Key Benefits of Inpatient Rehabilitation

Below is a care graph that further breaks down the key benefits inpatient rehabilitation provides for patients and what sets it apart from other care settings.

	Inpatient Rehabilitation Facility or Acute Rehabilitation Units	Skilled Nursing Facilities/ Transitional Care Units	Home Health Care
License/ Certification	Certified as acute care hospitals and licensed as freestanding inpatient rehabilitation hospitals or distinct rehabilitation units within a host hospital.	Licensed as a skilled nursing facility.	Certified to provide skilled nursing and skilled therapy services for home-bound patients.
Physician Involvement	Daily physician visits including a medical director of rehabilitation who provides services in the facility on a full-time basis.	Required physician visit during first 30 days; one visit every following 60 days. May be more frequent based on patient need.	Patient's physician certifies need and oversees care; face-to-face encounter with physician required.
Nursing	Receive specialized training in rehab nursing; Provide 24-hour nursing care; intervention, assessment, monitoring of: VS, IVFs/ antibiotics, ostomy, catheter, trach, NG care; routine labs and diagnostics and respiratory equipment.	Must have at least one RN for at least eight straight hours a day, seven days a week, and either an RN or LPN/LVN on duty 24 hours per day; intervention, assessment, monitoring of: VS, IVFs/antibiotics, ostomy, catheter, trach, NG care; routine labs and diagnostics and respiratory equipment.	Nursing supervision of acute and chronic medical conditions. Teach/train/observe/assess and provide care plan management; instruct on medication administration, including oral, injections, infusions or tube feeding; wound, catheter and ostomy care; NG/trach aspiration and care.
Rehab Therapy	PT/OT/ST available. Patient able to participate in therapy three hrs/day, five days a week or 15 hours over seven days. Requires the services of at least two therapy disciplines. Level of rehab services provided in an IRF is more intense than other levels of post-acute care.	PT/OT/ST available. Participation varies based on medical needs and functional potential. Type and amount of therapy based on patient condition and medical needs. Patient prognosis varies. When possible, goal is to return patient to prior living setting but expectation that patient will return home or to community setting not required for admission.	PT/OT/SLP available. Participation varies based on medical needs and functional potential. Type and amount of therapy depends on patient condition and medical needs. Therapy goals are to restore function and improve patient independence and safety in the home environment. As patient function improves and patient is no longer homebound, therapy may be transferred to outpatient setting.
Team Treatment	Interdisciplinary approach between physician, therapy team, and nursing to facilitate recovery. Physician-led weekly team conferences required.	Interdisciplinary approach between therapy and nursing to facilitate recovery.	Multidisciplinary team with nursing, therapy, social worker and home health aide. Visits are intermittent based on patient need and physician orders. Private duty (usually paid for by patient) may be available.
Ancillary Services	Services on site: pharmacy, lab, radiology.	Services readily available, but not on site: pharmacy consultant, lab, radiology.	Not available.
Patient Characteristics	Patient's functional prognosis is good with the goal that they will return to home or a community-based setting. Patient demonstrates sufficient endurance and potential to participate in a rehab program and make significant gains in functional capabilities. Common admission patient description: • Stroke or other neurologic disorder • Multiple major trauma to brain, spinal cord, or amputation • Burns • Arthritic and pain syndromes • Orthopedic fracture or bilateral joint replacement • Medically complex patients such as those with CHF, COPD, post-COVID-19 or other cardiac conditions that have good endurance and potential for significant functional gains	Common admission patient description: • Medically complex patients such as those with CHF, COPD and diabetes exacerbation requiring monitoring, management • Wound care > stage 2 • Orthopedic surgery, surgery with complications or stroke requiring mobility and activity of daily living recovery (tolerates less than three hrs therapy/day) • Infections requiring ongoing IV antibiotics • Neurological illnesses	The patient must be considered "confined to the home," defined as: 1. Due to illness or injury the aid of a supportive device, the use of special transportation, or the assistance of another person is required in order to leave home, or they have a condition that makes leaving home contraindicated. 2. If either of the above are true then there must also exist a normal inability to leave home and leaving home must require a considerable and taxing effort. Common patient needs: • Wound, ostomy, catheter, NG, tube feeding or tracheostomy care • Medication reconciliation and management • Treatment of gait disturbances and balance disorders • Infusion therapy • Management of chronic, complex medical diagnoses (CHF, COPD, diabetes, arthritis) • Teaching patients self-management techniques • In-home rehabilitation • Post-op therapy visits for orthopedic conditions (e.g., hip/knee replacement).

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