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SPECIAL COMMUNICATION

Postacute Rehabilitation Quality of Care: Toward a Shared Conceptual Framework

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Abstract

There is substantial interest in mechanisms for measuring, reporting, and improving the quality of health care, including postacute care (PAC) and rehabilitation. Unfortunately, current activities generally are either too narrow or too poorly specified to reflect PAC rehabilitation quality of care. In part, this is caused by a lack of a shared conceptual understanding of what construes quality of care in PAC rehabilitation. This article presents the PAC-rehab quality framework: an evidence-based conceptual framework articulating elements specifically pertaining to PAC rehabilitation quality of care. The widely recognized Donabedian structure, process, and outcomes (SPO) model furnished the underlying structure for the PAC-rehab quality framework, and the *International Classification of Functioning, Disability and Health* (ICF) framed the functional outcomes. A comprehensive literature review provided the evidence base to specify elements within the SPO model and ICF-derived framework. A set of macrolevel-outcomes (functional performance, quality of life of patient and caregivers, consumers' experience, place of discharge, health care utilization) were defined for PAC rehabilitation and then related to their (1) immediate and intermediate outcomes, (2) underpinning care processes, (3) supportive team functioning and improvement processes, and (4) underlying care structures. The role of environmental factors and centrality of patients in the framework are explicated as well. Finally, we discuss why outcomes may best measure and reflect the quality of PAC rehabilitation. The PAC-rehab quality framework provides a conceptually sound, evidence-based framework appropriate for quality of care activities across the PAC rehabilitation continuum.
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Concerns about quality pervade health care. Countless reports show that substandard care is common[1]; evidence-based guidelines take too long to diffuse into practice[2]; hospital-acquired conditions occur all too often[3]; quality of care differ across patients[4]; health care expenditures vary geographically and across providers[5]; and health care services are fragmented, are hard to navigate, and are not patient centered.[1,6] This quality chasm calls for transformational changes in the way health care services are organized and made accountable for the quality and value of care delivered.[1,7,8]

Concerns about quality of care extend to postacute care (PAC) and rehabilitation; however, empirical study has been limited, particularly by efforts to enhance quality. For example, considerable variation exists in the provision of and the outcomes from PAC rehabilitation services.[9] Additionally, fragmentation in the health care system is considered a major threat for the quality of PAC rehabilitation. In the United States, PAC rehabilitation services can be provided in diverse settings (eg, inpatient rehabilitation facilities, skilled nursing facilities [SNFs], long-term care hospitals, home health agencies [HHAs]); however, currently, each of these settings has its own regulations, data sets, and reimbursement mechanisms,[10,11] which in turn hinders identifying optimal trajectories of recovery, smooth transitions of care, and the ability to monitor or compare the quality of care across the rehabilitation care continuum.[11-13]

Moreover, current mechanisms for measuring and reporting on rehabilitation quality of care seem poorly designed and/or narrow in content. For example, rehabilitation consumers report it is difficult to obtain and understand currently available information on rehabilitation quality of care,[14,15] in turn leading consumers not to use such information to choose prospective rehabilitation providers.[14] Moreover, at least 1 study of PAC rehabilitation found that "no quality measures correlated with any rehabilitation

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outcomes,"(p1021) leading the authors to conclude that current quality measures are not specific enough to reflect PAC rehabilitation quality of care.[16]

Unfortunately, with few exceptions,[17,18] most national and even local quality improvement initiatives are designed first to address pressing quality issues in acute medical/surgical health care and applied secondarily to rehabilitation. This phenomenon seems to foster a quality paradox, wherein generic improvement activities (eg, imposed top down by hospital administration) are easily undermined by frontline rehabilitation practitioners who perceive them as suboptimal, distracting, or even counterproductive.[19]

In summary, there is substantial interest in developing mechanisms for measuring, reporting, and improving the quality of PAC rehabilitation. Unfortunately, current approaches to quality of care activities poorly reflect PAC rehabilitation quality of care. In part, this may be caused by the lack of a shared conceptual understanding regarding what, in the very first place, construes quality of care in PAC rehabilitation.[19] Toward catalyzing such crucial development, this article presents the PAC-rehab quality framework: an evidence-based conceptual framework that articulates the elements pertaining to PAC rehabilitation quality of care.

