medbridge

2026 Rehabilitation Therapy Benchmark Report

This industry report is the result of 2,880 responses from clinicians and leaders across the healthcare industry. The report explores all the components of connected care, describing how rehab therapy continues beyond the treatment room: measuring patient outcomes, using that data to guide care, and keeping patients engaged between visits through home exercise programs, digital tools, and remote therapeutic monitoring (RTM).

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Executive Summary

Rehab therapy is increasingly asked to prove its value to payers, to referral partners and to patients recovering at home. Proving value depends on seeing care clearly, from the first visit through the last home exercise.

The data in this report points to an important conclusion: rehab therapy can't see enough of the care it delivers. Outcomes are collected but hard to reach, care between visits goes largely unmeasured, and the people responsible for both are working with partial information. As outcomes begin to shape how rehab is paid for and judged, that blind spot carries real stakes.

The gap appears at every stage the survey examined. It shows up in how outcomes are collected, often on paper or by hand; in how home programs are delivered and followed up; and in whether organizations track if patients finish care at all. It also cuts across roles: clinicians and leaders describe the field in nearly the same terms, including the parts neither can see clearly.

The pressure to close this gap is building on several fronts at once. Payers and referral sources are asking for results more often, new payment models are tying revenue to outcomes, and clinicians are already stretched for time. In that environment, care that can't be seen is hard to improve, hard to prove, and hard to sustain.

Why visibility matters

Outcomes are already part of how rehab gets paid, but collecting them hasn't meant seeing them. Only 37% of clinicians find their outcomes data easy to access, and those who can reach it are more likely to say it changes their care.

The blind spot widens between visits. With home programs still largely on paper and many organizations not tracking completion, clinicians name lack of visibility as one of their top three barriers to engaging patients (43%), more often in hospital outpatient settings than in private practice. Even basic measures go unseen: 15% of clinicians don't know their own no-show rate.

Where visibility is stronger, the picture looks different. Private practice clinicians rate their visibility into patient drop-off higher than hospital outpatient clinicians (3.44 vs 3.13 out of 5), use digital home programs more often (71% vs 59%), and deliver home programs through remote therapeutic monitoring four times as often (12% vs 3%). Clinicians who already use RTM are also more confident that engaging patients between visits pays off: only 28% doubt it improves outcomes, compared with 41% of those who don't.

Visibility matters for the workforce too. Clinicians with the most visibility into patient drop-off report more sustainable caseloads and stronger intent to stay than those with the least. And clinicians and leaders, who rate the field almost identically, share the same blind spot: 15% of clinicians and 7% of leaders aren't sure how many patients finish their plan of care.

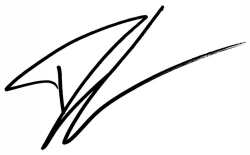
There is a foundation to build on. 41% of clinicians already rate their visibility into patient drop-off as high, a third of organizations manage plan-of-care completion as a key performance indicator, and 91% have a formal approach to keeping patients engaged between visits. The next generation of clinicians may help close the gap: those in their first two years collect outcomes more often than clinicians with 20 years or more in the field (84% vs 65%), find the data easier to access, and feel readier for AI-driven tools. Clinicians who can easily reach their outcomes data also rate themselves readier for AI, a sign that visibility today lays the groundwork for what comes next.

What it means for the industry

Closing the gap starts with measurement. Organizations that track plan-of-care completion and home program adherence give clinicians and leaders a baseline driven by data rather than one driven by estimates.

Outcomes data earns its value when it reaches clinicians during daily care planning, not just in quarterly reports. And none of it works if it adds to caseloads already stretched thin, so visibility has to come with less documentation burden, the single change clinicians most often say would improve their day (31%), and with clear ownership of between-visit work. The findings that follow in the 2026 State of Rehab Care report show where those gaps are widest, and where the field is already beginning to close them.





Donovan Campbell
Chief Executive Officer, Medbridge

Introduction

The responsibility of rehab therapy has continued to expand, from the treatment room into patients' homes and into payer and referral relationships. As it has, demonstrating impact has moved from a nice-to-have toward a requirement. Outcome measures, once used mainly to track an individual patient's progress, now inform payer contracts, referral relationships, and new payment models. Meanwhile, most of a patient's recovery takes place at home, between visits, where adherence is hard to see and harder to influence.

To understand how the field is adapting to the changing state of rehab care, Medbridge surveyed 2,880 rehab professionals (2,670 clinicians and 210 practice and health-system leaders) between August 24 and September 22, 2026. Clinicians answered about their own patients and practice; leaders answered for their organization. The survey asked how clinicians and organizations collect and use outcomes, how they support patients between visits, and what constrains them. Because the two questionnaires shared several identical questions, the survey offers a rare side-by-side view of how the clinicians delivering care and the leaders running organizations see the same issues.

This report presents those findings and outlines three opportunities for the field: turning outcomes data into usable information, making between-visit care visible, and protecting clinician time.

High-level takeaways

35% have used outcomes data to win or defend a contract. **61% are in or exploring at least one new care or payment model**. **35% of leaders field more payer or referral requests for outcomes data than a year ago**, while **32% have not received any requests (yet)**.

75% of clinicians routinely collect patient outcomes, and **89% of leaders say their organization does**. Collection leans on the EMR (52%), paper or PDF forms (42%), and manual tracking (29%). **However, only about a third of clinicians (35%) and leaders (32%) say outcomes data often or always changes care.**

84% of clinicians send home programs on paper. Only **9% say most of their patients complete their home program as prescribed**, and **22% don't know**. **A quarter of organizations (25%) don't track plan-of-care completion.**

High-level takeaways

36% of leaders say their organization uses RTM in some form, **19% are considering it**, and **45% have ruled it out or haven't put it on the radar**. The top six barriers to between-visit engagement sit within nine points of each other.

38% of 1,450 written answers point to time pressure. **15% of clinicians are forced to shorten or skip treatment often or very often due to time constraints**, and they do so more when caseloads feel unsustainable.

Clinicians and leaders often see the field the same way

On identical 1–5 scales, clinicians and leaders give near-identical average ratings for first-year clinician readiness (2.91 vs 2.92), caseload sustainability (3.58 vs 3.54), and how often outcomes change care (3.16 vs 3.16).

Methodology

Survey design

Medbridge fielded the State of Connected Care survey online from August 24 to September 22, 2026, using two parallel questionnaires. Clinicians answered about their own patients and practice; leaders answered for their organization. Several questions were asked of both groups in identical wording, allowing a direct comparison of their views.

Sample

The final sample of 2,880 includes 2,670 clinicians and 210 leaders.

Who responded

Physical therapists make up about half of clinicians (49%), followed by occupational therapists (16%) and physical therapist assistants (13%). Clinicians work mainly in hospital or health-system outpatient clinics (37%), private outpatient practice (28%), and acute or inpatient care (20%), with experience ranging from under two years (12%) to more than 20 years (29%). Leaders are mostly clinic directors or managers (44%), and their organizations range from 1–10 clinicians (31%) to 200 or more (18%).

Clinicians by discipline (n=2,665)



Also: AT 6%, OTA 2%, Other 5%

Clinicians by practice setting (n=2,670)



Clinicians by years in practice (n=2,659)



Leaders by role (n=210)



Source: State of Connected Care survey, 2026.

Representativeness

Respondents were recruited through Medbridge outreach, and 83% identify as Medbridge subscribers. Subscriber status was associated with differences in answers less often than discipline, career stage, or setting.

How results are reported

Percentages are rounded, and questions allowing several answers total more than 100%. Results appear only for groups of at least 100 respondents, so leader results are reported as totals. Links between answers are associations within one survey, not evidence of cause, and career-stage comparisons describe different clinicians at one point in time. Themes from 3,019 written answers were keyword-coded and are indicative.

Full respondent characteristics can be found on Appendix A at the end of the report.

SECTION 1

Patient-reported outcomes are a business asset

Patient-reported outcomes data now serves dual purposes: guiding the care of individual patients, and demonstrating value to payers and referral sources. The survey finds that organizations are using outcomes in both ways, but that the data collected in clinics often doesn't reach clinicians in a form they can act on.

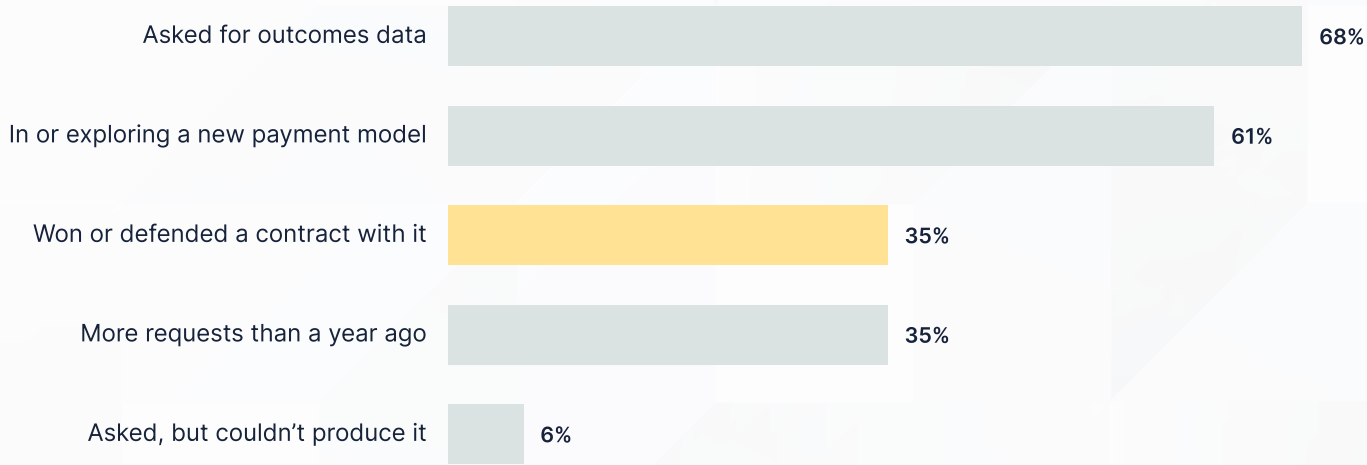
Outcomes as a business asset

Outcomes data has entered the business conversation, and for some, it is already paying dividends. 35% of organizations have used outcomes data to win or defend a contract (see Exhibit 1). About two in three leaders (68%) have been asked for outcomes data by payers or referral sources.

