

How the inpatient to post-acute transition affects system performance

A trifecta of forces—higher-acuity inpatients, an aging population and rising utilization—is increasing pressure on post-acute care (PAC) demand. The case mix index rose 3% between 2019 and 2024, and PAC growth is not expected to slow, with Sg2 projecting a 31% increase over the next decade. As demand accelerates, capacity, performance and strategic alignment of PAC assets are becoming increasingly essential to managing overall health system performance.

PAC has evolved from care after hospital discharge to care settings that serve medically complex patients across multiple entry points. Defining which patients require facility-based care versus home-based services, as well as assessing quality performance for the inpatient to PAC

transition, are critical inputs for operational effectiveness across the system.

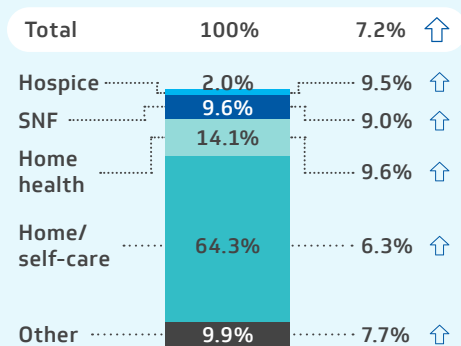
This report examines patterns of inpatient discharges to PAC as well as upstream PAC utilization across diverse prior care settings by leveraging the most recent Vizient Clinical Data Base data, Centers for Medicare & Medicaid Services Medicare fee-for-service claims data and the Sg2 Impact of Change® forecast. The findings reveal that inpatient discharges compete with a predominantly non-inpatient-discharged population, who are often medically complex and resource intensive. These dynamics highlight the need for health systems to align post-acute access and capacity with demand that extends well beyond inpatient discharges.

Home-based services drive PAC growth

Figure 1. PAC site of care utilization trends

Inpatient discharge disposition trends Q4 2024–Q3 2025

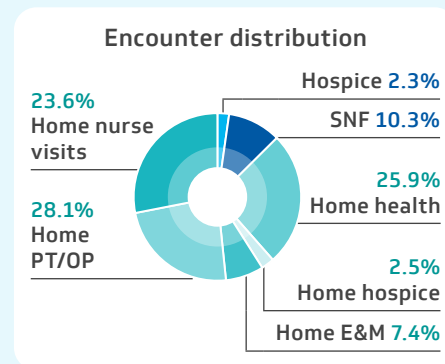
Volume distribution % change compared to Q4 2022–Q3 2023



IP services precede only 5% of PAC encounters.

PAC patient encounter origin Medicare FFS Q3 2024–Q2 2025

Post-acute care (home and facility-based)



31% Projected 10-year PAC growth

Figure 1 note and sources: See page 6.

Abbreviations: E&M=evaluation and management; FFS=fee-for-service; IP=inpatient; OT=occupational therapy; PAC=post-acute care; PT=physical therapy; SNF=skilled nursing facility.

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As inpatient utilization has increased 7% over the past three years and care has continued to shift toward outpatient services, a greater share of discharges requires PAC. Figure 1 shows that almost two-thirds of inpatient discharges return home with self-care, while 14% are discharged to home-based PAC and 12% to facility-based PAC, with both settings growing faster than home/self-care.

Most PAC utilization originates outside the inpatient setting, with 95% of PAC encounters not preceded by an inpatient hospitalization within the prior 30 days. These encounters largely reflect patients who require ongoing, longitudinal post-acute services. Inpatient discharges, by contrast, account for a relatively small share of total PAC utilization. Over the next decade, overall PAC volume is projected to increase by 31%, driven primarily by home-based services, while skilled nursing remains the dominant but slower-growing facility-based PAC setting.

As post-acute demand increasingly originates outside of the inpatient discharge process, planning strategies centered on hospital volume alone risk understating future post-acute capacity requirements.

