Building Seamless Care Transitions: Connecting Physical Therapy to Community Resources for Older Adults With Arthritis

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ABSTRACT

Background and Purpose: Physical therapists struggle to ensure continuity of care for older adults with arthritis and other chronic conditions at the completion of episodes of care. With osteoarthritis affecting 25 million older adults and causing activity limitations in at least 50% of cases, there is a critical need for a systematic approach to bridge the community-clinical gap between physical therapy and community-based organizations (CBOs) that offer evidence-based programming and address health-related social needs. This administrative case report presents a technology-enabled model for supporting patients' transition from physical therapy to community-based programs, transforming traditional siloed care into an integrated system through a coordinated community care hub (CCH).

Case Description: A physical therapist, Sarah, completes treatment for a 68-year-old patient with bilateral knee osteoarthritis. While the patient has made significant progress, they would benefit from ongoing community-based exercise and falls prevention programming. The patient also faces social isolation and food insecurity, which could undermine therapy gains. Sarah lacks an efficient way to connect the patient with appropriate services and follow up on progress. To address this use case, we developed a model linking health care providers with CCHs. The CCHs are local entities that coordinate networks of CBOs addressing health-related social needs and connect patients to evidence-based programs.

Outcomes: Our model, set to pilot in 2024, streamlines referrals from physical therapy to CBOs and programs through:

1. Simplified electronic referral process to community programs and resources.
2. Improved tracking of patient engagement in post-PT programs.
3. Enhanced communication between PTs and community service providers.
4. Enriched long-term monitoring of arthritis management, falls prevention, functional outcomes, and social support engagement.

Discussion: This approach offers a practical solution to a common challenge faced by physical therapists in managing the long-term care of older adults with arthritis. By leveraging technology to facilitate these community-clinical connections, we reduce the administrative burden on clinicians while improving both health outcomes and social support for patients. This model has the potential to transform how physical therapists ensure continuity of care and could be adapted for other chronic conditions.

Key Words: arthritis, community health services, continuity of care, health information interoperability

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CLINICAL IMPLICATIONS

- Limited resources within traditional clinical care models create practical challenges for physical therapists attempting to support patients' long-term success.
- Attention to both clinical workflow and technology support is needed to ensure that referrals and follow-up can occur within existing documentation systems.
- Models that provide streamlined referral processes and automated feedback about patient engagement in community programs should be implemented to enhance continuity of care for older adults with chronic conditions.

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INTRODUCTION

Arthritis Burden and the Importance of Collaborative Care

Osteoarthritis is a significant contributor to functional decline, persistent pain, and disability among older adults. In the United States 18.7% of adults, translating to 53.2 million individuals, have received a diagnosis of arthritis from a health care professional.[1] Since nearly half (47%) of outpatient physical therapy visits are for patients with an arthritis diagnosis,[2] physical therapists are uniquely positioned to address the functional limitations, disability, and participation restrictions associated with osteoarthritis.[3] Current clinical guidelines emphasize exercise and physical activity as foundational non-pharmacological interventions, requiring ongoing engagement beyond the episode of physical therapy care.[4,5] Concurrently, community-based organizations (CBOs) provide a diverse array of evidence-based interventions focused on physical activity and specifically tailored to alleviate arthritis symptoms, the arthritis-appropriate evidence-based interventions (AAEBI).[6] Community-based organizations are public or non-profit organizations that serve and represent a specific community through locally-identified needs.[7,8] Examples of CBOs include aging and senior services organizations, faith-based organizations and centers run by a local Young Men's Christian Association. Arthritis-appropriate evidence-based interventions are physical activity and self-management education programs designed to improve arthritis-related pain, physical function, and quality of life.[6] The primary mechanism of AAEBI delivery is through the vast array of agencies in the CBO system. The Osteoarthritis Action Alliance manages the AAEBI review process and ensures that each program adheres to preset criteria in order to be included on the list.[9] The current list of approved AAEBIs highlights physical activity programs and self-management education programs. Examples of these programs include the Arthritis Foundation's Walk With Ease program,[10] and the Otago Exercise Program.[11]

