNF = skilled nursing facility; LTACH = long-term acute care hospital; ADT = admission, discharge, transfer

Event-Driven Actions

CENSUS VIEW	ACTION WINDOW[23,31]	PRIMARY RESPONSE[6,31]
Active emergency or observation	About 2 hours when operationally feasible	**Contact ED** or **hospital liaison**; coordinate safe outpatient alternative when clinically appropriate
Active inpatient	Within 24 hours	Begin concurrent review and communicate baseline, risks, goals, and likely post-acute needs
Acute discharge	Within 24 to 48 hours	Complete outreach, medication review, service check, and rapid PCP scheduling

ABBREVIATIONS: ED = emergency department; PCP = primary care physician

QUALITY OUTCOME: CENSUS COVERAGE

Track the **percentage of true acute events** that **generate a usable alert** and the **percentage assigned and acted on** within the required clinical window.

DUAL-TRACK HOME AND SNF TRANSITIONS

A single hospitalization can generate **two distinct high-risk transitions**: one to the **initial destination** (home or SNF) and, for SNF patients, **a second when they return home**, each requiring its own reconciliation, service setup, and follow-up. This section runs the two discharge tracks in parallel, specifying the **primary contact**, **first-48-hour actions**, **clinical risks**, **follow-up cadence**, and **core measures** for home or home-health versus SNF placement, and treats the **SNF-to-home step as a separate transition bundle** rather than an afterthought.

DIMENSION	TRACK A: HOME OR HOME HEALTH[1,26,31]	TRACK B: SNF[76–78]
Primary contact	Patient, caregiver, and home-health team	SNF director of nursing, case manager, and attending clinician
First 48 hours	**Confirm**: symptoms, medications, pharmacy, services, equipment, and **PCP appointment**	**Confirm**: intake orders, medication transcription, hospital directives, goals, and **attending clinician**
Clinical risk	**Self-management failure**; medication confusion; missed follow-up; delayed home service	**Deconditioning**; **infection**; medication error; delayed clinician review; **avoidable emergency transfer**
Follow-up	PCP or TCM visit **within 3 to 7 days** according to risk	**Initial SNF clinician evaluation** and regular interdisciplinary review
Core measure	**Rapid PCP follow-up** and **30-day stabilization**	**Length of stay**, community discharge, and **SNF-to-hospital return**
Next transition	**Return to routine PCP management** when stable	Treat SNF-to-home discharge as a **second high-risk event**

ABBREVIATIONS: SNF = skilled nursing facility; PCP = primary care physician; TCM = transition care management

Secondary Transition from SNF to Home

- Obtain notice about **7 days before** planned community discharge **when feasible**[46]
- Schedule PCP follow-up **before** the patient leaves the SNF[46,76]
- Deliver DME and finalize home-health orders **before** arrival home[76]
- **Reconcile** the facility medication list against the outpatient plan[39,46]

- **Repeat 48-hour outreach** after return home and **verify the new plan**[31]

↔ MAKING CONNECTIONS

Use the **AAVBC Post-Acute Care Utilization QRG** to confirm whether the chosen post-acute level matches medical stability, daily skilled need, therapy tolerance, home readiness, and caregiver capacity.

CLINICAL PEARL: ONE HOSPITALIZATION CAN CREATE TWO HIGH-RISK TRANSITIONS

A patient discharged **from hospital to SNF** and later **from SNF to home** needs a new medication, service, equipment, caregiver, and follow-up **check at each boundary**.[26,46]

PREFERRED SNF AND SNF-CLINICAN MODEL

Preferred SNF relationships should be **based on outcomes** and **operational capability** rather than marketing or proximity alone.[8,79] **Maintain alternatives** for medical need, patient preference, network fit, geoaccess, capacity, language, and continuity.

SELECTION DOMAIN	HIGH-VALUE EXPECTATION[8,26,80]	EVIDENCE TO REVIEW[41,80,81]
Clinical outcomes	Risk-adjusted readmission **below the regional benchmark**; **ALOS matches disease/condition/ debility**; safe management of change	**Claims**; facility data; patient-level readmission review
Length and discharge	Efficient recovery with **timely community discharge** and **no premature step-down**	**Average and condition-specific length**; community discharge; **early return**
Capability	IV therapy, wound care, weekend rehabilitation, monitoring, and other services **match referred patients**	Staffing; hours; credentialing; **service availability**
Clinical access	**Initial evaluation within 24 to 48 hours** and increased rounding during instability	**Progress-note timestamps**; rounding logs; escalation response
Emergency- transfer process	Live clinician triage **before** non-emergent transfer **without delaying emergency care**	**Call logs**; **reason for transfer**; ED outcome

SELECTION DOMAIN	HIGH-VALUE EXPECTATION[8,26,80]	EVIDENCE TO REVIEW[41,80,81]
Data exchange	Hospital intake, progress, medication changes, and discharge packet **reach the PCP**	HIE or EHR **timeliness** and **completeness**

ABBREVIATIONS: IV = intravenous; ED = emergency department; PCP = primary care physician; HIE = health information exchange; EHR = electronic health record; ALOS = average length of stay

Dedicated SNF Clinician Expectations

- Perform initial medical assessment **within the governed 24- to 48-hour window**[79]
- **Round at least twice weekly** and more often when the patient is medically unstable[79]
- **Provide after-hours clinical triage** for non-life-threatening change in condition[77,81]
- Set and document a **diagnosis-** and **condition-specific expected length of stay** and manage toward it, without premature discharge or unnecessary prolongation once skilled needs are met. Traditional Medicare ALOS is typically **25 to 44 days**, versus **about 10 to 14 days** and up to 21 days for Medicare Advantage, reflecting active plan management and prior-authorization cycles[26,82,83]
- **Review**: hospital notes, medications, function, goals, and expected home date[41,46]

QUALITY OUTCOME: AVOIDABLE ER TRANSFERS FALL WHEN CLINICAL ACCESS RISES

The goal is not to block transfer. It is to **give SNF staff timely clinician support** so treatable, non-emergent changes can be managed safely while emergencies move without delay.[77,81]

CARE COMPACTS AND RESPONSIBILITIES

Care compacts are **written mutual-accountability agreements** that define **who does what**, and **by when**, **at each handoff** between the PCP, hospitalist, and SNF clinician, so that responsibility for notification, review cadence, discharge criteria, and data delivery is **explicit rather than assumed** across transitions.