An aging, Medicare population shapes PAC demand

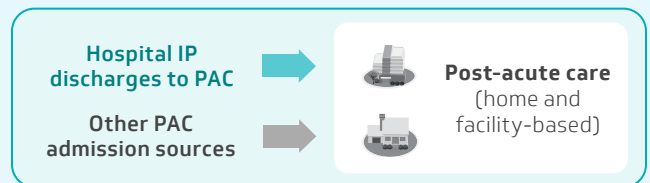
Table 1. Inpatient discharge disposition by age and payer class, Q4 2024–Q3 2025

	18–44	45–64	65+	Commercial	Medicaid	Medicare	Self-pay, charity
Home/self-care	39.4%	27.0%	33.6%	33.5%	22.1%	35.7%	² 4.5%
Home health	7.1%	22.3%	70.6%	14.3%	9.0%	72.6%	0.8%
PAC	2.4%	13.9%	¹ 83.7%	5.6%	6.5%	² 84.3%	0.5%
SNF	1.9%	13.3%	84.8%	4.5%	6.3%	85.8%	0.3%
Hospice	2.3%	13.6%	84.1%	8.7%	5.7%	80.9%	1.1%
LTC	12.2%	30.1%	57.7%	15.0%	16.1%	63.4%	0.7%
Rehab	12.1%	24.8%	63.1%	15.7%	15.2%	63.3%	2.1%
Overall total	28.6%	24.9%	¹ 46.6%	25.8%	18.2%	48.5%	3.4%

Note: Analysis excludes 0–17 age group. Percentages may not add to 100% due to rounding. “Other” payer class and discharge disposition are not shown.

Abbreviations: IP=inpatient; LTC=long-term care; PAC=post-acute care; SNF=skilled nursing facility.

Source: Vizient, Inc. Vizient Clinical Data Base. Q4 2024–Q3 2025. Irving, TX. 2026. Accessed January 2026. <https://www.vizientinc.com>



1 A substantial majority (**83.7%**) of PAC volume is attributable to patients aged 65 and older, compared with **46.6%** of overall inpatient discharges, underscoring the central role of skilled nursing and hospice services in caring for this population. Older adults are more likely to be discharged to facility-based PAC, while younger patients more frequently utilize home health services. In addition, long-term care and rehabilitation serve a relatively higher share of patients aged 18 to 64, reflecting different post-acute utilization patterns among younger populations.

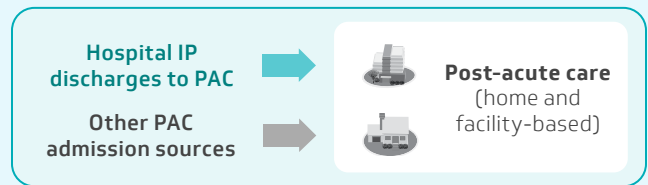
2 Consistent with this age distribution, nearly **85%** of PAC patients are covered by Medicare. Notably, **4.5%** of self-pay and charity-care patients are discharged to home or self-care, a higher share than overall, suggesting that discharge patterns for this population may reflect access limitations to PAC or home health services rather than clinical need alone.

Higher-acuity patients transitioning to and from PAC services

Table 2. Clinical outcomes by discharge site of care, Q4 2024–Q3 2025

Discharge site of care	Initial stay		Readmission	% change in ALOS (initial stay vs. readmission)
	ALOS (days)	Readmission rate	ALOS (days)	
Post-acute care	8.9	21.4%	8.8	-0.7%
Home health	6.2	19.7%	7.0	+13.4%
Home/self-care	3.7	8.8%	5.0	+35.7%
Overall total	5.0	12.6%	6.6	+31.4%

Note: Analysis excludes 0–17 age group. Total includes long-term care, hospital, inpatient, rehab and other sites of care not listed.
Abbreviations: ALOS=average length of stay; IP=inpatient; PAC=post-acute care.
Source: Vizient, Inc. Vizient Clinical Data Base. Q4 2024–Q3 2025. Irving, TX. 2026. Accessed January 2026. <https://www.vizientinc.com>



