

Assessment of Patient Functioning in Transitional Care: An Observational Study

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Abstract

Background: Transitional care requires effective coordination between hospital and community services to ensure continuity of care and appropriate post-acute rehabilitation pathways. In this context, physiotherapists may contribute to discharge planning through standardized assessment of patients' functional status and rehabilitation needs.

Objective: This study aimed to assess patients' functional status at hospital discharge, investigate variability in post-acute care allocation across three hospitals, and explore the contribution of physiotherapist-led functional assessment to hospital-to-community transitional care pathways.

Methods: A retrospective observational study was conducted within the Local Health Authority ASL Roma 2 and included patients from three hospitals (Sant'Eugenio, Sandro Pertini, and CTO Andrea Alesini) who required activation of a post-acute care pathway and were assessed by physiotherapists within the Hospital Operations Team (TOH) during 2024. Functional, cognitive, and health-related quality-of-life status were assessed using standardized instruments, including the Barthel Index, Modified Rankin Scale (mRS), Mini-Mental State Examination (MMSE), and EQ-5D-5L. Between-hospital differences were assessed using non-parametric tests, while the association between hospital of origin and discharge setting was evaluated using the chi-square test and Cramér's V.

Results: A total of 2,314 patients were included. Home care (ADI) was the most frequent discharge setting in Sant'Eugenio and Sandro Pertini, whereas intensive rehabilitation

(Code 56) predominated at CTO. Hospital of origin was significantly associated with discharge setting ($\chi^2=893.34$, $p<0.001$; Cramér's $V=0.456$), indicating substantial between-hospital variability in post-acute care allocation. Significant differences were also observed in age, length of stay, functional independence, cognitive status, and health-related quality of life (all $p<0.001$). Between-hospital heterogeneity was particularly pronounced for MMSE ($\epsilon^2=0.365$) and EQ-5D-5L index ($\epsilon^2=0.260$). Correlation analyses further showed significant relationships among functional, cognitive, and demographic measures.

Conclusions: Post-acute care allocation differed substantially across the three hospitals and was associated with differences in patient case-mix and hospital-specific organizational characteristics. Physiotherapist-led functional assessment may provide relevant multidimensional information to support discharge planning and the identification of appropriate post-acute rehabilitation pathways. These findings support the integration of physiotherapists within multidisciplinary transitional care teams, while further multicenter studies are needed to determine their specific impact on discharge appropriateness and long-term outcomes.

1. Introduction

Transitional care refers to a coordinated set of healthcare interventions provided to patients before discharge and continued after hospitalization, allowing continuity of care across different settings. It includes the assessment of patients' needs, the development of individualized care plans, and the coordination and monitoring of care following discharge, facilitating safe and effective transitions between hospital and community services. Transitional care interventions may involve organizational strategies, such as discharge planning and care coordination, as well as patient-centered approaches, including education, empowerment, and follow-up support. These interventions have been shown to reduce hospital readmissions, shorten length of stay, and improve patients' quality of life and satisfaction¹. However, transitions between healthcare settings are recognized as critical points in the care pathway, particularly for frail and complex patients. Inadequate coordination during these phases may lead to fragmentation of care, medication errors, delayed access to rehabilitation services, and an increased risk of adverse events. These issues are especially relevant in older populations, where clinical complexity and functional impairment require integrated and timely care responses. The progressive aging of the population and the increasing prevalence of chronic degenerative diseases have led to a growing number of patients with frailty, multimorbidity, and reduced functional autonomy^{2,3}. These conditions are associated with a higher risk of complications, hospital readmissions, and functional decline^{3,4}, requiring a reorganization of healthcare models toward more integrated and patient-centered approaches². Ineffective continuity of care has been identified as a major contributor to poor clinical outcomes and increased healthcare costs^{2,4}. In this context, transitional care has emerged as a key strategy to ensure coordination and continuity of care during transitions between different healthcare settings^{3,5}. These processes require a multidisciplinary and personalized approach aimed at optimizing clinical outcomes and improving patients' quality of life³. The identification of the most appropriate post-acute care setting is a critical step in transitional care and depends on a comprehensive evaluation of the patient's functional status². Functional status is particularly relevant in determining rehabilitation needs, the level of assistance required after discharge, and the most appropriate intensity of post-acute care. Standardized functional assessment may therefore provide objective and reproducible information to support multidisciplinary

