WHITE PAPER

Rehabilitation Services and Hospital Readmissions: A Call to Action

Solutions for improving physical function while reducing hospital readmissions

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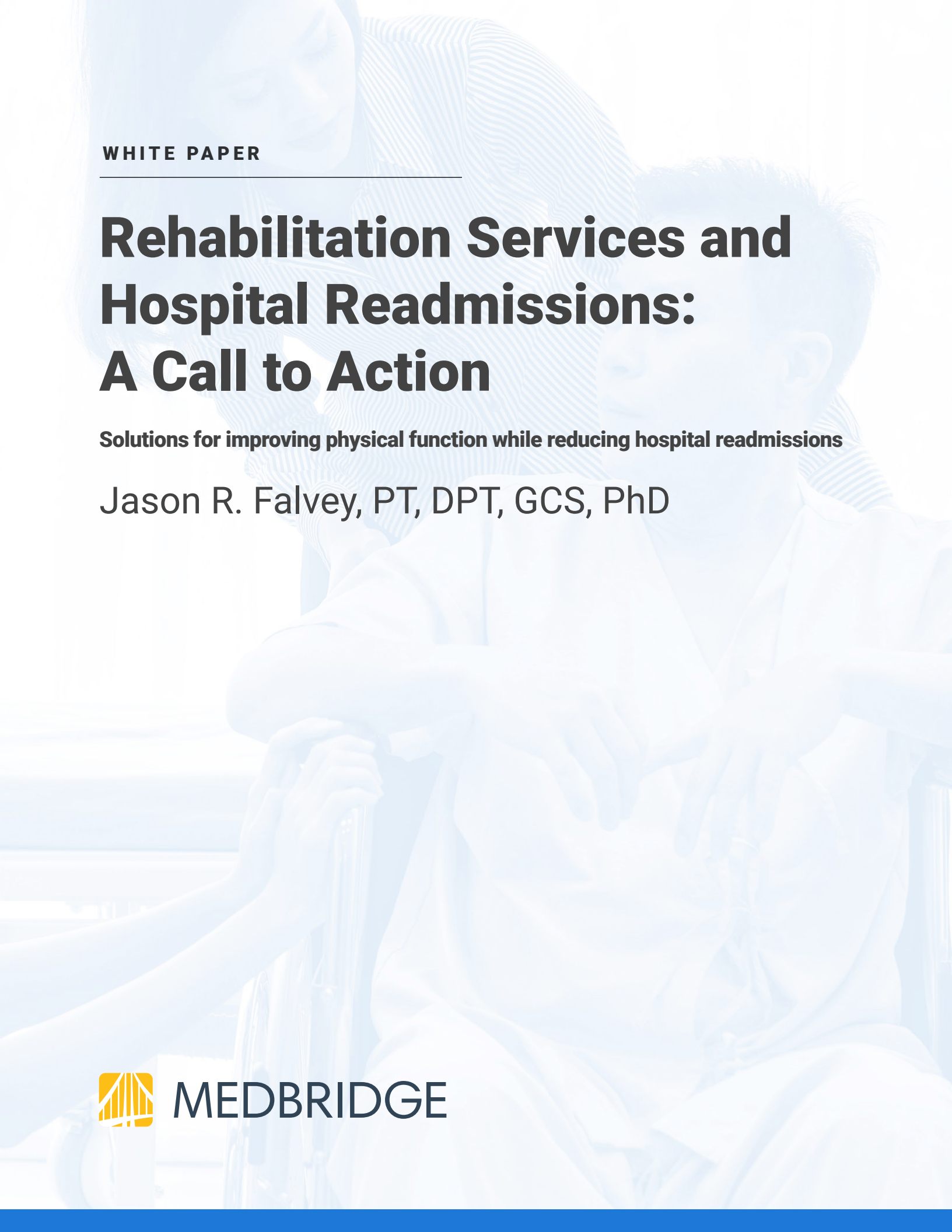

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INTRODUCTION

As Medicare and other healthcare payers continue to move towards value-based and alternative payment models, the pressure is building on hospital providers as well as post-acute care and outpatient providers to deliver care in a more efficient way while improving patient outcomes.