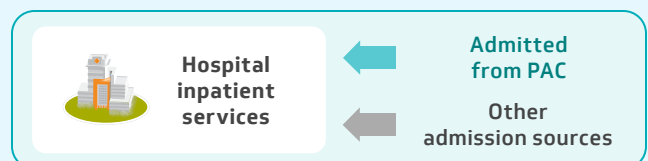
Patients transitioning to and from PAC services tend to have different quality outcomes. Average length of stay (ALOS) during the initial hospital admission is significantly higher for patients discharged to PAC (8.9 days) compared with those discharged home or to self-care (3.7 days). Readmission rates are approximately 20% for patients discharged to PAC facilities and home health, more than double the rate observed for patients discharged home for self-care (8.8%). Among patients readmitted from PAC to the same hospital, readmission ALOS remains consistent with the initial stay and is substantially higher than for patients initially discharged home.

These differences reflect the higher baseline acuity and clinical complexity of patients requiring PAC. Discharge patterns are also influenced by local access to appropriate post-acute services and vary by market and hospital.

Table 3. Clinical outcomes by admission source, Q4 2024–Q3 2025

	ALOS (days)	Mortality rate	Readmission rate
Post-acute	6.7	3.9%	33.4%
Transfer	7.6	3.1%	15.9%
Other	4.7	1.2%	12.3%
Overall total	5.0	1.4%	13.2%

Note: Analysis excludes 0–17 age group.
Abbreviations: ALOS=average length of stay; PAC=post-acute care.
Source: Vizient, Inc. Vizient Clinical Data Base. Q4 2024–Q3 2025. Irving, TX. 2026. Accessed January 2026. <https://www.vizientinc.com>



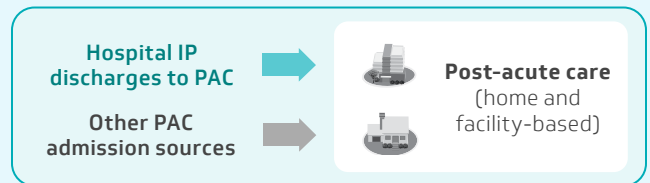
Hospital patients admitted from PAC facilities exhibit higher mortality and readmission rates, reinforcing that patients moving to and from PAC represent a clinically complex, high-acuity population. These patients are often older, sicker and more likely to have limited social support. The outcomes shown in Table 3 underscore the need for strong operational alignment at the inpatient to post-acute transition to ensure timely access, appropriate placement and adequate support for this vulnerable population.

Higher-impact conditions drive PAC growth

Table 4. Clinical outcomes by discharge site of care, Q4 2024–Q3 2025

Sg2 CARE Family for IP utilization	Discharged to PAC facility			Discharged to home health			10-year IP forecast 2025–2035
	% of total	ALOS (days)	Readmission rate	% of total	ALOS (days)	Readmission rate	
Septicemia	16.4%	10.8	24.7%	10.9%	7.6	20.1%	19.7%
Congestive heart failure	4.5%	8.4	30.2%	6.2%	6.5	25.5%	9.4%
Hip and femur fracture	6.5%	6.4	5.5%	1.6%	5.4	13.1%	18.8%
Complications of surgery, device, implant or graft-surgery	3.3%	9.1	53.8%	4.1%	6.5	9.7%	9.7%
Pneumonia including aspiration pneumonia	3.4%	7.4	28.1%	3.2%	5.4	54.3%	11.4%
Top 5 overall total	34.0%	9.1	25.0%	25.9%	6.8	26.6%	15.1%

Note: Analysis excludes 0–17 age group. Total includes long-term care, hospital, inpatient, rehab and other sites of care not listed.
Abbreviations: ALOS=average length of stay; IP=inpatient; PAC=post-acute care.
Source: Vizient, Inc. Vizient Clinical Data Base. Q4 2024–Q3 2025. Irving, TX. 2026. Accessed January 2026. <https://www.vizientinc.com>

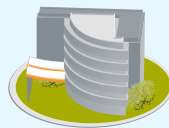


The top five clinical conditions discharged to PAC facilities and home health account for 34% of total post-acute discharges, highlighting the concentration of demand within a relatively small set of diagnoses. Most of these conditions represent common, morbid illnesses among older adults, for whom advancing age strongly correlates with both the likelihood of requiring PAC and the intensity of post-acute support. Overlap in leading conditions across PAC facilities and home health is expected, since discharge planning first determines the need for post-acute care before selecting the care setting.

