The Post-Acute Care Plan

A Proactive Approach to Discharge Readiness

Concept Paper

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Request for Feedback

This is a concept paper, not a finished proposal. The author seeks comments, criticism, and suggestions for improvement. If you see flaws in the logic, obstacles not considered, or ways to strengthen the concept, please reach out. Your input will help refine this idea.

Change Log

Version	Date	Changes
1.0	November 2025	Initial release
1.1	November 2025	Added "Why Hospitals Bear the Cost" subsection to clarify hospital payment dynamics (DRG-based reimbursement, utilization review denials) in response to reader feedback
1.2	November 2025	Added "Bundled Payments: An Emerging Consideration" subsection discussing the CMS TEAM model and how episode-based payment strengthens the PACP value proposition for participating hospitals
1.3	December 2025	Added "The Structural Nature of Discharge Barriers" subsection explaining why discharge complexity arises from boundary-crossing dependencies that hospitals cannot control internally, and why this causes case manager burnout. Added Section 8 "Implications for Public Hospital Districts" exploring the distinction between hospital districts and health districts, and the strategic case for community health investment
1.4	December 2025	Added paragraph in Section 4.2 clarifying patient motivations for completing a PACP. Added "Cross-System Considerations" subsection in Section 7 addressing interoperability and the strategic choice between single-system and multi-system implementation

Contents

Executive Summary

Every day across the United States, thousands of patients occupy acute care hospital beds despite being medically ready for discharge. They remain hospitalized not because they need hospital-level care, but because the information and arrangements required for safe discharge were never gathered in advance. Legal documents are missing. Family support networks are unknown. Preferences for post-acute care facilities have never been discussed. Insurance coverage for rehabilitation has not been verified.

These "complex discharges" cost the healthcare system billions of dollars annually, strain hospital capacity, and, most importantly, harm patients who receive inappropriate care in inappropriate settings while barriers are resolved.

The **Post-Acute Care Plan (PACP)** is a concept for addressing this problem at its source. Rather than scrambling to gather discharge-relevant information during a hospitalization, when patients are sick, stressed, and time is short, PACP captures this information proactively, during routine primary care, before any hospitalization occurs.

The approach is analogous to advance directives for end-of-life care. Just as patients are encouraged to document their wishes about life-sustaining treatment before a crisis, PACP encourages patients to document their preferences, practical circumstances, and legal arrangements for post-acute care before they need it.

This paper presents the PACP concept, describes the data model, explains how the information would be gathered and used, and outlines the benefits for patients, health systems, and the broader community. It also explores a deeper implication: if hospital performance depends on community infrastructure that hospitals cannot build alone, then perhaps the "public hospital district" model deserves reexamination. Section 8 considers what a "public health district" might look like—and why the distinction matters.

1 The Complex Discharge Problem

1.1 Scale of the Challenge

The discharge of hospitalized patients to post-acute care settings (skilled nursing facilities, rehabilitation centers, or home with support services) has become one of healthcare's most persistent operational challenges.

According to the American Hospital Association, the average length of stay in U.S. hospitals increased approximately 19% between 2019 and 2022. For patients being discharged to post-acute care providers, the increase was nearly 24%. This occurred even after accounting for patients being sicker and requiring more complex care than in pre-pandemic years.

Advisory Board analysis of CMS fee-for-service claims data found that 25% of hospital days are avoidable, representing an average of 1.2 avoidable days per patient against an average length of stay of 4.2 days. Extrapolated nationally, this represents approximately 10.8 million avoidable inpatient days annually, equivalent to 29,590 hospital beds occupied for an entire year by patients who no longer need acute care.

State-level data confirms the magnitude of the problem. In Minnesota, the Hospital Association's 2023 survey of 101 hospitals found nearly 195,000 patient days of avoidable care annually, costing hospitals an estimated $487 million in unreimbursed care. These delays included patients waiting for transfers to nursing homes, rehabilitation units, mental health treatment facilities, and other sub-acute care settings.

In Washington State, the Complex Discharge Task Force reported in 2025 that on any given day, nearly 850 patients are medically ready for discharge but unable to leave hospitals due to systemic barriers. The human cost is significant: some patients remain hospitalized for weeks, months, or even years longer than necessary.