Unfortunately, a significant community-clinical gap exists in connecting patients to these resources. A recent study on physical therapists' knowledge and use of community-based programs found that while most (74%) of those surveyed knew about these programs only 56% made referrals.[12] This disconnect represents more than a simple referral challenge; it reflects a fundamental community-clinical gap between parallel but often unconnected care systems developed for adults with osteoarthritis. Traditional clinical care, including physical therapy, prioritizes resolving individual patient complaints,[13] while public and community health programs focus on broader population health outcomes.[14] This siloed approach, illustrated in Figure 1, can be detrimental to patient care, particularly for those with chronic conditions who require ongoing support beyond their physical therapy episode of care. In addition, the siloed approach ignores the complexities of caring for adults with chronic diseases that may include health-related social needs.[15]

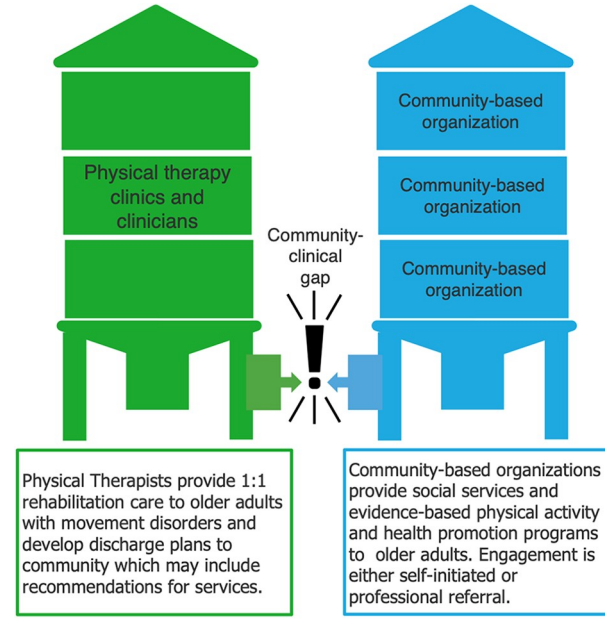

Figure 1. Traditional siloed care model demonstrating the community-clinical gap between physical therapy services and community-based organizations.

Limited resources within traditional clinical care models create practical challenges for physical therapists attempting to support patients' long-term success. Beyond the immediate rehabilitation needs, physical therapists increasingly recognize that health-related social needs significantly impact chronic disease management and therapeutic outcomes.[16] For example, a patient who has made excellent progress in physical therapy for knee osteoarthritis may be unable to participate in recommended community exercise programs due to transportation barriers or program costs. Social determinants of health such as these are now recognized as equally crucial to medical and rehabilitation management outcomes. Yet traditional clinical models, constrained by time and resources, often struggle to comprehensively evaluate the community context and connect patients with appropriate services.[17]

The health care landscape is evolving to address these challenges. The shift toward value-based payment models offers physical therapists new opportunities to focus on long-term patient outcomes rather than discrete services delivered. Additionally, there is increasing emphasis on screening and referral for health-related social needs across health care settings.[16,18] These reimbursement and regulatory changes acknowledge the impact of social needs on chronic disease management and could drive improved collaboration between physical therapists and

CBOs. However, without systematic infrastructure to support these connections, the community-clinical gap persists, as shown in Figure 1.

Collaborative care models that integrate clinical health care with community-based resources offer a promising solution to bridge the community-clinical gap for older adults with osteoarthritis.[17,19] The United States Centers for Disease Control and Prevention terms these approaches "community-clinical linkages," defining them as "connections between community and clinical sectors to improve population health."[20] To address this need, the National Association of Chronic Disease Directors has launched an innovation project that transforms traditional siloed care into an integrated model connecting physical therapy services with community-based programs through community care hubs (CCHs), as illustrated in Figure 2. The CCHs serve as centralized entities that coordinate networks of CBOs, manage referral processes, and facilitate communication between clinical and community settings. This integrated approach addresses both the practical needs of physical therapists and the complex needs of patients with chronic conditions, while accounting for the social factors that influence long-term outcomes.

Successful implementation of this integrated model requires infrastructure that supports seamless communication between physical therapy clinics and community partners. While technical considerations such as data exchange and interoperability standards are essential behind the scenes, the end goal is straightforward: ensuring physical therapists can easily refer patients to appropriate community programs and track their progress after physical therapy ends. By bridging the community-clinical gap, we create opportunities to enhance care coordination, improve quality of life, and promote independence for older adults with osteoarthritis.