Exhibit 1

Leaders' experience with outcomes data

35% have used outcomes data to win or defend a contract more than one allowed



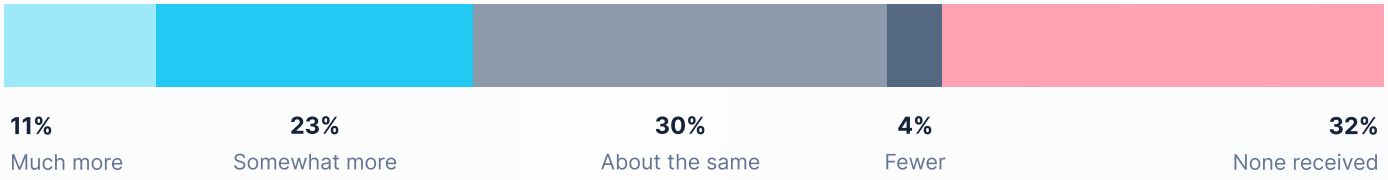
Source: State of Connected Care survey, 2026. Leaders, n=210.

However, demand is uneven. 34% say those requests have grown over the past year, 30% say they've held steady, and 32% have never been asked (see Exhibit 2).

Exhibit 2

Payer and referral requests for outcomes data

A third of leaders field more requests than a year ago; a third have never been asked



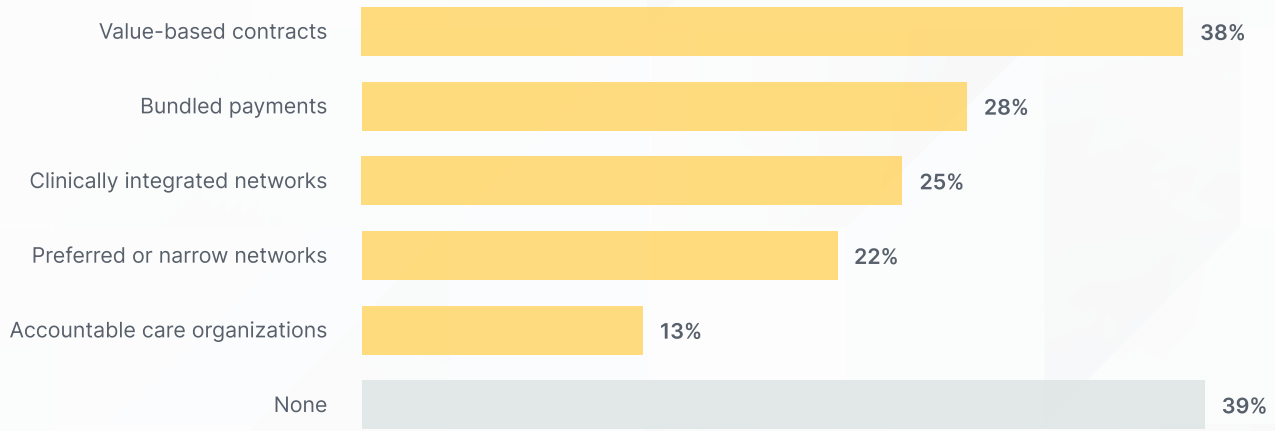
Source: State of Connected Care survey, 2026. Leaders, n=210.

The pressure reflects changes in how rehab therapy is paid for. 61% of organizations are in or exploring at least one new care or payment model, most often value-based contracts (38%), bundled payments (28%), and clinically integrated networks (25%) (see Exhibit 3).

Exhibit 3

Participation in new care and payment models

61% of organizations are in or exploring at least one model; more than one allowed



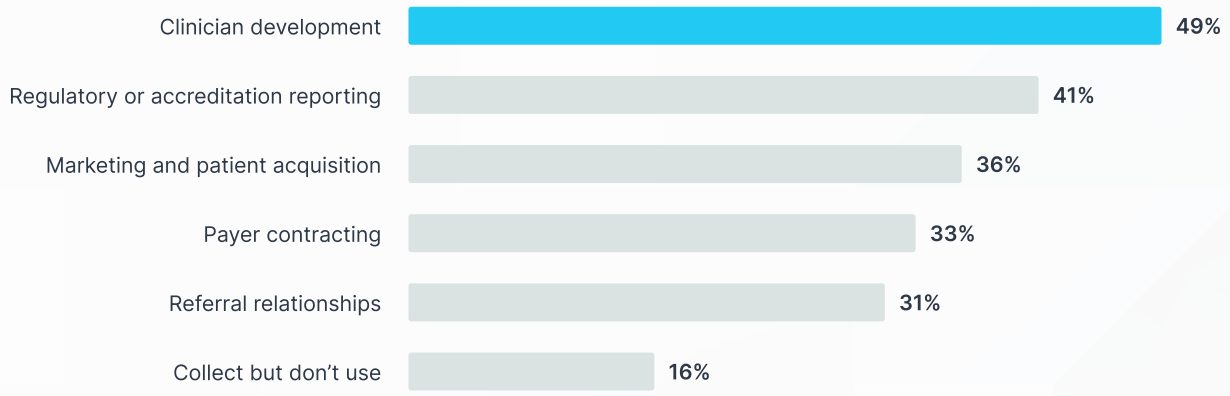
Source: State of Connected Care survey, 2026. Leaders, n=210.

Outcomes data also serves clinical purposes. Among organizations that measure outcomes, clinician development is the most common use (49%), ahead of regulatory or accreditation reporting (41%) and payer contracting (33%). 16% of measuring organizations collect outcomes but don't use the data (see Exhibit 4).

Exhibit 4

How organizations use outcomes data

Clinician development leads; leaders ranked their top three uses of the data



Source: State of Connected Care survey, 2026. Leaders whose organizations measure outcomes, n=187.

Key takeaways

Outcomes data has entered the business conversation.

68%
of leaders have been asked for outcomes data

35%
have used it to win or defend a contract.

61%
of organizations are in or exploring a new payment model.

49%
of organizations use outcomes data for clinician development.

SECTION 2

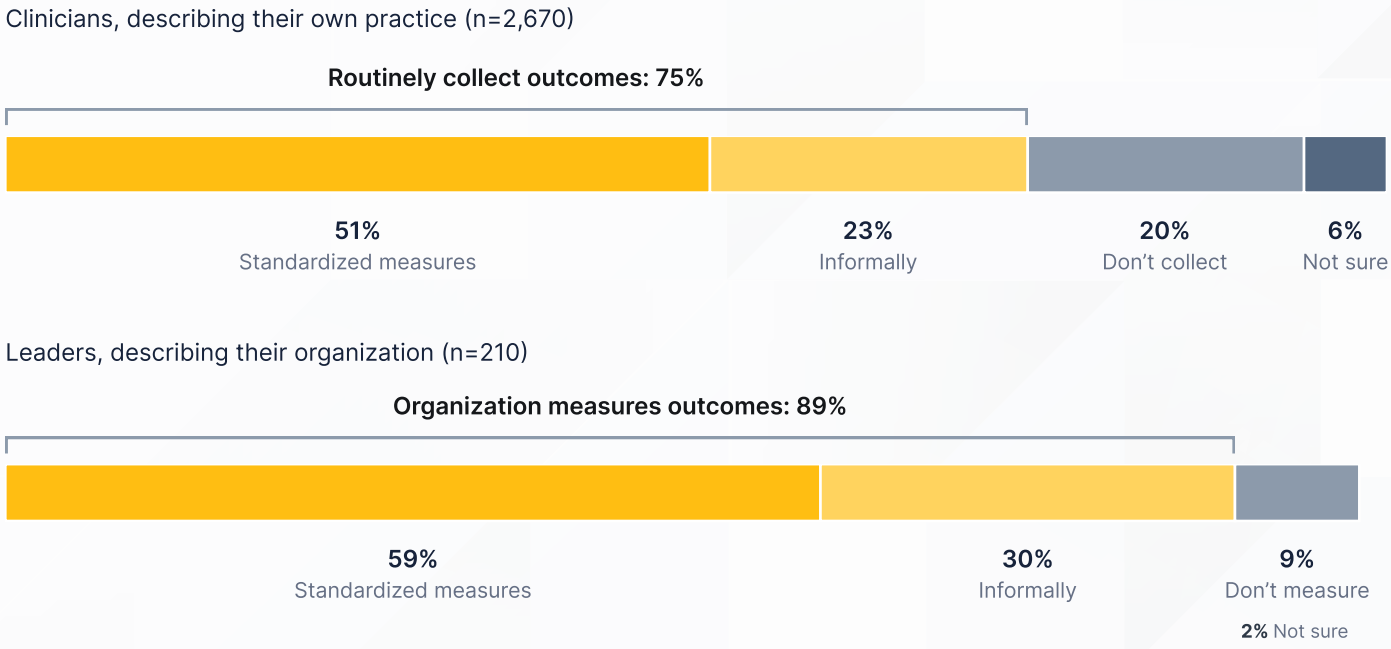
Outcomes are collected more often than they are used in clinical practice

Measurement is widespread, but how that collection happens varies. 75% of clinicians routinely collect patient outcomes (51% with standardized measures and 23% informally). Among leaders, 89% say their organization measures outcomes, 59% with standardized measures (see Exhibit 5).