OPERATIONAL DIMENSION	HOSPITALIST COMPACT[6,18,71]	SNF CLINICIAN COMPACT[26,46,79]
Primary focus	Use of **Observation Status** for sign and symptoms, acute admission, inpatient continuity, and **hospital-to-outpatient transition**	Subacute clinical oversight, appropriate ALOS management to avoid premature discharges and unnecessarily long LOS, rehabilitation, and **SNF-to-home transition**
Notification	Rapid admission notice **through HIE** or **direct channel**	SNF intake confirmation and **named attending clinician**
Initial review	Review PCP baseline **before** major chronic-regimen changes when feasible	Face-to-face assessment **within 24 to 48 hours**
Clinical cadence	**Daily inpatient rounding** and **contact for complex shared patients**	At least **twice-weekly rounding** with higher frequency for instability
Gatekeeping rule	Use **objective discharge criteria to appropriate level of care based on clinical needs** and a complete transition plan	Live triage **before** non-emergent ED transfer; **no delay for emergency care**
Discharge coordination	Book rapid PCP follow-up **before** hospital discharge	Notify PCP **before** community discharge and **finalize DME** and **home services**
Data delivery	Typed discharge summary **within 24 hours**	Discharge packet, updated medications, and therapy progress **within 24 hours**
PCP reciprocal commitment	**Provide**: baseline data, rapid access, 48-hour outreach, and closed-loop follow-up	**Provide**: **baseline ADLs** and **core chronic disease stages**, longitudinal context and repeat the transition bundle after home return

ABBREVIATIONS: SNF = skilled nursing facility; HIE = health information exchange; PCP = primary care physician; ED = emergency department; DME = durable medical equipment

Compact Governance

- Use a **nonfinancial agreement** unless a separately governed and legally reviewed arrangement applies
- **Name**: clinical and operational leads, response windows, secure channels, and backup coverage[40]

- **Review**: readmissions, length of stay, discharge level of care, quality, access, and communication together[17]
- **Preserve**: patient choice, medical necessity, network adequacy, and urgent access[26]

> ↔ **MAKING CONNECTIONS**
>
> Consult the **AAVBC Value-Based Care Specialist Management QRG** for consultation tracks, care-compact structure, note-return expectations, action triggers, and corrective-action governance.

PERFORMANCE METRICS AND TARGETS

The following targets can **support initial design**, but they **should be validated against**: local populations, current definitions, case mix, network capacity, and payer requirements before they become contractual standards.

METRIC	ILLUSTRATIVE TARGET	INTERPRETIVE QUESTION
Census match success	Above 98 percent	Are true acute events generating **usable alerts** for the attributed population?
Admission notification	Within 2 hours	Can the PCP team engage **early enough** to influence care and transition planning?
Discharge summary delivery	Within 24 hours	**Does the summary contain**: the medication, pending-result, destination, and follow-up information needed?
Direct PCP appointment booking	Above 90 percent before discharge	Does the patient leave with an **executable appointment**?
7-day TCM completion	Above 85 percent	Are high-risk patients actually **evaluated in time**?
SNF initial assessment	Within 24 to 48 hours for more than 95 percent	Does clinical review occur **before** early deterioration?
Non-emergent pre-transfer triage	100 percent	Did a clinician **assess alternatives without delaying emergency care**?
SNF average length	Approximately 12 to 16 days for standard rehabilitation	Is the comparison **clinically similar** and are **long or short stays justified**?

METRIC	ILLUSTRATIVE TARGET	INTERPRETIVE QUESTION
Cross-continuum readmission	Below 12 percent	Is performance **risk-adjusted** and are **preventable causes understood**?

ABBREVIATIONS: PCP = primary care physician; TCM = transition care management; SNF = skilled nursing facility

Balancing Measures

- **Mortality**, delayed emergency care, post-discharge harm, and **premature discharge**
- **Patient experience**, caregiver burden, access, geoaccess, and health-equity gaps
- **Total episode cost**, duplicate testing, medication adverse events, and **functional recovery**

QUALITY OUTCOME: ACCESS AND URGENCY ARE PERFORMANCE

Clinically effective, cost-efficient partners improve outcomes by **responding quickly**, **recognizing deterioration**, and **connecting patients to the appropriate service**.[36,81] Timely necessary care is a value measure, not an exception to it.[23]

ROOT-CAUSE REVIEW AND DASHBOARD

Every readmission or transition failure should be **traced to its earliest preventable cause**, and this section pairs a **structured root-cause review** across clinical, medication, information, access, patient, post-acute, and social domains **with dashboard measures** that distinguish sustained, fairly attributed performance patterns from short-term variation.

Readmission Root-Cause Domains and Corrective Responses

ROOT-CAUSE DOMAIN	REVIEW QUESTIONS[9,21,84]	CORRECTIVE RESPONSE[22,26,85]
Clinical trajectory	Was **discharge stability adequate**; were warning signs present; did the diagnosis or treatment change?	**Refine**: discharge criteria, monitoring, and escalation
Medication	Was a drug **omitted**, **duplicated**, **unaffordable**, **unavailable**, **misunderstood**, or **unsafe**?	**Improve**: reconciliation, supply, counseling, simplification, and monitoring