discharge planning. In this context, physiotherapists may play a key role in assessing functional capacity and supporting decision-making within multidisciplinary teams⁶. However, limited evidence exists on the specific contribution of physiotherapists in functional assessment within transitional care pathways. Moreover, little is known about whether differences in patient functional and cognitive profiles are associated with variability in post-acute care allocation across hospitals operating within the same healthcare system. In the Italian healthcare system, several organizational models have been developed to improve hospital-to-community transitions, with the aim of enhancing continuity of care and optimizing resource allocation. Among these, multidisciplinary hospital-based teams dedicated to discharge planning play a central role in coordinating care pathways and facilitating access to post-acute services. Within these models, the integration of different healthcare professionals, including physiotherapists, allows for a more comprehensive evaluation of patients' clinical and functional needs at discharge. However, the implementation of these models may vary across settings, potentially influencing the appropriateness of discharge decisions and the identification of the most suitable post-acute care pathway, such variability may reflect not only differences in organizational models and availability of post-acute services, but also differences in patient case-mix, including age, functional dependence, cognitive status, and health-related quality of life. Therefore, this study aimed to assess patients' functional status at hospital discharge, investigate variability in post-acute care allocation across three hospitals within the same Local Health Authority, and explore the contribution of physiotherapist-led functional assessment to hospital-to-community transitional care pathways. Despite the increasing implementation of transitional care models, variability in discharge planning and post-acute care allocation remains a relevant issue across healthcare settings. Differences in organizational structures, availability of rehabilitation services, and multidisciplinary team involvement may significantly influence the identification of the most appropriate care pathway. In this context, a structured and standardized functional assessment at discharge may represent a key element to improve the appropriateness of care transitions, optimize resource allocation, and ensure continuity of rehabilitation processes.

2. Materials and Methods

2. Methods

The study was conducted by ASL Roma 2 together with postgraduate trainees undertaking specialist training within the Local Health Authority, under training agreements established with Sapienza University of Rome and the University of Rome Tor Vergata^{7–18}.

2.1 Study Design and Setting

This is a retrospective observational study conducted within the Local Health Authority (ASL Roma 2), including three hospitals: Sandro Pertini, Sant'Eugenio, and CTO Andrea Alesini.

2.2 Study Population

All patients discharged in 2024 who required activation of a post-acute care pathway and

were assessed by physiotherapists within the Hospital Operations Team (TOH) were included in the study.

No exclusion criteria were applied.

2.3 Organizational Model

The Hospital Operational Team (TOH), established by the Lazio Region within the planning framework outlined in Regional Government Resolution No. 643 of 26 July 2022 and regulated by Regional Determination No. G15959 of 18 November 2022, is a multidisciplinary unit designed to facilitate admission and discharge processes and ensure continuity of care between hospital and community services. It acts as an interface between hospital wards and community services, supporting identification of the most appropriate post-acute care pathway. In each TOH, the multidisciplinary team includes:

- a nursing coordinator
- nurses with care management responsibilities
- nurses with bed management responsibilities
- physiotherapists with care management responsibilities

2.4 Data Collection

Physiotherapists collected data using standardized functional assessment tools as part of routine clinical practice.

2.5 Outcomes

The primary outcome of the study was the identification of the discharge setting. Secondary outcomes included patients' functional status, cognitive status, and quality of life at discharge.