Exhibit 5

Who collects outcomes

Three in four clinicians collect outcomes; 89% of leaders say their organization measures them



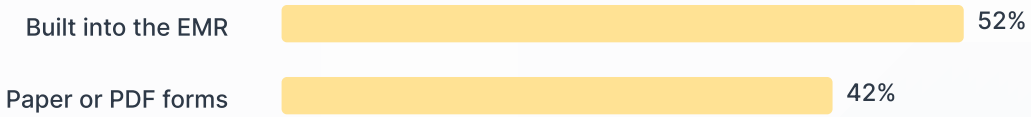
Source: State of Connected Care survey, 2026. Clinicians describing their own practice, n=2,670; leaders describing their organization, n=210.

Most outcomes are collected through systems built for documentation. Collection runs mainly through the EMR (52%) and paper or PDF forms (42%) (see Exhibit 5-B).

Exhibit 5-B

How clinicians collect outcomes: EMR and paper

The two most common methods among clinicians who collect; more than one allowed



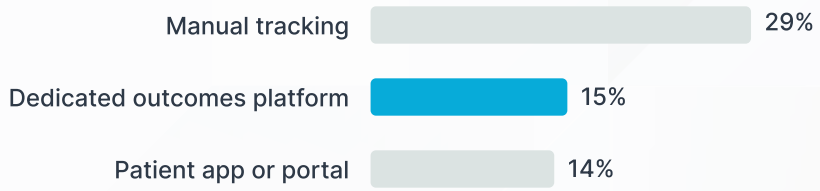
Source: State of Connected Care survey, 2026. Clinicians who collect outcomes, n=1,997.

However, collected isn't the same as usable. Outcomes data is most useful when clinicians can see it during care planning, yet only 37% of clinicians say their outcomes data is easy to access, and 31% say it's hard. 35% say outcomes often or always change how they deliver care, a share similar to leaders (32%). Nearly a third of collectors track outcomes by hand, and about one in seven uses a platform built for outcomes (see Exhibit 5-C). Clinicians who find their outcomes data easy to access are more likely to say it changes their care. Access is lowest for athletic trainers and for clinicians with more than 20 years in practice (see Exhibit 6).

Exhibit 5-C

How clinicians collect outcomes: other methods

About one in seven collectors uses a dedicated outcomes platform; more than one response allowed.

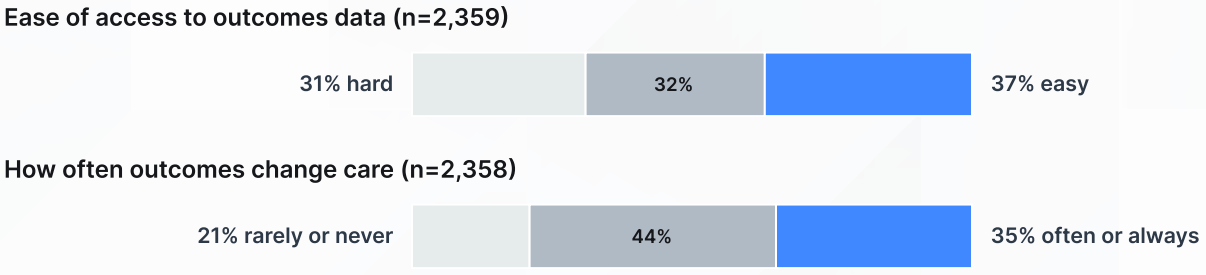


Source: State of Connected Care survey, 2026. Clinicians who collect outcomes, n=1,997. More than one method allowed; shown on the same scale as Exhibit 5-B.

Exhibit 5-D

Outcomes data: collected but underused

Only about a third find the data easy to access or say it often changes care; ratings on a 1–5 scale, with 3 as the middle segment

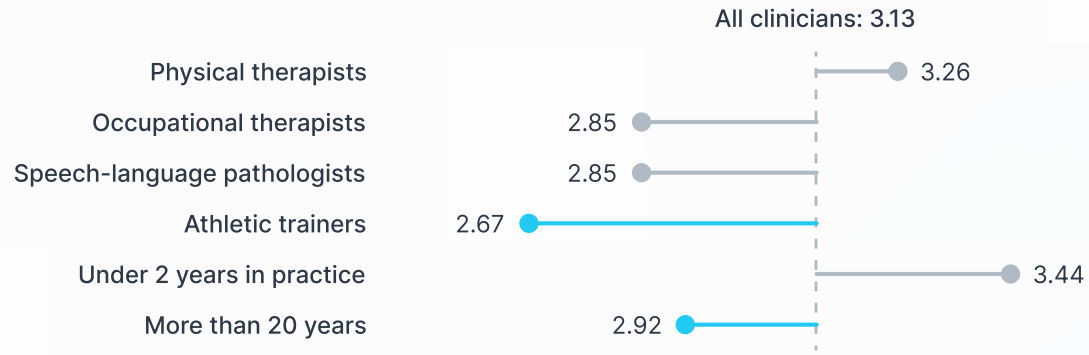


Source: State of Connected Care survey, 2026. Middle shares are the remainder after top and bottom ratings.

Exhibit 6

Ease of access to outcomes data

Average rating on a 1–5 scale against all clinicians; lowest for ATs and the most experienced



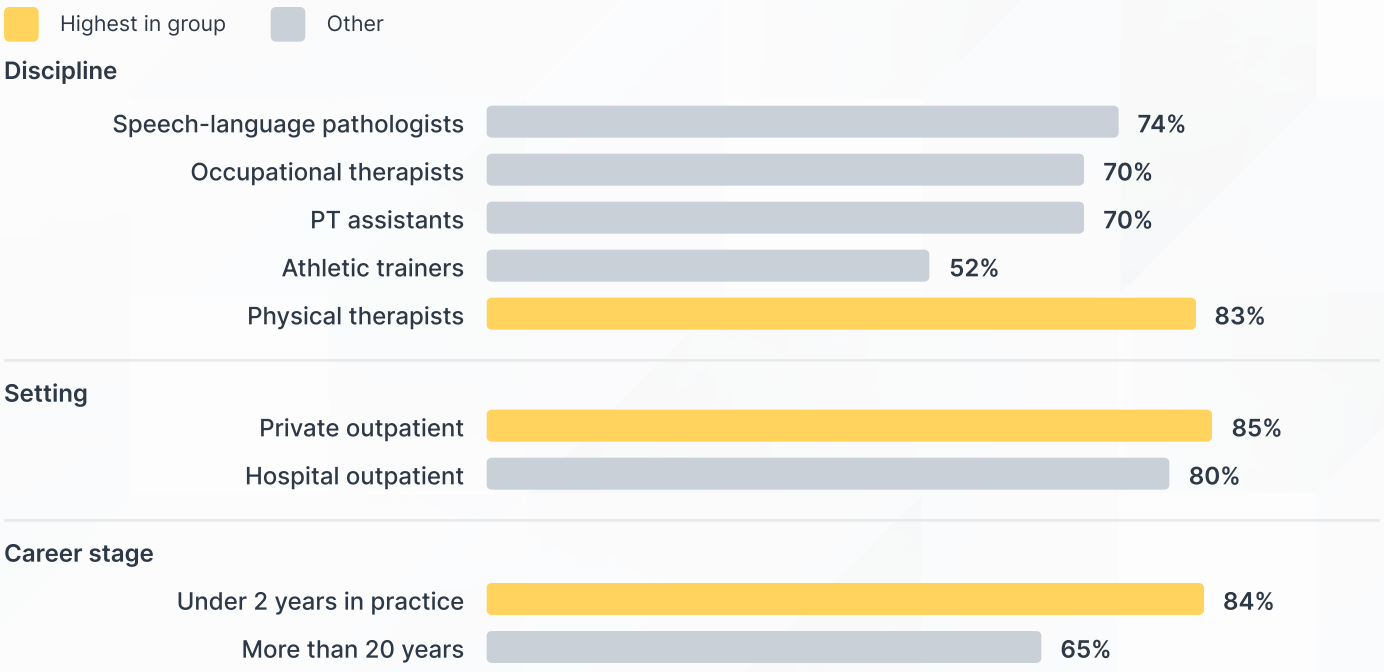
Source: State of Connected Care survey, 2026. Clinicians who rated access, n=2,359; discipline groups with at least 100 respondents.

Practice setting also shows slight differences in outcomes collection, with the most dramatic difference between disciplines. On an organizational level, private outpatient clinicians collect outcomes slightly more often than hospital outpatient clinicians (85% vs 80%). Collection is highest among physical therapists (83%) and lowest among athletic trainers (52%). The data also suggests a generational gap, with newer clinicians collecting outcomes more often than those who have more than 20 years in practice (84% vs 65%) (see Exhibit 7).