ROOT-CAUSE DOMAIN	REVIEW QUESTIONS[9,21,84]	CORRECTIVE RESPONSE[22,26,85]
Information transfer	Did the PCP, specialist, pharmacy, home health, or SNF **receive usable information in time**?	**Repair**: interface, routing, ownership, and confirmation
Access	Could the patient obtain **timely** PCP, specialist, home, pharmacy, transport, **or after-hours help**?	**Add**: protected access, backup providers, telehealth, transport, and triage
Patient and caregiver	Were cognition, function, literacy, preference, or caregiver capacity **misjudged**?	**Improve**: assessment, teach-back, training, and support
Post-acute setting	**Did the level of care match need**; did services start; was deterioration managed appropriately?	**Correct**: placement criteria, capability, milestones, and clinician access
Social and financial	Did food, housing, cost, coverage, language, or equipment **prevent plan execution**?	**Assign**: targeted resource and benefit interventions

ABBREVIATIONS: PCP = primary care physician; SNF = skilled nursing facility

Dashboard Review Questions

- Is the measure **clinically meaningful** and **attributed fairly**?[28]
- Are the numerator, denominator, exclusions, time window, risk adjustment, and data lag **defined**?[86]
- Does the result represent a **sustained clinically meaningful pattern** or **short-period variation**?[17]
- What proportion of reviewed returns **were preventable**, and **at which transition point did the failure occur**?[9,21]
- Did a corrective action improve **both the target measure** and its **balancing outcomes**?[2]

CLINICAL PEARL: REVIEW THE FAILED LINK, NOT ONLY THE RETURN

A readmission is the final event in a chain. Identify whether the **earliest preventable failure involved**: stability, information, medication, access, setting capability, caregiver support, or response to deterioration.[9,21]

OLDER ADULT IMPLEMENTATION PLAYBOOK

Older adults account for a disproportionate share of care transitions and are the most vulnerable to transition-related harm, so this playbook applies the general transitions-of-care model to the geriatric population **through two lenses**: a clinical overlay that specifies what to assess and act on at every handoff, and a phased operational timeline for standing up the program.[87,88] The overlay below targets the domains that most often **drive avoidable readmission**, **functional decline**, and **adverse drug events** in older patients, while the 90-day timeline sequences the build so accountability, data visibility, and partner compacts are **established before disease-specific pathways are layered on**.

Older Adult Overlay

DOMAIN	IMPLEMENTATION ACTION[19,20,61]
Frailty and function	**Document**: baseline and current ADLs, gait, falls, endurance, nutrition, and rehabilitation need at every transition
Cognition and delirium	**Assess**: decision-making, teach-back reliability, medication self-management, and caregiver availability
Sensory and communication	**Use**: hearing support, large-print instructions, language services, and caregiver reinforcement
Polypharmacy	**Prioritize**: high-risk medication changes, renal dosing, duplicate therapy, discontinued drugs, and regimen simplification
Medicare and network	**Verify**: the exact benefit, authorization, homebound or skilled need, cost sharing, provider participation, and geoaccess
Caregiver capacity	**Define**: tasks, availability, training, backup, respite, and signs of overload

ILLUSTRATIVE 90-DAY PHASED IMPLEMENTATION TIMELINE

Standing up a **PCP-led transitions program** is not a single event, but a **sequenced build**: **accountability and workflows have to exist** before data feeds can be routed anywhere useful, and **data visibility has to be reliable** before partner compacts and disease-specific pathways can be layered on top without collapsing under gaps. The sequence below **stages the work into three 30-day blocks** so that each phase's deliverables become the foundation the next phase depends on: team structure and workflow definitions first, then census and partner infrastructure, then measurement and refinement, with a quarterly cadence to **keep targets and partner performance honest** against real outcomes rather than initial assumptions.

Days 1–30: Foundation — Team, Workflows, and Access

WEEK	PRIORITY ACTION	OWNER	MILESTONE/DELIVERABLE
Week 1	**Name the transitions team**: lead PCP, lead care manager, UM nurse, medication reviewer, scheduling lead, data/quality lead	Practice leadership	**Roles assigned; RACI documented**
Week 1–2	Map **current admission** and **discharge visibility** (what alerts exist today, what gaps remain)	Data/quality lead	**Gap analysis of ADT/HIE coverage**
Week 2	Define **risk-stratification method** (LACE or governed hospital/payer score) and documentation standard	Lead PCP, UM nurse	**Risk-scoring protocol finalized**
Week 2–3	**Draft outreach workflow**: 48-hour contact script, escalation triggers, "Call Us First" messaging	Lead care manager	**Outreach protocol and call script**
Week 3	Draft **medication-reconciliation workflow** and reviewer responsibilities	Pharmacist/ medication reviewer	**Reconciliation workflow and ownership map**
Week 3–4	Protect **rapid-access scheduling capacity** for TCM and high-acuity visits	Scheduling team	**Reserved appointment slots confirmed**
Week 4	**Pilot the full workflow** (admission → 48-hour contact → risk score → visit booking) on a small cohort	Full transitions team	**Pilot run completed; friction points logged**

ABBREVIATIONS: ADT = admission, discharge, and transfer; HIE = health information exchange; LACE = Length of stay, Acuity of admission, Comorbidity, Emergency department use; PCP = primary care physician; RACI = Responsible, Accountable, Consulted, Informed; SNF = skilled nursing facility; TCM = transitional care management; UM = utilization management

End-of-phase gate: the team is named, every workflow has a **documented owner** and **time window**, and a small cohort has moved through the process end-to-end at least once.