This administrative case report presents our experience developing and implementing this coordinated care model. Our purpose is to provide physical therapists with practical insights into how this model can transform post-rehabilitation care for older adults with arthritis, while offering recommendations for broader application in other patient populations. We provide detailed technical specifications, definitions, and informatics requirements in this article's supplementary materials (available at: http://links.lww.com/JGPT/A273), focusing here on clinical implementation and outcomes.

CASE DESCRIPTION

The Use Case

During the landscape analysis phase of this project, we developed use cases that would become central to model development. In human-centered design,[21] use cases are detailed scenarios that illustrate how users interact with a system to accomplish specific goals. The use cases create

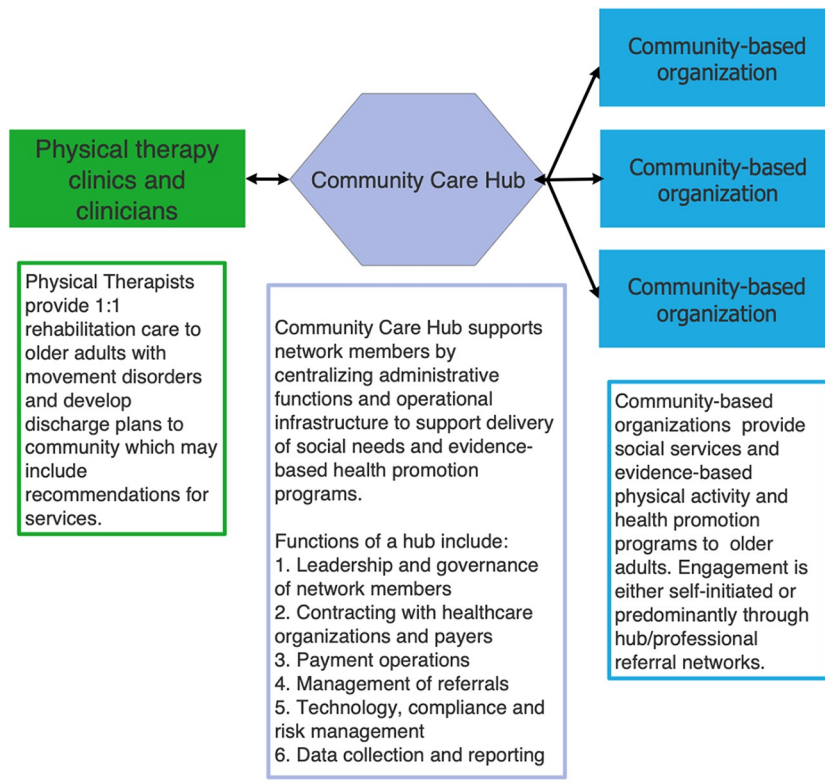

Figure 2. Integrated community care hub model.

empathy for the patient experience and provide realistic depictions of patients' challenges and needs. In the physical therapy use case Sarah, an outpatient physical therapist, was treating a 68-year-old patient with bilateral knee osteoarthritis. This case exemplified the challenges physical therapists face in ensuring continuity of care for patients with chronic conditions. While the patient made significant progress in therapy—improving their functional mobility, reducing pain, and increasing activity tolerance—Sarah identified that these gains could be short-lived without ongoing support for physical activity. Beyond the clinical improvements, Sarah learned that the patient lived alone, had limited transportation options, and sometimes struggled to afford groceries—factors that could significantly impact the patient's ability to maintain an exercise program and manage their arthritis effectively. Despite Sarah's knowledge of community-based exercise programs and social services, she lacked an efficient way to connect the patient with these resources or monitor their progress after discharge.