Among these conditions, septicemia represents the largest share of discharges to both PAC facilities and home health, and it is associated with higher ALOS and readmission rates prior to discharge. Notably, four of the top five conditions exhibit higher-than-average readmission rates—with hip and femur fracture as the exception—highlighting the burden of medical conditions rather than procedural episodes within post-acute pathways.

Looking ahead, these same high-impact clinical conditions are projected to grow at faster rates than overall inpatient services over the next decade. This suggests that future post-acute growth will be driven by increasing volume and complexity within already dominant conditions.

Table 5. Top Sg2 CARE Families for SNF and hospice stays, Q3 2024–Q2 2025



SNF stays

Total upstream encounters	% of total
Congestive heart failure	2.9%
Urinary tract infection	2.8%
Heart and femur failure	2.7%
Screenings and follow-up encounters	2.5%
Other musculoskeletal injuries and conditions	2.5%
Total	13.5%



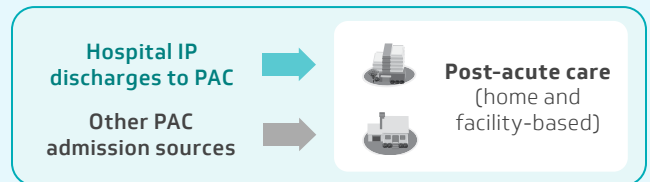
Hospice stays

Total upstream encounters	% of total
Dementia	7.2%
Congestive heart failure	6.3%
Septicemia	3.1%
Chronic obstructive pulmonary disease	2.9%
Respiratory conditions, including pleural effusions	2.8%
Total	22.2%

Note: Numbers may not add to shown total value due to rounding. Based on first occurrence of PAC procedure type between July 2024 and June 2025 and excludes patients with utilization in June 2024. Procedure date based on admission date for SNF stays and non-home hospice visits.

Abbreviations: CARE=Clinical Alignment and Resource Effectiveness; IP=inpatient; PAC=post-acute care; SNF=skilled nursing facility.

Sources: CMS. (2024–2025). Medicare fee-for-service claims data. Accessed January 29, 2026 from CMS Chronic Conditions Warehouse Virtual Research Data Center via the CMS Innovator Program.



As patients enter PAC from a wide range of upstream settings, not solely after hospital inpatient stays, it is critical to look beyond the clinical conditions for IP utilization that led to PAC services. To explore the upstream encounters, clinical conditions were analyzed by Sg2 CARE Family for skilled nursing facility (SNF) and hospice stays.

The CARE Families highlighted in Table 5 are the only ones that also rank among the top clinical conditions shown in Table 4, underscoring the limited overlap between discharge-driven and upstream PAC demand. Collectively, the top five CARE Families account for just 14% of SNF stays and 22% of hospice stays, which emphasizes the broad range of clinical conditions supported by post-acute care services.

Why it matters

Integrated insights across multiple data sources reveal outcomes from the inpatient to post-acute care transition that, if unaddressed, will negatively affect clinical performance and exacerbate both inpatient and PAC capacity constraints. As health systems reexamine their PAC strategies, several considerations emerge:

- Improved consistency and quality across the System of CARE remain critical given the high utilization, readmissions and mortality observed among patients moving to and from post-acute care.
- Targeting high-impact clinical conditions will be essential to manage future post-acute demand and outcomes, as these conditions span both PAC facilities and home health and are projected to grow faster than overall PAC volume.
- Septicemia drives disproportionate post-acute utilization, reflecting high acuity, long stays and increased discharges as the population ages and medical complexity rises. While improvements in early detection and outcome management may temper length of stay, rising discharges will continue to increase pressure on post-acute and home health services.
- Risk-prediction artificial intelligence and remote patient monitoring will increasingly shape home health delivery, enabling earlier identification of declining patient condition and more proactive intervention. Health systems should evaluate these capabilities and partnership opportunities as part of a broader PAC strategy.
- Operational misalignment at the inpatient to post-acute care transition can create bottlenecks that increase readmissions and cost, underscoring the need for payer strategies aligned with improved post-discharge outcomes.