1.2 Root Causes

Complex discharges arise from the convergence of multiple barriers. The Bree Collaborative's 2024 guidelines on complex patient discharge categorize these barriers into several domains:

Table 1: Categories of Complex Discharge Barriers

Category	Examples
Legal/Administrative	Patient lacks decision-making capacity; no healthcare power of attorney; guardianship proceedings required (can take 3–6 months)
Insurance/Payment	Prior authorization delays; Medicaid eligibility determination; coverage gaps for specific services
Capacity/Placement	Skilled nursing facilities at capacity; no beds for patients with specific needs (bariatric, behavioral health)
Medical Complexity	Wound care requirements; ventilator dependence; IV antibiotics; specialized equipment needs
Behavioral Health	Co-occurring mental illness; substance use history; behaviors that facilities decline to accept
Social/Practical	Homelessness; no family support; unsafe home environment; transportation barriers

Critically, these barriers frequently co-occur. A single patient may lack decision-making capacity (requiring guardianship), have complex wound care needs (limiting facility options), and have no family support (eliminating home discharge). Each barrier compounds the others, and sequential resolution fails because resolved barriers can re-emerge while waiting for others to be addressed.

1.3 The Human Cost

Behind the statistics are real people receiving inappropriate care. Patients stuck in acute care beds experience:

- **Inappropriate care setting:** Acute care units are designed for sick patients. The noise, disruption, and clinical intensity are poorly suited to patients who need time for paperwork to be processed.
- **Deconditioning:** Extended hospital stays lead to muscle loss, cognitive decline, and increased fall risk.
- **Infection exposure:** Hospitals concentrate sick patients; each additional day increases exposure to healthcare-associated infections.
- **Psychological distress:** Uncertainty, separation from familiar environments, and loss of autonomy take a toll.

Staff also bear a burden. Nurses and physicians experience moral distress when caring for patients they know are in the wrong setting, unable to provide what those patients actually need. Case managers and social workers, tasked with solving problems that are structurally unsolvable, face particularly high rates of burnout and turnover. Section 1.5 examines why.

1.4 Why Current Approaches Fall Short

The traditional approach to discharge planning is reactive. Planning begins at admission, or even later, and proceeds under time pressure while the patient is acutely ill. Information must be gathered from stressed family members. Legal documents must be located or created. Insurance coverage must be verified. Facility preferences must be identified and beds secured.

Research confirms the inadequacy of this approach. Studies show that patients needing post-acute care in skilled nursing facilities "have not planned for SNF placement and their choices generally are made quickly and under duress." Patients often receive minimal guidance, sometimes just a list of facility names, and make decisions based primarily on location because no other information is provided.

Even well-resourced hospitals with dedicated discharge planning staff struggle. A study of hospitalists found that 51.8% of avoidable days were attributed to post-acute care placement issues, the single largest category of delay.

The fundamental problem is that discharge planning treats essential information as something to be discovered during a crisis, rather than something to be captured in advance.

1.5 The Structural Nature of Discharge Barriers

A hospital can do many things for itself. It can stabilize patients medically, document clinical status, coordinate internal resources, arrange transportation, and generate paperwork. These activities may be slow or inefficient, but they are within the system's operational control.

The barriers that create complex discharges are different. They require action by parties outside the hospital's control:

- **Legal authority:** The hospital cannot grant itself permission to make decisions for an incapacitated patient. It needs a person—a POA agent, guardian, or surrogate—who exists outside the system.
- **Insurance authorization:** The hospital cannot approve its own requests. It needs a decision from an external payer.
- **Facility acceptance:** The hospital cannot compel another organization to accept a patient. It needs a receiving facility's agreement.
- **Family engagement:** The hospital cannot manufacture family members or force their participation.
- **Housing:** The hospital cannot create housing stock that does not exist in the community.

Each of these is a boundary problem. The hospital is operationally competent within its walls, but discharge requires crossing boundaries into domains the hospital does not control.

This explains why adding case managers and improving workflows, while helpful at the margins, cannot solve the complex discharge problem. The constraint is not internal operations. It is at the interface between the hospital and external actors. No amount of internal process improvement can accelerate a guardianship court, compel an insurance authorization, or create a willing family member.

It also explains something else: why hospital social workers and case managers experience high rates of burnout and turnover. Research documents 22% median annual turnover among frontline caseworkers, with 43% of healthcare social workers reporting burnout symptoms. The literature identifies a specific mechanism: "moral distress," which occurs when professionals know the right thing to do but cannot implement it due to constraints beyond their control. One researcher described it as "professional dissonance"—the conflict between professional values and workplace requirements.