Exhibit 7

Outcomes collection by discipline, setting, and career stage

Share of clinicians who routinely collect outcomes; the highest in each group is highlighted



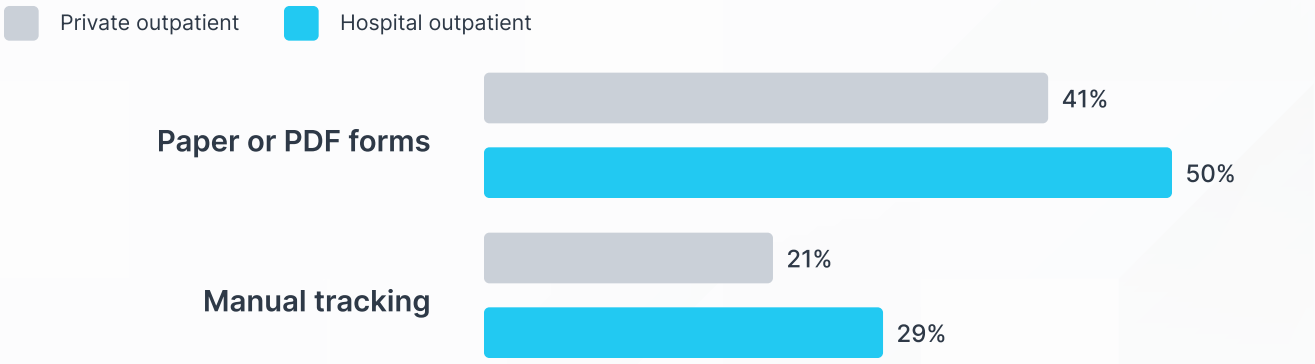
Source: State of Connected Care survey, 2026. All clinicians, n=2,670; private outpatient n=748; hospital outpatient n=996.

Hospital clinicians rely more on paper forms (50% vs 41%) and manual tracking (29% vs 21%). (See Exhibit 7-B)

Exhibit 7-B

Collection methods by setting

Hospital outpatient clinicians rely more on paper forms and manual tracking



Source: State of Connected Care survey, 2026. Clinicians who collect outcomes: private outpatient and hospital outpatient settings.

Key takeaways

Measurement is common, but the data is hard to utilize.

> 75% of clinicians collect outcomes, mostly through the EMR or paper.
>
> 37% find the data easy to access.
>
> 35% say it often changes care.

Hospital outpatient clinicians rely more on manual collection.

> Paper forms (50% vs 41%) and manual tracking (29% vs 21%) are more common than in private practice.

SECTION 3

Engagement between visits is largely out of view

Most of a patient's recovery happens between visits, through home exercise programs and the habits patients build on their own. The survey finds that this part of care is largely unmeasured: completion is more often estimated than tracked, and the tools that could increase visibility are early in adoption.

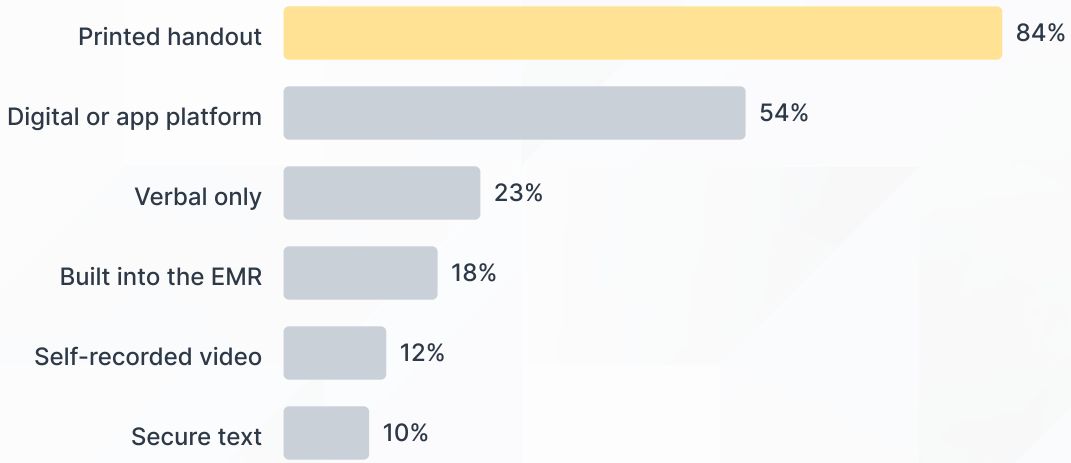
Home programs and plan-of-care completion

Despite the proliferation of digital HEP providers in recent years, paper still remains the default: 84% of clinicians send home programs as printed handouts, 54% use a digital platform (Exhibit 8).

Exhibit 8

How clinicians deliver home programs

Paper remains the most common method; more than one allowed



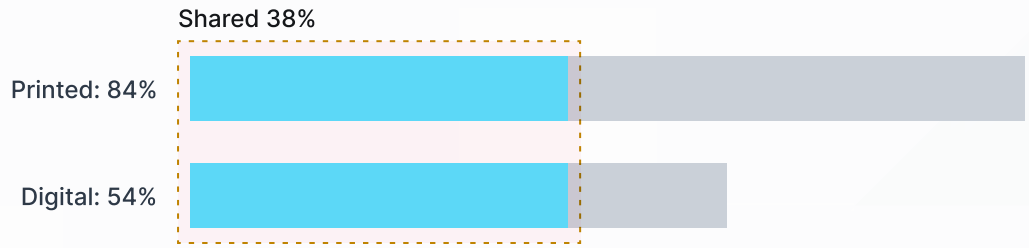
Source: State of Connected Care survey, 2026. All clinicians, n=2,670. More than one method allowed.

Interestingly, even in cases when clinicians use a digital platform for HEP, digital hasn't fully replaced paper handouts: at least 38% of all clinicians send both (see Exhibit 8-B). Patient comfort could be a driver, as it's the top barrier to between-visit engagement (47%). Running both channels splits visibility, however, because when a patient gets the same program on paper and in an app, only the digital side can track whether they did it.

Exhibit 8-B

Paper and digital together

At least 38% of clinicians use both printed and digital home programs



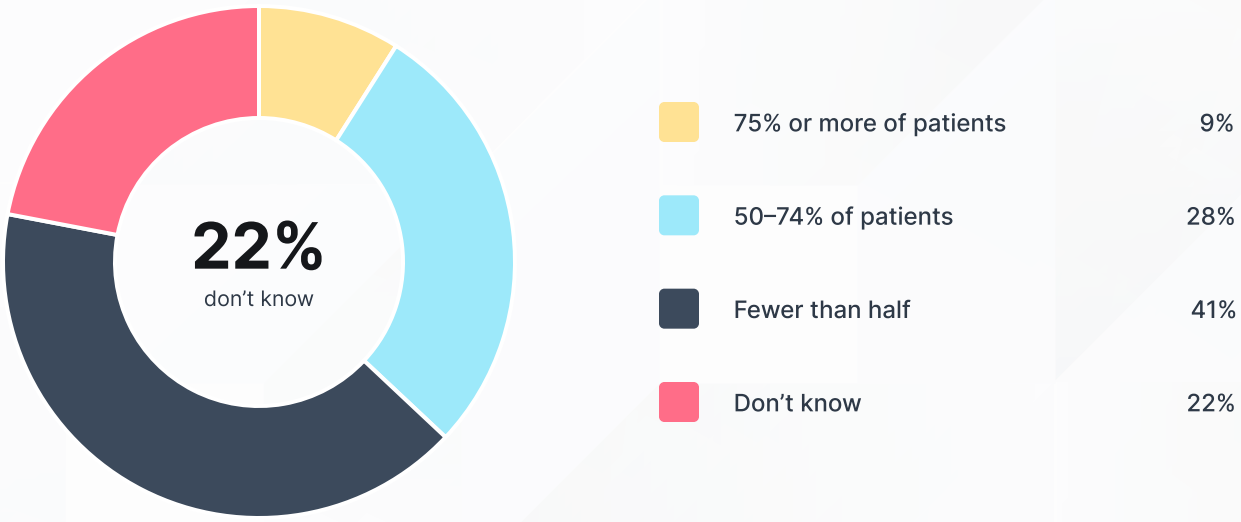
Source: State of Connected Care survey, 2026. All clinicians, n=2,670. More than one method allowed.

Regardless of how home programs are delivered, the reality is that few clinicians can see whether patients follow through. Only 9% say most of their patients (75% or more) complete their home program as prescribed; 41% say fewer than half do, and 22% don't know (see Exhibit 9).

