Geriatric Admission Recovery Facility Care GRG

GRG: GRG-GER-RF (RFC)

MCG Health
Recovery Facility Care
30th Edition

Note: An appropriate Optimal Recovery Guideline (ORG) should be identified and used whenever possible. This General Recovery Guideline (GRG) is intended to aid only in situations in which no ORG appears applicable.

Clinical Indications for Admission to Recovery Facility

- Skilled nursing facility (SNF) or subacute facility is/was needed for appropriate care of the patient because of **ALL** of the following:
  - There are no acute hospital care needs and **1 or more** of the following(1):
    - Patient requires 3-day qualifying hospital stay or applicable waiver, and care is related to hospital condition.[A]
    - Patient does not require a prequalifying stay.
  - The patient has Intense and complex care needs that make recovery facility care safer and more practical than attempting care at a lower level and **ALL** of the following(3):
    - These care needs include the multiple components of care that are delivered by skilled professionals at a recovery facility.
    - There is a plan to provide **ALL** of the following(4)(5):
      - Care plan management and evaluation to meet patient needs, achieve treatment goals, and ensure medical safety(2)
      - Observation and assessment of patient's changing condition to evaluate need for treatment modification or for additional procedures until condition stabilized
      - Education services to teach patient self-maintenance or to teach caregiver patient care(6)
      - Skilled care daily (or more frequently), including **1 or more** of the following[B](7)(8):

- Nursing treatments needed for **1 or more** of the following(5):
  - Intravenous (IV) infusion, IV injection, or intramuscular (IM) injection(9)
  - Insulin regimen establishment in presence of unstable blood sugar readings
  - Tube feeding (ie, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes, nasogastric tubes) required because patient needs feeding to supply at least 26% of daily calories and at least 501 mL of daily fluids.(10)
  - Nasopharyngeal or tracheostomy suctioning
  - Suprapubic catheter sterile irrigation or replacement
  - Wound management that requires dressing changes with prescription medication or clean technique and treatment for **1 or more** of the following(9):
    - Burns
    - Foot infection or wounds with application of dressing
    - Open lesions
    - Surgical wound complications
    - Treatment with any stage III or IV pressure injury(11)
    - Treatment with 2 or more ulcers, including venous ulcers, arterial ulcers, or stage II pressure injuries
    - Widespread skin disorder treatments(11)
  - Heat treatments that require nurse observation to evaluate response(5)
  - Oxygen administration, starting or managing changes(12)
  - Patient care training and assistance for **1 or more** of the following(13):
    - Exercise program (eg, range of motion, pulmonary, cardiac)(14)
    - Safe performance of ADL (eg, dressing, communicating, eating)
    - Splint, brace, cast, prosthesis, or orthosis management
    - Urinary or bowel toileting program
    - Skilled restorative nursing program[C](2)
  - Pain management for infusion of pain medications
- Therapy services (PT, OT, or SLP) needed for **1 or more** of the following(2):
  - Rehabilitation therapy treatments needed for **1 or more** of the following:
    - Ongoing assessment of rehabilitation needs and potential (eg, range of motion, strength, balance)
    - Supervision of therapeutic exercises or activities to ensure patient safety and treatment effectiveness
    - Gait evaluation and training
    - Therapy modalities that require PT or OT observation to evaluate response
    - Restoration of speech or swallowing with services of speech-language pathologist
    - Prosthesis evaluation and training
  - Maintenance therapy treatments needed for **ALL** of the following[D]:
    - Maintain the patient's current condition or prevent or slow further deterioration.
    - Supervision of therapeutic exercises or activities to ensure patient safety and treatment effectiveness

Alternative Levels of Care

- Patient may be candidate for other levels of care, including:
  - Home care. For admission criteria, see:
    - Medical Admission Home Care GRG HC