Social workers and case managers are trained to solve problems. They are professionally obligated to arrange safe discharges. But many discharge barriers are structurally unsolvable by any action the case manager can take. The POA agent is dead. The guardian is unresponsive. The insurance company has not authorized. The family cannot be located. The skilled nursing facility has no beds. The patient has no housing.

Repeatedly encountering problems you are professionally obligated to solve but structurally cannot creates what researchers call a "crescendo effect"—moral distress accumulating over time, eventually driving talented professionals out of the field. This is not a failure of individual resilience. It is a predictable consequence of asking people to solve boundary problems with internal tools.

PACP addresses this structural reality. By capturing external dependencies—legal arrangements, family contacts, insurance details, placement preferences—before hospitalization, PACP pre-positions the boundary-crossing elements while there is still time. The POA agent's willingness can be verified. The family's contact information can be confirmed. The insurance coverage can be clarified. The patient's preferences can be documented.

This does not eliminate all barriers. Some external dependencies cannot be pre-positioned (a skilled nursing facility's census on a future date, for instance). But it converts many boundary problems from discoveries during hospitalization into resolved issues before admission. The case manager's job shifts from crisis-driven problem-solving toward coordinated execution of a known plan.

The implications of this structural analysis extend beyond PACP itself. Section 8 explores what it might mean for how public hospital districts conceive of their mission.

1.6 Why Hospitals Bear the Cost

A reasonable question arises: if hospitals keep patients longer than necessary, why don't they simply bill for those extra days? The answer lies in how hospital care is paid for in the United States.

For Medicare patients, who represent a substantial portion of those needing post-acute care, hospitals are paid a fixed amount per admission based on the diagnosis, not per day. This system, called Diagnosis Related Group (DRG) payment, assigns each admission to a category with a predetermined reimbursement. If a patient with pneumonia is assigned to a DRG that pays $12,000, the hospital receives $12,000 whether the patient stays 4 days or 14 days. Every day beyond what is clinically necessary comes directly out of the hospital's operating margin.

For commercially insured patients, the situation is more nuanced but often reaches the same result. Insurance companies employ utilization review processes that examine whether each day of hospitalization is "medically necessary." A patient who is medically ready for discharge but waiting for a skilled nursing facility bed is, by definition, not receiving medically necessary acute care. Those days are frequently denied on retrospective review, leaving the hospital uncompensated.

There is also an opportunity cost. A bed occupied by a patient waiting for placement cannot be used for a patient who actually needs acute care and for whom the hospital would receive appropriate reimbursement. During periods of high census, this creates a cascading effect: surgical cases are delayed, emergency department patients board for hours awaiting admission, and the entire system slows down.

The $2,000 to $3,000 per day figure cited later in this paper represents the average cost to hospitals of these avoidable days, accounting for staffing, supplies, overhead, and lost opportunity. This cost is real, measurable, and largely unreimbursed. Hospitals do not benefit from the status quo; they bear its burden.

1.7 Bundled Payments: An Emerging Consideration

The payment dynamics described above apply to most hospital admissions today. However, the Centers for Medicare and Medicaid Services (CMS) is moving toward episode-based payment models that extend hospital financial accountability beyond the inpatient stay.

The Transforming Episode Accountability Model (TEAM), launching January 1, 2026, represents the most significant step in this direction. Under TEAM, hospitals receive a target price covering not only the inpatient stay but also all Medicare Part A and Part B services for 30 days following discharge, including skilled nursing facility care, home health services, and follow-up visits. If total episode costs fall below the target price, the hospital keeps the difference. If costs exceed the target, the hospital owes CMS a repayment.

TEAM currently applies to five surgical procedures (lower extremity joint replacement, surgical hip and femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedures) in 188 selected metropolitan areas covering approximately 741 hospitals. Critical access hospitals and hospitals in non-selected regions are not included.

For hospitals participating in TEAM, the case for PACP becomes even stronger. Under traditional DRG payment, hospitals bear the cost of avoidable inpatient days but have limited financial stake

in what happens after discharge. Under bundled payment, the hospital is financially responsible for the entire episode. Inefficient discharge to an inappropriate post-acute setting, or a preventable readmission caused by poor care coordination, directly affects the hospital's reconciliation payment.

Having patient preferences, legal arrangements, and practical circumstances documented in advance through PACP supports several TEAM success factors: faster discharge to appropriate settings, better matching of patients to post-acute providers, and stronger coordination across the care continuum. Hospitals in TEAM regions may find that proactive discharge planning is not merely good practice but a financial imperative.