Model Development

This use case became the foundation for a national model development initiative, funded by the United States Centers for Disease Control and Prevention. This 5-year project was designed to develop and test approaches for bridging the community-clinical gap across diverse health care settings. Rather than focusing on a single health care system, the project aims to create a model that could support health care providers like Sarah across the country in connecting patients with arthritis to community-based services, including AAEBI. Using a sociotechnical systems approach informed by Deming's system of profound knowledge,[22] the initiative addresses both the technical barriers (such as referral systems) and social factors (such as workflow integration) that impact successful implementation of community-clinical linkages.[23,24] This comprehensive framework recognizes that improving care quality requires attention to both the systems that support care delivery and the human interactions that make these systems effective.[22,25]

The initial year of the project involved a comprehensive landscape analysis to identify key considerations and barriers faced by physical therapists like Sarah. Through literature review and stakeholder interviews,[26,27] we documented the challenges of transitioning patients from clinical care to community-based care. The analysis included interviews with 28 stakeholders across 24 organizations, including payers, health systems, state health departments, and arthritis advocacy organizations, to understand current practices, barriers to referral, and potential solutions. Representatives from the American Physical Therapy Association's practice and quality departments provided specific insights into clinical workflow considerations for physical therapists. The literature review encompassed both peer-reviewed research on chronic care models, community-clinical linkages and transitions of care, and gray literature on existing approaches to health care-community partnerships.

The resultant report was a compilation of learnings, opportunities, barriers, and challenges related to social and technical elements of model development. The analysis revealed that Sarah's experience was not unique—physical therapists consistently reported difficulties in maintaining communication with community organizations, tracking patient progress after discharge, and addressing social factors that impact program participation. Table 1 provides an overview of these landscape analysis findings.

In the second year, we used these insights to guide an intensive human-centered design process, bringing together an advisory panel[28] that included stakeholders from across the care continuum.[21] This aligns with health equity models that focus on co-creation, rather than informing.[29] The panel—comprising patients, physical therapists like Sarah, other health care providers, public health practitioners, community health workers, CBOs, and payers—worked to design a solution that would address real-world clinical challenges. This collaborative approach ensured the resulting model would fit seamlessly into physical therapy practice while meeting the needs of both health care providers and patients.[30] To further understand health care provider needs, we conducted a Medscape clinical practice assessment to evaluate current practices and educational needs.[31] The clinical practice assessment findings reinforced the importance of developing user-friendly systems that could easily integrate into existing clinical workflows.

The model that emerged from this process (Figure 2) directly addresses the challenges identified in Sarah's case by integrating clinical care with a new entity, the CCH. In practice, this means Sarah would now have a structured way to connect patients to both exercise programs and social services. On the clinical side, physical therapists like Sarah use a straightforward screening-brief advice-referral approach that fits within existing workflows. This approach allows Sarah to efficiently screen for both physical activity needs and social factors that might impact patient success, such as transportation and food security concerns.

The CCH serves as the bridge between Sarah's clinical practice and the community resources patients need. Rather than Sarah having to identify, contact, and follow up with multiple community organizations individually, the CCH provides streamlined access to a coordinated network of CBOs and their resources.[32] The CCH is the bridge between clinic and community addressing chronic disease prevention and management holistically, including addressing health-related social needs. For example, through a single referral to the CCH, Sarah could connect the patient to both an AAEBI and transportation assistance. The CCH coordinates these services, through system navigation, screening, shared-decision making and referral

Table 1. Findings From the Landscape Analysis

TOPIC 1: Function, Pain and Physical Activity Screening	
TOPIC 1: Learnings and Opportunities	TOPIC 1: Barriers and Challenges
• Common function and pain assessments can support arthritis care, but there are limitations to these tools. • Physical activity screening tools can be used for patients with arthritis, among other chronic diseases. • It is important to assess patient readiness in the physical activity screening process. • Arthritis screening strategies and tools should be integrated into the clinical and technological workflows. • Annual wellness visits are an opportunity for screenings. • Care teams should leverage community health workers in proactive screening processes.	• Limited health care provider time during patient visits reduces opportunities to screen. • Unwillingness to integrate Physical Activity as a Vital Sign into workflow and limited time with patients prevents health care providers from using the tool. • Obstacles exist to integrating physical activity-related screenings into electronic health records. • Lack of arthritis-specific measures prevents potential improvements in screening efforts. • Lack of payer involvement prevents increased screenings.
TOPIC 2: Counseling on the Benefits of Physical Activity	
TOPIC 2: Learnings and Opportunities	TOPIC 2: Barriers and Challenges
• Leveraging coordinated and integrated care teams boosts counseling opportunities. • Providers applying a tailored, patient-centered care approach can enhance counseling efforts.	• Although providers may understand the benefits of physical activity, they may lack resources to instruct patients. • Insufficient health care provider training prevents efficient and timely counseling. • Limited provider time during patient visits prevents effective counseling. • Patient challenges to engaging in physical activity can impact counseling efforts. • Patient fear of physical activity can challenge provider counseling efforts. • Arthritis is seen as lower priority compared to other conditions. • There are limited coding and billing opportunities for arthritis counseling. • There is a lack of value-based reimbursements for arthritis counseling.
TOPIC 3: Referral to Physical Activity-Based Interventions	
TOPIC 3: Learnings and Opportunities	TOPIC 3: Barriers and Challenges
• Despite access challenges to arthritis-appropriate evidence-based interventions, tools and resources exist to support provider referral efforts. • Connecting individuals to resources through community-based work is a popular strategy for improving access. • Centralized referral models ease provider and payer burden.	• Access to programs is limited in rural areas. • Integrating referral processes into existing workflows can be difficult for providers and community-based organizations. • Payer efforts to refer members to programs are limited. • Opportunities for reimbursement and funding for referral efforts are limited.