2.6 Statistical Analysis

Continuous variables were summarized using means and standard deviations (SD), as well as medians and interquartile ranges (IQR), as appropriate. Categorical variables were expressed as absolute frequencies and percentages. Given the distributional characteristics of the continuous variables, differences among the three hospitals were assessed using the Kruskal-Wallis test. When a significant overall difference was identified, pairwise comparisons were performed using the Mann-Whitney U test with Holm correction for multiple comparisons. Effect sizes for between-hospital comparisons were estimated using epsilon-squared (ϵ^2).

Differences in the distribution of post-acute discharge settings across hospitals were assessed using Pearson's chi-square test. The strength of the association between hospital of origin and discharge setting was quantified using Cramér's V. Relationships between functional, cognitive, demographic, and quality-of-life measures were explored using Spearman's rank correlation coefficient (ρ). MMSE values coded as zero when the assessment was not administered were treated as missing for inferential analyses. Implausible length-of-stay values were excluded from the corresponding analyses. All tests were two-sided, and statistical significance was set at $p < 0.05$.

2.7 Ethical Considerations

Ethical approval was waived due to the retrospective and anonymized nature of the study.

2.8 Intervention

Within the Hospital Operational Team (TOH), physiotherapists contribute, within their professional scope, to the assessment of patients' functional status at discharge and to

supporting identification of the most appropriate post-acute setting. In 2024, data were collected from patients admitted to the three ASL Roma 2 hospitals using standardized outcome measures validated in their respective Italian versions. Functional status was assessed using the Barthel Index and Modified Rankin Scale (mRS), cognitive status using the Mini-Mental State Examination (MMSE), and health-related quality of life using the EQ-5D-5L, introduced in March 2024. The assessment was based on functional indicators, transition indicators, and organizational outcome indicators related to the care pathway.

2.9 Assessment Tools

As part of the development of clinical documentation for use by healthcare professionals, the Healthcare Professions Unit reviewed the assessment instruments relevant to the activities of physiotherapists working in the three hospitals of the Local Health Authority. In this context, a single functional assessment form was developed, bringing together and integrating the main validated scales used in hospital settings. The tool can be fully adapted to the heterogeneous characteristics of the three hospitals, which differ both in their clinical specialties and in the local context of the Rome metropolitan area they serve. It therefore allows data collection and assessment procedures to be standardized, facilitates information sharing through a common language, and supports identification of the most appropriate post-acute rehabilitation setting. The form includes validated instruments, most of which are widely used:

- The **Modified Rankin Scale (mRS)** is used to measure the level of disability and dependence in daily activities. It assigns a score from 0 to 5, where 0 indicates no symptoms and 5 indicates severe disability requiring constant assistance^{19,20}.
- The **Disability Rating Scale (DRS)** is a tool used to assess the level of disability in patients following brain injury or other conditions affecting cognitive and communicative functioning. The scale evaluates several aspects of disability, including level of consciousness, cognitive abilities, functional dependence, and participation in daily activities²¹.
- The **Numeric Pain Rating Scale (NPRS)** is used to assess pain, a factor that is often overlooked but highly relevant in the rehabilitation process. Patients are asked to rate their pain on a scale from 0 to 10, where 0 represents no pain and 10 represents the worst imaginable pain^{22,23}.
- The **Barthel Index** is used to evaluate patient independence in activities of daily living, such as feeding, personal hygiene, mobility, and continence. Scores range from 0 to 100, with higher scores indicating greater independence. This scale is essential for determining the appropriate discharge setting^{24–26}.
- **Mini-Mental State Examination (MMSE)**, a test that evaluates temporal and spatial orientation, memory, attention, language, and the ability to follow simple commands. The maximum score is 30, and a score below 24 suggests possible cognitive impairment^{27,28}.
- The **Trunk Control Test (TCT)** measures a patient's ability to control the trunk in both supine and sitting positions, which is a key component in neurorehabilitation. Good trunk control is a positive prognostic indicator for gait recovery. The test evaluates four movements: rolling to the affected side, rolling to the unaffected side, transitioning from supine to sitting, and sitting balance²⁹.
- The **Six-Minute Walk Test (6MWT)** and the **Timed Up and Go Test (TUG)**. The former evaluates a patient's endurance by measuring the distance walked in six minutes

on a flat surface, providing information on walking ability and cardiovascular function. The latter measures the time required for a patient to stand up from a chair, walk three meters, turn, walk back, and sit down^{30,31}.