Exhibit 9

Share of patients completing home programs as prescribed

Clinicians' estimates for their own patients; one in five don't know



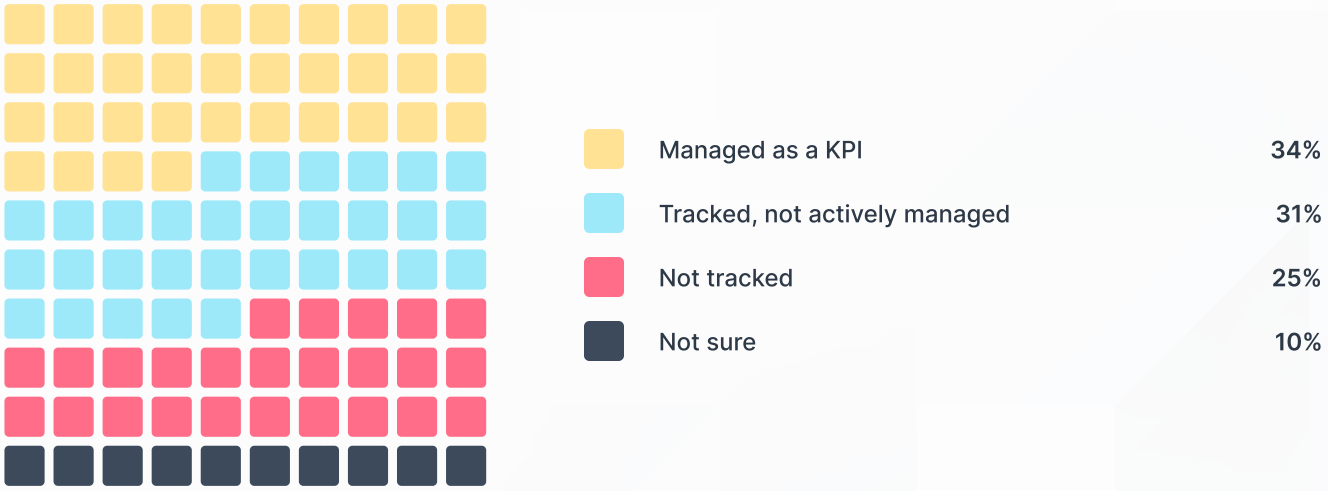
Source: State of Connected Care survey, 2026. All clinicians, n=2,670.

Plan-of-care completion is similarly uncertain. 25% of organizations don't track it, 31% track it without actively managing it, and 34% manage it as a key performance indicator (see Exhibit 10).

Exhibit 10

How organizations manage plan-of-care completion

A quarter of organizations don’t track it; each square represents 1% of organizations



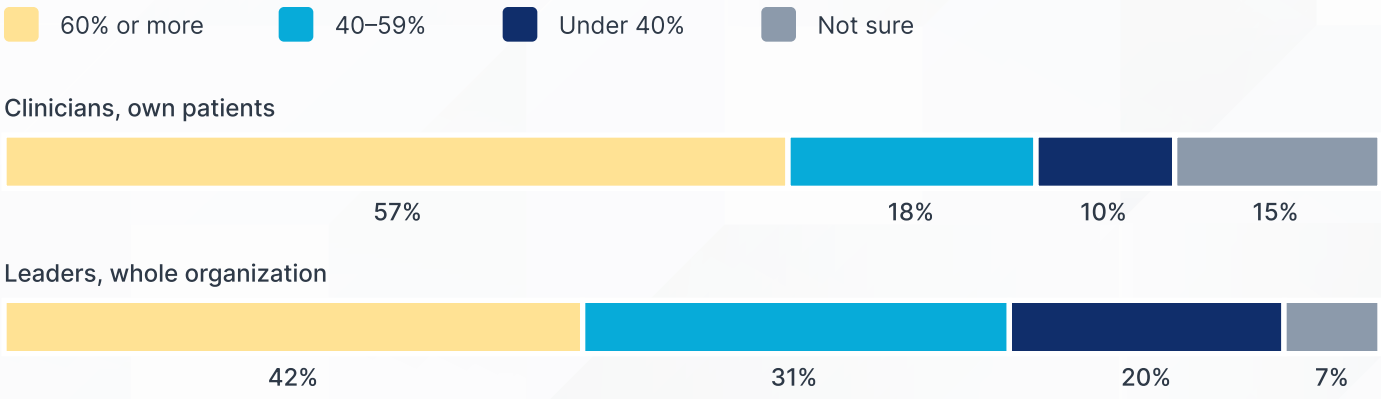
Source: State of Connected Care survey, 2026. Leaders, n=210.

57% of clinicians estimate that most of their own patients finish the plan, compared with 42% of leaders estimating for their whole organization. 15% of clinicians aren't sure (see Exhibit 11).

Exhibit 11

Estimated plan-of-care completion

Share of patients estimated to complete the full plan; the two groups estimate different patients



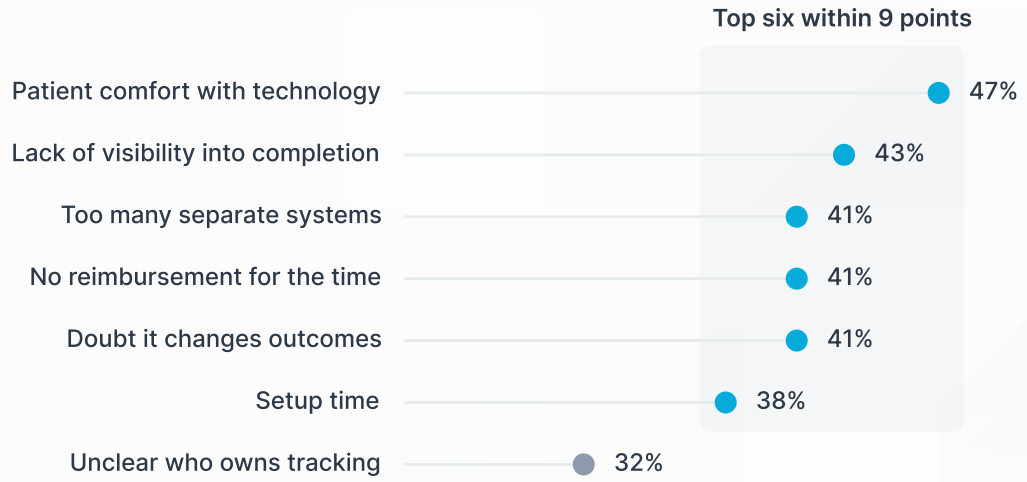
Source: State of Connected Care survey, 2026. Clinicians, n=2,670; leaders, n=210.

The barriers to engaging patients between visits are spread across technology, visibility, systems, payment, and belief in the impact (see Exhibit 12). No single fix addresses them.

Exhibit 12

Barriers to between-visit engagement

No single barrier dominates; clinicians rank top three barriers



Source: State of Connected Care survey, 2026. All clinicians, n=2,670.

Visibility trends

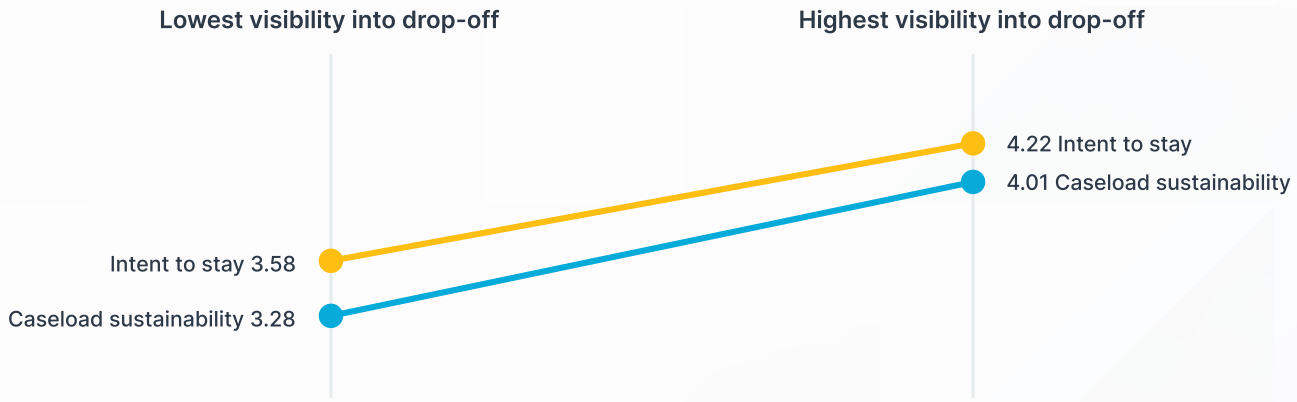
Clinicians who can see their patients' drop-off rates report better conditions across several measures. However, it should be noted that these are associations from a single survey, not necessarily evidence of cause:

- Caseload sustainability rises from 3.28 to 4.01 (on a 5-point scale) between the lowest and highest visibility ratings (see Exhibit 13).
- Intent to stay at their organization rises from 3.58 to 4.22 (on a 5-point scale).
- Clinicians with easy access to their outcomes data also report more visibility into drop-off.
- Clinicians who use RTM are less likely than non-users to doubt that between-visit engagement improves outcomes (28% vs 41%).

Exhibit 13

Caseload and retention by visibility into patient drop-off

Average rating on a 1–5 scale



Source: State of Connected Care survey, 2026. All clinicians, n=2,670

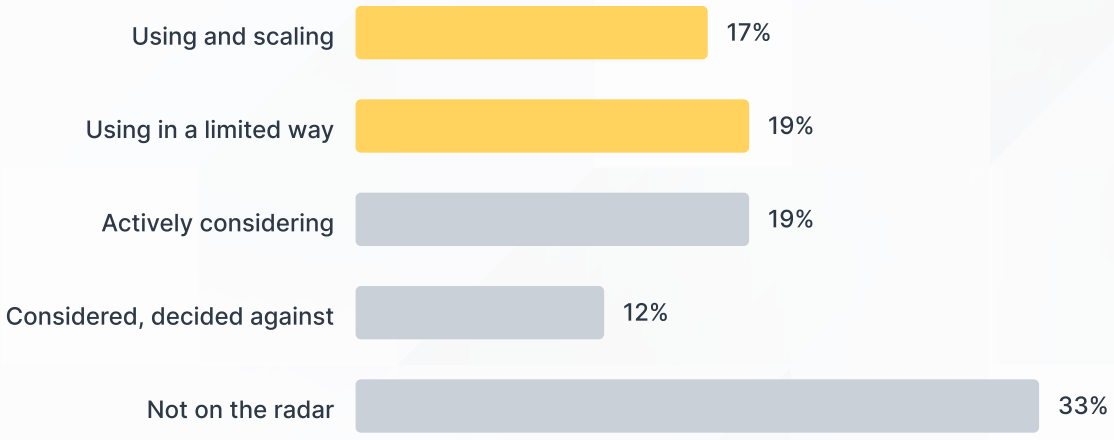
Remote therapeutic monitoring

Remote therapeutic monitoring divides the field, but is gaining ground. More than half of organizations are using RTM or actively considering it: 36% use it, half of them at scale, and another 19% are actively considering it. (see Exhibit 14).

