WHITE PAPER:

# Closing the Gap Between Stabilization and Recovery

Complete Care℠

## Reducing Avoidable Readmissions and Improving Outcomes for Motor Vehicle Accident Patients

Hospitals are highly effective at stabilizing patients in the emergency department (ED). National CDC data indicate that 88% of ED visits result in discharge rather than admission.[1]

For many of these patients, discharge marks the end of acute treatment but not the end of recovery.

This gap is especially visible among motor vehicle accident (MVA) patients, where personal injury protection (PIP) requirements and related administrative complexities can delay or complicate timely follow-up care.

The downstream impact is measurable. In a prospective cohort of motor vehicle crash patients, 25% reported hospital readmission within 12 months of discharge, with 66% of those readmissions occurring within the first 60 days.[2]

For hospitals, repeat ED readmissions can create a material operational and financial burden. Published estimates place hospital readmission costs between $8,000 and $15,200.[3,5,6] Beyond direct cost, readmissions can also increase demand on bed capacity, staffing resources, and emergency department throughput.[3,4]

These findings suggest that repeat utilization is concentrated in the early recovery period, when timely follow-up and coordinated recovery support may have the greatest impact.

Addressing this gap is not about changing how hospitals deliver emergency care, it is about ensuring patients have access to a reliable, accountable pathway for recovery after discharge.

## Hospitals Excel at Stabilization — But the Model Is Episodic by Design

Emergency departments are designed to deliver rapid evaluation and stabilization for acute conditions. They are highly effective at rapidly assessing acute conditions, stabilizing patients and determining the next appropriate level of care.

However, this model is intentionally episodic. It is built to manage acute events, not to oversee ongoing recovery.

As a result, for the 88% of patients discharged rather than admitted, leaving the emergency department also means leaving a highly coordinated acute-care environment.[1]

Within the ED, care is coordinated, time-bound and clearly owned. After discharge, that structure does not consistently persist.

## The Post-Discharge Gap: No Defined Ownership

Patients discharged from the emergency department are typically provided with follow-up recommendations. While this reflects standard clinical practice, recommendations alone do not inherently establish a structured or accountable pathway for recovery.

For many patients, particularly those with non-surgical conditions, there is often no single provider or organization clearly responsible for coordinating recovery after discharge.

**This reflects a structural limitation in how post-discharge care is organized:**

- Primary care is rarely structured to manage auto injury recovery.
  Most primary care practices do not accept PIP claims, and PIP-related rehabilitation, diagnostic and referral needs often fall outside typical primary care workflows.
- Hospital-based specialists appropriately focus on higher-acuity and surgical conditions.
  Non-surgical injuries often fall outside these established specialty pathways.
- Many patients require more than episodic follow-up, but less than hospital-level intervention.
  As a result, no single provider is consistently responsible for coordinating recovery.

These patients often exist between established care models, without a single accountable pathway through recovery.

## Readmissions and System Impact

When recovery lacks a defined point of accountability, readmission becomes a predictable downstream outcome.

Among motor vehicle crash patients, published research found that:

**25%** experienced hospital readmission within 12 months[2]

**66%** of readmissions occurred within the first 60 days[2]

These patterns indicate a meaningful concentration of return visits early in recovery, underscoring how even modest MVA volumes can translate into significant downstream utilization.

Readmissions add operational burden, reimbursement complexity, and pressure on quality, patient flow, and post-discharge outcomes..[3-4]

**Figure 1** illustrates how this dynamic can translate into substantial capacity demands and financial exposure over time.

FIGURE 1.

### Estimated Financial Impact of Repeat MVA Readmissions

**Modeled Scenario Assumptions**

| | |
|---|---|
| MVA patients per month | 40 |
| Patients returning at least once within 12 months | 25% |
| Estimated readmissions per year | 120 |
| Average hospital readmission cost[3,5,6] | $8,000-$15,200 |
| **Estimated annual readmission-related financial exposure (using conservative $8,000 benchmark)** | **$960,000** |

**Figure Note:** Assumes 40 MVA patients/month, 25% 12-month readmission rate, and a conservative $8,000 readmission cost estimate.[2,3,5,6]

Repeat utilization may also place added demand on emergency department capacity, inpatient resources, discharge flow and care coordination teams.

In Florida motor vehicle accident cases, reimbursement for repeat care may become less predictable once initial PIP benefits are exhausted or additional payer coordination is required.

These dynamics reinforce the value of addressing the recovery gap early—particularly during the first 60 days after discharge, when repeat utilization is most concentrated.[2]

## Establishing a Defined Recovery Pathway

### The gap is structural, not clinical.

The solution is not to expand hospital-based services, but to extend continuity beyond discharge through a defined, accountable recovery pathway.

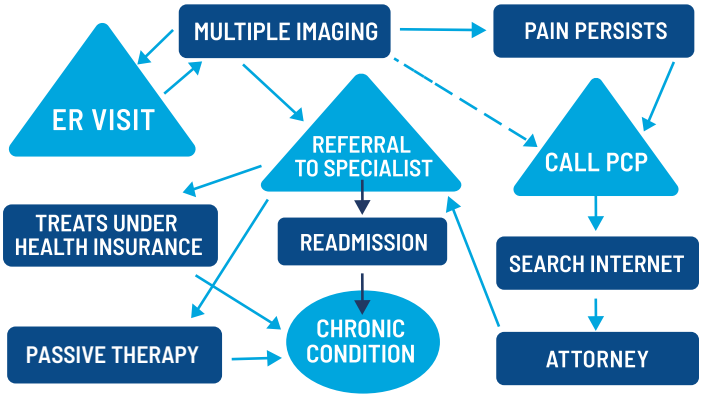
### An effective pathway includes:

- Timely access to care following discharge
- Comprehensive evaluation and structured treatment planning
- Coordinated, multidisciplinary care delivery
- Clear accountability for patient progression

FIGURE 2.