- The **EQ-5D-5L** is a standardized instrument used to measure health-related quality of life at discharge. It evaluates five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression, each with five levels of severity, allowing for a detailed description of the patient's health status. The resulting score can be converted into a quality-of-life index, useful for comparing outcomes across patients or groups^{32–34}.
- The **Glasgow Coma Scale (GCS)** is a neurological assessment tool used to measure the level of consciousness in patients with head injury or other neurological conditions. It is based on three parameters: eye opening, verbal response, and motor response, with scores ranging from 3 (deep coma) to 15 (full consciousness)^{35,36}.

Standardized tables include patient demographic data, diagnosis, admission and discharge dates, along with the calculation of length of stay and the identified setting for the continuation of care. These data refer to organization-oriented outcome indicators. In addition, all scores from the assessment scales included in the VFD (mRS, Disability Rating Scale, Barthel Index, NPRS, GOS, Six-Minute Walk Test, Timed Up and Go Test, EQ-5D-5L) are recorded, including both individual items and total scores, as required by patient-oriented outcome indicators within the “functional measures” subdimension.

3. Results

A total of 2314 patients were included, showing significant variability in discharge pathways across hospitals. All the patient assessed in 2024 by physiotherapists within the TOH across the three hospitals of ASL Roma 2.

The main demographic and clinical characteristics of the study population are reported as shown in Table 1, patients admitted to CTO were younger and had a shorter length of stay compared to the other hospitals.

Characteristic	Sant'Eugenio	Sandro Pertini	CTO	p value
Patients, n	905	850	559	n.r.
Women, n (%)	487 (53.8%)	474 (55.8%)	357 (63.9%)	<0.001
Age, years, mean	79.45	80.51	73.00	<0.001
Length of stay, days, mean	16.26	22.43	8.27	<0.001
Deaths, n	10	14	6	524

Table 1 Characteristics across the three hospitals

The distribution of discharge settings across the three hospitals is presented as shown in Table 2, ADI represents the most frequent discharge setting in Sant'Eugenio and Sandro Pertini, whereas Code 56 is predominant in CTO.

Patients' demographic and hospitalization characteristics differed significantly across the three hospitals. Age differed across hospitals (Kruskal-Wallis $H=247.38$, $p<0.001$, $\epsilon^2=0.106$), with median ages of 84 years at Sant'Eugenio, 85 years at Sandro Pertini, and 74 years at CTO. Length of stay also differed significantly ($H=575.20$, $p<0.001$, $\epsilon^2=0.249$),

with median values of 13, 17, and 8 days, respectively. These findings indicate a relevant difference in case-mix across hospitals, particularly for age and hospitalization duration.