management, ensuring a patient-centered approach to care that addresses both clinical and social need.[32]

During the design process, use cases highlighted how significantly social factors impact chronic disease management. The CCH model emerged as a promising solution to address these complex needs through coordinated health care and social care services.[32-34] The CCHs serve as "backbone organizations" that "facilitate coordination between health and social care providers,"[33] offering comprehensive support through:

- Centralized administrative functions,
- Health care contracting management,
- Patient enrollment assistance,
- Resource coordination,
- Progress tracking and feedback to referring health care providers.

This structure allows Sarah to maintain awareness of patient progress while the CCH manages the complex coordination of services. As Medicare and other payers increasingly require screening for health-related social needs, this model provides physical therapists with a practical solution for meeting these requirements while improving patient care.

Pilot Testing the Model

The third and fourth years of the project, currently underway, focus on testing this model in real clinical settings. We selected 2 distinct pilot sites: a primary care practice

partnered with a statewide CCH and a physical therapy clinic in an academic medical center. The latter setting closely mirrors Sarah's practice environment, with an established rehabilitation program for adults with osteoarthritis. Through the pilot project, we're addressing the practical challenges physical therapists face when implementing new care processes. These include integrating screening tools into existing documentation systems, establishing efficient referral workflows, training staff on CCH resources and referral processes, developing communication channels for patient progress updates, and tracking outcomes that matter to both clinicians and patients.

The pilot phase aims to assess both the feasibility of the model and its impact on key clinical outcomes. We are measuring whether the model increases identification of patients who could benefit from community resources and improves referral rates to AAEBIs. Additionally, we are evaluating the model's effectiveness in tracking patient engagement in post-PT services, managing health-related social needs, and enhancing continuity of care for patients with chronic conditions.

To assess the impact of our intervention, we are collecting both quantitative and qualitative data. Quantitative measures include number of referrals made, percentage of successful connections to community programs, patient engagement rates, and completion rates for recommended programs. Qualitative data includes health care provider feedback on workflow integration and post program patient experience surveys. To establish that outcomes are due to our intervention, we are documenting baseline referral practices and tracking changes in referral patterns and patient engagement following implementation.

INTERVENTION

Technical Solutions Supporting Clinical Care

To support physical therapists like Sarah in connecting patients to community resources, our model required robust yet user-friendly technical infrastructure. We used the Consolidated Framework for Implementation Research,[35] a model originating from implementation science, to guide our understanding of how technology could best serve clinical needs. Rather than forcing clinicians to adapt to new technology, we focused on how technical solutions could seamlessly integrate into existing clinical workflows while solving real practice challenges.

Through our workflow and use case analysis, we identified 3 key needs that the technical infrastructure needed to address: standardized documentation of community referrals within the clinical record, efficient bidirectional electronic communication between physical therapists and community programs, and the ability to track patient progress across settings. These practical needs drove our technical development, ensuring that solutions would enhance rather than complicate clinical care.

Interoperability

To bridge the community-clinical gap faced by clinicians like Sarah, seamless information sharing between physical therapy clinics and community partners is essential. This exchange of information, known as interoperability, enables physical therapists to efficiently refer patients to community programs and track their progress.[36] In this use case, this means Sarah could, with patient consent, securely share relevant clinical information with the community exercise program, receive updates about attendance and participation, and document outcomes in her clinical records—all within her existing electronic health record (EHR) system.