Methods

The Donabedian structure, process, and outcomes (SPO) model[20] is widely recognized and one of the most used models to frame health care; therefore, it was used to provide the overall structure for the PAC-rehab quality framework, informed by diverse articles that previously have applied the SPO model to rehabilitation.[19,21-25] In addition, the *International Classification of Functioning, Disability and Health* (ICF)[26] provided a classification framework for incorporating functional outcomes into the PAC-rehab quality framework.

Based on such conceptual foundations, we reviewed the literature on health care quality and PAC rehabilitation to critically revise and adapt the SPO model for rehabilitation and ensure the PAC-rehab quality framework was based on the best available evidence. Not only did the literature review provide substance and illustration to the framework, but it resulted in substantive additions and revisions to the original SPO model and prior adaptations of it for rehabilitation. Therefore, the developmental process for the PAC-rehab quality framework began with a deductive approach (ie, axes and categories provided by foundational articles).[19-26] It then was adapted and updated using a systematic inductive approach via a comprehensive review of the literature.

Rather than a Cochrane-style systematic review, which is most suitable for narrow-based, homogenous topics, this literature review was modeled instead by a commonly used approach for literature reviews of complex health care or health policy topics.[27-29] It consisted of a highly iterative and nonlinear process, with stages overlapping each other. For example, we started with sequential searches of major databases (PubMed, Embase, Cumulative Index to Nursing and Allied Health Literature) mixing broad keywords (eg, quality, rehabilitation, systematic review) and keywords from seminal articles on rehabilitation quality of care.[19-26] These iterative searches fed a comprehensive snowballing process (ie, following of reference lists, citation tracking).[28] Iterations within search strategies occurred as well, with repeated searches of major databases, further snowballing, feeding additional databases searches, and more snowballing. The search process was extended until the very end of the peer-review process (September 2014). Abstraction of information occurred alongside iterative searches, and information preliminarily abstracted was continuously mapped by scope[30] onto evolving drafts of the framework. The final selection of citations occurred during the synthesis stage, when the authors had full appreciation for the breadth of the literature and its contents[28] and focused on retaining the most recent, conceptually relevant, and empirically solid citations.

List of abbreviations:

HHA	**home health agency**
HRQOL	**health-related quality of life**
ICF	***International Classification of Functioning, Disability and Health***
PAC	**postacute care**
SNF	**skilled nursing facility**
SPO	**structure, process, and outcomes**

Results

Figure 1 provides an overview of the elements included in the framework and their relations. Although the figure, as is typical for the SPO model, reads from left to right, in the article the constituents are described in a stepwise, reverse order from outcomes to their conductive processes and underlying care structures. Outcomes are described first because evidence-based approaches to quality of care increasingly focus on outcomes as the best way both to influence improvements in structure and process and to ensure that quality of care activities make a difference in what really matters: patient outcomes.

Outcomes

Outcomes refer to the positive effects produced by health care.[20,24] To reflect different time frames and levels of complexity,[25] the outcomes axis was divided into the macro-outcomes or end goals of PAC rehabilitation and the immediate and intermediate outcomes, which are their preceding or mediating outcomes.

Macro-outcomes

Given the focus on functional recovery, the first macro-outcome for PAC rehabilitation is the ICF-based construct of functional performance,[26,31] meaning the extent to which individuals in their own environment execute tasks of daily living (activity) and fulfill social roles (participation).[26,32] The ICF is ambiguous in the operational distinction between activity and participation[33]; nevertheless, participation has a more complex conceptualization, in part because participation is determined by the dynamic intersection among variables from the person, their social roles, and the environment in which it is performed.[33,34] Although there are measures of activity in widespread use (eg, FIM), and indeed they are used to investigate rehabilitation quality of care, the added conceptual complexity of participation is such that its measurement is an active area of research,[32] with no single broadly used measure.

Patient health-related quality of life (HRQOL) is an umbrella construct which covers domains beyond functional performance that impact quality of life, including symptoms (eg, pain, fatigue) and psychosocial dimensions (eg, mental health, subjective well-being, life satisfaction).[35,36] The relevance of each of these domains can vary across rehabilitation populations, and its measurement can be adjusted accordingly.[37,38] Family/caregiver HRQOL refers to the adjustment of the family and caregivers to

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