Among the most important issues in alternative payment models are hospital readmissions—readmissions are expensive, a metric of poor quality care, and often a sign of poor downstream functional outcomes. However, many readmissions are potentially preventable. Many root cause analyses have shown a direct relationship between poor care communications and readmission rates. But an insidious modifiable factor of hospital readmissions often goes unrecognized and unaddressed during care transitions: impaired physical function.[1, 10]

Across a wide range of diagnoses, healthcare settings, and patient populations, impairments in activities of daily living function (ADLs) are strongly associated with readmissions.[11, 12] Yet rehabilitation professionals often have a limited role in care transitions—they are called on to provide input on discharge location within acute and post-acute settings but are rarely involved in other important communications or interventions.[1-3]

Clearly, rehabilitation input on discharge destination is important. Rehabilitation professionals have the skills and knowledge to accurately judge post-discharge success both after acute hospitalization and skilled nursing facility stays; in some cases, rehabilitation professionals' predictions about post-discharge outcomes are more accurate than other providers.[7, 8] Yet most major care-transition models do not formally include rehabilitation professionals, nor do they specifically promote measurement or intervention of functional impairments—gaps in care that may contribute to unmet care needs and increased hospitalization risk.

But an insidious modifiable factor of hospital readmissions often goes unrecognized and unaddressed during care transitions: impaired physical function.[1, 10]

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[1] Falvey, J. R., Burke, R. E., Malone, D., Ridgeway, K. J., McManus, B. M., &; Stevens-Lapsley, J. E. (2016). Role of physical therapists in reducing hospital readmissions: optimizing outcomes for older adults during care transitions from hospital to community. *Physical Therapy, 96*(8): 1125–1134.

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INTRODUCTION

Information about physical function is included in physician discharge summaries only 26 percent of the time.[13] Rehabilitation professionals can fill this gap by communicating between themselves across care settings, but examples of this occurring are extremely rare. To allow for innovation to flourish, hospitals, clinical managers, and administrators need to think beyond the historical transition process and work to breakdown the traditional silos of care.[2]

When functional information is not passed between care settings, the risk of patients being discharged with unmet care needs rises.[14] These needs may include durable medical equipment (such as a tub bench) needed for ADL tasks, or formal caregiver assistance with dressing or meal preparation. Additionally, referrals for rehabilitation made at the hospital discharge are often not followed up on, so patients who require community-based rehabilitation are unable to access this valuable service. In some cases, older patients get caught in the functional gray zone—they are too high-functioning to be considered homebound but too impaired to easily access outpatient care.

Poor physical function at the time of hospital discharge is also a robust risk factor for readmissions; failure to improve physical function in the 30-day post-hospital window is associated with a 250 percent increase in the risk of hospital readmissions or death.[15] The negative effect of functional impairment after hospitalization is troubling, but in many ways modifiable. However, barriers to change abound and thus far have not been overcome by rehabilitation professionals in any care setting in a systematic and reproducible way. As rehabilitation professionals, we urgently need to overhaul how we think about care transitions because simple changes will not be enough. Rehabilitation professionals have the skills to be successful players in the hospital readmission reduction game, but unfortunately we do not yet have the reputation or visibility to claim that seat at the table.

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For more on this topic, refer to the five-course Medbridge series on hospital readmissions presented by Dr. Jason Falvey and Dr. Kyle Ridgeway.

Learn More

The Time for Innovative Solutions Is Now

How rehabilitation providers can assert their role in care transitions is an open question; however, the environment is ripe for disruptive innovations. Many solutions proposed here have their roots in a singular core message—**physical therapists are more than just exercise professionals.**

Each readmission risk mitigation solution encourages rehabilitation professionals across all care settings to practice to the fullest scope of their abilities and not simply rely on being the "exercise expert." The roles of rehabilitation in communicating, identifying unsafe home and neighborhood environments, reducing fall risk, and facilitating re-entry into the community cannot be understated. Including physical therapists in every aspect of care transition, from planning discharge and transmitting information within the hospital setting to interventions in the outpatient setting is key. This involvement may be passive (assisting with the design of new information-transfer workflows, for instance) or active (such as acute care or outpatient therapists participating in home visits). **The most sustainable solutions are those that include the interdisciplinary team along with rehabilitation professionals.**

Beyond changing how rehabilitation is delivered during care transitions, there is a growing impetus to consider to whom we are delivering interventions. The following questions need to be answered:

- Are we targeting the populations most at risk?
- Are we capturing the full spectrum of patients who would benefit from our services?