- Surgical Admission Home Care GRG HC
- Geriatric Admission Home Care GRG HC

Evaluation and Treatment

General Treatment Course

Stage	Clinical Status	Interventions
1	• **Clinical indications for admission met** • Recovery facility comprehensive assessment and initial evaluation complete[E] **QM**(15) • Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment SR complete for evaluation of current level of functioning (eg, Activities of Daily Living (ADL) Scoring Tool Calculator) **QM** • Psychosocial Assessment SR complete **QM** • Social determinants of health screening complete. See Social Determinants of Health Screening Tool SR for further information. **QM** • Medication reconciliation complete. See Medication Reconciliation Tool SR for further information. **QM**(16)(17) • Hospital readmission risk factor evaluation **QM** (18) • Rehabilitation or maintenance therapy program initiated with service frequency at patient's maximum participation level without compromising safety or exceeding ability or tolerance[F](2) • Skilled needs identified	• Transition of care planning initiated with evaluation for next level of care **QM** • Interdisciplinary care plan established and implemented **QM** • Amputation management • Behavior management • Chemotherapy(19) • Chronic condition management as indicated(20) • Cognitive management techniques • Daily weights • Device monitoring • Dialysis coordination(21) • Drain management • DVT prophylaxis • Education for self-care **QM** (22) • Fall risk management **QM** • Fluid and electrolyte management • Glucose management(23) • IV infusion (eg, fluids, antibiotics, parenteral nutrition)(24) • Laboratory testing or monitoring, if ordered(25) • Medication management **QM** • Nutrition management(10) • Ostomy management • Pain management[G] **QM**(27) • Pressure injury risk management **QM** (28) • Psychosocial issues identified and management initiated as needed **QM** • Radiation therapy • Respiratory care[H]

		• Skin and cast or immobilizer care • Suicide risk management • Thromboprophylaxis **QM** • Tracheostomy management • Transfusions as indicated • Wound or dressing management(11) • Physical therapy (PT) referral and evaluation • Occupational therapy (OT) referral and evaluation • Speech-language pathology (SLP) referral and evaluation
2	• **Therapeutic response to interventions QM** • **Rehabilitation or maintenance therapy program established and patient participating as able with evaluation of current level of functioning (eg, Activities of Daily Living (ADL) Scoring Tool Calculator)[F] QM(2)** • **Physical therapy (PT) progression** • **Occupational therapy (OT) progression** • **Speech-language pathology (SLP) progression**	• Care plan continues. • Ongoing assessment of clinical needs • Transition of care planning continues with evaluation for next level of care. **QM** • Education continues. **QM**
3	• **Behavioral health status stable for patient's condition and manageable at lower level of care** • **Inserted or implanted device discontinued, or functioning normally and manageable at lower level of care** • Medical equipment and supplies available at next level of care, and safe use demonstrated • **Medical status stable for patient's condition and manageable at lower level of care** • **Medication regimen established and reconciliation completed QM** • Outpatient center care coordinated and can be independently managed by patient/caregiver • **Rehabilitation or maintenance therapy program completed for safe transfer to lower level of care, or patient no longer demonstrating significant functional gains (eg, Activities of Daily Living (ADL) Scoring Tool Calculator)[F](2)** • **Skilled services (as needed) and logistical requirements can be met at lower level of care.** • **Transition plans and education understood** • **Wound(s) or dressing changes manageable at lower level of care**	• **Transition of care planning completed QM** • Safe to go home and transition to community or transition to alternative level of care (eg, home care) **QM**

Recovery Milestones are indicated in **bold**.

Patient Education

- Patient education for geriatric conditions may include:
  - Medication
    - Special instructions based on underlying condition (eg, antibiotics, anticoagulants)
  - Nutrition(29)
    - Nutritional food label reading information includes(30)(31):
      - Percent of daily values is usually based on a 2000-calorie (8374-kJ) diet.
      - Nutrition information is listed per serving, not per total contents of package.
        - Packages may contain more than 1 serving.
        - Two servings double the amount of nutrients, including calories, fat, and sodium.
        - Size of serving varies from product to product.
      - Form of food has impact on nutrition (eg, increased sugar content of orange juice vs one orange).
    - Wound healing diet recommendations include(31)(32):
      - Eat 25 to 45 kcal/kg (105 to 188 kJ/kg) per day, adjusted based on wound severity, nutritional status, and catabolic stress.
      - Consume sufficient amount of Protein to promote healing (generally 1.0 to 1.5 grams of protein/kg body weight per day).
      - Eat foods rich in Vitamin A, Vitamin B-complex, Vitamin C, and Zinc.
      - Add supplements of vitamin A, B-complex, vitamin C, and zinc to improve tissue healing if diet inadequate.
    - Address nutritional needs specific to condition.
    - Possible caloric reduction related to decreased caloric needs (eg, less activity, slower metabolism)
    - Address fluid requirements based on specific condition.
  - Activity level(20)
    - Base exercise counseling on patient's functional abilities, treatments, or underlying condition.
    - Educate patient on restrictions related to health condition.
    - Driving considerations for the elderly include(33):
      - Complete medication assessment for drugs that could impair driving ability (eg, drowsiness).
      - Regular assessments to determine driving fitness
      - Consider driver functional assessment and OT rehabilitation program, if available.[I]
      - Instruct patient(35):
        - Use hearing aids or glasses while driving, if needed.[J]
        - Have additional driver in car to assist with navigation or to take over if necessary.(34)
        - Drive only to familiar places.
        - Obtain conditional licensing as required.
        - Avoid driving:
          - While any medical or behavioral health condition symptoms are active (eg, dizziness, confusion)
          - Alone
          - Long distances
          - In poor visual conditions (eg, nighttime, rain)
          - On high-traffic roads, freeways, and rush-hour traffic whenever possible
          - With distractions (eg, radio, mobile phone)
  - Self-management
    - Condition management(20)(36)
      - Determine knowledge base, pertinent factors in providing education, and develop plan of care that is realistic for patient's abilities, desires, and resources.

