

## EXECUTIVE SUMMARY

### **Title: Reinvigorating the Inpatient Rehabilitation Unit via a Strategic Plan Focused on Growth and Outcomes, Including Optimal Disposition**

The Inpatient Rehabilitation Facility (IRF) at our community hospital faced significant challenges, consistently underperforming financially, clinically, and in terms of quality. For years, the unit experienced a chronically low patient census, indicative of insufficient physician engagement and a lack of appropriate referrals. This underutilization directly contributed to prolonged acute care length of stay (LOS) for patients awaiting post-acute placement, exacerbating hospital-wide throughput issues. Furthermore, the IRF exhibited an excessive rate of discharges to skilled nursing facilities (SNFs) instead of directly to the community, highlighting suboptimal patient outcomes and missed opportunities for greater independence. This collective underperformance represented a major strategic failure to leverage a critical service for both patient benefit and institutional revenue preservation.

In response, our institution launched a comprehensive two-year revitalization initiative. The overarching goal was to strategically reposition the IRF as a high-value, efficient post-acute care option, integral to the regional healthcare continuum. Our specific objectives included: achieving a significant increase in appropriate IRF admissions, demonstrably improving patient functional outcomes, attaining higher community discharge rates, sustaining robust Centers for Medicare & Medicaid Services (CMS) IRF compliance, substantially growing departmental net revenue, and critically, optimizing overall hospital patient throughput by establishing the IRF as a timely, appropriate, and readily accessible discharge destination.

The target audience for this initiative was broad, encompassing medically complex adult patients requiring intensive post-acute rehabilitation; our internal acute care leadership and referring clinicians (hospitalists, intensivists, specialists, and residents); external healthcare providers and facilities within our primary and secondary service areas; and, fundamentally, the broader community served by our hospital, ensuring equitable access to high-quality local rehabilitation services.

**Evidence and Baseline Data:** A rigorous needs assessment identified five primary, interconnected drivers of the IRF's underperformance: a demographic imperative with growing disability needs (WHO, n.d.); significant regulatory risk due to sub-60% CMS qualifying diagnosis rates; substantial hospital-wide impact from prolonged acute care LOS (averaging nearly 6.0 days in early 2024); poor baseline community discharge rates of 55.4% (Graham et al., 2017); and critically suboptimal utilization with an average daily census of only two patients.

**Intervention:** In early 2024, C-suite and mid-level leaders convened a strategic retreat, approving a targeted, multi-faceted intervention. Key actions included: appointing a board-certified Psychiatrist as Medical Director to enhance clinical triage and physician engagement; hiring dedicated specialized therapists and rehabilitation-trained nursing staff; assigning a new departmental operations leader; deploying a focused marketing plan to internal and external referral partners; providing comprehensive education to attending physicians and residents on IRF benefits and admission criteria; and implementing standardized patient selection, interdisciplinary care plans, and robust outcome tracking mechanisms.

**Results:** The strategic interventions yielded immediate, significant, and sustained positive impacts: overall IRF admissions increased dramatically by 91% (CY2024 to CY2025); departmental net revenue grew by 52.3% year-over-year; clinical productivity improved by 27% while maintaining high care standards; the community discharge rate significantly climbed to 69.3% from 55.4%; and regulatory compliance was exceeded, with 76.81% of patients meeting CMS qualifying rehabilitation diagnoses. Additionally, referral sources broadened, and staff retention improved. These outcomes demonstrate a profound transformation, establishing the IRF as a critical operational and clinical asset for the hospital and a cornerstone of optimal operations and local post-acute care delivery.