While rehabilitation services have targeted orthopedic conditions and populations of people with musculoskeletal pain, this approach has led to some degree of bias in how services are delivered. Patients recovering from orthopedic surgery may receive a highly protocolized, twice-daily regimen of acute hospital rehabilitation followed by 8 to 12 weeks of skilled rehabilitation outside the hospital. However, a frail older adult recovering from pneumonia may receive rehab three times per week in the hospital, be offered minimal services in the home, and likely not pursue outpatient rehabilitation despite the high need for, and potential benefit from, structured rehabilitation.[1,3] Other emerging populations, such as those recovering from critical illnesses or major non-orthopedic surgery, may be underserved by rehabilitation professionals.[16] Addressing these populations allows population health as a whole to be improved while tapping new revenue streams.

It's Time for New Thinking

Expanding the reach of therapists during care transitions is another area of interest. Leveraging telehealth and mobile interventions to expand PT services both during and subsequent to the 30-day readmission window has strong potential to reduce unmet needs for mobility assistance.

These interventions are especially critical for patients in rural areas who receive fewer post-acute care visits.[17] But telehealth interventions may be useful for frail older adults as well, maximizing limited functional reserve during therapy that may otherwise be exhausted traveling to and from clinic settings. Innovative models of care should be developed to use telehealth during care transitions, specifically allowing acute or post-acute therapists to provide input on the rehabilitation trajectory of complex patients—such as post-stroke or hip fracture—so all relevant information is shared.

What is provided here is just a framework. Many innovative solutions from therapists are already being tested in small cohorts or single-site settings. The goal of this paper is to provide a springboard for even more innovation and encourage the growth of these programs from single-site successes to larger, more widely disseminated models.

There are many ways for rehabilitation professionals to impact the care of patients during care transitions. Within this paper, we'll outline potential solutions and provide suggestions for administrators and clinicians to develop tailored, innovative care models that demonstrate the value of rehabilitation professionals during care transitions.

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Solutions for Shifting the Rehabilitation Paradigm for Care Transitions

Transforming the way physical therapists are viewed and utilized during care transitions will not only require therapists to assert themselves and show a willingness to become a core part of strategic decision-making teams and departments, but will also require organizational administrators to keep an open mind and show a willingness to try a new approach. It's not a change that will happen overnight, but as these solutions are implemented, the situation will improve for everyone as patients receive better care and organizations meet key value-based care goals.

Four solutions that can help you get there are:

1. Remove administrative barriers to evidence-based best practices
2. Improve functional information communication across care settings
3. Optimize outpatient rehabilitation as part of readmission reduction strategies
4. Redesign rehabilitation for disadvantaged patient populations

This next section of the paper will explore these solutions and provide actionable steps for applying them at your organization.

Solution #1: Remove Administrative Barriers to Evidence-Based Best Practices

Physical therapists are often unnecessarily handcuffed by the nebulous "productivity" standards that govern the business side of healthcare practices.[2] Rationalized as ensuring high-value healthcare, these standards sometimes fly in the face of evidence-based practices.

A majority of physical therapists report having productivity standards in the acute-care hospital.[18] While these standards are wildly variable, they consistently require "hands-on" patient time. Yet care communication and coordination activities essential to protecting patient safety and reducing unmet care needs often require phone calls, emails, or other forms of indirect patient care. This mismatch is felt by therapists and often contributes to documented low communication frequency between therapists at different levels of care.

Removing these barriers—and valuing time spent in care-coordination activities—can be a high-value activity. In fact, rehabilitation therapist judgments of discharge location and likelihood of post-discharge success are potent indicators of readmission risk. Integrating acute-care therapists into other activities, such as tele-follow-ups or virtual home environment screenings, may similarly be ways in which the value of therapy can truly be realized.