- Condition education includes(22)(37):
  - Specific information about condition (eg, diagnosis, procedure)
  - Anatomy and functional impact
  - Signs and symptoms of complications
  - Whom and how to contact for questions or if complications occur
  - Health promotion or self-management activities
- Bladder and bowel management
  - Address urinary incontinence, if appropriate.
  - Assess need for bowel or bladder program.
  - Provide care and education for ostomies or catheters, if present.
- Cardiac/circulatory system management
  - Blood pressure monitoring, as needed
  - Cardiac status assessment, as needed
  - Lymphedema education and management
- Central nervous system management
  - Delirium monitoring and management, as needed
- Gastrointestinal management
  - Gastrointestinal status assessment, as needed
  - Address diarrhea or constipation.
- Hygiene management
- Immunosuppression management
- Infusion management
- Musculoskeletal management
  - Provide care and education for immobilizers, orthoses, or prostheses, as needed.
  - Provide education on hip precautions, as needed.
  - Provide care and education on contracture prevention.
  - Provide caregiver education on ADL support.
- Pain management
- Prevention strategies
  - DVT prevention
  - Compression stocking use and care
  - Fall prevention
  - Infection prevention
- Respiratory management
  - Monitor and provide education on use of needed respiratory equipment (eg, spirometer, inhaler).
  - Smoking cessation information includes(38)(39):
    - Benefits of quitting
    - Counseling and plan development; considerations include[K](41):
      - Willingness to quit and encouraging caregivers to quit
      - Education and formal cessation programs
      - Behavior modification
      - Medication or nicotine replacement, as appropriate(42)

- Stress management
- Exercise program
- Identification of support group
- Relapse prevention

- Safety management
  - Provide education on visual impairment.
  - Provide education on hazard avoidance (eg, emergency plan, smoke detectors, temperature detectors).
- Skin integrity management
- Weight management
- Vital sign management
- Wound and dressing management

- Provide education on complications to report to provider based on treatments or underlying condition.

− Rehabilitation
- Rehabilitation techniques and training(43)

− Treatment and follow-up care

− Importance of(44)(45):
- Keeping all follow-up appointments
- Adherence to self-management plan and consequences of nonadherence
- Seeking help for potential barriers that may prevent adherence to prescribed treatment plan
- Keeping providers informed of changes in physical condition
- Coordinate or facilitate communication regarding care plan with all appropriate care providers.

- Follow-up care may include:
  - Cardiac rehabilitation program
  - Central dual-energy x-ray absorptiometry (DXA) every 2 years for osteoporosis monitoring, if indicated(46)
  - Outpatient therapy (eg, radiation, infusion, chemotherapy)
  - Pain management
  - Participation in chronic condition management program
  - Participation in rehabilitation program
  - Patient-centered medical home (PCMH)(47)
  - Pulmonary rehabilitation program
  - Social services

− Other learning needs
- Advance care planning, as indicated
- Emergency planning, as indicated
- Recovery expectations
- Psychosocial management

− Resources
- Internet sources include:
  - Information for Senior Citizens. U.S. Government Services and Information: www.usa.gov

  − Assistance programs to help finance prescription drug costs such as www.needymeds.org, https://medicineassistancetool.org, www.medicare.gov/drug-coverage-part-d, or individual pharmaceutical company websites

  − MedlinePlus, a service of the U.S. National Library of Medicine and National Institutes of Health: www.medlineplus.gov