Days 31–60: Infrastructure — Census, Partners, and Dual Tracks

WEEK	PRIORITY ACTION	OWNER	MILESTONE/DELIVERABLE
Week 5	Activate the **automated common census**; submit attributed roster (Medicare, ACO, Medicare Advantage)	Data/quality lead	**Live census feeding the care-management queue**

WEEK	PRIORITY ACTION	OWNER	MILESTONE/DELIVERABLE
Week 5–6	Establish direct contact channels with the **designated hospitalist group**	Lead PCP	**Hospitalist communication channel and escalation path live**
Week 6	Establish direct contact channels with **preferred SNF partners**; confirm SNF-clinician expectations	UM nurse, lead care manager	**SNF contact list and access agreements in place**
Week 6–7	**Standardize discharge data intake** (summary format, medication list, pending results)	Data/quality lead	**Standardized discharge-data template adopted**
Week 7	Test the **home/home-health track end-to-end** with real patients	Lead care manager	**Home-track workflow validated**
Week 7–8	Test the **SNF track end-to-end**, including the SNF-to-home secondary transition	UM nurse	**SNF-track workflow validated, including second transition handoff**
Week 8	**Reconcile alert accuracy** (patient-matching, duplicate suppression) and adjust routing	Data/quality lead	**Alert accuracy above target threshold**

ABBREVIATIONS: ADT = admission, discharge, and transfer; ACO = accountable care organization; MA = Medicare Advantage; SNF = skilled nursing facility; UM = utilization management

End-of-phase gate: the census is **live** and **matching patients reliably**, both home and SNF tracks have been exercised with real cases, and hospitalist/SNF contact channels are functioning.

Days 61–90: Measurement - Dashboards, Root-Cause Review, and Compacts

WEEK	PRIORITY ACTION	OWNER	MILESTONE/DELIVERABLE
Week 9	**Launch the performance dashboard** (census match, notification timing, TCM completion, readmission rate)	Data/quality lead	**Dashboard live and reviewed weekly**
Week 9–10	Begin root-cause review of **every early readmission or transition failure**	Full transitions team	**Root-cause review process running with documented findings**
Week 10	Draft and negotiate **care compacts** with the **hospitalist group**	Lead PCP	**Hospitalist compact signed or in final review**
Week 10–11	Draft and negotiate **care compacts** with **preferred SNF partners**	UM nurse	**SNF compact signed or in final review**

WEEK	PRIORITY ACTION	OWNER	MILESTONE/DELIVERABLE
Week 11	**Refine alert routing** and **outreach scripts** based on the first month of dashboard and root-cause data	Data/quality lead, lead care manager	**Updated protocols reflecting early lessons**
Week 12	**Layer in the first disease-specific pathway** (typically heart failure or COPD, given readmission volume)	Lead PCP	**First disease pathway checklist adopted into workflow**
Week 12	Conduct a **90-day retrospective** with the full team	Practice leadership	**Retrospective summary and Phase 2 priorities documented**

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease; SNF = skilled nursing facility; TCM = transitional care management; UM = utilization management

End-of-phase gate: a **working dashboard** exists, at least **one full root-cause review cycle** has occurred, **compacts** with the hospitalist and SNF partners are signed or nearly final, and **one disease-specific pathway is active**.

Quarterly, Ongoing

Validate targets, access, patient experience, risk adjustment, partner performance, and corrective actions. Treat each cycle as an opportunity to **reset expectations** rather than simply confirm the prior quarter's numbers. Add remaining **disease-specific pathways** (sepsis, pneumonia, diabetes, kidney disease) **one at a time** rather than all at once, so **each pathway's checklist and escalation criteria are actually adopted** rather than merely distributed.

↔ MAKING CONNECTIONS

Use the **AAVBC When to Refer to a Specialist QRG** for urgent red flags, e-consult suitability, SOS referral communication, and specialty-specific escalation. Use the Specialist Selection and Specialist Management QRGs to choose and govern specialty partners.

QUALITY OUTCOME: EXECUTABLE CARE

For an older adult, a technically correct plan is **not high value if** hearing, cognition, dexterity, cost, transport, caregiver capacity, or service availability **prevents execution**.[19,20]

TEN KEY TAKEAWAYS

1 Create real-time visibility

Use accurate rosters and ADT/HIE alerts to identify emergency, inpatient, discharge, and post-acute events.

2 Assign an accountable team

A lead PCP, care manager, UM nurse, medication reviewer, scheduler, and data lead should own the workflow.

3 Risk-stratify immediately

Use LACE or a governed score and add clinical, functional, cognitive, and social judgment.

4 Engage during admission

Share the baseline and co-create a stable, feasible discharge plan with the hospitalist team.

5 Contact within 48 hours

Verify symptoms, medication access, services, appointments, and red flags rather than only attempting a call.

6 Provide rapid clinical follow-up

Evaluate high-risk patients within the earliest feasible window and all transitioning patients within the governed standard.

7 Reconcile the entire plan

Connect medications, tests, services, equipment, specialists, caregivers, and pending results to owners.

8 Use different home and SNF workflows

Facility transitions require institutional contact, clinician oversight, length of stay review, and a second home transition.

9 Select accountable partners

Hospitalists and SNF clinicians should meet clinical, access, communication, and outcome standards.

10 Learn from every return

Use patient-level root-cause review and balanced metrics to correct sustained process failures.

AAVBC SUMMARY AND CONCLUSION

AAVBC supports PCP-led readmission reduction that begins with visibility and continues through 30-day stabilization. The PCP practice should know **when** an attributed patient **enters acute care**, **communicate the longitudinal baseline**, **risk-stratify the transition**, **reconcile medications**, **reserve timely follow-up**, and coordinate the **home** or **facility plan before deterioration occurs**.[17,36]

High-performing hospitalist, home-health, SNF, specialist, pharmacy, and community partners should be **selected** and **governed on clinical effectiveness**, **access**, **communication**, **patient experience**, and **total episode value**.[8,85] Technology enables the model, but **named ownership converts an alert into care**.[74] The most reliable system does not attempt to prevent every hospital return; it **prevents avoidable returns** while preserving immediate access to medically necessary emergency and inpatient care.[9]

REFERENCES

1. Donzé J, John G, Genné D, et al. Effects of a Multimodal Transitional Care Intervention in Patients at High Risk of Readmission: The TARGET-READ Randomized Clinical Trial. *JAMA Intern Med*. 2023;183(7): 658-668. doi:10.1001/jamainternmed.2023.0791

2.Pugh J, Penney LS, Noël PH, et al. Evidence based processes to prevent readmissions: more is better, a ten-site observational study. *BMC Health Serv Res*. 2021;21(1):189. doi:10.1186/s12913-021-06193-x