However, implementing these connections presents several practical challenges in clinical settings. Physical therapy clinics and community organizations often use different documentation systems, have varying levels of technical capability, and must navigate the complex patient privacy requirements. Our landscape analysis had revealed that many community organizations were unfamiliar with health care privacy regulations (ie, Health Insurance Portability and Accountability Act), while clinical settings needed guidance on appropriate information sharing with community partners. The CCH plays a crucial role in addressing these challenges by providing training, technical support, and standardized processes for secure information exchange to the CBOs and developing data use agreements with the community and clinical settings.

For example, when Sarah refers the patient to community programs through the CCH, she can be confident that only essential clinical information is shared with community partners, that patient privacy is protected through secure communication channels, that documentation meets both clinical and regulatory requirements, and that progress updates return through established channels to her clinical record. As with all health information sharing, this process requires patient informed consent, which includes explaining how the information will be used to coordinate care across clinical and community settings.

Electronic Health Records Standards and Measures

In clinical practice, physical therapists work with various EHR systems, each configured differently but all required to meet national standards for health care documentation. For Sarah, the physical therapist in the use case, the success of community referrals depends on having the right tools in the everyday documentation system. Our pilot work to date has revealed that effective community connections require 3 key EHR elements: standardized screening templates for social and activity needs, streamlined referral processes, and efficient methods to track patient progress.

To achieve this in practice, we worked with the pilot sites to integrate community referral workflows into existing EHR systems. Rather than requiring clinicians

to use separate platforms or duplicate documentation, we developed approaches that fit within existing clinical workflows. For a clinician, this means they can screen a patient for both clinical and social needs, initiate referrals to the CCH directly from the documentation system and receive automated updates about their patient's participation in community programs.

While some health care systems leverage Health Information Exchanges to share patient information across settings,[37] we found that direct partnerships between physical therapy clinics and CCHs often provide a more practical solution. The CCH can serve as a central point for managing referrals and tracking outcomes, reducing the technical burden on clinical practices while ensuring consistent communication channels. This approach allows physical therapists to focus on patient care rather than managing technical connections with multiple community organizations.

Standardized data exchange is critical for building successful community-clinical linkages. The Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT plays a key role in promoting data standardization through initiatives like the United States Core Data for Interoperability.[38] The United States Core Data for Interoperability is a "standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange."[38] This set provides a foundation to exchange data across systems. In addition, data standards in health care are critical to effectively share data across systems. Most community-clinical linkages include the use of electronic referrals from EHR to key intermediaries. In addition to interoperability and EHR, electronic referrals and intermediaries like CCHs are critical to build successful community-clinical linkages.

Electronic Referral

The core of the model's success lies in making referrals to community resources as straightforward as traditional clinical referrals. Electronic referrals provide physical therapists with a reliable way to connect patients to community programs while maintaining professional documentation standards. In practice, this means physical therapists like Sarah can refer patients to both an arthritis exercise program and food assistance services as easily as they would refer to another health care provider, using familiar tools within her clinical documentation system.

Electronic referrals can take several forms depending on a clinic's technical capabilities. Some physical therapy practices use their EHR built-in referral system, while others might use secure email or specialized referral platforms. Regardless of the method, the CCH ensures that referrals reach the appropriate community organizations and that information flows back to the referring physical therapist. For example, when a physical therapist makes a referral through the CCH, they receive confirmation when the patient is connected with services, updates about program participation, and notifications about any challenges that might require clinical attention.

The CCH serves as an intermediary, managing the complex network of community organizations and their varying technical capabilities. This role is particularly important when connecting clinical practices with smaller community organizations that may still rely on traditional communication methods like faxes or phone calls. The CCH translates between these different systems, ensuring that physical therapists receive consistent, structured feedback about their patients regardless of which community programs they access.

OUTCOMES

The Pilot Project: Quality Improvement in Action

Our pilot implementation brings the CCH model to life in clinical settings, demonstrating how it transforms post-rehabilitation care for patients. Using a quality improvement approach through Plan-Do-Study-Act cycles, we systematically evaluate how the model impacts both clinical practice and patient outcomes. Our measurement approach to the quality improvement cycles is found in Table 2 and incorporates process measures, patient outcome measures, contextual factors and metrics to assess data quality. The institutional review board for our evaluation team approved the project as a non-research quality improvement process.