For hospitals outside TEAM's geographic scope, or for medical (non-surgical) admissions not covered by the model, the traditional DRG economics described in the previous section continue to apply. The PACP value proposition remains intact: hospitals still bear the cost of avoidable days, and proactive information capture still transforms discharge planning from crisis management to coordinated execution.

In short, bundled payment models strengthen the argument for PACP where they apply, and do not diminish it where they do not.

2 The Post-Acute Care Plan Concept

2.1 Core Idea

The Post-Acute Care Plan (PACP) applies proactive planning to hospital discharge, capturing discharge-relevant information during routine primary care before any hospitalization occurs.

The analogy to advance directives is instructive. Advance directives for end-of-life care ask patients, during calm, non-crisis moments: "If you become unable to make decisions and face a terminal condition, what do you want? Who should speak for you?" This information is documented, stored in the medical record, and surfaces when needed, preventing crisis decision-making when families are distressed and time is short.

PACP asks similar questions, but for post-acute care: "If you are hospitalized and need skilled nursing or rehabilitation care afterward, what are your preferences? What is your home situation? Who is your support network? What legal arrangements are in place?"

By capturing this information in advance, PACP transforms discharge planning from a reactive scramble into a coordinated process that begins with known information rather than unknown questions.

2.2 What PACP Is Not

It is important to clarify what PACP is not:

- **Not a form:** PACP is not a paper document to be filed. It is structured data integrated into the electronic health record, accessible to care teams when needed.
- **Not a PCP burden:** The health system, not the primary care physician, owns the outreach and data collection process. PCPs may reinforce the program's value and handle sensitive conversations, but they are not responsible for administering questionnaires.
- **Not a one-time event:** PACP data requires maintenance. Circumstances change, facilities change, and preferences evolve. The system must prompt periodic updates.
- **Not legally binding:** Unlike advance directives, PACP does not create legal obligations. It captures preferences and practical information to inform, not dictate, discharge planning.

2.3 Intellectual Foundation

This approach is informed by Theory of Constraints (TOC) thinking, which focuses on identifying and addressing the limiting factors in a system. In hospital operations, discharge is often the constraint, the bottleneck that limits throughput. When discharge is slow or unpredictable, everything upstream backs up: patients occupy beds who don't need acute care, surgical cases are delayed, and emergency departments board patients awaiting admission.

Traditional improvement efforts focus on the discharge process itself: more case managers, better tools, earlier in-hospitalization planning. These help at the margins but don't address a root cause: the discharge process is often fed poor-quality inputs. Missing legal documents, unknown home environments, undocumented preferences, and unverified insurance coverage all create delays that no amount of process improvement can eliminate.

PACP improves the quality of inputs to the discharge process. The goal is not simply to make discharge planning faster, but to make it easier because the hard work has already been done.

3 What a PACP Contains

The PACP data model is designed around the barriers that cause discharge delays. For each category of barrier, the relevant question is: "What information, if known in advance, would eliminate or reduce this delay?"

3.1 Legal and Decision-Making

When patients lack decision-making capacity and no one has legal authority to make healthcare decisions, guardianship proceedings can delay discharge for months.

Table 2: Legal/Decision-Making Data Elements

Data Element	Purpose
Healthcare Power of Attorney status	Identifies whether legal decision-maker exists
POA agent name and contact information	Enables immediate contact if patient cannot decide
Backup agent designation	Provides alternative if primary agent unavailable
Existing guardianship (if any)	Documents existing legal arrangements
POLST on file	Links to existing physician orders for life-sustaining treatment
Family conflict indicators	Alerts care team to potential decision-making complications

Importantly, the PACP conversation is an opportunity to prompt creation of missing documents. If no POA exists, the system can provide resources and encourage completion, converting an information gap into a resolved issue.

3.2 Insurance and Financial

Prior authorization delays and coverage gaps cause significant discharge delays, particularly for Medicare Advantage patients.

Table 3: Insurance/Financial Data Elements

Data Element	Purpose
Current insurance verification	Confirms coverage is active and details are current
Medicare Advantage plan details	MA plans vary significantly in post-acute coverage
Medicaid eligibility likelihood	Anticipates potential Medicaid conversion during long stays
Long-term care insurance	Identifies supplemental coverage for extended care
Private pay capacity (sensitive)	Informs options if coverage gaps exist
Prior authorization history	Flags patients who have experienced authorization issues

3.3 Placement Preferences

Patients and families make better decisions when they have time to consider options thoughtfully, rather than under the pressure of an acute hospitalization.