3.Fry CH, Heppleston E, Fluck D, Han TS. Derivation of age-adjusted LACE index thresholds in the prediction of mortality and frequent hospital readmissions in adults. *Intern Emerg Med*. 2020;15(7): 1319-1325. doi:10.1007/s11739-020-02448-3

4.Balucan FS, French B, Shi Y, Kripalani S, Vasilevskis EE. Screening for the high-need population using single institution versus state-wide admissions discharge transfer feed. *BMC Health Serv Res*. 2023;23(1):1111. doi:10.1186/s12913-023-10017-5

5.Jackson C, Shahsahebi M, Wedlake T, DuBard CA. Timeliness of outpatient follow-up: an evidence-based approach for planning after hospital discharge. *Ann Fam Med*. 2015;13(2):115-122. doi:10.1370/afm.1753

6.Goroll Allan H., Hunt Daniel P. Bridging the Hospitalist–Primary Care Divide through Collaborative Care. *N Engl J Med*. 372(4):308-309. doi:10.1056/NEJMp1411416

7.Studer H, Imfeld-Isenegger TL, Beeler PE, et al. The impact of pharmacist-led medication reconciliation and interprofessional ward rounds on drug-related problems at hospital discharge. *Int J Clin Pharm*. 2023;45(1):117-125. doi:10.1007/s11096-022-01496-3

8.Neuman MD, Wirtalla C, Werner RM. Association Between Skilled Nursing Facility Quality Indicators and Hospital Readmissions. *JAMA*. 2014;312(15):1542-1551. doi:10.1001/jama.2014.13513

9.Auerbach AD, Kripalani S, Vasilevskis EE, et al. Preventability and Causes of Readmissions in a National Cohort of General Medicine Patients. *JAMA Intern Med*. 2016;176(4):484-493. doi:10.1001/jamainternmed.2015.7863

10.Tyler N, Hodkinson A, Planner C, et al. Transitional Care Interventions From Hospital to Community to Reduce Health Care Use and Improve Patient Outcomes: A Systematic Review and Network Meta-Analysis. *JAMA Netw Open*. 2023;6(11):e2344825-e2344825. doi:10.1001/jamanetworkopen.2023.44825

11.Rothman Marc, Bretz Theresa, Farinella Angela, et al. Transition to Home: Rapid Scaling of a Multistate Readmission Prevention Program for Advanced Alternative Payment Model Participants. *NEJM Catal*. 3(7):CAT.21.0409. doi:10.1056/CAT.21.0409

12.Kim EJ, Coppa K, Abrahams S, et al. Utilization of transitional care management services and 30-day readmission. *PloS One*. 2025;20(1):e0316892. doi:10.1371/journal.pone.0316892

13.Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care. *JAMA*. 2007;297(8):831-841. doi:10.1001/jama.297.8.831

14.Trivedi SP, Corderman S, Berlinberg E, Schoenthaler A, Horwitz LI. Assessment of Patient Education Delivered at Time of Hospital Discharge. *JAMA Intern Med*. 2023;183(5):417-423. doi:10.1001/jamainternmed.2023.0070

15.Takahashi PY, Leppin AL, Hanson GJ. Hospital to Community Transitions for Older Adults: An Update for the Practicing Clinician. *Mayo Clin Proc*. 2020;95(10):2253-2262. doi:10.1016/j.mayocp.2020.02.001

16.Burdick TE, Moran DS, Oliver BJ, et al. Transitional Care Management Quality Improvement Methods That Reduced Readmissions in a Rural, Primary Care System. *J Am Board Fam Med JABFM*. 2022;35(3):537-547. doi:10.3122/jabfm.2022.03.190435

17.Burdick TE, Moran DS, Oliver BJ, et al. Transitional Care Management Quality Improvement Methods That Reduced Readmissions in a Rural, Primary Care System. *J Am Board Fam Med JABFM*. 2022;35(3):537-547. doi:10.3122/jabfm.2022.03.190435

18.Anderson TS, Herzig SJ, Marcantonio ER, Yeh RW, Souza J, Landon BE. Medicare Transitional Care Management Program and Changes in Timely Postdischarge Follow-Up. *JAMA Health Forum*. 2024;5(4):e240417-e240417. doi:10.1001/jamahealthforum.2024.0417

19.Rubenstein CM, Blinkhorn L, Weiss BD. The Age-Friendly Geriatric Assessment. *Am Fam Physician*. 2026;113(1):24-33.

20.Hoel RW, Giddings Connolly RM, Takahashi PY. *Polypharmacy Management in Older Patients.* Vol 96. 2021. doi:10.1016/j.mayocp.2020.06.012

21.Singotani RG, Karapinar F, Brouwers C, Wagner C, de Bruijne MC. Towards a patient journey perspective on causes of unplanned readmissions using a classification framework: results of a systematic review with narrative synthesis. *BMC Med Res Methodol*. 2019;19(1):189. doi:10.1186/s12874-019-0822-9

22.Jacob A, Enzinger I, Gopinadh N, LaMaina L, Shapiro Z. Decreasing 30-day hospital readmissions by addressing social determinants of health using a bundled discharge approach: An evidence-based practice project recommendations. *J Eval Clin Pract*. 2025;31(5):e14188. doi:10.1111/jep.14188

23.Riverin BD, Strumpf EC, Naimi AI, Li P. Optimal Timing of Physician Visits after Hospital Discharge to Reduce Readmission. *Health Serv Res*. 2018;53(6):4682-4703. doi:10.1111/1475-6773.12976

24.Charlson ME, Carrozzino D, Guidi J, Patierno C. Charlson Comorbidity Index: A Critical Review of Clinimetric Properties. *Psychother Psychosom*. 2022;91(1):8-35. doi:10.1159/000521288

25.Charlson M, Wells MT, Hollenberg JP. Charlson comorbidity health analytics: A population management strategy to identify risk of hospitalizations, repeated hospitalizations, and resultant high cost. *PloS One*. 2026;21(6):e0351956. doi:10.1371/journal.pone.0351956