The planning phase focused on establishing practical goals for each partner in the care network. For physical therapists, these included developing efficient screening and referral processes within existing documentation systems, creating standardized templates for community program referrals, and establishing methods to track patient progress after discharge. We worked closely with clinicians to ensure these processes enhanced rather than disrupted clinical workflows.

Implementation began with staff training through an online learning platform, introducing physical therapists to the screening-brief advice-referral model and the CCH's role in coordinating community services. At our pilot sites, physical therapists learned to use new EHR tools that streamlined the referral process while maintaining complete documentation. For instance, therapists could now generate community referrals using standardized templates, track referral status, and receive automated updates about patient participation in community programs.

Data collection is currently underway at the pilot sites. We are gathering information about referral processes, communication patterns between clinical and community settings, the coordination of services through the CCH and patient outcomes. These data will help us understand the model's impact on clinical workflow, patient transitions to community programs, and the addressing of activity and social needs identified during physical therapy care.

Table 2. Quality Improvement Measures for Community Care Hub Model Implementation

Category	Measure	Data Source	Collection Frequency
Process Measures	Number of referrals to CCH	EHR/CCH platform	Monthly
	Time from referral to program enrollment	CCH tracking system	Monthly
	Provider engagement in screening-brief advice-referral process	EHR analytics	Monthly
	Provider use of CCH referral system	EHR analytics	Monthly
	Completion of social needs screening	CCH tracking system	Monthly
Outcome Measures	Patient engagement in and completion of recommended programs	CCH attendance records	Monthly
	Patient functional outcomes measured using Patient-Reported Outcomes Measurement Information System family of surveys.	Standardized assessments in EHR	At discharge and 3 months
	Provider satisfaction with CCH model	CCH Survey	Quarterly
	Patient experience with AAEBI program	CCH Survey	Post-program
Contextual Factors	Technical infrastructure status	System reports	Quarterly
	Staff training completion rates	Learning management system	Quarterly
	Community program availability	CCH network data	Quarterly
Data Quality Metrics	Referral documentation completeness	Chart audit	Weekly
	Data accuracy verification	Cross-system checks	Monthly
	Missing data rates	Database review	Monthly

Abbreviations: CCH, community care hub; EHR, electronic health record; AAEBI, arthritis-appropriate evidence-based interventions.

DISCUSSION AND SUMMARY

Bridging the Community-Clinical Gap: Lessons Learned

Our work to bridge the community-clinical gap through the CCH model offers important insights for physical therapy practice. By examining the challenge through both clinical and systems perspectives, we identified that successful community transitions require more than just knowledge of available resources—they need infrastructure that supports communication, coordination, and outcome tracking.

The sociotechnical approach proved valuable in understanding how to integrate new processes into clinical practice without adding burden to physical therapists. Through our pilot work, we observed that physical therapists need solutions that fit within their existing workflows and documentation systems. The CCH model shows promise in this regard by centralizing the complex work of community resource coordination and providing a structured channel for ongoing communication about patient progress.

The human-centered design process highlighted several key considerations for implementing similar models in other settings. First, the relationship between physical therapy clinics and CCHs must be built on clear communication channels and shared expectations about information exchange. Second, both clinical and community partners need support in understanding and implementing appropriate data sharing practices. Third, the technology infrastructure must be flexible enough to accommodate varying levels of technical capability across different organizations while maintaining consistent communication channels.

Looking ahead, several questions warrant further investigation as we complete our pilot implementation:

1. How does this model impact physical therapists' ability to support long-term patient engagement in physical activity?
2. How might this approach be adapted for other patient populations and practice settings?
3. What policy and payment changes might support broader adoption of this model?

