After Discharge from Mass General - Inpatient Rehab? Home?

Before surgery, your surgical team will begin a discussion about your discharge needs and the level of postop care you may require. Case Management (a team of nurses specializing in discharge planning) may contact you to discuss this.

The levels of postop care (pictured below) are based on a patient's **medical/ surgical needs** AND **insurance coverage**. Your discharge plan will be dependent upon your needs after surgery, the interdisciplinary team assessment (surgeon, therapist, other specialists and case manager) and insurance approval.

Evaluation of your post-acute level of care means: Does your condition qualify for an inpatient long-term or acute rehab facility with specialized hospital level care and intense rehab? Or do you qualify for less acute nursing care allowing transfer to a skilled nursing facility (SNF) for PT/OT services? Or are you medically stable enough to be discharged home in our home hospital program, or with VNA services or even independent/safe enough for no services?

Health care has changed immensely over the years. All facilities are challenged with staff shortages and capacity issues. Length of stay has decreased, and inpatient rehab placement totally depends on your postop level of care needs and insurance coverage - *no longer the preference of you or your surgical team.*

Long Term Acute Care Facility (LTAC)

For patients with complex medical problems and rehab needs that require highly skilled MDs, nurses and other providers (e.g. wound care, dialysis, heart monitoring, chemo, therapies).

Average: LOS: > 25 days

Inpatient Rehab Facility (IRF)

For patients requiring specialized hospital-level care and intense rehab, recovering from serious illness, surgery or injury (e.g. stroke, spinal cord injury, brain injury).

Average LOS: 12-16 days

Skilled Nursing Facility (SNF)

For patients requiring moderate medical care, lower intensity rehab and nursing care (e.g. recovering from hip or knee replacement without other complicating conditions).

Average LOS: 10-20 days

Home Hospital Program

Eligible patients receive traditional hospital care in the comfort of their home. These patients recieve 24/7 remote vital sign monitoring, visits from clinicians each day regarding their disease treatment. With the use of telehealth technology, the team is available around the clock.

Home Care/VNA

For patients who require minimal medical care and can independently function to safely return to their home but require ongoing nursing and therapy.

Average of 10-15 visits (or per insurance coverage) for medically complex patients

Outpatient Care

For patients who are not homebound but require ongoing therapy. Transportation must be available and accessible.

Number and types of appts are based on patient's progression and insurace coverage.

Hospice Care: Patient Home or Hospice Facility

For patients with terminal illness, usually with a life expectancy of less than 6 months (federal law). May go home or to a hospice care facility.

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