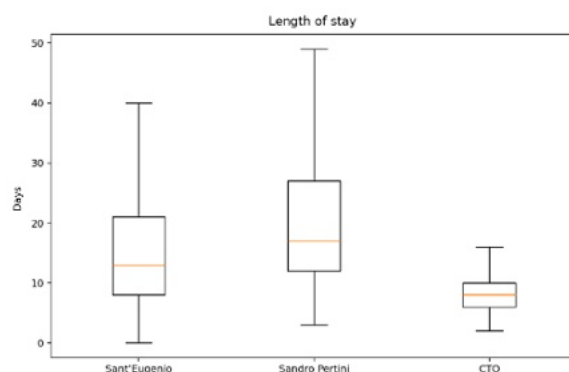


Figure 1 Distribution of hospital length of stay across the three hospitals

Discharge setting	Sant'Eugenio n (%)	Sandro Pertini n (%)	CTO n (%)
ADI	602 (66.52%)	581 (68.35%)	86 (15.38%)
Code 56	141 (15.58%)	42 (4.94%)	406 (72.63%)
Code 60	109 (12.04%)	105 (12.35%)	38 (6.80%)
Hospice	8 (0.88%)	5 (0.59%)	0
RSA	3 (0.33%)	11 (1.29%)	0
Home	21 (2.32%)	83 (9.76%)	20 (3.58%)
Former Art. 26	2 (0.22%)	2 (0.23%)	11 (1.97%)
Outpatient	1 (0.11%)	2 (0.23%)	2 (0.36%)
ODC	0	1 (0.12%)	0
Code 75	1 (0.11%)	1 (0.12%)	0
Other acute care unit	0	1 (0.12%)	0

Table 2 Discharge settings across the three hospitals

The distribution of post-acute discharge settings differed significantly across hospitals ($\chi^2=893.34$, $df=8$, $p<0.001$). The magnitude of the association was substantial (Cramér's $V=0.456$), indicating that hospital of origin was strongly associated with the type of post-acute care pathway identified at discharge. Home-based care was predominant in Sant'Eugenio and Sandro Pertini, whereas intensive rehabilitation (Code 56) was markedly more frequent at CTO.

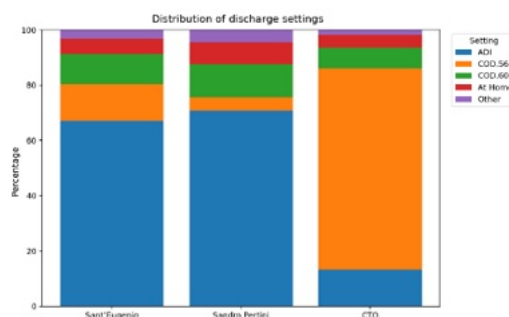


Figure 2 Distribution of post-acute discharge settings across the three hospitals

Health-related quality of life outcomes are reported in Table 3. The EQ-5D-5L index values were 0.341 in Sant'Eugenio, 0.312 in Sandro Pertini, and -0.027 in CTO. The corresponding self-reported health status scores were 43.22, 42.39, and 50.42, respectively. As shown in Table 3, patients in CTO reported higher perceived health status despite lower index values.

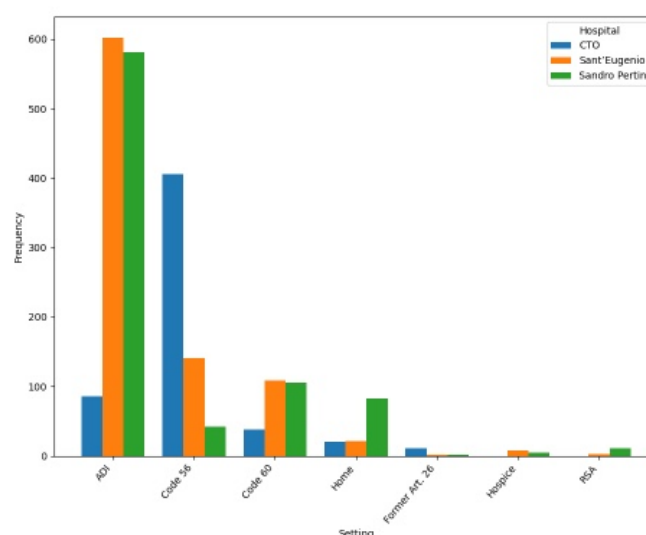


Figure 3 Frequency distribution of post-acute discharge settings by hospital

Outcome	Sant'Eugenio	Sandro Pertini	CTO	p value
EQ-5D-5L index, mean $\pm$ SD	0.341 $\pm$ 0.239	0.312 $\pm$ 0.377	-0.027 ± 0.280	<0.001
EQ-5D-5L health status, mean $\pm$ SD	43.22 $\pm$ 10.61	42.39 $\pm$ 13.46	50.42 $\pm$ 9.76	n.r.

