Workers' Comp

Managing the Seismic Shift from Inpatient to Outpatient Physical Medicine Services

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Tom Kerr (TK): Costs and patient preferences have driven rehabilitative care toward outpatient services earlier in the recovery process. In today's podcast, we talk with Kim Radcliffe, senior vice president of product management at Enlyte, to discuss how this trend has impacted physical medicine networks and return-to-work outcomes.

Kim, thanks for joining us today.

Kim Radcliffe (KR): Thanks. I'm glad to be here.

TK: So, let's start with the first question, Kim. Hospital stays have increasingly been trending shorter over the last decade. What challenges does this present to physical medicine professionals?

KR: Yes, the big challenge is patients are starting therapy often the same day or 24 to 48 hours after the operation. So physical therapists had traditionally seen patients a week or two weeks after postop for orthopedic surgeries like joint replacements, hip replacements and such. And so, therapists are now having to become more

than just physical therapists (PTs) dealing with range of motion and strength. They've always dealt with pain and swelling, but now they're dealing with a little more of the medical components associated with coming out of a surgery, and the doctors also have very specific protocols they want addressed such as wound management.

So, therapists are having to expand their knowledge on the medical healing of wounds, joint replacement, and other orthopedic conditions that they might not have otherwise been experts in on a subacute level.

TK: So, they're seeing patients at a higher acuity level?

KR: Yes, that's really the biggest thing. The acuity level that patients are entering rehab because they're really having to start therapy pretty quickly.

TK: So with that, has training or continuing education changed for occupational therapists (OTs) and PTs who work outpatient to make them better prepared in treating injured employees at a higher acuity level than in the past?

KR: I would say that the core schooling hasn't changed, but there are more continuing education courses focusing on medical management or post?discharge care. You are also making those decisions to decide whether they need home health first or go straight to outpatient therapy depending on the patient's mobility and transportation. So, depending on your focus as a therapist, whether you're going to be a home health therapist or an outpatient therapist, you're having to shift your training. Home health therapists had always had a bit more training and experience with some of the challenges I mentioned, like pain, nausea, and wound care. But outpatient therapists, because of the advances in surgical techniques and even the age and fitness of patients, are seeing patients sooner. And those clinicians hadn't normally seen as many wounds and dealt with as much of that really acute care.

So, it's really addressing it through continuing education. I don't think the schools have necessarily changed. The core programs give you everything you need, and then you have to decide on which setting you're working in as a therapist. You really must make sure you focus on understanding the trends and what kind of patients you're seeing and what level of function they're at when they come to see you.

TK: And we talked about some of the challenges, but it can't be all bad when it comes to having patients leave the hospital early [laughs]. So, what are some advantages to a limited hospital stay and patients receiving more care on the outpatient side?

KR: Right. That's a really great question because it is a challenge for therapists to address as they're seeing the shift. But from a patient perspective, it's mostly positive.

You know, my mom just had a hip replacement and it was outpatient, and she's 72 and she was a bit flabbergasted that she wasn't getting to stay at the hospital. And she might be one of those patients that wanted to be pampered by nurses for a couple days. But the actual recovery and the actual impact and outcomes have proven to be much better the sooner you get patients at home.

You hear the word nosocomial, the actual complications and infections that can happen in a hospital are worse. And when you have relatively healthy patients who are undergoing joint replacement or orthopedic procedures, they are really going to have fewer complications and concerns at home than they might at the hospital.

You also are usually getting the patients up quicker because they're receiving care at home and then shifting into outpatient. It's more comprehensive and aggressive than traditional inpatient protocol performed in the hospital, where patients would receive basic therapy for transferring in and out of bed, walking to the toilet. Now, the

actual mobility, range of motion and recovery protocols from an outpatient center is better.

Another thing to consider is the economic impact. An outpatient procedure has been proven to save over $8,000 than doing it inpatient. Sometimes that's not directly seen by patients depending on their insurance, but in the overall scheme of things, the economic impact is really important as we try to look at ways to lower health care costs as a whole.

And, as I was talking about infection rate risks with inpatient stays, that has always been a concern; but COVID?19 was one of the accelerators toward more outpatient procedures because many patients did not want to go to a hospital and surgeons shifted to outpatient because of that reason as well.

TK: What are some ways strong physical medicine networks manage this trend towards outpatient care?

KR: The most critical thing is getting access to the surgeon's protocols as soon as possible because the patient is not going to be in a controlled setting as a hospital to follow those first few days of protocol.

So, with hip replacements, the surgical techniques have changed, so the precautions aren't as specific as in the past. For instance, patients couldn't bend their hip a certain degree forward and sideways or rotate it in fear it could pop out. That, fortunately, has changed quite a bit. The precautions are less stringent, but those precautions are there.

And so, the network needs to know the date of surgery, the surgical technique, the precautions and whether the patient has been set up for home health or outpatient therapy. So often we're trying to work on coordinating with the adjusters to understand when that date's going to happen and do pre?coordination of services. And that way, as soon as the patient is released, if needed, the home health therapist or nurse can be there after the patient returns home to make sure he or she has all medications managed and any durable medical equipment —walkers, or wheelchairs, elevated commodes for hips and knees, shower chairs — is available and prepared ahead of time.

And that's probably the most critical aspect of it, that timeliness and efficiency, and then the follow?up with the patient to make sure he or she is progressing and the services have started on time.

TK: Yeah, communication is key in terms of making that transition. And I guess it's really important the PTs and OTs have strong relationships with the facilities they're working with or the people who are doing the transfers to make sure there's an easier transition from inpatient to outpatient. Right?

KR: Yes. And early intervention is really important because staffing shortages have been a factor. For a lot of outpatient surgical centers, their surgical process is the patient checks in, goes into surgery and then, as surgery is finishing up, the staff will write the orders and push them out to a network.

So as much as you try to do early intervention or prepare, sometimes you get those orders same day. So, another critical aspect is just making sure you have strong geographic coverage in the network. We tend to prioritize and build out network partnerships with our providers to give centralized scheduling priority. So, if there's limited availability of PTs or home health nurses in a certain area, we have a central location to contact for urgent cases to make sure that patients get the care they need.

TK: Was there anything else you wanted to add that we didn't cover?

KR: Well, one of the things I would add is just the preparation and the awareness in the market that this trend is growing by leaps and bounds. It's important for networks to be prepared and have that availability of staff. It's predicted that 75% of joint replacements are going to be performed outpatient by 2026. Back in 2010, outpatient

procedures represented just 10-15% of all joint replacements, and it’s already grown to 50% now. So having that availability and that expertise in early medical management is critical.



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