- Smokefree. National Institutes of Health: www.smokefree.gov
- Related guidelines include:
  - Antibiotic Management SR
  - Bladder Management SR
  - Blood Sugar Management SR
  - Caregiver Support SR
  - Constipation Management SR
  - Dysphagia Management SR
  - Enteral Nutrition Management SR
  - General Nutrition SR
  - Hygiene Management SR
  - Intravenous (IV) Infusion Management SR
  - Lifestyle Change Management SR
  - Medication Management SR
  - Ostomy Management SR
  - Oxygen Management SR
  - Pressure Injury Prevention and Management SR
  - Quality-of-Life Management SR
  - Safety, Preventive, and Routine Care SR
  - Seizure Management SR.
  - Transition Planning SR
  - Urinary Catheter Management SR

Discharge Planning

- Transition of care planning may include(13):
  - Assessment and early establishment of anticipated discharge destination and plans for care, including(3):
    - Treatment plan development involving multiple providers
    - Premorbid functioning
    - Patient and caregiver preferences and abilities
    - Evaluation for skilled services at next level of care as appropriate for patient's continued needs
    - Psychosocial status. See Psychosocial Assessment SR for further information. **QM**(48)
    - Social determinants of health screening. See Social Determinants of Health Screening Tool SR for further information. **QM**(49)
    - Acceptance for care for patient at next level of care, as appropriate.
  - Transition of care plan complete, which may include:

- Patient and caregiver education complete. See Teach-Back Tool SR for further information.
- Medication reconciliation completion includes **QM** (50)(51):
  - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
  - Assess each medication for correlation to disease state or medical condition.
  - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
  - Provide reconciled medication list to all treating providers.
  - Confirm that patient or caregiver can acquire medication.
  - Educate patient and caregiver.
    - Provide complete medication list to patient and caregiver.
    - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
    - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(6)(52)
  - Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
  - See Medication Reconciliation Tool SR for further information.
- Appointments planned or scheduled
- Referrals made for assistance and support
- Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), as indicated(53)
- Transition plan communicated to all members of patient's care team **QM**

Quality Measures

- HEDIS® Measures include(54):
  - Medication reconciliation is completed.
  - Transition of care needs are assessed and addressed.
  - Psychosocial status (eg, depression screening) is assessed and addressed.
  - Fall risk is assessed and addressed.
  - Immunization status is assessed and addressed.
  - Readmission risk is assessed and addressed.
  - Social needs screening and intervention is completed.
- Nursing Home Compare Quality Measures include(55):
  - ADL status is assessed for improvement.
  - Readmission risk is assessed and addressed.
  - Antipsychotic medication use is assessed.
  - Immunization status is assessed and addressed.
  - Pressure injury risk is assessed and addressed.
  - Medication reconciliation is completed.
  - Discharge to the community is completed.
- Skilled Nursing Facility Quality Reporting Program measures include(56):
  - Pressure injury risk is assessed and addressed.
  - Medication reconciliation is completed.
  - Readmission risk is assessed and addressed.

  - Transfer of health information to patient and provider is completed.
  - ADL status is assessed for improvement.
  - Immunization status is assessed and addressed.
  - Discharge to the community is completed.
  - Healthcare-associated infection risk is reduced.
- Skilled Nursing Facility Value-Based Purchasing Program quality measures include(57):
  - Readmission risk is assessed and addressed.
  - Healthcare-associated infection risk is reduced.
- The Joint Commission Nursing Care Center National Patient Safety Goals include(58):
  - Medication reconciliation is completed. Education is provided on medication administration including the importance of bringing up-to-date medication lists to all provider visits.
  - Healthcare-associated infection risk is reduced.
  - Fall risk is assessed and addressed.
  - Pressure injury risk is assessed and addressed.
  - Blood thinning medication-associated risk is reduced.

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 2 published peer reviewed articles and 8 book sections.

Rationale

Use of this MCG care guideline helps the clinician identify patients who, by virtue of their nursing, medical management, and rehabilitation needs, require post-acute care to either improve their current level of functioning or prevent or slow the deterioration of their condition.