## ASSESSMENT

The contemporary healthcare landscape presents an intricate web of challenges and opportunities, particularly for small community hospitals. Their long-term viability is inextricably linked to dynamic, forward-thinking leadership, the implementation of strategic growth initiatives, and an unwavering, demonstrable commitment to delivering high-quality, patient-centered care. In the specialized realm of post-acute services, the strategic decision to place patients in an Inpatient Rehabilitation Facility (IRF) versus a Skilled Nursing Facility (SNF) carries significant implications for patient prognosis. Evidence consistently demonstrates that appropriate IRF admissions are associated with a higher potential for direct discharge to the community, thereby actively preventing prolonged institutionalization and fostering greater independence. The recent global health crisis, specifically the COVID-19 pandemic, exerted immense pressure on healthcare systems worldwide, often disrupting and impairing the growth and development of rehabilitation models, which in turn contributed to widespread capacity challenges across the entire continuum of care. Despite the presence of several IRFs within the broader regional catchment area, both anecdotal feedback and structured patient surveys consistently indicate a strong, prevailing preference among patients and their families for local IRFs situated within their residential communities. This preference underscores the critical importance of accessible, localized rehabilitation services that support family engagement and maintain social ties crucial for holistic recovery.

Against this complex backdrop, a comprehensive needs assessment and environmental scan were meticulously conducted at our community hospital. This rigorous preparatory phase was not merely an administrative exercise; it was a crucial, data-driven endeavor designed to precisely identify and quantify both the internal systemic challenges that were inhibiting the optimal performance of our IRF and the latent, external market opportunities that, if strategically leveraged, held the potential to transform the unit into a high-value asset, delivering superior patient outcomes and contributing significantly to the hospital's overall mission.

## INTERVENTION

The initiative, a two-year strategic plan, began with a leadership retreat in early 2024. Hospital executives and mid-level leaders aligned on a vision: transforming the underperforming rehabilitation unit from a liability into a vital asset. This recognized the unit's challenges were linked to broader systemic issues like patient throughput and financial stability.

The plan comprised three interconnected pillars: Clinical Excellence and Access to Care, Operational and Workforce Optimization, and Financial Stewardship and Alignment with Hospital Goals. Each pillar addressed root causes of underperformance.

### Strategies and Implementation Plan:

#### Pillar 1: Clinical Excellence and Access to Care

This pillar focused on elevating clinical quality, standardizing evidence-based protocols, and ensuring appropriate patient access to specialized rehabilitation services.

- **Intervention:** Addition of a New, Trained Physiatrist Medical Director.
  - **Strategy:** To infuse specialized medical expertise and dedicated clinical leadership into the IRF, driving best practices, enhancing physician engagement, and refining patient selection for optimal outcomes and regulatory compliance.
- **Implementation:** A national search successfully recruited a board-certified physiatrist with extensive IRF experience. The Medical Director led protocol development, interdisciplinary rounds, engaged referring physicians, and served as a clinical liaison between the IRF and acute care staff, improving continuity of care and referrals.
- **Intervention:** Education of Attending Physicians and Residents on IRFs, Advantages, and Benefits.
  - **Strategy:** To systematically increase awareness among acute care providers regarding IRF admission criteria and the benefits of IRF care for specific patient populations, emphasizing more intensive therapy, shorter post-acute stays, and higher community discharge rates.
- **Implementation:** The new Medical Director, collaborating with the departmental leader, delivered regular educational sessions, including in-service presentations, grand rounds, and bedside interactions. These sessions used local case studies, national outcome data, and clear explanations of admission criteria.

- **Intervention:** Standardized Clinical Pathways and Outcome Tracking.
  - **Strategy:** To ensure consistent, high-quality, evidence-based care, facilitate measurable patient progress, and provide data-driven insights for individualized treatment strategies.
- **Implementation:** Diagnosis-specific clinical pathways were developed and implemented for common IRF conditions (e.g., stroke, spinal cord injury). Standardized functional outcome measures (e.g., Section GG metrics) were integrated into the EHR for real-time tracking and dynamic treatment planning. The Physiatrist and IRF team proactively rounded on acute care inpatients to identify suitable candidates early, streamlining transitions.

## **Pillar 2: Operational and Workforce Optimization**

This pillar focused on enhancing IRF operational efficiency and cultivating a skilled, engaged, and stable workforce.

