LEVELS OF CARE

Kindred Healthcare

	Long-Term Acute Care Hospitals	Inpatient Rehabilitation Facility or Acute Rehabilitation Units	Skilled Nursing Facilities/ Transitional Care Units
License/ Certification	Comparable to and licensed, accredited and certified as an acute care hospital (med/surg floors, telemetry and ICU)	Licensed as inpatient hospitals or distinct rehabilitation units within a hospital	Licensed as a skilled nursing facility
Physician Involvement	Daily physician visits	Daily physician visits	Physician or a non-physician professional (NP, PA, clinical nurse specialist) visits frequently, not daily
Nursing	24-hour nursing care; intervention, assessment, monitoring of: VS, IVFs/antibiotics/drips, critical labs and diagnostics, respiratory and cardiac equipment	Receive specialized training in rehab nursing; 24-hour nursing care; intervention, assessment, monitoring of: VS, IVFs/ antibiotics, ostomy, catheter, trach, NG care; routine labs and diagnostics and respiratory equipment	24-hour nursing care; intervention, assessment, monitoring of: VS, IVFs/antibiotics, ostomy, catheter, trach, NG care; routine labs and diagnostics and respiratory equipment
Rehab Therapy	PT/OT/ST available. Participation in therapy varies due to stability of medical condition. No minimal level of therapy participation required for admission. Therapy intensity often ramped up during course of care as patient condition improves.	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 a minimum of two therapy disciplines (PT & OT, PT & ST). 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.
Team Treatment	Interdisciplinary approach between the physician, therapy, nursing and respiratory to facilitate recovery.	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.
Ancillary Services	Services on site: pharmacy, lab, radiology, procedure rooms and operating rooms	Services on site: pharmacy, lab, radiology	Services readily available, but not on site: pharmacy consultant, lab, radiology
Patient Characteristics	Specializes in patients not meeting acute med/surg hospital clinical milestones Common admission patient description: • Prolonged mechanical ventilation requiring weaning and pulmonary care • Complex wound care • Complex resistant infections • Complex medical issues requiring daily management • Post-surgical complications • Multiple concurrent acute and/or unstable illnesses	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, 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 ***Note:*** *Some of Kindred's Long-Term Acute Care Hospitals contain Subacute Skilled Units that provide a skilled level of therapy for patients with higher acuity needs*

For more information contact your Kindred Clinical Liaison.

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	Home Health Care	Outpatient Therapy	Palliative Care Consultation	Hospice Care
License/ Certification	Certified to provide skilled nursing and skilled therapy services for patients for whom leaving home takes considerable effort or is otherwise unsafe	Licensed/certified for patients whose rehabilitation and medical needs can be met in an outpatient setting	Specialized consultative care for patients with serious or life-threatening illness. This can occur in any care setting.	Certified services that provide care for those with a terminal illness in a setting that the patient considers home
Physician Involvement	Patient's physician certifies need and oversees care	Physician or non-physician practitioner (NPP) review/ certifies outpatient therapy plan of care	Physician or non-physician professional (PA, NP) consultations for those with serious illness	Hospice physician certifies terminal illness and, in coordination with attending, directs medical management of the hospice plan of care, with visits as indicated
Nursing	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.	Patients do not have skilled nursing needs	Nursing intervention, frequency and intensity is based on patient's care setting. This could be in any of the other referenced care settings	Nursing services are intermittent and individualized to meet the needs of the patient, typically increasing in frequency with patient decline
Rehab Therapy	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.	Participation in therapy varies based on medical needs and functional potential. PT/OT/ST available. Type and amount of therapy depends on the patient's condition and rehab prognosis. Frequency can range from one to five days per week.	Care is focused on improving or maintaining function and providing relief from symptoms.	PT/OT/ST services are available when their provision meets the patient's palliative goals of care, usually meaning providing relief from distressing symptoms.
Team Treatment	Multidisciplinary team with nursing, therapy, social worker, home health aide. Visits are intermittent based on patient need and physician orders. Private Duty (usually paid for by patient) may be available.	PT/OT/ST provided	May include additional team members including social work, nursing and counseling.	The core hospice team includes physician, nursing, social work, and counselor services. Counseling can be provided by spiritual care counselors, bereavement counselors, or nutritional counselors; volunteers, hospice aides, and others may also be included on the interdisciplinary team.
Patient Characteristics	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)	Stable medical condition that does not require frequent adjustments. Patient has functional limitations as compared to prior level of function. Potential for function to improve with therapy intervention exist.	Provides specialized medical care focused on providing relief from the symptoms, pain and stresses of a serious illness, regardless of prognosis. Can be provided together to supplement curative treatment or as a standalone service. Common patient diagnoses: • Cancer • CHF • COPD • Dialysis • MS, ALS, Parkinson's or any other neurological illnesses	Focus is on management of pain and other distressing symptoms to improve quality of life. Typical patients have a likely life expectancy of six months or less, if the illness runs its normal course. Common patient diagnoses: • Cancer • End-stage heart, lung or kidney disease • Alzheimer's, Parkinson's, other neurologic illnesses • Failure to thrive