Ideally, patients would have an opportunity to tour or virtually visit preferred facilities before making these selections, converting an abstract choice into an informed decision.

Table 4: Placement Preference Data Elements

Data Element	Purpose
Ranked preferred SNFs (3–5 facilities)	Documents considered preferences after review or visits
Geographic constraints	"Within 30 minutes of daughter in [city]"
Explicit exclusions	"Will not go to Facility X under any circumstances"
Openness to alternatives	Willingness to consider facilities farther away, CAH swing beds, etc.
Prior facility experiences	History of stays at specific facilities and outcomes

3.4 Home Environment and Support

Social and practical barriers cause many discharge delays that have nothing to do with medical complexity.

Table 5: Home Environment and Support Data Elements

Data Element	Purpose
Current living situation	Own home, rental, assisted living, with family, unstable/homeless
Physical environment	Stairs to enter, stairs inside, bathroom accessibility, doorway widths
Household composition	Who lives with patient; capability to provide care
Primary caregiver	Name, relationship, contact, availability (24/7, daytime, limited)
Backup caregiver	Alternative support if primary unavailable
Transportation resources	Own vehicle, family transport, requires medical transport
Pet care arrangements	Unresolved pet care actually delays discharges

3.5 Preferences and Values

Patient and family preferences should guide discharge planning, but these preferences are rarely documented in advance.

Table 6: Preferences and Values Data Elements

Data Element	Purpose
Home vs. facility philosophy	"I want to go home no matter what" vs. preference for professional care
Hospice/palliative awareness	Has patient considered comfort-focused care?
Cultural or religious considerations	Factors affecting care preferences
Language preferences	Interpreter needs for care coordination
Family dynamics notes	Key decision-makers; potential conflicts

3.6 Risk Flags

Some information is sensitive but essential for realistic discharge planning.

This category requires particular sensitivity. The information is useful for planning but could stigmatize patients if handled poorly. The PCP's role in gathering this information, within an established trust relationship, is especially important here.

Table 7: Risk Flag Data Elements

Data Element	Purpose
Prior facility refusals	History of being declined by facilities
Behavioral considerations	Factors that may affect placement options
History of placement difficulties	Patterns that predict future challenges

4 How PACP Works

4.1 System-Driven Prioritization

PACP is implemented as a health system program, not a primary care initiative. The system owns the infrastructure, outreach, and data collection burden.

The program begins with prioritization. Using data available in the electronic health record (age, diagnoses, utilization history, risk scores), the system identifies patients most likely to need post-acute care in the near term. These patients are queued for outreach first.

Over time, as high-risk patients complete their PACP, the program expands to broader populations. The goal is eventual coverage of all patients for whom hospitalization and post-acute care are reasonably foreseeable, recognizing that anyone can have an unexpected hospitalization.

4.2 Patient Engagement

Patient outreach emphasizes education and choice. The initial contact, likely through the patient portal, explains the program's purpose and benefits:

> *"We have an important service for you to review. [Health System] is offering a new program to help you prepare for any future hospital stay. By sharing some information about your preferences and circumstances now, you can help ensure that if you ever need care after a hospitalization, the process goes smoothly and your wishes are honored."*

Patients are given time to absorb the concept before being asked to act. Links to educational materials, FAQs, and testimonials help patients understand why investing time in the program benefits them and their families.

Educational materials explain why completing a PACP matters: it ensures your wishes guide care when you cannot easily speak for yourself, reduces the burden on family members during a health crisis, and contributes to a healthcare system that works better for everyone.

Data collection can occur through multiple channels:

- **Patient portal:** Web-based questionnaire completed at the patient's convenience
- **Phone support:** Staff-assisted completion for patients who prefer voice interaction or lack portal access
- **AI voice agent:** Automated phone-based collection using natural language interaction
- **In-person:** Staff-assisted completion during clinic visits when appropriate

The multi-channel approach recognizes that the target population, often older adults, has diverse comfort levels with technology.

4.3 Role of the Primary Care Physician

The PCP is aware of PACP and may reinforce its value during visits, but the PCP is not the primary data collector. The system handles routine data gathering.

PCP involvement is reserved for sensitive items that require clinical judgment and a trust relationship: behavioral considerations, family conflict, financial capacity, and potentially the conversation about creating a healthcare power of attorney if none exists.

When the PCP addresses these topics, they frame the conversation around patient benefit: "This information helps us take better care of you. It's kept confidential and protected."

4.4 Keeping Data Current

PACP data has a freshness requirement. Stale data is less useful than no data, because it may lead to incorrect assumptions.