- **Intervention:** Addition of New Therapists and Nursing Team Members Dedicated to the IRF.
  - **Strategy:** To ensure adequate, specialized staffing levels for intensive IRF therapy (three hours/day, five days/week) and expert rehabilitation nursing care, reducing reliance on costly agency staff.
- **Implementation:** A targeted recruitment campaign, in collaboration with HR, sought qualified physical therapists, occupational therapists, speech-language pathologists, and rehabilitation-certified nurses. Recruitment emphasized the unique, patient-centered culture of IRF care.
- **Intervention:** Addition of a New Departmental Leader.
  - **Strategy:** To provide dedicated, expert operational leadership for the IRF, managing daily operations, fostering staff development, and ensuring seamless interdepartmental coordination.
- **Implementation:** An experienced rehabilitation manager with a strong background in IRF operations, fiscal management, and team leadership was recruited. This leader was instrumental in implementing productivity benchmarks, optimizing workflows, and fostering an engaged staff culture.
- **Intervention:** Strategic Staffing Models and Productivity Benchmarks.
  - **Strategy:** To optimize human resource utilization, ensure maximal operational efficiency, and maintain high standards of patient care amidst fluctuating patient volumes and acuity.
- **Implementation:** Flexible staffing models were developed, tested, and deployed, adjusted based on real-time census projections and patient acuity. Rigorous productivity benchmarks for therapy staff were established, aligned with national best practices for IRFs, with regular feedback provided.
- **Intervention:** Staff Development and Engagement Initiatives.
  - **Strategy:** To improve staff retention, enhance clinical skill sets, and cultivate a positive work environment, boosting job satisfaction and organizational loyalty.
- **Implementation:** Comprehensive mentorship programs were introduced. Staff were supported in pursuing advanced certifications. A culture of shared accountability, collaborative problem-solving, and continuous improvement was fostered through regular interdisciplinary team meetings, recognition programs, and opportunities for cross-training.

## **Pillar 3: Financial Stewardship and Alignment with Hospital Goals**

This pillar focused on strategically positioning the IRF as a key financial contributor and vital strategic asset, aligning it with hospital goals for sustainability.

- **Intervention:** Marketing Plan Designed to Focus on Inpatients in Need of an IRF and All Neighboring Hospital and Healthcare Providers.
  - **Strategy:** To significantly expand the IRF's referral base, educate the broader healthcare community about its value proposition, superior clinical outcomes, and distinct advantages.
- **Implementation:** A comprehensive, multi-channel marketing strategy was executed, including direct outreach by a dedicated liaison to acute care case managers and physicians both internally and at regional facilities. Targeted visits to neighboring hospitals and physician offices, along with compelling informational brochures and digital content,

highlighted IRF services and patient success stories. IRF staff were strategically positioned at key referral sources to facilitate immediate consultations and streamline referrals.

- **Intervention:** Aligned Growth Targets with Broader Organizational Priorities.
  - **Strategy:** To firmly position the IRF as a critical contributor to overall hospital sustainability and value, demonstrating its positive impact on system-wide performance indicators.
- **Implementation:** The IRF’s growth and outcome metrics (e.g., reductions in acute care LOS, decreased 30-day readmission rates, enhanced patient satisfaction) were integrated into the hospital’s overarching performance dashboards and routinely reviewed by executive leadership. This ensured the IRF’s contributions were recognized as supporting broader hospital financial health and reputation.

Through these interconnected and rigorously implemented efforts, the community hospital successfully transformed its IRF, addressing internal inefficiencies and capitalizing on external market opportunities, leading to a profound and sustainable revitalization benefitting both patients and the institution.

## RESULTS

The strategic initiatives implemented within the Inpatient Rehabilitation Unit yielded significant, measurable, and sustained improvements across clinical, operational, and financial domains within a 12-month impact period (CY 2024 to CY 2025).