Table 3 EQ-5D-5L outcomes

EQ-5D-5L index values differed significantly among hospitals (Kruskal-Wallis $H=291.76$, $p<0.001$, $\varepsilon^2=0.260$). Median index values were approximately 0.41 at Sant'Eugenio, 0.31 at Sandro Pertini, and -0.10 at CTO. The magnitude of the effect indicates substantial heterogeneity in health-related quality-of-life profiles across hospital populations. These findings should, however, be interpreted considering differences in EQ-5D-5L data availability during the study period.

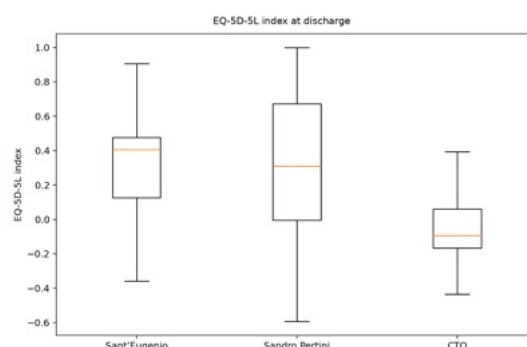


Figure 4 Distribution of EQ-5D-5L index scores at discharge across the three hospitals

Functional and cognitive outcomes at discharge are presented in Table 4.

The mean Barthel Index was 23.69 in Sant'Eugenio, 32.00 in Sandro Pertini, and 31.75 in CTO. The mean Modified Rankin Scale (mRS) score was 3.794, 3.806, and 4.041, respectively. The mean MMSE score was 23.61 in Sant'Eugenio, 24.25 in Sandro Pertini, and 26.5 in CTO.

As shown in Table 4, Sant'Eugenio patients presented lower functional scores, while CTO patients showed higher cognitive scores.

Outcome	Sant'Eugenio mean $\pm$ SD	Sandro Pertini mean $\pm$ SD	CTO mean $\pm$ SD	p value
Barthel Index	23.69 $\pm$ 13.958	32.00 $\pm$ 20.418	31.75 $\pm$ 9.515	<0.001
Modified Rankin Scale	3.794 $\pm$ 0.894	3.806 $\pm$ 1.006	4.041 $\pm$ 0.215	<0.001
MMSE	23.61 $\pm$ 6.513	24.25 $\pm$ 3.374	26.50 $\pm$ 6.693	<0.001

Table 4 Barthel Index, Modified Rankin Scale, and MMSE outcomes

Functional status differed significantly across hospitals. Barthel Index scores showed a significant between-hospital difference (Kruskal-Wallis $H=246.10$, $p<0.001$, $\epsilon^2=0.106$), with median scores of 25 at Sant'Eugenio, 30 at Sandro Pertini, and 35 at CTO. Modified Rankin Scale scores also differed significantly ($H=22.34$, $p<0.001$); however, the corresponding effect size was small ($\epsilon^2=0.009$), suggesting limited clinical magnitude despite statistical significance. Cognitive status showed marked between-hospital heterogeneity. After excluding values indicating that MMSE had not been administered, median MMSE scores were 24 at Sant'Eugenio, 26 at Sandro Pertini, and 30 at CTO. The overall difference was statistically significant (Kruskal-Wallis $H=482.90$, $p<0.001$) and was associated with a comparatively large effect size ($\epsilon^2=0.365$), indicating a substantially different cognitive profile of the CTO population.

