Supplement 1

Table S1. Bed-based intermediate care models in the Netherlands

Bed-based intermediate care for frail older adults in the Netherlands		
Geriatric revalidation	**Short-term residential stay**	**Acute Geriatric Community Hospital**
Definition: Post-acute multidisciplinary (para)medic care for older and frail patients, including those with pre-existing functional decline or specific care needs.[46,47]	*Definition:* Medical care for older adults with general health problems that do not require specialist care nor geriatric rehabilitation, but whose treatment and care needs cannot be met at home.[7]	*Definition:* (Sub)acute specialized geriatric medical care for older patients with frailty.[15]
Goal: To optimize functional capacities and support societal participation despite impairments, so that frail and/or older individuals can return home and live independently in the community.[33]	*Goal:* Recovery so that older adults can return home and live independently in the community. [7]	*Goal:* To provide medical specialist care for frail older adults in an adapted environment, so they can return home, live independently in the community and hospital (re)admissions are prevented.[15]
Admission route: Admission from hospital, ED, or home.[34] Referral by a medical specialist or ECP using a comprehensive geriatric assessment.[33]	*Admission route:* Admission from home, ED, or hospital. [7] Referral by GP or medical specialist. [7]	*Admission route:* Admission from ED.[15] Referral by a medical specialist.[15]
Admission criteria:[48] (i). Medical stability (ii). Multidisciplinary rehabilitation needs (iii). Frailty and/or multimorbidity (iv). Motivation/preference to undergo rehabilitation treatment (v). A cognitive and physical status that allows participation in geriatric rehabilitation. Targeted diagnoses: (1) stroke, (2) elective orthopedics, (3) trauma surgery (e.g., hip fractures), (4) amputations, and (5) other disorders (neurodegenerative diseases, oncological diseases, COPD, cardiac failure, internal- and multi-system failure).	*Admission critera*[7]: No guidelines or targeted patient groups.	*Admission criteria (before 2023)* [15]: (i). Older patient with an acute medical problem that requires hospitalization, such as pneumonia or exacerbation of chronic conditions such as heart failure (ii). Geriatric conditions (e.g. delirium, cognitive/functional impairment, falls) (iii). Hemodynamic stability (iv). No complex diagnostic testing needed such as CT or MRI scans during admission (v). Return to previous living situation expected in 14 days
Staffing: A multidisciplinary team with special training in rehabilitation consisting of the elderly care physician, nurses, carers, physical therapists, psychologists, dieticians, social workers, and behavioral scientists.[33]	*Staffing:* A multidisciplinary team consisting of the elderly care physician (or general practitioner), nurses, carers, physical therapists, and other paramedics if needed.[7]	*Staffing:* An interdisciplinary team of healthcare professionals with geriatric expertise, including a geriatrician and/or medical specialist(s), elderly care physician, nurses, physical therapists, and other paramedics if needed.[15]
Coordinating practitioner: The elderly care physician, nurse practitioner, or physician assistant.	Coordinating practitioner: The elderly care physician (high-complex STRC), general practitioner (low-complex STRC), nurse practitioner, or physician assistant.	Coordinating practitioner: The geriatrician, elderly care physician, nurse practitioner, or physician assistant.
Treatment: A multidisciplinary set of evaluative, diagnostic and therapeutic interventions that are adapted to the rehabilitation needs of the frail elderly individual. [33]	*Treatment*[12]*:* Three different STRC care paths exist - STRC low complex provides regular care for patients who are not in need for specific paramedic treatment, but temporarily need more care than homecare can provide. - STRC high complex provides not only increased care, but also (multidisciplinary) treatment or rehabilitation in a slower pace than geriatric revalidation. - STRC hospice care provides care for patients in the last 3 months of their life.	*Treatment:* The four AGCH core components are: (1) low-complex acute specialized geriatric care is safely provided (2) care is focused on rehabilitation and return home (e.g. CGA, ACP, early rehabilitation, function focused care, caregivers involved) (3) integrated care: transmural and close to home (e.g. comprehensive discharge planning, warm handover to general practitioner and district nurse) (4) fitting environment to prevent delirium and functional decline (e.g. rooming-in, noise reduction, management of delirium-inducing drugs).
Indication: Medical generalist care (primary care)	Indication: Medical generalist care (primary care)	Indication: Medical specialist care + medical generalist care

† Abbreviations: ACP = Advance Care Planning; AGCH = Acute Geriatric Community Hospital; CGA = comprehensive geriatric assessment, COPD = chronic obstructive pulmonary disorder; CT = computed tomography; ED = emergency department; MRI = magnetic resonance imaging; STRC = Short-Term Residential Stay

A case vignette study to refine the target group of an intermediate care model: the Acute Geriatric Community Hospital. European Geriatrics Medicine. Kroeze ED, de Groot AJ, Smorenburg SM, MacNeil Vroomen JL, van Vught AJAH, Buurman BM. Section of Geriatric Medicine, Department of Internal Medicine, Amsterdam Public Heatlh Research Insitute, Amsterdam UMC, University of Amsterdam, Amsterdam, the Netherlands, e.d.kroeze@amsterdamumc.nl