### Post-Discharge Pathway: Unstructured vs. Structured Recovery

**Without a Structured ER Referral Pathway**




**A Direct ER Referral Pathway with Complete Care**


**When these elements are in place, patients are more likely to complete recovery and avoid unnecessary return visits**

## The Complete Care Recovery Model for Motor Vehicle Accident Patients

Complete Care provides a rehabilitation-first model designed to support motor vehicle accident patients through the recovery phase following emergency department discharge.

To date, Complete Care has delivered more than 1 million patient visits and maintains referral relationships with more than 750 medical practices.

Following discharge, patients may be scheduled for timely follow-up care, with same-day availability in many cases and an average time to first visit of approximately two days.

The Complete Care model emphasizes restoring function, reducing pain and supporting recovery through coordinated conservative care, with only a small percentage requiring surgical escalation (~2%).

## Complete Care Outcomes Snapshot

| | |
|---|---|
| Current pain (VAS): Average improvement of | **4.11 points** |
| Worst pain (VAS): Average improvement of | **5.36 points** |
| Activities of daily living (ADL): Average improvement of | **4.41 points** |

**Note:** Average improvements of 4–5 points on 10-point scales indicate substantial symptom and functional gains. Internal outcomes data on file.[8]

### Complete Care Core services include:

- **Physical rehabilitation and functional recovery**
  Physiotherapy, chiropractic care, mobility restoration and targeted treatment plans
- **Neurologic and concussion-focused rehabilitation**
  Evaluation, monitoring and treatment for traumatic brain injury (TBI) and related symptoms
- **Diagnostic and specialty escalation when clinically indicated**
  Including imaging, pain management, spine, orthopedic or surgical consultation
- **Administrative coordination and provider communication**
  Support with PIP requirements, scheduling coordination and progress updates, including electronic record sharing to referring or existing physicians

This model is intended to complement hospital-based care rather than replace existing provider relationships. Higher-acuity needs remain within established hospital pathways, while broader long-term health needs continue with the patient's existing primary care provider.

## Closing the Recovery Gap

Hospitals are highly effective at managing the acute phase of care. For many patients discharged from the emergency department - particularly after motor vehicle accidents—the recovery phase is less clearly defined.

When patients are discharged without a defined recovery pathway, preventable return visits and readmissions become more likely, increasing pressure on emergency department capacity.

Broader healthcare research has shown that timely outpatient follow-up can reduce subsequent readmissions, reinforcing the value of structured post-discharge recovery pathways.[7]

By extending continuity beyond discharge through a reliable, accountable recovery pathway, hospitals can strengthen continuity of care, reduce unnecessary return visits and support performance metrics tied to patient flow and post-discharge outcomes. For appropriate patients, Complete Care provides a structured recovery pathway that complements hospital-based care after discharge.

### Interested in exploring a structured post-discharge recovery pathway for motor vehicle accident patients?

Scan the QR code to learn more.

www.complete-care.com/for-providers

## References


1. Centers for Disease Control and Prevention, National Center for Health Statistics. (2024). National Hospital Ambulatory Medical Care Survey: 2022 emergency department summary tables (Table 23). https://www.cdc.gov/nchs/data/nhamcs/web_tables/2022-nhamcs-ed-web-tables.pdf

2. Carmo, É. A., Nery, A. A., Cardoso, J. P., et al. (2023). Predictors of hospital readmission after motor vehicle crash: Prospective cohort study. Journal of Trauma Nursing, 30(2), 83–91. https://doi.org/10.1097/JTN.0000000000000707

3. Agency for Healthcare Research and Quality. (2021). Conditions with the largest number of adult hospital readmissions by payer, 2018: HCUP Statistical Brief No. 278. https://hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp

4. Moore, L., Stelfox, H. T., Turgeon, A. F., et al. (2013). Rates, patterns, and determinants of unplanned readmission after traumatic injury: A multicenter cohort study. Annals of Surgery, 258(5), 722–729. https://doi.org/10.1097/SLA.0b013e31828b0fae

5. Parreco, J., Buicko, J., Cortolillo, N., et al. (2017). Risk factors and costs associated with nationwide nonelective readmission after trauma. Journal of Trauma and Acute Care Surgery, 83(1), 126–134. https://doi.org/10.1097/TA.0000000000001505

6. Scott, J. W., Neiman, P. U., Brown, C. S., et al. (2021). Targeting zero preventable trauma readmissions. Journal of Trauma and Acute Care Surgery, 91(4), 728–735. https://doi.org/10.1097/TA.0000000000003351

7. Leppin, A. L., Gionfriddo, M. R., Kessler, M., et al. (2014). Preventing 30-day hospital readmissions: A systematic review and meta-analysis of randomized trials. JAMA Internal Medicine, 174(7), 1095–1107. https://doi.org/10.1001/jamainternmed.2014.1608

8. Complete Care Centers, LLC. (2026). Internal outcomes data on file: Sample of 100 patients demonstrating measurable improvement. Pain and functional outcomes assessed using standardized 10-point patient-reported scales.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