Use of these evidence-based clinical criteria benefits the patient by complementing existing CMS regulations and expanding examples of services that meet CMS' definition of a skilled nursing service and/or skilled rehabilitation service. This evidence-based guidance ensures that Medicare and Medicare Advantage patients receive full access to Medicare benefits without risk of delay or decreased access. Additional evidence-based guidance benefits the patient by allowing for continued documentation of the need for skilled services, outlining complicating factors (eg, pain exacerbations, infection, comorbid disease exacerbation) that could extend recovery facility care stays, and providing criteria for transitioning a patient to the next appropriate level of care (eg, acute care, home care). This support can increase consistency in treatment thresholds, leading to less variation in care and promoting equitable treatment among patients.

Related CMS Coverage Guidance

This guideline supplements but does not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Code of Federal Regulations (CFR): 42 CFR 409.32(7); 42 CFR 409.33(5); 42 CFR 409.35(59); 42 CFR 409.44(8); 42 CFR 410.38(53)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance(2); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6 - Medical Review of Inpatient Hospital Claims for Part A(60)

Medicare Coverage Determinations: Medicare Coverage Database(61)

Other CMS Guidance: Centers for Medicare and Medicaid Services, "Long-term care facility resident assessment instrument 3.0 user's manual" version 1.20.1v4 2025(15)

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Footnotes

[A] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) may require specific considerations for admission to this level of care, which may include an inpatient hospital stay for a medically necessary condition of at least 3 consecutive calendar days, excluding the day of discharge or time spent in observation. Specific considerations are outlined in the CMS document: Medicare Benefit Policy Manual, Chapter 8.(2) [A in Context Link 1]

[B] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) defines reasonable and necessary skilled care as a service that is "so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical personnel" based on the documented assessment of the patient's individual care needs. In some cases, a service that would originally be considered unskilled may be considered skilled if the patient's underlying conditions or complications require the involvement of licensed personnel to ensure that essential nonskilled care is achieving its purpose.(7)(8) [B in Context Link 1]

[C] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) specifies that skilled restorative nursing services are intended to positively affect the patient's functional well-being, with the expectation that the program be rendered at least 6 days a week. When a patient's skilled status is based on a restorative program, medical evidence must be documented to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.(2) [C in Context Link 1]

[D] **National guidelines:** According to the Centers for Medicare and Medicaid Services (CMS), a maintenance therapy program helps to maintain the patient's current condition or to prevent or slow further deterioration. CMS specifies that skilled therapy services are necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered nonskilled, or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.(2) [D in Context Link 1]

[E] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) uses a data collection system to establish best practice, understand costs, and identify cost-effective systems and procedures. The current data collection system for eligible patients is the Minimum Data Set (MDS). MDS is an assessment tool used to identify patient problems, strengths, and preferences. The MDS used to create an individualized care plan can be found at www.cms.gov by searching Minimum Data Set.(15) [E in Context Link 1]

[F] **National guidelines:** According to the Centers for Medicare and Medicaid Services (CMS), a maintenance therapy program helps to maintain the patient's current condition or to prevent or slow further deterioration.(2) [F in Context Link 1, 2, 3]

[G] Naloxone rescue training and education about overdoses should be offered to the patient and family/caregiver as indicated.(26) [G in Context Link 1]

[H] Respiratory care services may be provided by a qualified professional (eg, respiratory therapist or nursing staff) in accordance with state laws.(2) [H in Context Link 1]

[I] Many driver rehabilitation programs provide therapy and behind-the-wheel assessments. Therapy assessment covers motor, cognitive, perception, and reaction times. The behind-the-wheel assessment covers fitness to drive.(34) [I in Context Link 1]

[J] Some states require routine vision screening for geriatrics. [J in Context Link 1]

[K] **Specialty society:** The American College of Cardiology (ACC) supports combining pharmacotherapy with behavioral/psychosocial interventions to help smokers sustain abstinence.(40) [K in Context Link 1]

Definitions

Custodial care

- Custodial care is personal unskilled care to support the patient's care of activities of daily living (ADL), such as bathing, dressing, and eating.(1)

References

1. Mauk KL. Post-acute care. In: Larsen PD, editor. Lubkin's Chronic Illness: Impact and Intervention. 11th ed. Jones & Bartlett Learning; 2022:477-520.