Exhibit 14

Organizations' stance on remote therapeutic monitoring

More than half of organizations use RTM or are actively considering it

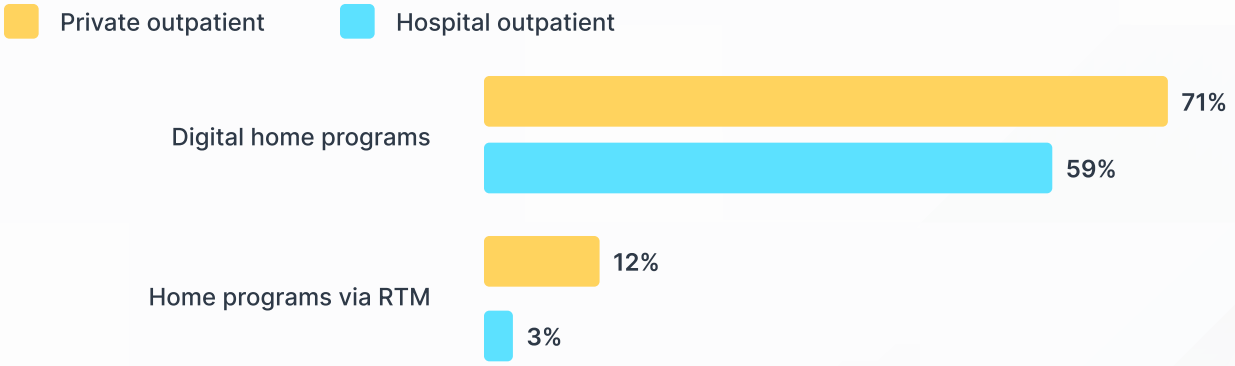


Source: State of Connected Care survey, 2026. Leaders, n=210.

Exhibit 14-B

Digital and RTM home program delivery by setting

Private practice clinicians deliver home programs through RTM four times as often



Source: State of Connected Care survey, 2026. Clinicians in private outpatient practice, n=748; hospital outpatient, n=996. More than one delivery method allowed.

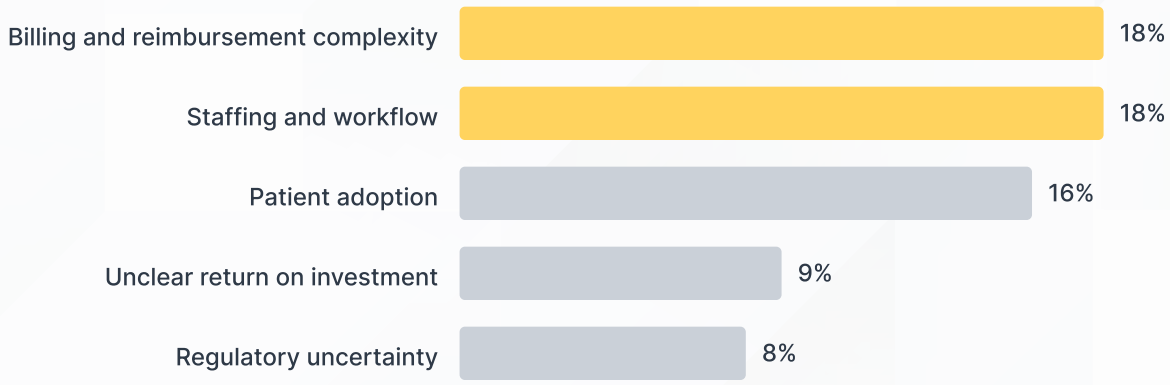
Running RTM well requires billing, coordination, and workflow support beyond the treating clinician. Clinicians who use RTM (n=146) are more confident that engaging patients between visits pays off. Only 28% doubt it improves outcomes, compared with 41% of clinicians who don't use RTM. Asked to name their single biggest obstacle, RTM users most often cite patient adoption (32%), billing (21%), and workflow (20%), while 13% say they have no major obstacle because their program is running smoothly.

Organizations are building on a strong base: 91% have a formal approach to keeping patients engaged between visits, most often printed home programs (51%), messaging and outreach (50%), and digital home programs (49%). Among leaders, the most common practical obstacles to RTM are billing and reimbursement complexity and staffing and workflow (18% each), followed by patient adoption (16%) (see Exhibit 15).

Exhibit 15

Leaders' biggest practical obstacles to RTM

Billing and staffing lead; share of leaders naming each as their biggest obstacle



Source: State of Connected Care survey, 2026. Leaders, n=210; one answer per leader.

Private practice vs. health systems: care between visits

MEASURE	PRIVATE OUTPATIENT	HOSPITAL OUTPATIENT
Use digital home programs	**71%**	**59%**
Use printed home programs	**82%**	**90%**
Deliver home programs via RTM	**12%**	**3%**
Visibility into patient drop-off (mean of 5)	**3.44**	**3.13**
Cite unpaid time as a barrier	**51%**	**40%**
Cite lack of visibility as a barrier	**39%**	**46%**

Source: State of Connected Care survey, 2026. Private outpatient clinicians, n=748; hospital outpatient clinicians, n=996. Visibility is rated from 1 (no visibility) to 5 (full, real-time visibility); both settings fall near the middle of the scale, indicating partial visibility.

Key takeaways

Home programs still go home on paper.

> 84% of clinicians print home programs
>
> 38% send paper and digital together

Completion is more often estimated than measured.

> 22% of clinicians don't know whether patients complete home programs
>
> 25% of organizations don't track plan-of-care completion

RTM adoption is early and uneven.

> 36% of organizations use RTM in some form

Private outpatient clinicians use RTM four times as often as hospital outpatient clinicians.

Private practice clinicians rate their visibility into patient drop-off higher.

> They rate their visibility into patient drop-off higher than hospital outpatient clinicians (3.44 vs 3.13 on a 5-point scale), use digital home programs more often (71% vs 59%), and are less likely to name lack of visibility as a barrier (39% vs 46%).

SECTION 4

The workforce is stretched for time and capacity

Every finding in this report depends on the providers delivering care. The survey finds that time is the constraint clinicians feel first, that stretched caseloads go hand in hand with shortened treatment and weaker intent to stay, and that what clinicians need to learn shifts across a career.

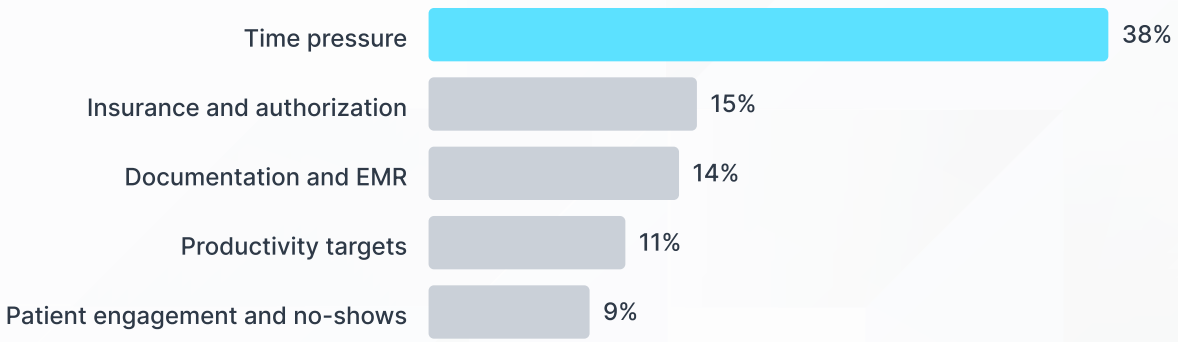
Time and caseloads

Time is rehab's scarcest resource. Asked for the hardest part of delivering great care, 38% of clinicians' 1,450 written answers point to time, more than insurance and authorization (15%), documentation (14%), or productivity targets (11%) (see Exhibit 17). Asked for the one change that would most improve their working day, clinicians most often name less documentation and EMR burden (31%), followed by more time (24%).

Exhibit 17

The hardest part of delivering great care

Time leads by a wide margin; share of clinicians' written answers by theme



Source: State of Connected Care survey, 2026. Clinicians' written answers, n=1,450.

Where caseloads feel unsustainable, clinicians are forced into hard choices about how to spend each visit: 15% of clinicians are forced to shorten or skip treatment due to time constraints. The practice rises steeply as caseloads become less sustainable: on a five-point frequency scale, the average climbs from 2.08 among clinicians with the most sustainable caseloads to 3.36 among those with the least.

The positive news is that a majority of clinicians (59%) describe their caseload as sustainable at the quality of care they want, and leaders say the same of their clinicians (55%). 26% of clinicians see 12 or more patients on a full day, while demand continues to grow. 25% of leaders say waits for a first visit grew over the past year, compared with 19% who say they shrank (see Exhibit 17-B).