The system maintains PACP data through several mechanisms:

- **Annual review prompts:** Patients receive periodic requests to confirm or update their information
- **Triggered updates:** Changes in the post-acute care landscape (facilities going out of network, closing, changing capabilities) trigger notifications to affected patients
- **Event-driven updates:** Significant life events (change of address, loss of spouse) prompt review

4.5 Community Outreach

PACP is not solely a hospital efficiency measure. It is a community health program. Effective implementation requires community awareness and buy-in.

Community outreach explains how the program benefits everyone:

- Patients receive care aligned with their preferences
- Families experience less stress during health crises
- Hospitals can serve more patients who need acute care
- Post-acute facilities can plan more effectively
- The community's healthcare resources are used more efficiently

Other healthcare facilities in the community also benefit. When patients have documented preferences and arrangements, the entire system works better, regardless of which hospital admits them.

5 How PACP Data Is Used

5.1 At Admission: Immediate Triage

When a patient with a completed PACP is admitted, the EHR surfaces this information to the care team immediately. The discharge planning team receives an alert indicating whether the patient is likely to have a straightforward or complex discharge path.

An elderly patient with a current healthcare POA, documented facility preferences, a capable caregiver at home, and verified insurance is very different from a patient who lacks all of these. The first can be managed with standard protocols; the second requires intensive case management from day one.

This stratification happens at admission, not when discharge planning becomes urgent. Early identification of complex cases enables early intervention.

5.2 During Hospitalization: Informed Planning

Throughout the hospitalization, the care team has access to the patient's documented preferences. If the clinical trajectory indicates that post-acute care will be needed, the team can:

- Contact the patient's preferred facilities early to assess availability
- Begin insurance pre-authorization processes promptly
- Engage the designated healthcare agent in planning conversations
- Prepare the home environment for return if home discharge is preferred and feasible

When complications arise (the patient's first-choice facility has no beds, insurance denies coverage for the preferred option), the team can reference documented backup preferences rather than starting from scratch.

5.3 Proactive Maintenance: Responding to Change

The post-acute care landscape changes. Facilities go out of network, close, or change their capabilities. When these changes affect patients with documented preferences, the system can notify them proactively:

> *"Your preferred care facility, [Facility Name], is no longer in our network. We will use your second choice, [Alternate Facility], should you become hospitalized and need post-acute care. You can update your preferences at any time through [Portal/Phone]."*

This proactive communication keeps PACP data current and maintains patient engagement with the program.

5.4 Strategic Forecasting: Informing Downstream Providers

Aggregated, anonymized PACP data provides valuable information for system-wide planning.

If a health system knows that 200 patients have expressed a preference for Facility A, and another 150 have named Facility B, this information can be shared (in aggregate, without patient identifiers) with those facilities. Downstream providers can then:

- Staff appropriately for anticipated demand
- Negotiate payer contracts based on expected patient volume

- Plan capital investments using actual preference data
- Recruit personnel ahead of anticipated need

This transforms the relationship between hospitals and post-acute providers from reactive ("Can you take this patient today?") to proactive ("Based on patient preferences, we anticipate X patients per month will prefer your facility over the next year").

6 Benefits

6.1 For Patients and Families

Patients who complete a PACP benefit from:

- **Care aligned with preferences:** Their documented wishes guide decisions
- **Reduced crisis decision-making:** Families are not forced to make major choices under duress
- **Faster transitions:** Less time waiting in acute care beds for logistics to be resolved
- **Peace of mind:** Knowing that plans are in place reduces anxiety about potential hospitalization

For families, the benefit is particularly significant. Research shows that family members are often more involved than patients in discharge decisions. When preferences are documented in advance, families have guidance rather than guessing what their loved one would want.

6.2 For Health Systems

Health systems implementing PACP can expect:

- **Reduced avoidable days:** Faster discharge for patients whose barriers have been pre-resolved
- **Improved throughput:** Beds freed for patients who need acute care
- **Reduced staff burden:** Case managers spend less time gathering basic information and more time on complex problem-solving
- **Financial improvement:** Each avoidable day costs $2,000–$3,000 depending on hospital type; reducing these days directly improves margins
- **Better patient satisfaction:** Patients experience smoother transitions

6.3 For Post-Acute Care Providers

Downstream facilities benefit from:

- **Better information:** Patients arrive with documented preferences and known circumstances
- **Demand visibility:** Aggregated preference data enables planning
- **Stronger referral relationships:** Preferred-facility status creates reliable patient flow

6.4 For the Broader Community

The community benefits when healthcare resources are used efficiently:

- **Improved access:** When patients who don't need acute care leave promptly, beds are available for those who do
- **Reduced emergency department boarding:** Better inpatient flow reduces ED crowding
- **Lower healthcare costs:** System efficiency benefits payers and ultimately the community

7 Implementation Considerations

This paper presents a concept, not an implementation specification. However, several principles should guide implementation efforts.