For post-acute and outpatient therapists, productivity standards are just as stringent—and sometimes even more so. Hospitals, clinical managers, and administrators need to remove the handcuffs of historical transition from the rehabilitation team and allow innovation to flourish. **Rehabilitation therapists are more than just a discharge recommendation and have much more to offer patients beyond exercise interventions**. Allowing therapists to practice to the full scope of licensure and training, removing unnecessary limitations on practice, and supporting the development and testing of new interventions will improve care transitions and inevitably reduce avoidable readmissions.

Solution 1 Key Takeaways

- Impaired physical function is a robust risk factor for readmission—and potentially modifiable!
- Rehabilitation during and after hospitalization has tremendous benefits for improving function and reducing readmissions.
- Removing barriers and limitations and extending the role of therapists may well benefit both patients and clinic revenue.

Hospitals, clinical managers, and administrators need to remove the handcuffs of historical transition from the rehabilitation team and allow innovation to flourish.

[2] Falvey, J. R., Burke, R. E., Ridgeway, K. J., Malone, D. J., Forster, J. E., & Stevens-Lapsley, J. E. (2019). Involvement of acute care physical therapists in care transitions for older adults following acute hospitalization: a cross-sectional national survey. *Journal of Geriatric Physical Therapy, 42*(3): E73–E80.

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Solution #2: Improve Functional Information Communication Across Care Settings

Bridging the gap between acute hospital discharge and community reintegration is a starting point for any discussion of care transitions.[19] This starts with improving functional information communication between hospitals and post-acute care/outpatient settings.

Despite the importance of functional information in identifying those at high risk for readmissions, this information is often omitted from physician discharge summaries at high rates.[20] Information about discharge functional status, recovery trajectory, and durable medical equipment needs is often missing—even critical safety information such as weight-bearing status, fall risk, and assistance needed with basic ambulation and transfers is not explicitly recorded on discharge summaries. For patients who receive rehabilitation, this information may be in hospital treatment notes, but those are provided to the next level of care only sporadically. And electronic medical record systems are often not designed with rehabilitation input. Frequently, notes are difficult to access and in a format unconducive to perusal; therefore, they are not used beyond recommendations for discharge setting.

So how can rehabilitation therapists address what is clearly a pervasive problem? Because rehabilitation does not touch every patient in the hospital setting (nor is it appropriate to recommend that), solutions need to be upstream from direct rehabilitation staff involvement and more focused on care redesign. Working with health information technology teams within hospital settings to place specific fields for key functional information within the system and encourage a common language to record functional ability is a key first step.

Tools like the Activity Measure for Post-Acute Care (AM-PAC) 6-Clicks assessment may be useful for recording functional information.[21] The second step is putting this information within the EMR in a place where it is easily accessible to clinicians and part of clinical decision making and documentation standards. This could be done by auto-populating the most recent 6-Clicks score and interpretation into physician discharge summaries or care referrals.

> **Tools like the Activity Measure for Post-Acute Care (AM-PAC) 6-Clicks assessment may be useful for recording functional information.[21]**

[19] Burke, R. E., Kripalani, S., Vasilevskis, E. E., & Schnipper, J. L. (2013). Moving beyond readmission penalties: creating an ideal process to improve transitional care. *Journal of Hospital Medicine, 8*(2): 102–109.
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Rehabilitation professionals could help design these templates, lead education in-services, and routinely participate in future EMR redesigns to make sure functional information is included in key discharge communications. Triggers for referral to outpatient and home-based rehabilitation could be designed to help spur physicians to consider these options for patients with documented impairments in functional status that may be amenable to skilled interventions.

Beyond the walls of the hospital, these principles apply to post-acute care settings as well. Rehabilitation professionals touch a higher percentage of patients in rehabilitation hospital and skilled nursing facilities, so these solutions may be more driven by direct interventions. Screening of physical function for all patients pending community discharge could be routinely conducted, and the results of these screenings can (and should) be directly communicated to the next level of care.