Exhibit 17-B

Caseload is sustainable at desired quality

Clinicians 59%

Leaders 55%

Clinicians seeing 12+ patients on a full day

26%

About 1 in 4

Leaders: first-visit waits, past year

Grew 25%

Shrank 19%

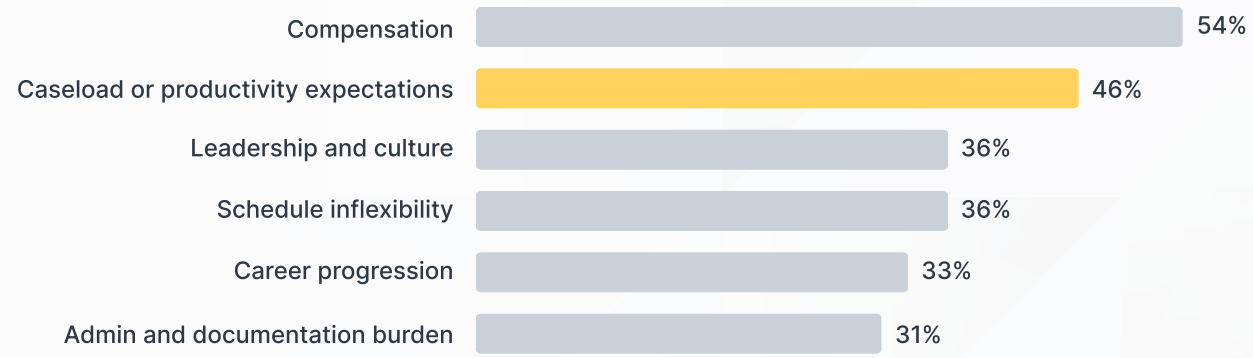
Retention

65% of clinicians expect to remain at their organization in two years, and 15% do not. Where caseloads feel unsustainable, fewer clinicians plan to stay—one of the stronger links in the survey. Compensation is the most common reason why clinicians say they would leave, followed by caseload and productivity expectations (see Exhibit 18).

Exhibit 18

Why clinicians would leave their organization

After pay, caseload expectations are the most common reason; clinicians rank their top three



Source: State of Connected Care survey, 2026. All clinicians, n=2,670.

Organizational leaders report the same pressure from the other side. Turnover rose at 37% of organizations over the past year and fell at 13%. 26% report clinical vacancy rates of 10% or more, and staffing is the most common limit on capacity (42%). Intent to stay is nearly identical across private and hospital outpatient settings.

Preparedness and learning

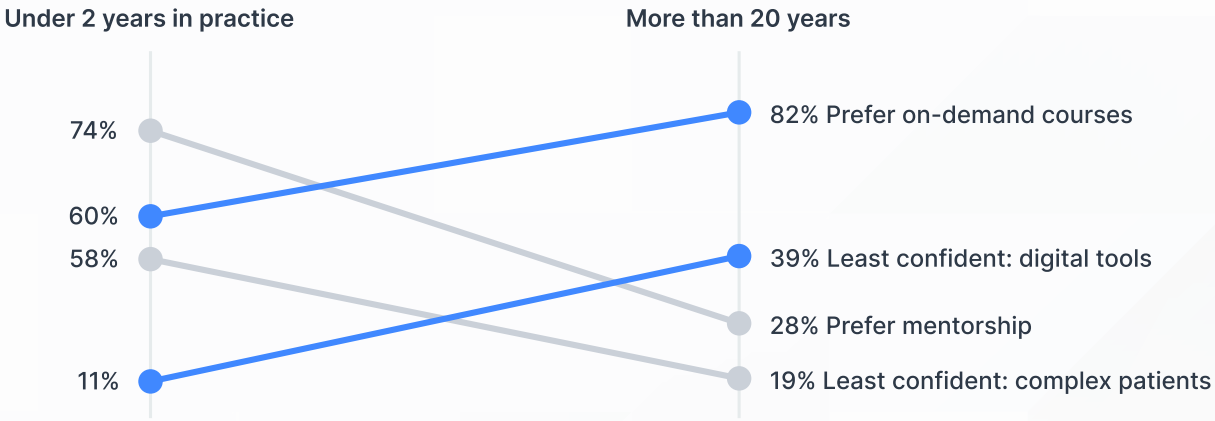
Many clinicians begin practice feeling underprepared. 31% felt unprepared to practice independently in their first year, and leaders rate the new graduates they hire almost identically (2.92 vs clinicians' 2.91 on a five-point scale). Occupational therapists (2.62) and speech-language pathologists (2.57) felt least prepared, compared with physical therapists (3.04).

Learning needs also change with experience (see Exhibit 19). Mentorship is the preferred way to build skills early in a career and fades over time, while on-demand courses rise. Confidence gaps move from medically complex patients to digital tools.

Exhibit 19

Learning needs across a career

Mentorship gives way to on-demand learning; confidence gaps move to digital tools



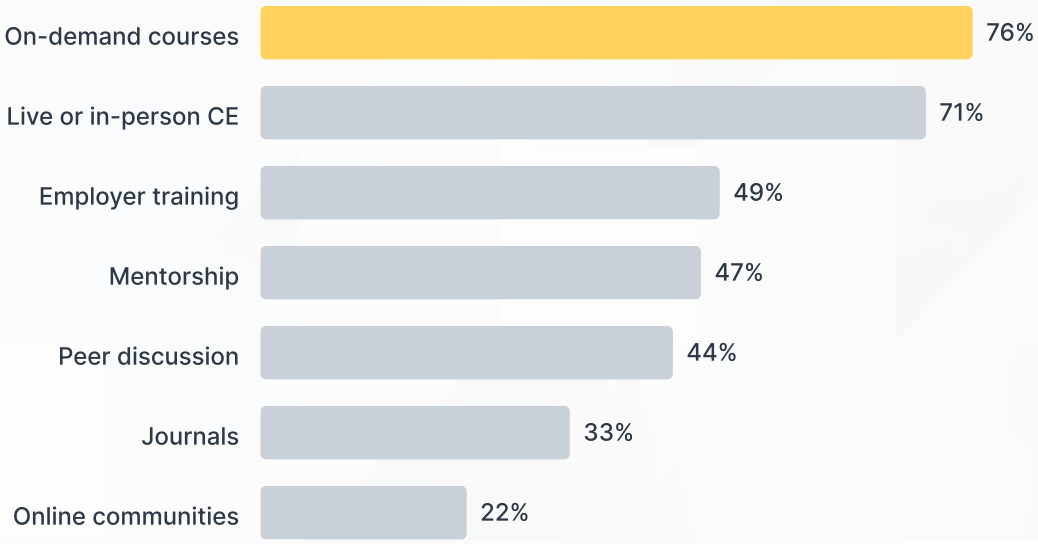
Source: State of Connected Care survey, 2026. Clinicians under 2 years in practice and more than 20 years in practice.

Across all clinicians, on-demand courses (76%) and live or in-person continuing education (71%) are the most popular ways to learn (see Exhibit 20).

Exhibit 20

How clinicians prefer to build skills

On-demand courses and live continuing education (CE) lead; more than one allowed



Source: State of Connected Care survey, 2026. All clinicians, n=2,670.

Career-stage groups are different clinicians at one point in time, not the same people followed over years, so differences may partly reflect when clinicians trained as well as how long they've practiced. Because most respondents are Medbridge subscribers, preference for on-demand learning may run higher than in the profession overall.

How clinicians and leaders see the field

On every question asked of both groups in identical words, clinicians and leaders give nearly the same answer (see Exhibit 21). They rate how often outcomes change care identically, and their ratings of new clinicians' first-year readiness and of caseload sustainability differ by less than 0.05 points. 59% of clinicians and 55% of leaders describe caseloads as sustainable, and 35% and 32% say outcomes data often change care.

Exhibit 21

Clinician and leader ratings on paired questions

Average rating on a 1–5 scale; the same question asked of both groups



Source: State of Connected Care survey, 2026. Clinicians, n=2,670; leaders, n=210.

Key takeaways

Time is the constraint clinicians name most.

> 38% of written answers cite time as the hardest part of delivering great care.

Stretched caseloads go with shortened care and weaker retention.

- Treatment shortening rises from 2.08 to 3.36 (of 5) as caseloads become less sustainable.
- Clinicians with less sustainable caseloads are less likely to plan to stay.

Learning needs shift across a career.

> Mentorship preference falls from 74% to 28%; on-demand preference rises from 60% to 82%.

Clinicians and leaders see the field the same way.

> Paired ratings differ by less than 0.05 points on a five-point scale.

SECTION 5

AI-readiness is strongest where outcomes data is easiest to reach

The survey was designed to compare how clinicians and leaders see the same issues. It finds wide variation in how ready clinicians feel for AI-driven care tools.