7.1 EHR Integration

PACP data must be integrated into the electronic health record, not stored in a separate system. The data should:

- Surface automatically when a patient is admitted
- Be accessible to authorized care team members
- Trigger appropriate alerts and workflows
- Support reporting and analytics

Major EHR platforms (Epic, Cerner, Meditech, etc.) have capabilities for custom data capture and workflow integration. Implementation will require collaboration with clinical informatics teams.

7.2 Cross-System Considerations

PACP data is most useful when a patient is admitted to the health system that holds it. A patient who completes PACP at one system but is admitted to another will not benefit unless the data is shared.

This raises a strategic question that leadership should consider early: Is PACP a single-system initiative, or a joint project with other health systems in the region? A multi-system approach would require agreement on data standards, sharing protocols, and potentially integration with regional Health Information Exchanges. The complexity increases, but so does the value—patients would benefit regardless of where they are admitted.

For initial implementation, a single-system approach is simpler and allows refinement before broader collaboration. However, framing PACP as eventually regional may influence early design decisions and create opportunities for cross-system partnership.

7.3 Staffing Model

The program requires dedicated staff for:

- Outreach and patient engagement
- Phone-based data collection support
- Data quality maintenance
- Community education

This investment should be weighed against the cost of current discharge delays. If a health system experiences significant avoidable days, the staffing cost may be a fraction of the savings from improved throughput.

7.4 Phased Rollout

Implementation should proceed in phases:

1. **Pilot population:** Begin with a defined high-risk group (e.g., patients over 75 with recent hospitalizations)

2. **Process refinement:** Adjust workflows based on pilot experience
3. **Gradual expansion:** Extend to broader populations as capacity allows
4. **Steady state:** Maintain program with ongoing enrollment and data maintenance

7.5 Privacy and Sensitivity

Some PACP data is sensitive. Implementation must address:

- Appropriate access controls within the EHR
- Staff training on handling sensitive information
- Patient communication about how data is protected and used
- Compliance with HIPAA and state privacy requirements

The behavioral and financial data elements require particular care. Patients must trust that this information will be used to help them, not to stigmatize or disadvantage them.

7.6 What Makes This Different

PACP differs from "just better discharge planning" in several ways:

- **Timing:** Information is captured before hospitalization, not during
- **Ownership:** The health system owns the program, not individual care teams
- **Scope:** All relevant information is gathered systematically, not ad hoc
- **Maintenance:** Data is actively maintained, not captured once and forgotten
- **Integration:** Information flows into clinical workflows automatically

8 Implications for Public Hospital Districts

The structural analysis in Section 1.5 has implications beyond PACP itself. If hospital performance depends on community infrastructure that hospitals cannot create alone, then the hospital district's mission may be framed too narrowly.

8.1 The Boundary Problem Revisited

Complex discharges arise from boundary-crossing dependencies: legal authority, insurance authorization, facility acceptance, family engagement, housing. These are not hospital operations problems. They are community infrastructure problems that manifest inside hospitals.

A hospital that invests only in internal process improvement—more case managers, better workflows, earlier discharge planning—will see limited returns. The constraint is not inside the hospital. It is at the interface between the hospital and the community.

8.2 Inputs and Outputs

Consider an analogy from manufacturing. If a factory wants to improve its output, it can improve its processes—invest in better equipment, train workers, streamline workflows. But it can also improve its inputs—source higher-quality raw materials that require less rework and produce better results. Manufacturing has long understood that input quality determines output quality. Healthcare has focused almost entirely on process improvement while largely ignoring input improvement.

A hospital's "inputs" are the people who arrive for care. Their baseline health status, the complexity of their conditions, and the state of their personal affairs all determine how much work the hospital must do and how smoothly that work proceeds. A patient who arrives with well-managed chronic conditions, an operative POA, verified insurance, identified family support, and documented care preferences is a fundamentally different input than a patient who arrives with uncontrolled diabetes, no legal arrangements, lapsed insurance, no family contact, and unknown preferences. The hospital's process may be identical; the outcomes and resource consumption will differ dramatically.