Green leafy vegetables

- Green leafy vegetables include broccoli, cabbage, spinach, and greens (turnip or mustard).(1)

References

1. Dietary Guidelines for Americans, 2020-2025. 9th ed [Internet] U.S. Department of Agriculture and U.S. Department of Health and Human Services. 2020 Dec Accessed at: https://www.dietaryguidelines.gov/. [accessed 2025 Sep 17]

Intense and complex care needs

- Intense and complex care needs require assessment of the patient's clinical needs, ability, and tolerance for treatment, with an evaluation of logistical requirements of needed services. Care must support positive outcomes and safe transition to the next level of care.(1) Logistical requirements of needed services is the ability to coordinate and transfer the patient from various care settings. Logistical requirements may increase the complexity of the patient's care; for example, conditions requiring extensive assistance (eg, body cast, burns, being bedbound) may create an excessive physical hardship or safety concern for the patient to receive needed care on an outpatient basis. Consideration must be given to the patient's condition, what is the most effective care, and to the availability and feasibility of using more economical alternative facilities and services (eg, daily transportation by ambulance to a facility vs inpatient care).(2)

References

1. Shyu SG, Liang HW. The physiatric history and physical examination. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:3-16.
2. Centers for Medicare and Medicaid Services. "Criteria for 'practical matter'." 42 CFR Pt. 409.35 Washington, DC 2023 Oct [accessed 2025 Jul 22] Accessed at: https://www.ecfr.gov/.

Occupational therapy (OT) progression

- OT progression includes **ALL** of the following(1)(2):
  - Ongoing evaluation of treatment plan with measurable short-term and long-term goals
  - Documentation of effectiveness and efficiency toward achieving established goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Objective measurements document progress toward goals in reasonable and predictable time frame based on treatment plan.[A](4)

- Minimal progress due to unexpected clinical event, but progress expected to resume toward goals as condition improves

References

1. Bennett K. Setting rehabilitation goals. In: O'Hanlon S, Smith M, editors. Comprehensive Guide to Rehabilitation of the Older Patient. 4th ed. Elsevier; 2021:49-52.
2. Pryor J, O'Reilly K, Bonser M, Garret G, McKenchnie D. Rehabilitation for the individual and family. In: Chang E, Johnson A, editors. Living With Chronic Illness and Disability. 4th ed. Chatswood NSW 2067: Elsevier; 2022:161-182.
3. Carter WE III, Peretiatko S. Quality and outcome measures for medical rehabilitation. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:55-62.
4. Kee YYK. Measuring progress with rehabilitation. In: O'Hanlon S, Smith M, editors. Comprehensive Guide to Rehabilitation of the Older Patient. 4th ed. Elsevier; 2021:111-115.

Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, increased ROM/strength, increased balance scores, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, Continuity Assessment Record and Evaluation (CARE), WeeFIM®, Tinetti, Berg Balance Scale).(3)(4) Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.

Pain management for infusion of pain medications

- **Evidence:** The use of structured protocols and guidelines are required for the use of IV pain medication infusions, such as dosage check by 2 clinicians, close nurse monitoring (eg, hourly), and management of significant side effects (eg, respiratory depression). These protocols may make providing this care more safe and practical in a skilled care setting.(1)

References

1. Snyder JS, Sump CA. Pain. In: Snyder JS, Sump CA, editors. Swearingen's All-in-One Nursing Care Planning Resource. 6th ed. Elsevier; 2024:47-52.

Physical therapy (PT) progression

- PT progression includes **ALL** of the following(1)(2)(3)(4):
  - Ongoing evaluation of treatment plan with measurable short-term and long-term goals
  - Documentation of effectiveness and efficiency toward achieving established goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Objective measurements document progress toward goals in reasonable and predictable time frame based on treatment plan.[A]
    - Minimal progress due to unexpected clinical event, but progress expected to resume toward goals as condition improves

References

1. Centers for Medicare and Medicaid Services. "Skilled services requirements." 42 CFR Pt. 409.44 Washington, DC 2023 Oct 02 [accessed 2025 Jul 23] Accessed at: https://www.ecfr.gov/.

2. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Rev. 12283 [Internet] Centers for Medicare and Medicaid Services. 2023 Oct 05 Accessed at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/. [accessed 2025 Sep 09]
3. Hussein N. Acute medical conditions. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:253-264.
4. Carter WE III, Peretiatko S. Quality and outcome measures for medical rehabilitation. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:55-62.
5. Scalzitti DA. Examination of function. In: Fulk G, Chui K, editors. O'Sullivan & Schmitz's Physical Rehabilitation. 8th ed. USA: F.A. Davis Company; 2024:270-291.

Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, increased ROM/strength, increased balance scores, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, Continuity Assessment Record and Evaluation (CARE), WeeFIM®, Tinetti, Berg Balance Scale). Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.(4)(5)

Protein

- Protein can be found in fish, poultry, meat, peanut butter, beans, nuts, tofu, cottage cheese, eggs, and yogurt.(1)(2)

References

1. Dietary Guidelines for Americans, 2020-2025. 9th ed [Internet] U.S. Department of Agriculture and U.S. Department of Health and Human Services. 2020 Dec Accessed at: https://www.dietaryguidelines.gov/. [accessed 2025 Sep 17]
2. Basic nutrition principles, nutrients, and dietary supplements: appendix A. In: Escott-Stump S, editor. Nutrition and Diagnosis-Related Care. 9th ed. Wolters Kluwer; 2022:1190-1232.

Safe to go home

- Patient safe to go home if **ALL** of the following exist(1)(2)(3):
  - Medical condition manageable at home
  - Functional status manageable at home
  - Mental status stable for patient's condition
  - Medication availability confirmed and reconciliation complete
  - Patient/caregiver education complete and written discharge instructions provided
  - Caregiver and community resources identified (as needed)
  - Community resources identified and referrals made, as needed
  - Home care arranged, if indicated
  - Necessary medical equipment delivery arranged or available in home, if indicated
  - Necessary medical supplies ordered, or patient/caregiver can obtain, if indicated

References

1. Elements of Excellence in Transitions of Care (TOC). TOC Checklist [Internet] National Transitions of Care Coalition. 2006 Accessed at: https://www.ntocc.org. [accessed 2025 Sep 16]
2. Medical-surgical nursing. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:33-55.
3. Admitting, transfer, and discharge. In: Perry AG, Potter PA, Ostendorf WR, Laplante N, editors. Clinical Nursing Skills and Techniques. 11th ed. Elsevier; 2025:40-51.

Skilled care

- Skilled care may be direct (eg, in-person assessment and administration of treatments) or indirect (eg, coordinating care between providers, supervising care aides); examples include(1)(2)(3)(4):
  - Performed or supervised by professional or technical personnel
  - Exceed scope of Custodial care
  - Service is considered skilled as indicated by either of the following:
    - Service that is "so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical personnel" based on the documented assessment of the patient's individual care needs.
    - Service that would originally be considered unskilled may be considered skilled if the patient's underlying conditions or complications require the involvement of licensed personnel to ensure that essential nonskilled care is achieving its purpose.

References

1. Centers for Medicare and Medicaid Services. "Criteria for skilled services and the need for skilled service." 42 CFR Pt. 409.32 Washington, DC 2023 Oct 02 [accessed 2025 Jul 22] Accessed at: https://www.ecfr.gov/.
2. Harding MM. Professional nursing. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:1-18.
3. Medical-surgical nursing. In: Hinkle JL, Cheever KH, Overbaugh KJ, editors. Brunner & Suddarth's Textbook of Medical-Surgical Nursing. 15th ed. Wolters Kluwer; 2022:33-55.
4. Centers for Medicare and Medicaid Services. Medicare Program Integrity Manual. Chapter 6 - Medical Review of Inpatient Hospital Claims for Part A Payment Rev. 10365 [Internet] Centers for Medicare and Medicaid Services. 2020 Oct 02 Accessed at: https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms. [accessed 2025 Sep 09]

Speech-language pathology (SLP) progression

- SLP progression includes **ALL** of the following(1)(2)(3)(4):
  - Ongoing evaluation of treatment plan with measurable short-term and long-term goals
  - Documentation of effectiveness and efficiency toward achieving established goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Objective measurements document progress toward goals in reasonable and predictable time frame based on treatment plan.[A](5)
    - Minimal progress due to unexpected clinical event, but progress expected to resume toward goals as condition improves

References

1. The essential ingredients of good therapy: basic skills. In: Roth FP, Worthington CK, editors. Treatment Resource Manual for Speech-Language Pathology. 7th ed. San Diego, CA: Plural Publishing, Inc; 2025:16-38.