26.Deardorff WJ, Burke RE, Makam AN. Navigating Postacute Care Options for Patients After Hospital Discharge: A Review. *JAMA Intern Med*. 2026;186(3):362-373. doi:10.1001/jamainternmed.2025.7422

27.Nguyen HQ, Baecker A, Ho T, et al. Association between post-hospital clinic and telephone follow-up provider visits with 30-day readmission risk in an integrated health system. *BMC Health Serv Res*. 2021;21(1):826. doi:10.1186/s12913-021-06848-9

28.Sandhu Sahil, Liu Michael, Wadhera Rishi K. Hospitals and Health Equity — Translating Measurement into Action. *N Engl J Med*. 2022;387(26):2395-2397. doi:10.1056/NEJMp2211648

29.Liaw S, Escober Doran C, Farzadfar D, Ho C, Galla AR, Cha A. Evaluation of a pharmacist-led telehealth transitions-of-care program: A multisite analysis of program impact on readmissions. *Am J Health-Syst Pharm AJHP Off J Am Soc Health-Syst Pharm*. Published online April 22, 2026:zxag111. doi:10.1093/ajhp/zxag111

30.Li J, Reuter MD, Schmidt JM, et al. Virtual Patient-PCP-Hospitalist Care Transition Meeting Before Hospital Discharge. *JAMA Netw Open*. 2025;8(6):e2515848-e2515848. doi:10.1001/jamanetworkopen.2025.15848

31.Boggan JC, Sankineni S, Dennis PA, et al. Effectiveness of Synchronous Postdischarge Contacts on Health Care Use and Patient Satisfaction : A Systematic Review and Meta-analysis. *Ann Intern Med*. 2025;178(2):229-240. doi:10.7326/ANNALS-24-01140

32.Du S, Anada A, Montenegro M, et al. Effectiveness of Postdischarge Telephone Calls in Reducing Hospital Utilization: Quasi-Randomized Controlled Trial. *J Med Internet Res*. 2026;28:e80529. doi:10.2196/80529

33.Carmel AS, Steel P, Tanouye R, et al. Rapid Primary Care Follow-up from the ED to Reduce Avoidable Hospital Admissions. *West J Emerg Med*. 2017;18(5):870-877. doi:10.5811/westjem.2017.5.33593

34.Fruhan S, Bills CB. Association of a Callback Program With Emergency Department Revisit Rates Among Patients Seeking Emergency Care. *JAMA Netw Open*. 2022;5(5):e2213154-e2213154. doi: 10.1001/jamanetworkopen.2022.13154

35.Whittaker W, Anselmi L, Kristensen SR, et al. Associations between Extending Access to Primary Care and Emergency Department Visits: A Difference-In-Differences Analysis. *PLoS Med*. 2016;13(9):e1002113. doi:10.1371/journal.pmed.1002113

36.Saxena FE, Bierman AS, Glazier RH, et al. Association of Early Physician Follow-up With Readmission Among Patients Hospitalized for Acute Myocardial Infarction, Congestive Heart Failure, or Chronic Obstructive Pulmonary Disease. *JAMA Netw Open*. 2022;5(7):e2222056-e2222056. doi:10.1001/jamanetworkopen.2022.22056

37.Hollenberg Steven M., Stevenson Lynne Warner, Ahmad Tariq, et al. 2024 ACC Expert Consensus Decision Pathway on Clinical Assessment, Management, and Trajectory of Patients Hospitalized With Heart Failure Focused Update. *JACC*. 2024;84(13):1241-1267. doi:10.1016/j.jacc.2024.06.002

38.Naylor MD, Brooten D, Campbell R, et al. Comprehensive Discharge Planning and Home Follow-up of Hospitalized EldersA Randomized Clinical Trial. *JAMA*. 1999;281(7):613-620. doi:10.1001/jama.281.7.613

39.Han Y, Chen J, Xu Y, Huang P, Hou L. Nurse-led medication management as a critical component of transitional care for preventing drug-related problems. *Aging Clin Exp Res*. 2024;36(1):151. doi: 10.1007/s40520-024-02799-3

40.Hesselink G, Schoonhoven L, Barach P, et al. Improving patient handovers from hospital to primary care: a systematic review. *Ann Intern Med*. 2012;157(6):417-428. doi: 10.7326/0003-4819-157-6-201209180-00006

41.Adler-Milstein J, Raphael K, O'Malley TA, Cross DA. Information Sharing Practices Between US Hospitals and Skilled Nursing Facilities to Support Care Transitions. *JAMA Netw Open*. 2021;4(1):e2033980-e2033980. doi:10.1001/jamanetworkopen.2020.33980

42.Taylor ML, Thomas EE, Snoswell CL, Smith AC, Caffery LJ. Does remote patient monitoring reduce acute care use? A systematic review. *BMJ Open*. 2021;11(3):e040232. doi:10.1136/bmjopen-2020-040232

43.Chauhan U, McAlister FA. Comparison of Mortality and Hospital Readmissions Among Patients Receiving Virtual Ward Transitional Care vs Usual Postdischarge Care: A Systematic Review and Meta-analysis. *JAMA Netw Open*. 2022;5(6):e2219113-e2219113. doi:10.1001/jamanetworkopen.2022.19113

44.Becker C, Zumbrunn S, Beck K, et al. Interventions to Improve Communication at Hospital Discharge and Rates of Readmission: A Systematic Review and Meta-analysis. *JAMA Netw Open*. 2021;4(8):e2119346-e2119346. doi:10.1001/jamanetworkopen.2021.19346

45.De Lathauwer ILJ, Nieuwenhuys WW, Hafkamp F, et al. Remote patient monitoring in heart failure: A comprehensive meta-analysis of effective programme components for hospitalization and mortality reduction. *Eur J Heart Fail*. 2025;27(9):1670-1685. doi:10.1002/ejhf.3568