Dsch Year	Visit Count	AVG LOS	AVG Age
2024	74	14.9	64.1
2025	137	12.7	59.6
<b>Grand Total</b>	<b>211</b>	<b>13.5</b>	<b>61.2</b>

*Figure 1: 12-Month Impact of Average Visit, Length of Stay (LOS) by Age Group.*

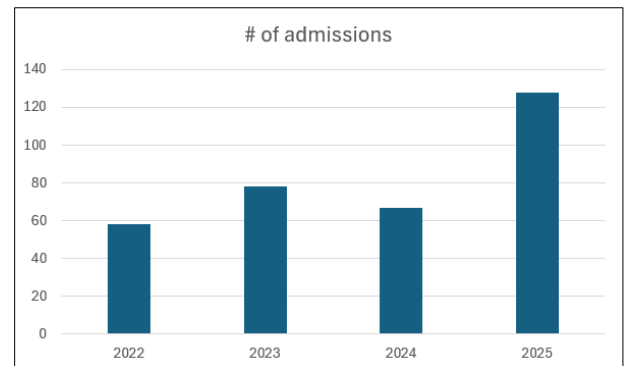
### Measurable Outcomes (CY2024 to CY2025 Impact):

#### 1. Volume Growth:

- **Admissions:** IRF admissions surged by an impressive 91%, reflecting expanded access and stronger referral alignments.
- **Discharges:** Total patient discharges increased by 85%, representing 63 additional patients receiving optimal rehabilitation services, achieving functional goals, and experiencing timely outcomes.

#### 2. Financial Performance:

- **Revenue Impact:** Departmental net revenue grew by 52.3%, transforming the IRF into a profitable service line contributing significantly to the hospital's financial health.
- **Cost Reduction (Indirect):** Improved patient throughput and reduced acute care Length of Stay (LOS) indirectly generated significant cost efficiencies for the broader hospital system by freeing up acute care beds faster.



*Figure 2: Screenshot for the Number of Admissions*

#### 3. Operational Efficiency and Quality:

- **Productivity:** Clinical productivity across therapy and nursing improved by 27%, achieved while maintaining high standards of patient care.
- **Community Discharge Rate:** The return-to-community rate rose sharply to 69.3% from 55.4%, exceeding median rates for comparable facilities and underscoring commitment to patient-centered outcomes.
- **CMS Regulatory Compliance for IRF Criteria:** The IRF successfully achieved renewal and maintained its designation, with 76.81% of patients meeting qualifying rehabilitation diagnoses criteria, substantially surpassing the 60% regulatory threshold.

#### 4. Workforce Stability and Engagement:

- **Staff Retention:** Staff retention significantly increased, cultivating a more stable, experienced, and expert workforce, which supported increased patient volume and enhanced care quality.
- **Interdisciplinary Collaboration:** A positive cultural shift fostered enhanced interdisciplinary collaboration, strengthening shared accountability and leading to improved care coordination.

**System-wide reinvigoration:** The IRF's turnaround produced cascading benefits across the hospital. By restoring the IRF as a timely, appropriate, and reliable discharge destination, it directly reduced acute-care LOS, improved bed availability, eased patient flow, and optimized inpatient bed utilization. The unit's performance renewed confidence among leadership and staff, bolstering morale and fostering innovation. Crucially, its success reinforced the hospital's mission to deliver high-quality, local care, preserving vital community access to essential rehabilitation services.

**Evidence of Sustained Improvements:** These gains are systematically maintained through robust governance and embedded operational practices. A dedicated performance dashboard, reviewed monthly by executive leadership, tracks key metrics. Standardized clinical pathways and refined referral protocols are integrated into daily workflows. Stable clinical and operational leadership ensures ongoing oversight and continuous quality improvement. Targeted marketing efforts have expanded and diversified the referral network, ensuring sustained demand for IRF services.

This transformation exemplifies excellence in healthcare operations and strategic management, demonstrating that a strengthened Rehabilitation Department can become a pivotal cornerstone of enduring hospital viability.

## ADAPTABILITY

The initiative to reinvigorate our Inpatient Rehabilitation Unit is a highly adaptable and replicable model for other community hospitals and healthcare organizations facing similar challenges or seeking to optimize their post-acute care continuum.

### Potential for Replication:

**1. Core Components are Universal and Transferable:** The initiative's foundational pillars are universally applicable to virtually any healthcare service line, particularly in rehabilitation.