More than 80 percent of acute care physical therapists feel that care coordination activities are not valued as productive time by their hospitals.[2]

Solution 2 Key Takeaways

More than 80 percent of acute care physical therapists feel that care coordination activities are not valued as productive time by their hospitals.[2] Yet care communication is one of the most important roles a therapist plays, along with discharge planning. Improving communication about physical function across the continuum of care can lower readmission risk. Here are two recommended strategies:

- Have physical therapists in meetings with EMR planners and health IT to work on ways to automate inclusion of all relevant PT and functional information into MD discharge summaries.
- Support and encourage the writing of PT discharge summaries and ensure information is provided to the next level in a timely manner.

[2] Falvey, J. R., Burke, R. E., Ridgeway, K. J., Malone, D. J., Forster, J. E., & Stevens-Lapsley, J. E. (2019). Involvement of acute care physical therapists in care transitions for older adults following acute hospitalization: a cross-sectional national survey. *Journal of Geriatric Physical Therapy, 42*(3): E73–E80.

Solution #3: Optimize Outpatient Rehabilitation as Part of Readmission Reduction Strategies

Medicare and private payer payment changes are disincentivizing volume of therapy across most settings, suggesting that re-organizing and showing the value of novel models of therapy delivery are important future considerations. Moving away from fee-for-services models means that clinic administrators will need to be nimble in how therapy resources are allocated and identify new populations for whom therapy can be delivered, new models of care delivery, and new measures of rehabilitation success that go beyond physical performance outcomes.

Return to community—a new Medicare metric for post-acute care settings[22]—is understudied but likely will require much stronger coordination between post-acute and outpatient providers. For high-need patients, such as those recovering from a stroke, hip fracture, or spinal cord injury, care coordination between rehabilitation professionals may be critical to ensure needed resources are in place for transportation, durable medical equipment, and caregiver assistance.[20]

Beyond coordinating care better with upstream providers, outpatient clinics need to measure outcomes that are more aligned with healthcare system value. Measures of physical performance and disability are critically important, but measures of healthcare utilization during and after outpatient episodes are equally essential in showing the overall value of rehabilitation. Populations with high risks of readmission and institutionalization, such as frail or cognitively impaired older adults,[23, 24] are often not well-accommodated in outpatient rehabilitation clinics, which may contribute to the relatively poor functional outcomes for these patients after acute hospitalization. Outpatient clinicians who design care models for these vulnerable patients, therefore, may both improve population health outcomes and tap into revenue streams that only increase as the population continues to age rapidly.

To be successful in improving care transitions, outpatient providers may need to rethink clinic-based models and consider developing an arm of the practice that delivers outpatient services. These services, even provided transiently, may help patients overcome home barriers to outpatient attendance, build trust, and overall allow patients to participate more fully in rehabilitation. But creativity is needed for outpatient providers to determine how to use tele-rehabilitation and home visits appropriately and still maintain slim profit margins. Testing new models in clinical-academic partnerships where some reimbursement protection can be provided may be high-value propositions for both researchers and clinicians.

Solution 3 Key Takeaways

- Extending rehabilitation clinicians' role will reduce hospital readmissions.
- By letting clinicians use their full complement of skills, readmission risk factors will likely be addressed, thereby providing better care and patient satisfaction.
- Administrators and clinic managers can lead substantial innovation in this area by developing new care pathways or QI programs.

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Solution #4: Redesign Rehabilitation for Disadvantaged Patient Populations

Across the rehabilitation continuum, increasing attention is being paid to social determinants of health. Patients living in disadvantaged neighborhoods have higher rates of disability, which may contribute to elevated risks of readmission.[25, 26] Rural populations have similar concerns—the lower density of medical providers combined with longer distances required to travel to appointments leaves rural patients vulnerable to both readmissions and morbidities like increased disability after acute hospitalization.[27] Thus, finding ways to extend rehabilitation care and tailor it to the needs of disadvantaged populations is essential.