46.Lindquist LA, Miller RK, Saltsman WS, et al. SGIM-AMDA-AGS Consensus Best Practice Recommendations for Transitioning Patients' Healthcare from Skilled Nursing Facilities to the Community. *J Gen Intern Med*. 2017;32(2):199-203. doi:10.1007/s11606-016-3850-8

47.Heidenreich P, Bozkurt B, Aguilar D. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure. *J Am Coll Cardiol*. 2022;79(17):e263-e421. doi:10.1016/j.jacc.2021.12.012

48.Evans L, Rhodes A, Alhazzani W, et al. Surviving sepsis campaign: international guidelines for management of sepsis and septic shock 2021. *Intensive Care Med*. 2021;47(11):1181-1247. doi: 10.1007/s00134-021-06506-y

49.Hollenberg Steven M., Warner Stevenson Lynne, Ahmad Tariq, et al. 2019 ACC Expert Consensus Decision Pathway on Risk Assessment, Management, and Clinical Trajectory of Patients Hospitalized With Heart Failure. *JACC*. 2019;74(15):1966-2011. doi:10.1016/j.jacc.2019.08.001

50.McDonagh TA, Metra M, Adamo M, et al. 2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure: Developed by the Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC) With the special contribution of the Heart Failure Association (HFA) of the ESC. *Eur Heart J*. 2021;42(36):3599-3726. doi:10.1093/eurheartj/ehab368

51.Meyer Nuala J., Prescott Hallie C. Sepsis and Septic Shock. *N Engl J Med*. 2024;391(22):2133-2146. doi:10.1056/NEJMra2403213

52.Global Initiative for Chronic Obstructive Lung Disease (GOLD). *Global Strategy for Prevention, Diagnosis, and Management of COPD: 2026 Report*. Global Initiative for Chronic Obstructive Lung Disease; 2025. https://goldcopd.org/wp-content/uploads/2026/01/GOLD-REPORT-2026-v1.3-8Dec2025_WMV2.pdf*

53.Cerezo Lajas A, Gutiérrez González E, Llorente Parrado C, Puente Maestu L, de Miguel-Díez J. Readmission Due to Exacerbation of COPD: Associated Factors. *Lung*. 2018;196(2):185-193. doi: 10.1007/s00408-018-0093-y

54.Capelastegui A, España Yandiola PP, Quintana JM, et al. Predictors of short-term rehospitalization following discharge of patients hospitalized with community-acquired pneumonia. *Chest*. 2009;136(4):1079-1085. doi:10.1378/chest.08-2950

55.Tekle MT, Jara AG, Sema FD. Thirty-day hospital readmission and its determinants among patients with severe community-acquired pneumonia: a prospective cross-sectional study in Northwest Ethiopia. *BMC Infect Dis*. 2026;26(1):827. doi:10.1186/s12879-026-13064-5

56.Miravitlles M, Auladell-Rispau A, Monteagudo M, et al. Systematic review on long-term adverse effects of inhaled corticosteroids in the treatment of COPD. *Eur Respir Rev Off J Eur Respir Soc*. 2021;30(160). doi:10.1183/16000617.0075-2021

57.Phillips SA, Sill JD, Qayyum R. Interventions to reduce readmissions after pneumonia hospitalization: A systematic review and meta-analysis. *J Hosp Med*. 2025;20(9):988-997. doi:10.1002/jhm.70073

58.Riley C, Sciurba F. Diagnosis and Outpatient Management of Chronic Obstructive Pulmonary Disease: A Review. *JAMA*. 2019;321(8):786-797. doi:10.1001/jama.2019.0131

59.Howcroft M, Walters E, Wood-Baker R, Walters J. Action plans with brief patient education for exacerbations in chronic obstructive pulmonary disease. *Cochrane Database Syst Rev*. 2016;(12). doi: 10.1002/14651858.CD005074.pub4

60.Siddharthan T, Pollard SL, Quaderi SA, et al. Effectiveness-implementation of COPD case finding and self-management action plans in low- and middle-income countries: global excellence in COPD outcomes (GECo) study protocol. *Trials*. 2018;19(1):571. doi:10.1186/s13063-018-2909-8

61.Jilla AM, Reed NS, Oh ES, Lin FR. A Geriatrician's Guide to Hearing Loss. *J Am Geriatr Soc*. 2021;69(5): 1190-1198. doi:10.1111/jgs.17073

62.American Diabetes Association Professional Practice Committee for Diabetes*. 16. Diabetes Care in the Hospital: Standards of Care in Diabetes—2026. *Diabetes Care*. 2025;49(Supplement_1):S339-S355. doi:10.2337/dc26-S016

63.McCoy RG, Lipska KJ, Herrin J, Jeffery MM, Krumholz HM, Shah ND. Hospital Readmissions among Commercially Insured and Medicare Advantage Beneficiaries with Diabetes and the Impact of Severe Hypoglycemic and Hyperglycemic Events. *J Gen Intern Med*. 2017;32(10):1097-1105. doi:10.1007/s11606-017-4095-x

64.Ostermann M, Lumlertgul N, Jeong R, See E, Joannidis M, James M. Acute kidney injury. *Lancet Lond Engl*. 2025;405(10474):241-256. doi:10.1016/S0140-6736(24)02385-7

65.Korytkowski MT, Muniyappa R, Antinori-Lent K, et al. Management of Hyperglycemia in Hospitalized Adult Patients in Non-Critical Care Settings: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2022;107(8):2101-2128. doi:10.1210/clinem/dgac278

66.Gameiro J, Gouveia B, Fonseca JA, Lopes JA. The burden of acute kidney disease: an epidemiological review and importance of follow-up care. *Clin Kidney J*. 2025;18(6):sfaf169. doi:10.1093/ckj/sfaf169

67.Selby NM, De Seigneux S, Saritas T, et al. Top ten tips to manage patients after acute kidney injury. *Clin Kidney J*. 2026;19(4):sfag104. doi:10.1093/ckj/sfag104