Abbreviations: CARE=Clinical Alignment and Resource Effectiveness.

Source: American Hospital Association. New Analysis Shows Hospitals Improving Performance on Key Patient Safety Measures Surpassing Pre-pandemic Levels. 2024.

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To speak with one of our experts about the System of CARE, post-acute care or clinical program strategies, email membercenter@sg2.com.

Figure 1 Note: Analysis excludes 0–17 age group. Percentages may not add to 100% due to rounding. Other includes long-term care, hospital, inpatient, rehab and other sites of care not listed. Inpatient utilization within last 30 days includes first occurrence of PAC procedure type between July 2024 and June 2025 and excludes patients with utilization in June 2024. Procedure date based on admission date for SNF stays and hospice utilization. Encounter distribution analysis does not include home infusion chemotherapy and medications due to low volume.

Sources: CMS. (2024–2025). Medicare fee-for-service claims data. Accessed January 29, 2026 from CMS Chronic Conditions Warehouse Virtual Research Data Center via the CMS Innovator Program.; Vizient, Inc. Vizient Clinical Data Base. Q4 2024–Q3 2025. Irving, TX. 2026. Accessed January 2026.

<https://www.vizientinc.com>; Impact of Change®, 2025; Proprietary Sg2 All-Payer Claims Data Set, 2023; The following 2023 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2025; Sg2 Analysis, 2025.

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This report's analysis leverages the following proprietary data and analytics assets.

Sg2 Intelligence is a diverse team of subject matter experts and thought leaders who represent specialties ranging from clinical service lines to enterprise strategy. The team develops strategy-specific content in the form of editorial reports, including the Data on the Edge series, and perspective-based analytics, such as the Impact of Change® forecast.

The **Vizient Clinical Data Base** (CDB) is the definitive healthcare analytics platform for performance improvement. The CDB provides high-quality, accurate and transparent data on patient outcomes such as mortality, length of stay, complication and readmission rates, and hospital-acquired conditions. This data enables hospitals to benchmark against peers; identify, accelerate and sustain improvements; reduce variation and expedite data collection to fulfill agency reporting requirements. Clinical benchmarking tools such as dashboards, simulation calculators and templated and customizable reports enable you to quickly identify improvement opportunities and their potential impact.

The **Sg2 CARE Grouper** is Sg2's proprietary methodology that organizes data across all sites into standardized, clinically relevant categories. It amalgamates ICD-10 diagnosis codes into clinically pertinent disease categories, which are then organized into broader service lines and service line groups. It also groups ICD-10 codes and CPT/HCPCS procedure codes into inpatient and outpatient procedure categories, respectively. These categories facilitate a standardized approach to tracking patient volumes and service utilization seamlessly across inpatient and outpatient settings. The Sg2 CARE Grouper is foundational for our analytics offerings and also serves as a stand-alone product that health systems rely on to manage their organizational data efficiently.

Sg2's Impact of Change® model forecasts demand for healthcare services over the next decade, examining the cumulative effects and interdependencies of key impact factors driving change in utilization. Using both disease-based and diagnosis related group-based analyses, the forecast provides a comprehensive picture of how patients will access inpatient and outpatient services along the continuum of care.

The Vizient Data on the Edge series team includes Brianna Motley, Catherine Maji, Eric Lam, Beatrice Gaturu, Vernon Herbener, Victoria Beal, Daniel Becker and Barbara Mulhern.

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