Recommendations for Implementation

Before implementing community-clinical linkages, practices must consider several key factors, particularly financial sustainability. Under current payment models, physical therapists generally cannot bill for time spent on discharge planning or tracking outcomes after an episode of care ends. However, the shift toward value-based care models creates opportunities for practices to demonstrate improved long-term outcomes, some that may be achieved through CCH partnerships. Many health care systems are exploring ways to integrate community referral coordination into existing workflow and documentation processes, potentially allowing this work to be captured within standard visit documentation. Additionally, as Medicare and other payers

increase emphasis on addressing social needs, new billing codes and payment models may emerge to support these activities.[39] The evidence is present in the Centers for Medicare & Medicaid Services new 2024 requirements that include screening for health-related social needs for all hospitalized Medicare Part A beneficiaries. While ICD-10-Z codes exist to document health-related social needs, they are rarely linked to reimbursement. The Centers for Medicare & Medicaid Services also introduced new Healthcare Common Procedure Coding System codes in 2024 for Community Health Integration and Principal Health Navigation services for Medicare Part B beneficiaries.[39] As of this date these requirements and codes are too new to document experience, but health systems are currently piloting various implementation approaches to determine best practices which will likely lean on community-clinical linkages.

Drawing from our initial pilot experience, we offer several considerations for physical therapy clinics interested in developing these community-clinical linkages:

1. Prepare for Integration: Physical therapy practices should first assess their readiness for implementing community transitions. This includes evaluating current discharge planning processes, identifying common patient needs that extend beyond the episode of care, and understanding the local landscape of community-based programs. Clinics should also examine their EHR capabilities for supporting external referrals and communication.
2. Identify Community Partners: Successful implementation requires strong community partnerships. Physical therapy clinics can benefit from identifying existing CCHs or similar organizations in their region that coordinate community-based services. Where formal CCH structures do not exist, clinics might explore partnerships with local Area Agencies on Aging, Social Health Access Referral Platforms, 211 services, public health departments, or other organizations that could serve a coordinating function.
3. Build Staff Engagement: Staff involvement in planning and implementation is crucial. Physical therapists should be included in discussions about workflow changes, documentation requirements, and communication processes. Their practical insights about patient needs and clinical workflows are invaluable in developing effective transition processes.
4. Cost considerations: Implementation considerations include technical infrastructure costs, staff training time, and ongoing CCH support. These investments should be weighed against potential benefits including improved patient outcomes and reduced administrative burden.
5. Consider Sustainability: Long-term success requires attention to sustainability. Clinics should consider how community transitions align with value-based care initiatives, quality improvement goals, and evolving payment models. Documentation should capture both clinical outcomes and social needs to demonstrate the value of community-clinical linkages.

LIMITATIONS

Several factors may influence the generalizability and implementation of this model in different settings. The successful implementation of community-clinical linkages through CCHs depends heavily on the technical infrastructure available to physical therapy practices, particularly their EHR capabilities and ability to support secure data exchange. Smaller practices or those in resource-constrained settings may face challenges in implementing the necessary technical solutions. Additionally, the availability and capacity of CCHs or similar organizations varies right now by state, potentially limiting the model's immediate applicability in some areas. Rural communities may need to identify and develop alternative community partners to achieve similar coordination functions.

Additionally, in communities with limited community-based programs, CCHs serve a crucial development role that goes beyond simple program coordination. The CCHs actively build community capacity by creating and supporting networks of diverse service providers, conducting needs assessments, and providing technical assistance to expand program offerings.[32] This capacity-building function includes helping organizations access funding, providing operational support, and facilitating data sharing to improve service delivery. In rural areas where resources are currently limited, CCHs can work strategically with existing organizations to develop new AAEBI offerings, implement virtual delivery options, and strengthen the overall infrastructure for community-based services. This development approach ensures that even resource-constrained communities can build sustainable networks to support patients transitioning from physical therapy care.

We are addressing these limitations through several strategies. First, we are developing flexible technical solutions that can accommodate varying levels of EHR sophistication, including options for practices without robust electronic referral capabilities. Finally, we acknowledge that our pilot sites, being in relatively well-resourced settings, may not fully represent the challenges faced by all physical therapy practices. Future research should examine implementation in diverse practice settings to better understand the adaptations needed for broader adoption.

CONCLUSION

The community-clinical gap in physical therapy represents a significant challenge in ensuring optimal outcomes for patients with chronic conditions like osteoarthritis. While our pilot implementation is still underway, the CCH model offers a promising framework for addressing this challenge. By creating structured connections between physical

therapy clinics and community resources, while accounting for both technical and human factors, we may better support patients in maintaining the gains achieved during physical therapy. Future research will be needed to evaluate the model's impact on patient outcomes, clinical efficiency, and the broader goal of creating sustainable community-clinical linkages.

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