8.3 Hospital Districts and Health Districts

A "public hospital district" focuses on operating hospitals—improving the process. A "public health district" would take responsibility for community health—improving the inputs. The distinction determines what the district considers its problem to solve.

A public health district would concern itself with the overall health of people in its service area, recognizing that healthier community members mean:

- Fewer hospitalizations in the first place
- Lower acuity when hospitalizations do occur
- Shorter stays and smoother discharges
- Better post-acute outcomes and fewer readmissions

This suggests a different investment strategy. Instead of asking only "how do we run the hospital more efficiently," a public health district would ask "how do we make our community healthier so that hospital care, when needed, is more straightforward?" Investments in wellness programs, chronic disease management, social determinants of health, and community infrastructure like POA

completion are not peripheral to hospital performance—they directly improve it by improving the inputs.

8.4 The Strategic Case

Public hospital districts were created to serve communities. If community health outcomes depend on infrastructure beyond hospital walls, then serving the community may require building that infrastructure. The POA completion work described in this paper is one example: it is community health investment that happens to also improve hospital operations. But it points toward a broader question.

A public health district could contain hospitals—perhaps multiple hospitals—as components of a larger community health system. The hospitals would remain essential for acute care. But the district's mission would extend upstream (prevention, wellness, chronic disease management) and downstream (post-acute capacity, community support networks, recovery infrastructure). The hospital becomes one node in a system, not the system itself.

Public hospital districts increasingly face questions about their value. Why should taxpayers support a hospital district when private hospitals exist? What does the community get that it would not otherwise receive? A public health district model offers one answer: proactive investment in community health, not just reactive treatment of illness.

For the community member whose chronic conditions are well-managed, whose legal affairs are in order, whose support network is documented—that person will have better outcomes if hospitalized, and may avoid hospitalization entirely. A public health district that helped ensure these conditions is delivering value no private hospital would provide.

8.5 A Question, Not a Proposal

This paper does not propose how to organize a transition from hospital district to health district. The legal, governance, and operational implications would require careful analysis beyond this paper's scope.

But it suggests the question is worth asking: Is the public hospital district model adequate to the actual problem? If the hospital's performance depends on community health, and community health depends on infrastructure the hospital alone cannot build, then perhaps the organizing concept needs to expand.

The PACP concept is one small piece of this larger picture. It addresses the "affairs in order" dimension of community health infrastructure. But it points toward a broader vision: a community where the systems that support health extend well beyond hospital walls, and where the institutions responsible for health take ownership of that entire system.

9 Conclusion

The complex discharge problem costs the U.S. healthcare system billions of dollars annually, strains hospital capacity, and harms patients who receive inappropriate care while waiting for barriers to be resolved. Current approaches, specifically reactive discharge planning during hospitalization, are inadequate because they treat essential information as something to be discovered during a crisis.

The Post-Acute Care Plan (PACP) offers a different approach: proactive capture of discharge-relevant information during routine primary care, before any hospitalization occurs. By gathering legal arrangements, insurance details, care preferences, home environment information, and support networks in advance, PACP transforms discharge planning from crisis management into coordinated execution.

The concept is straightforward. The implementation will require investment in systems, staff, and community engagement. But the potential return (reduced avoidable days, improved patient outcomes, and better use of healthcare resources) justifies serious consideration.

Section 1.5 identified why the problem is structural: discharge complexity arises from boundary-crossing dependencies that hospitals cannot control internally. Section 8 explored what this might mean for public hospital districts—whether the mission itself needs to expand from operating hospitals to building community health infrastructure.

These are big questions. This paper does not answer them definitively. But it suggests that the complex discharge problem, properly understood, points toward something larger than operational improvement. It points toward a different conception of what health systems are for.

Request for Feedback

This is a concept paper, and concepts improve through criticism.

If you have read this far, I have a request: **tell me what is wrong with this analysis.**

I am not looking for validation. I am looking for the holes in the logic, the assumptions I have gotten wrong, the obstacles I have not considered, the reasons this will not work. If there is a fatal flaw in this thinking, I would rather discover it now than later.

Specifically, I welcome input on:

- Is the problem framed correctly?
- Is the data model complete, or are important elements missing?
- What implementation obstacles have I underestimated?
- Are there existing programs or approaches that attempt something similar?
- What would prevent a health system from adopting this concept?
- What would make this concept more compelling or practical?

If something here interests you, or if you see a problem I have missed, please reach out.

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