One solution may be increasing the use of tele-rehabilitation during care transitions. Using tele-rehabilitation to bridge care gaps may reduce unmet care needs and serves as a useful model for patients who return to far-flung rural communities or those with conditions that make it difficult to leave home without taxing effort.[28] Tele-rehabilitation also saves patients the costs of driving to and from a clinic; for rural patients, this could mean a full day off work to travel back and forth. Using remote treatment modalities is also a more financially viable model for outpatient clinics than doing home visits alone. This allows for models that, for example, combine occasional home visits with more frequent tele-rehabilitation follow-up. In turn, this allows clinics to extend the reach of therapy without substantially challenging profit margins. Outcomes of early tele-rehabilitation studies across many conditions have been promising, suggesting that replacing some face-to-face visits with remote visits does not substantially impact patient outcomes in a negative way.[29, 30]

Acute care or post-acute care providers could also use tele-rehabilitation to support transitions into the community while also generating revenue. In the 30-day post-discharge period, it would be easy to justify the need for transient rehabilitation services for patients who have slowed gait or impaired muscle performance. New Medicare codes supporting tele-rehabilitation and tele-monitoring may allow delivery of rehabilitation to vulnerable patients who may not be homebound but otherwise have difficulty participating in recommended care. This may open up new avenues for outpatient clinicians to focus on frail or underserved medical populations or provide care that bridges home-to-outpatient transitions in a meaningful way.

Solution 4 Key Takeaways

Attendance at follow-up outpatient clinics for adults recovering from critical illness is poor—and especially dismal for underserved communities. Rethinking care-delivery models and employing technological advances like tele-rehabilitation and tele-monitoring can go a long way toward ensuring these communities receive the care they require.

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Putting it Together: Actionable Steps to Create a Real-World Shift in Care Transitions

While transforming care transitions might seem like a daunting task, these action steps provide you with a clear way forward. You don't have to tackle all of them at once, of course, but each one will bring you and your organization closer to practicing value-based care in a way that significantly improves patient lives and meets organizational goals.

1 Remove administrative barriers to evidence-based best practices.

- ☐ Include physical therapists as a key part of your core discharge team.
- ☐ Integrate acute-care therapists into activities like tele-follow-ups and virtual home screenings.
- ☐ Support the development and testing of new interventions.

2 Improve functional information communication across care settings.

- ☐ Include rehabilitation professionals in EMR template design, education in-services, and future EMR redesigns.
- ☐ Work with health information technology teams to place specific fields for key functional information within the system.
- ☐ Assess whether incorporating the Activity Measure for Post-Acute Care (AM-PAC) 6-Clicks tool in your organization's EMR would be beneficial.

3 Optimize outpatient rehabilitation as part of readmission reduction strategies.

- ☐ Measure healthcare utilization during and after outpatient episodes, particularly in patients with an increased risk of readmission and reinstitutionalization.
- ☐ Assess the way your organization uses tele-rehabilitation and home visits to determine whether these programs can be expanded or implemented.

4 Redesign rehabilitation for disadvantaged patient populations.

- ☐ Increase the use of tele-rehabilitation during care transitions—particularly if you are serving disadvantaged populations.
- ☐ Encourage acute care and post-acute care providers to use tele-rehabilitation during transitions into the community.

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- Evidence-Based Rehabilitation to Reduce Readmissions

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ABOUT

Jason R. Falvey, PT, DPT, GCS, PhD

Jason Falvey is a post-doctoral fellow at Yale University. His research training focuses on disability and recovery for older adults after acute hospitalization, and how physical function contributes to hospital readmission risk. He received his PhD in Rehabilitation Science from the University of Colorado, Anschutz Medical Campus in 2018. He previously received a dual BS and DPT from Husson University in Bangor, Maine.

Jason is particularly interested in how rehabilitation utilization after an acute hospitalization impacts trajectories of functional recovery, risk for readmission, and downstream healthcare utilization. He also has worked with long-term care providers to evaluate optimal measurement of physical function and relationships between function and hospital utilization. Prior to his matriculation in the PhD program, Jason obtained his board certification in geriatric physical therapy in 2013 and worked as a home health therapist and rehabilitation director of a home health agency in Cheyenne, Wyoming.

Jason maintains an active social media presence on Twitter (@JRayFalvey) and is a frequent podcast guest for topics related to geriatrics and health care policy.