68.American Diabetes Association Professional Practice Committee for Diabetes*. 6. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises: Standards of Care in Diabetes—2026. *Diabetes Care*. 2025;49(Supplement_1):S132-S149. doi:10.2337/dc26-S006

69.Umpierrez GE, Davis GM, ElSayed NA, et al. Hyperglycaemic crises in adults with diabetes: a consensus report. *Diabetologia*. 2024;67(8):1455-1479. doi:10.1007/s00125-024-06183-8

70.Jones CD, Vu MB, O'Donnell CM, et al. A failure to communicate: a qualitative exploration of care coordination between hospitalists and primary care providers around patient hospitalizations. *J Gen Intern Med*. 2015;30(4):417-424. doi:10.1007/s11606-014-3056-x

71.Munchhof A, Gruber R, Lane KA, Bo N, Rattray NA. Beyond Discharge Summaries: Communication Preferences in Care Transitions Between Hospitalists and Primary Care Providers Using Electronic Medical Records. *J Gen Intern Med*. 2020;35(6):1789-1796. doi:10.1007/s11606-020-05786-2

72.Williams MV, White-Williams C, Li J. Hospital Discharge: Best Practices for a Seamless Transition. *Med Clin North Am*. 2026;110(4):535-553. doi:10.1016/j.mcna.2025.11.012

73.Ghazalbash S, Zargoush M, Verter V, Perri D. Data-driven insights into interhospital care fragmentation: Implications for health policy and equity among older adults. *PloS One*. 2025;20(2):e0316829. doi:10.1371/journal.pone.0316829

74.Boockvar KS, Koufacos NS, May J, et al. Effect of Health Information Exchange Plus a Care Transitions Intervention on Post-Hospital Outcomes Among VA Primary Care Patients: a Randomized Clinical Trial. *J Gen Intern Med*. 2022;37(16):4054-4061. doi:10.1007/s11606-022-07397-5

75.Jošt M, Kerec Kos M, Kos M, Knez L. Effectiveness of pharmacist-led medication reconciliation on medication errors at hospital discharge and healthcare utilization in the next 30 days: a pragmatic clinical trial. *Front Pharmacol*. 2024;15:1377781. doi:10.3389/fphar.2024.1377781

76.Toles M, Preisser JS, Colón-Emeric C, et al. Connect-Home transitional care from skilled nursing facilities to home: A stepped wedge, cluster randomized trial. *J Am Geriatr Soc*. 2023;71(4): 1068-1080. doi:10.1111/jgs.18218

77.Ouslander JG, Bonner A, Herndon L, Shutes J. The Interventions to Reduce Acute Care Transfers (INTERACT) quality improvement program: an overview for medical directors and primary care clinicians in long term care. *J Am Med Dir Assoc*. 2014;15(3):162-170. doi:10.1016/j.jamda. 2013.12.005

78.Burke RE, Xu Y, Ritter AZ. Outcomes of post-acute care in skilled nursing facilities in Medicare beneficiaries with and without a diagnosis of dementia. *J Am Geriatr Soc*. 2021;69(10):2899-2907. doi:10.1111/jgs.17321

79.Ryskina KL, Geng Z, Raghavan S, Waddell KJ, Burke RE. Association between Timing of Clinical Evaluation by a Physician or Advanced Practitioner and Risk of Rehospitalization in Older Adults Admitted to a Skilled Nursing Facility Following Hospitalization: A Cohort Study. *J Am Med Dir Assoc*. 2023;24(12):1881-1887. doi:10.1016/j.jamda.2023.09.004

80.Prusynski RA, Gustavson AM, Shrivastav SR, Mroz TM. Rehabilitation Intensity and Patient Outcomes in Skilled Nursing Facilities in the United States: A Systematic Review. *Phys Ther*. 2021;101(3):pzaa230. doi:10.1093/ptj/pzaa230

81.Hullick CJ, Hall AE, Conway JF, et al. Reducing Hospital Transfers from Aged Care Facilities: A Large-Scale Stepped Wedge Evaluation. *J Am Geriatr Soc*. 2021;69(1):201-209. doi:10.1111/jgs.16890

82.Byrd MC, Stark A, Head J, et al. Skilled Nursing Facility Population Characteristics and Length of Stay: A Prospective Cohort Study. *J Am Med Dir Assoc*. 2025;26(11):105853. doi:10.1016/j.jamda. 2025.105853

83.Shi S, Olivieri-Mui B, Oh G, McCarthy E, Kim DH. Analysis of Functional Recovery in Older Adults Discharged to Skilled Nursing Facilities and Then Home. *JAMA Netw Open*. 2022;5(8):e2225452-e2225452. doi:10.1001/jamanetworkopen.2022.25452

84.Boahene KK. Operational Determinants of Preventable Hospital Readmissions From US Post-Acute Care Settings: A Structured Narrative Review (2021-2026). *J Am Med Dir Assoc*. 2026;27(11):106467. doi:10.1016/j.jamda.2026.106467

85.Weber C, Meyer-Massetti C, Schönenberger N. Pharmacist-led interventions at hospital discharge: a scoping review of studies demonstrating reduced readmission rates. *Int J Clin Pharm*. 2025;47(1): 15-30. doi:10.1007/s11096-024-01821-y

86.Fernando RL, Inacio MC, Sluggett JK, et al. Quality and Safety Indicators for Care Transitions by Older Adults: A Scoping Review. *J Am Med Dir Assoc*. 2025;26(3):105424. doi:10.1016/j.jamda.2024.105424

87.Wagenaar B, Schouten B, Ket JCF, Wagner C, Merten H. Addressing organizational risk factors and interventions during transitions of care for older patients: a systematic umbrella review. *BMC Health Serv Res*. 2026;26(1):530. doi:10.1186/s12913-026-14222-w

88.Baxter R, Shannon R, Murray J, et al. Delivering exceptionally safe transitions of care to older people: a qualitative study of multidisciplinary staff perspectives. *BMC Health Serv Res*. 2020;20(1):780. doi: 10.1186/s12913-020-05641-4

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