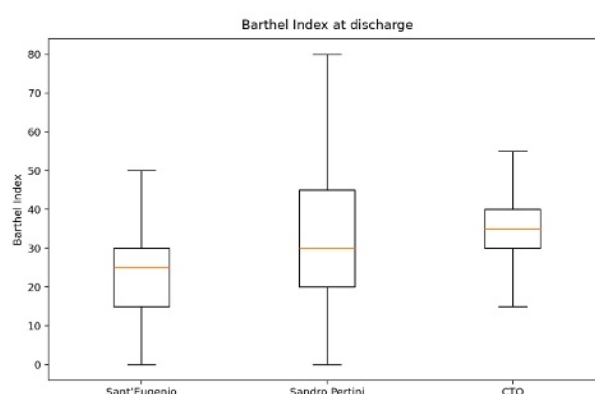


Figure 5 Distribution of Barthel Index scores at discharge across the three hospitals

Correlation analyses showed significant relationships between functional disability and the other patient-level measures. Barthel Index and mRS scores were inversely correlated in all three hospitals (Spearman's $\rho=-0.397$ at Sant'Eugenio, -0.631 at Sandro Pertini,

and -0.254 at CTO; all $p < 0.001$), confirming the expected inverse relationship between independence in activities of daily living and global disability. Barthel Index was also positively associated with cognitive status. This relationship was particularly evident at CTO ($p = 0.504$, $p < 0.001$). Within the CTO population, increasing age was associated with both lower functional independence (age vs Barthel Index: $p = -0.540$, $p < 0.001$) and poorer cognitive status (age vs MMSE: $p = -0.603$, $p < 0.001$). These findings suggest that functional, cognitive, and demographic dimensions provide complementary information in defining patients' care needs at discharge.

4. Discussions

The variability observed among the three hospitals highlights the influence of organizational and clinical factors on discharge planning. In particular, the higher rate of intensive rehabilitation at CTO reflects its orthopedic specialization and the availability of dedicated rehabilitation units (Code 56), likely contributing to more structured post-acute pathways and shorter hospital stays. In contrast, the predominance of home care (ADI) in Sant'Eugenio and Sandro Pertini suggests differences in patient case-mix, availability of post-acute services, and territorial healthcare resources. The socio-healthcare context of the catchment areas may also play a relevant role. For instance, the area served by Sandro Pertini includes semi-peripheral districts characterized by a higher prevalence of chronic conditions and reduced access to rehabilitation facilities, potentially increasing the complexity of discharge planning.

The statistical analyses strengthen this interpretation. Hospital of origin showed a strong association with discharge destination (Cramér's $V = 0.456$), while significant differences were also observed in age, length of stay, functional independence, cognitive status, and health-related quality of life. Therefore, the observed variability in post-acute allocation is likely to reflect a combination of differences in patient case-mix and hospital-specific organizational characteristics.

The significant association between hospital of origin and discharge setting indicates that post-acute care allocation is strongly influenced not only by clinical conditions but also by organizational factors and the availability of local healthcare resources. This interpretation is consistent with recent evidence showing that structured transitional care models may improve access to rehabilitation and promote more timely initiation of post-acute services. This interpretation is consistent with recent evidence suggesting that structured transitional care models may improve access to rehabilitation and promote timely initiation of post-acute services. Transitional care programs incorporating rehabilitation interventions have also been associated with improvements in the continuity and organization of post-acute rehabilitation pathways 6, 37.

Importantly, the association between hospital of origin and discharge setting was not only statistically significant but also characterized by a relevant effect size (Cramér's $V = 0.456$). This finding suggests that differences in discharge pathways are unlikely to represent random variation alone. Nevertheless, because hospital specialization and patient case-mix differ substantially across sites, the observed association should not be interpreted as evidence of a direct causal effect of hospital organization on discharge destination.

The effect-size analysis provides additional insight into these differences. Between-hospital heterogeneity was particularly pronounced for cognitive status (MMSE, $\epsilon^2 = 0.365$) and EQ-5D-5L index values ($\epsilon^2 = 0.260$), whereas the difference in mRS, although statistically

significant, showed only a small effect size ($\epsilon^2=0.009$). This distinction is relevant because the large sample size increases the probability of detecting statistically significant differences even when their magnitude is limited. Reporting effect sizes therefore provides a more clinically meaningful interpretation of between-hospital variability.