2. Shyu SG, Liang HW. The physiatric history and physical examination. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:3-16.
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4. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Rev. 12283 [Internet] Centers for Medicare and Medicaid Services. 2023 Oct 05 Accessed at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/. [accessed 2025 Sep 09]
5. Carter WE III, Peretiatko S. Quality and outcome measures for medical rehabilitation. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:55-62.
6. National Outcomes Measurement System (NOMS). [Internet] American Speech-Language-Hearing Association. Accessed at: https://www.asha.org/noms/. Updated 2025 [accessed 2025 Feb 11]

Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, Continuity Assessment Record and Evaluation (CARE), WeeFIM®, National Outcomes Measurement System (NOMS)). Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.(1)(5)(6)

Therapy modalities

- Therapy modalities include(1)(2):
  - Cryotherapy
  - Electrical stimulation
  - Hot pack, hydrocollator, infrared treatments
  - Paraffin and whirlpool baths
  - Thermotherapy
  - Ultrasound, short-wave, and microwave therapy

References

1. Centers for Medicare and Medicaid Services. "Examples of skilled nursing and rehabilitation services." 42 CFR Pt. 409.33 Washington, DC 2023 Oct [accessed 2025 Jul 22] Accessed at: https://www.ecfr.gov/.
2. Wu CH. Physical agent modalities. In: Cifu DX, Lew HL, editors. Braddom's Rehabilitation Care: A Clinical Handbook. 2nd ed. Elsevier; 2025:165-172.

Transition of care planning completed

- Transition of care planning completed, including **ALL** of the following(1)(2):
  - Transition plan communicated to all members of patient's healthcare team
  - Summary of care, discharge list of medications, and transition plan communicated to primary care provider
  - Medication reconciliation complete
  - Education on condition management and complications to report provided to patient or caregiver[A]

- Follow-up appointments scheduled
- Referrals to continue medical and rehabilitation goals (eg, outpatient) arranged, if needed
- Services (eg, equipment, environment modifications, transportation) arranged, if needed
- Psychosocial issues addressed, or plan for management, if needed

References

1. Standards of Practice for Case Management. [Internet] Case Management Society of America. 2024 Oct Accessed at: https://www.cmsa.org/. [created 2022; accessed 2025 Sep 09]
2. Transitions of Care Standards. A New Way Forward [Internet] American Case Management Association. Accessed at: https://www.acmaweb.org/. [accessed 2025 Sep 05]
3. Myers CR. Health equity and population vulnerability. In: Stanhope M, Lancaster J, Hoffman JE, Levin PF, Turner L, editors. Public Health Nursing: Population-Centered Health Care in the Community. 11th ed. Elsevier; 2025:127a-145.

Footnotes

A. Health education materials should be given in patient's and caregiver's native language using trained language interpreters whenever possible.(3)

Vitamin A

- Vitamin A can be found in beef, organ meats (eg, liver, giblets), Green leafy vegetables, carrots, sweet potatoes, and dairy products.(1)(2)

References

1. Vitamins. In: Grodner M, Escott-Stump S, Dorner S, editors. Nutritional Foundations and Clinical Applications. 8th ed. Elsevier; 2023:104-125.
2. Basic nutrition principles, nutrients, and dietary supplements: appendix A. In: Escott-Stump S, editor. Nutrition and Diagnosis-Related Care. 9th ed. Wolters Kluwer; 2022:1190-1232.

Vitamin B-complex

- Vitamin B-complex can be found in legumes, whole grains, chicken, pork, fish, potatoes, and bananas.(1)

References

1. Basic nutrition principles, nutrients, and dietary supplements: appendix A. In: Escott-Stump S, editor. Nutrition and Diagnosis-Related Care. 9th ed. Wolters Kluwer; 2022:1190-1232.

Vitamin C

- Vitamin C can be found in citrus fruits and juices, berries, tomatoes, baked potatoes, and Green leafy vegetables.(1)(2)

References

1. Nutritional facts on vitamin C. In: Raymond JL, Morrow K, editors. Krause and Mahan's Food and the Nutrition Care Process. 16th ed. Elsevier; 2023:1176-1177.
2. Basic nutrition principles, nutrients, and dietary supplements: appendix A. In: Escott-Stump S, editor. Nutrition and Diagnosis-Related Care. 9th ed. Wolters Kluwer; 2022:1190-1232.

Zinc

- Zinc can be found in whole grains (eg, oatmeal, bran), lean red meat, skinless poultry, seafood, beans, cashews, and yogurt.(1)(2)

References

1. Nutritional facts on zinc. In: Raymond JL, Morrow K, editors. Krause and Mahan's Food and the Nutrition Care Process. 16th ed. Elsevier; 2023:1200-1202.
2. Basic nutrition principles, nutrients, and dietary supplements: appendix A. In: Escott-Stump S, editor. Nutrition and Diagnosis-Related Care. 9th ed. Wolters Kluwer; 2022:1190-1232.

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