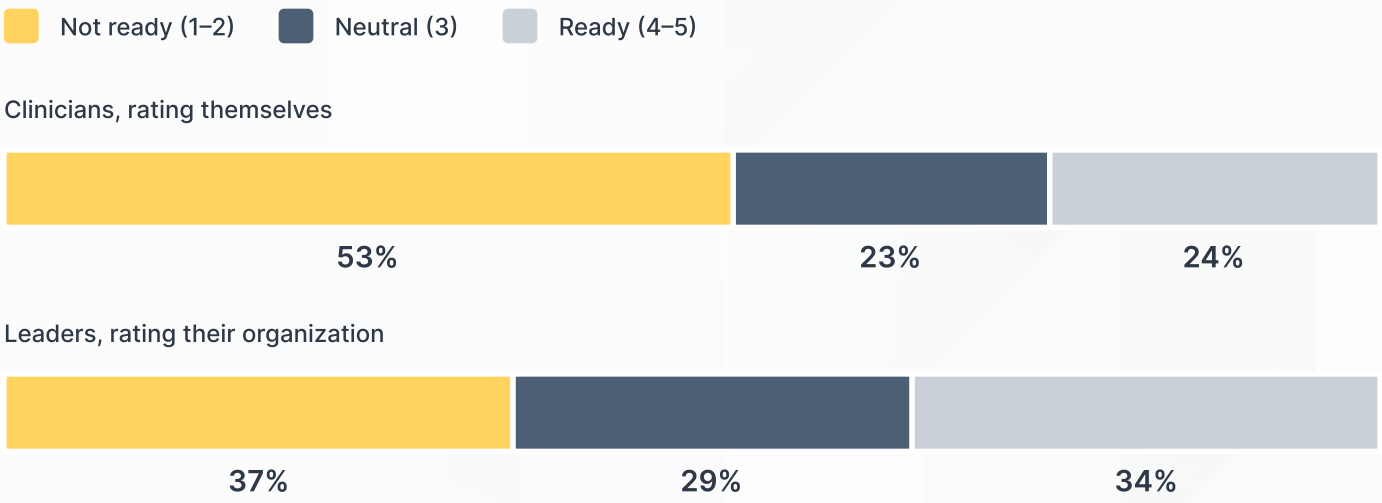
AI readiness

Half of clinicians (53%) don't feel ready to use AI-driven care tools, and 24% do. Leaders rating their organization are split: 34% say it is ready and 37% say it isn't (see Exhibit 22).

Exhibit 22

Readiness for AI-driven care tools

Half of clinicians don’t feel ready; the two groups rate different things



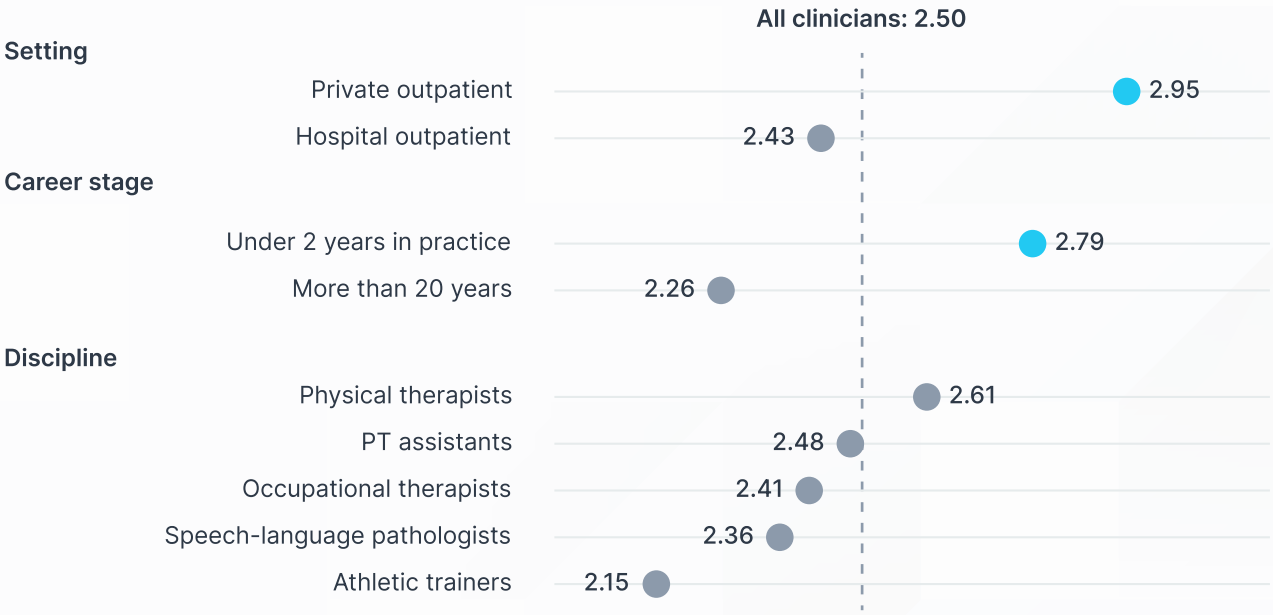
Source: State of Connected Care survey, 2026. Clinicians, n=2,670; leaders, n=210. Neutral shares (23% and 29%) are the remainder after "not ready" and "ready".

Readiness varies by setting, career stage, and discipline (see Exhibit 23). Private outpatient clinicians rated themselves more ready for AI-driven care tools than hospital outpatient clinicians, and clinicians in their first two years rated themselves more ready for AI-driven care tools than those with more than 20 years in the field. Clinicians who can easily reach their outcomes data also rate themselves more prepared for AI.

Exhibit 23

Clinician readiness to use AI-driven care tools

Average self-rating on a 1–5 scale; highest in private practice and among newer clinicians



Source: State of Connected Care survey, 2026. All clinicians, n=2,670.

Views on AI are mixed. Some clinicians see clear uses, particularly for documentation; others report that AI tools create errors they must correct. Because "AI-driven care tools" can describe anything from note-taking assistance to clinical decision support, these results measure how ready clinicians feel rather than which tools they use.

Key takeaways

Most clinicians don't yet feel ready for AI.

> 53% rate themselves not ready; leaders are split on their organization's readiness.

Readiness is uneven among setting and disciplines.

> It is highest in private practice (2.95 vs 2.43) and among newer clinicians (2.79 vs 2.26).

Conclusion

Outcomes are becoming part of how rehab therapy is paid for and judged. The field already collects more data than it can see or use, and the people closing that gap are short on time. Clinicians and leaders agree on where rehab stands, which gives the field a shared starting point. Progress can come in three ways:

1. By turning outcomes data into information clinicians and leaders can act on during care, not only collect.
2. By making care between visits visible, so completion of home programs and plans of care is measured rather than estimated.
3. By protecting clinician time, reducing documentation burden, and defining who owns between-visit work.

Outcomes are entering payer and contract decisions, yet much of the data rehab therapy collects never reaches the people who could act on it, and much of care between visits goes unmeasured. The survey points to three opportunities for practices, health systems, and the organizations that support them:

Turn outcomes data into usable information

Three in four clinicians collect outcomes, but only 37% find the data easy to access, and only 35% say it often changes their care. Clinicians who can reach their data are more likely to use it.

Put outcomes where clinicians work

Outcomes data can’t just surface in quarterly reports; it's most useful when clinicians can see it during care planning. Organizations should review how quickly collected outcomes become visible to the treating clinician, and reduce reliance on paper forms and manual tracking where they slow that loop.

Prepare for outcomes requests before they arrive

68% of leaders have already been asked for outcomes data. Organizations that haven't been asked yet can benefit from establishing standardized measures and reporting now.

Make care between visits more visible

A quarter of organizations don't track plan-of-care completion, and 22% of clinicians don't know whether patients complete their home programs.

Measure completion before managing it

Tracking plan-of-care completion and home program adherence, even in simple terms, gives clinicians and leaders a shared baseline rather than estimates. Clinicians with more visibility into drop-off also report more sustainable caseloads and stronger intent to stay.

Address barriers together

The top six barriers to between-visit engagement sit within nine points of each other, spanning patient technology comfort, visibility, fragmented systems, payment, and confidence in impact. Approaches that address only one are unlikely to change engagement on their own.

Protect clinician time

Time is the constraint clinicians name most, and where caseloads feel unsustainable, treatment is shortened more often, and fewer clinicians plan to stay.

Reduce documentation burden

Less documentation and EMR work is the single change clinicians most often say would improve their day (31%).

Clarify who owns between-visit work

32% of clinicians cite unclear ownership of tracking as a barrier, and RTM depends on billing and coordination beyond the treating clinician. Defining those roles can let new models of care grow without adding to clinicians' caseloads.

Clinicians and leaders already agree on where rehab stands. The next step is to give both the information and the means to act on it.

About Medbridge

Medbridge empowers clinicians and organizations to improve outcomes, consistency of care, and patient satisfaction through data-driven insights and streamlined workflows. Medbridge's integrated platform provides the highest quality continuing education, patient engagement, and enterprise tools.

Appendix A: Respondent Characteristics

Clinicians (n=2,665)

- Discipline (n=2,665): physical therapist 49%, occupational therapist 16%, physical therapist assistant 13%, speech-language pathologist 8%, athletic trainer 6%, occupational therapy assistant 2%, other (including nurses) 5%.
- Setting: hospital or health-system outpatient 37%, private outpatient 28%, acute or inpatient 20%, other 15%.
- Years in practice (n=2,659): under 2 years 12%, 2–5 years 20%, 6–10 years 19%, 11–20 years 21%, more than 20 years 29%.
- Patients per full day: fewer than 8, 31%; 8–11, 42%; 12–15, 19%; 16 or more, 7%.

Leaders (n=210)

- Role: clinic director or manager 44%, owner or partner 16%, regional or operations 15%, executive 7%, other 19%.
- Organization type: private outpatient 35%, hospital outpatient 31%, acute 15%, other 18%.
- Organization size: 31% have 1–10 clinicians; 18% have 200 or more.
- Payer mix (average share of patients): commercial 24.7%, Medicare 23.5%, Medicaid 15.1%, self-pay 12.1%, Medicare Advantage 10.8%, workers' compensation 4.8%, other 9.0%.

Source: State of Connected Care survey, 2026.

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