- **Specialized and Accountable Leadership:** Recruiting a dedicated physiatrist and an experienced departmental leader provides essential clinical expertise and operational oversight, a model highly replicable for elevating IRF performance.
- **Targeted Workforce Development and Engagement:** Implementing dedicated, specialized rehabilitation teams and focusing on staff retention, development, and engagement can be readily adopted to improve care quality and foster a stable, expert workforce.
- **Process Standardization and Evidence-Based Practice:** Developing and implementing standardized admission criteria, clinical pathways, and outcome tracking tools are foundational elements for consistent, high-quality care, adaptable to specific patient populations and resources.
- **Strategic Referral Management and Outreach:** Active and targeted marketing strategies are scalable and customizable to local market dynamics, enabling other organizations to optimize patient acquisition.
- **Data-Driven Performance Monitoring and Continuous Improvement:** Continuous data collection, rigorous analysis, and transparent KPI reporting are critical for sustained success, informing timely adjustments and driving continuous improvement.

**2. Scalability Across Organizational Sizes and Resources:** The initiative is inherently scalable. A larger integrated health system could implement it across multiple units, leveraging centralized resources. A smaller community hospital could adopt a phased approach, scaling interventions as capacity and financial performance allow.

**3. Population Versatility and Clinical Breadth:** While focused on general inpatient rehabilitation for medically complex adults, the principles of optimizing care intensity, improving discharge planning, and enhancing community reintegration are relevant for diverse patient populations, including those with complex neurological, orthopedic, or multi-system medical conditions.

## MAINTAINING THE INITIATIVE AND RESULTS:

### **Sustaining improvements requires a continuous, proactive, and embedded approach:**

- **Sustained Leadership & Governance:** Ongoing executive sponsorship and active participation from the Medical Director and departmental leader are paramount. Regular performance reviews using the KPI dashboard ensure accountability and agile course corrections.
- **Continuous Staff Development & Positive Culture:** Investing in ongoing staff education, professional development, and a supportive work environment is vital for maintaining morale, engagement, and low turnover.
- **Dynamic Referral Management & Market Responsiveness:** Maintaining robust relationships with referring providers requires continuous outreach, transparent outcome data sharing, and responsiveness to their needs. Monitoring and adapting marketing efforts to evolving market dynamics is essential.
- **Continuous Quality Improvement Cycles:** Institutionalizing regular Plan-Do-Study-Act (PDSA) cycles for refining clinical pathways and discharge planning ensures an adaptive, continuous quality improvement culture, allowing the program to evolve with new evidence and patient needs.

### **Negative Outcomes and Lessons Learned:**

Early implementation of the revitalization initiative revealed critical challenges and lessons. First, recruiting specialized rehabilitation clinicians took longer than expected, limiting initial census growth. This highlighted the need for effective recruitment pipelines, including academic partnerships, career ladder programs, and accelerated onboarding. Second, some acute care providers resisted changing referral patterns due to unfamiliarity with the benefits of IRF care. Sustained education by the IRF Medical Director and clinical champions was necessary to demonstrate patient-specific benefits. Third, incomplete integration of functional assessment metrics into the electronic health record (EHR) led to manual data entry, emphasizing the need for seamless Health Information Technology (HIT) interoperability in future initiatives. Finally, the dynamics of payer mix and reimbursement policies necessitate continuous monitoring and strategic engagement with payers, showcasing the IRF's value. Collectively, these lessons underscore the importance of proactive leadership, strategic workforce planning, and robust education to sustain successful IRF transformation efforts.

### **HEALTH EQUITY**

Advancing health equity was a fundamental goal embedded throughout the initiative to reinvigorate our Inpatient Rehabilitation Unit. Our aim extended beyond operational efficiency and financial gains; we focused on achieving positive health outcomes and improving experiences for all patients, especially those from marginalized communities. This integration of health equity principles ensured that the revitalized IRF excelled clinically while promoting equitable healthcare delivery. We improved health outcomes by dismantling geographical barriers and enhancing access to rehabilitation services. To reduce harm, we implemented personalized discharge planning that addressed social determinants of health. Strengthening our healthcare workforce involved mandatory cultural competence training, fostering a diverse team capable of delivering tailored care. Finally, we prioritized local care access, ensured culturally sensitive communication, and addressed logistical needs during discharge to empower patients and families. Through these strategies, we aimed to bridge care gaps, tackle systemic disparities, and ensure that the benefits of our unit reached all community members.

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