Differences in functional and cognitive outcomes across hospitals further support this interpretation. Lower Barthel Index scores observed in Sant'Eugenio may reflect greater clinical complexity and heterogeneity of patients, while higher cognitive scores in CTO are consistent with its more selective patient population. Health-related quality of life results showed higher perceived health status in CTO despite lower index values, suggesting a discrepancy between subjective perception and objective measures. Similarly, transitional care programs integrated with rehabilitation interventions have been shown to lead to clinically relevant improvements in physical functioning in frail patients³⁸.

Within this context, physiotherapists played a key role in the early identification of patients' functional status, supporting clinical decision-making in the allocation of the most appropriate post-acute care setting. This contribution is particularly relevant in complex patients, where functional limitations are a major determinant of care needs. Recent evidence suggests that transitional care models incorporating rehabilitation professionals may improve access to post-acute therapy and optimize rehabilitation pathways. Moreover, multidisciplinary transitional care interventions have been shown to positively influence mobility and care needs^{6,37}. Moreover, multidisciplinary transitional care interventions have been shown to positively influence mobility and care needs³⁸. Finally, growing international interest has been observed in physiotherapy-centered interventions within transitional care settings, particularly for frail post-hospitalized patients, although further evidence is still needed to confirm their long-term effectiveness³⁹.

These findings support the integration of physiotherapists within multidisciplinary teams involved in transitional care, contributing to improved appropriateness of care pathways and more efficient use of healthcare resources. They also suggest that the effectiveness of transitional care depends not only on clinical factors but also on the level of organizational integration, availability of rehabilitation services, and the early implementation of functional assessment strategies.

The correlation analyses further suggest that discharge needs should be interpreted from a multidimensional perspective. The inverse relationship between Barthel Index and mRS confirms the convergence of complementary measures of functional dependence and global disability. Moreover, the positive association between Barthel Index and MMSE suggests that cognitive status and functional independence are interconnected dimensions of patient complexity. The relatively strong associations observed at CTO between age, functional independence, and cognitive status further highlight the importance of integrating demographic, functional, and cognitive information rather than relying on a single assessment scale when planning post-acute care.

5. Conclusions

The integration of physiotherapists into Hospital Operational Teams (TOH) plays a central role in assessing functional status at discharge and supporting the appropriate identification of post-acute care and rehabilitation settings, in collaboration with the treating specialist and other professionals involved. This study supports the development of organizational models for hospital-community integration and the evolution of the

framework outlined by Ministerial Decree 77/2022, which does not explicitly identify physiotherapists as reference professionals within Operations Centers and transitional care models for functional assessment and discharge pathway planning^{40,41}.

This evolution should also be accompanied by a revision of the hospital standards established by Ministerial Decree 70/2015, which currently do not explicitly and systematically include physiotherapists in acute care hospitals. Existing experiences largely derive from good organizational practices developed at the local level, which have not yet been matched by full regulatory and organizational recognition of the professional value of physiotherapists or by their systematic integration into hospital care pathways^{40–43}.

More than ever, timely and early rehabilitation must be ensured to promote functional recovery, prevent complications related to immobility and disability, and ensure continuity of care. This need is widely recognized in the scientific literature and in numerous international guidelines across multiple clinical fields. The findings therefore highlight the importance of early, structured functional assessment to guide rehabilitation pathways, support timely and appropriate multiprofessional decision-making, and reduce variability in transitional care processes.

Stable and structured involvement of physiotherapists in multidisciplinary teams may help improve discharge appropriateness, optimize resource use, and develop truly person-centered care models across the entire hospital-to-community continuum.

6. Limitations of The Study

This study has some limitations. It was conducted within a single Local Health Authority, which may limit the generalizability of the results. In addition, the observational design does not allow causal inferences. Further multicenter studies are needed to confirm these findings and to better clarify the impact of physiotherapist-led functional assessment on discharge appropriateness, rehabilitation access, and long-term outcomes.

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