	Home w/o services	Home with Skilled Care	Skilled nursing Facility	Inpatient Rehabilitation Facility	Long Term Acute Care Facility
Level of Need	Patient is independent in all areas Patient can safely navigate their home and community	Patient is deemed homebound with physician order present - Help with personal care, pt/ot/slp, social services, on-call services **Homebound:** Patient demonstrates a taxing effort to leave the home unassisted	Patient is in need of on-going daily skilled service daily skilled nursing needs and physician order. - Need for 24/7 services **ALOS – 15.9 days** See below for wound requirements also consider IV abx for SNF care Always think: Is this a decline? What was PLOF (not a year ago, but recently – if patient went to 3 SNFs and no improvement wont be auth-ed); is this for a SKILLED need or custodial. (has to be skilled! Otherwise long term care)	Patient needs two disciplines and physician services daily and overnight. - Must be able to participate in 3 hours per day 5 days a week - Treatment is aimed at enabling the patient to return home/community based **ALOS = 10-15 days**	Patient has complex medical needs with functional impairment that cannot be met in a lesser setting. Requires daily physician visits. **EXPECTED LOS is >25 days**
Functional Status	Ambulation - Negotiate community **distances independently** with or without assistive devices or at prior level of function with caregiver support - Able to leave home - Able to use equipment/DME independently - Able to navigate varying levels of terrain with or without assistive device ADLS - Independent IADLS - Independent Other - No cognitive impairment	Ambulation - May/may not be able to walk around home - Because of illness or injury need the aid of supportive devices in order to leave their place of residence - Patient can ambulate "household" distances ADLS - Needs help not dependent - Supervision to dependent with caregiver support IADLS - Min A to Dependent Other - Baseline cognition Examples: - Home PT/OT services - Home RN 1-2 /week for medication management, abx, disease mgmt etc - On-call line for patients	Ambulation - **Unable to walk household distances** (20-40 or 50-70 feet varying definitions) **with less than minimal assistance** - Requiring greater than minimal assistance with ambulation Contact guard/supervision = red flag for denial (min A itself not a reason for SNF) ADLS - Requiring greater than minimal assistance for ADLS IADLS - Min A to Dependent Other - Dysphagia/choking risk - Bowel/bladder dysfunction Custodial Care does NOT meet for SNF (i.e. help with walking, bathing, dressing, feeding, diet, medications). RT needs also doesn't qualify SEE RED FLAGS on back!!	Ambulation - Min A to dependent - Transfers may be difficult min A to dependent IADLS - Min A to Dependent Other - Cognition : communication disorders, aphasia, memory - Dysphagia - Bowel/bladder dysfunction Expectation is to improve within 10 days **KEY = Has to have medical needs (need physician daily = medically complex cases – see back)**	Ambulation - Significant impairment - Requires an acute hospital stay beyond the typical 4-7 day LOS to address acute medical issues ADLs - Max A to dependent - Typical patient scenario for our hospital: - New trach patients on vent (studies have shown when referred to LTACH right after trach the weaning is quicker) ** If referred several weeks after trach placement then insurance less likely to approve due to less benefit at this stage ** There are vent facilities that can do similar things as LTACH level and closer to us that DC – also they can take care of difficult RT needs (i.e. suctioning frequent)
Medical Management Required	- Independent with medication, wound care, transportation, medication, treatment (i.e. dialysis, chemo), primary care doctor	- General physician supervision at least **once a month** - Intermittent skilled service need **(pt/ot/slp/rn**) - Homebound patient - May require medical management, assistance with wound management	- Condition is expected to improve in a reasonable and predictable period - IV abx, IT- feedings, naso/trach, catheters, medicated dressings, stage 3+ wounds, ostomies - Therapy that required the skill of a qualified pt/ot/slp Poor Cognitive baseline does NOT meet for SNF then CM to address.	- 3+ hours daily therapy - Rehab physician 3X/week (some state daily) - Active medical management of comorbidities	Capabilities: - Line placement (PICC, central, permacath) - IV drips inclu pressors - HD, PD, TPN, tube feeds - PT/OT/SLP - Would vac therapy, complex wound needs - Hiflo, BiPAP, trach vent mgmg, bronch, CTube - 24/7 RT services

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