BRIDGEPOINT+

Understanding Your Loved One's Rehabilitation

LTACH vs. Skilled Nursing Facility (SNF): A Family Guide to OT, PT & SLP

When a loved one is discharged from the hospital, they may continue their recovery in either a Long-Term Acute Care Hospital (LTACH) or a Skilled Nursing Facility (SNF). Both settings offer Occupational Therapy (OT), Physical Therapy (PT), and Speech-Language Pathology (SLP) but the intensity, goals, and approach can look very different. This handout will help you understand what to expect.

In both settings you can typically expect that your loved one will be evaluated by therapy within the first 24-72 hours after admission. Timing of evaluation can depend on several factors including time of admission, day of the week (weekday vs weekend) and staffing. Frequency and duration of therapy sessions depend on multiple factors including clinical complexity, medical stability and your loved ones ability to participate.

Any questions on when or how often a loved one will be seen by therapy please reach out to your care team.

What Are These Settings?

LTACH

Long-Term Acute Care Hospital

An LTACH is a hospital, not a nursing home. It is licensed and staffed to care for patients who are medically complex but need a longer time to stabilize.

Typical patients include those recovering from:

- Ventilator dependence / respiratory failure
- Sepsis or multi-organ failure
- Complex wounds or post-surgical complications
- Neurological events (stroke, TBI) with significant medical needs

SNF

Skilled Nursing Facility

An SNF is a licensed post-acute care facility that provides skilled nursing and therapy services. Patients are medically stable but still require professional rehabilitation before returning home.

Typical patients include those recovering from:

- Hip or knee replacement surgery
- Heart failure or pneumonia
- Mild stroke or other neurological events
- Falls or fractures requiring rehab

LTACH vs. SNF: At-a-Glance Comparison

Feature	LTACH	SNF (Skilled Nursing Facility)
Full Name	Long-Term Acute Care Hospital	Skilled Nursing Facility
Who It's For	Medically complex patients still needing hospital-level care	Patients stable enough to leave the hospital but not ready for home
Average Stay	Weeks, averaging around 25 days	Weeks to Months
Medical Acuity	High – ongoing acute medical needs and stabilization	Lower – medically stable but requiring skilled care
Physician Visits	Daily physician oversight	Weekly or as-needed physician visits
Therapy Goal	Initiate therapy and early mobility for functional recovery as medically appropriate	Recovery focused with goal of regaining as much independence as possible
OT Focus	Rebuilding basic function post-acute illness/surgery	ADL retraining, home modification planning
PT Focus	Early mobility in medically complex patients	Strength, balance, gait training for return home
SLP Focus	Dysphagia, trach/vent weaning, cognitive-communication	Swallowing, speech, and cognitive support
Insurance	Depends on insurance Medicare Part A (hospital benefit), MCO or commercial plans may require preauthorization	Depends on insurance Medicare Part A (up to 100 days/benefit period- must qualify) MCO or commercial plans may require preauthorization

Rehabilitation Therapies: What Each Discipline Does

	In an LTACH Setting	In an SNF Setting
OT Occupational Therapy	Focuses on rebuilding foundational skills while managing medical complexity: • Bed mobility & safe sitting balance • Basic self-care (grooming, feeding) with equipment • Cognitive screening & attention retraining • Fatigue management for medically fragile patients • Upper extremity strengthening tied to function • Caregiver education early in the process	Focuses on preparing the patient to return home safely: • Dressing, bathing, and personal hygiene training • Kitchen and meal preparation tasks • Home safety assessment & recommendations • Adaptive equipment training (grab bars, reachers, self-care aides, etc.) • Community re-entry and driving readiness • Family training for home discharge

PT Physical Therapy	Early mobility is the priority — safely, even for fragile patients: • Bed-to-chair and chair-to-stand transfers • Sitting & standing tolerance with monitoring • Early walking with close supervision • Respiratory support during exercise • Managing lines, tubes, and equipment during mobility • Preventing deconditioning during extended hospitalization	Progressive strengthening and functional mobility for home discharge: • Gait training (walking on various surfaces, stairs) • Balance and fall prevention programs • Strength and endurance building • Assistive device training (cane, walker, wheelchair) • Transfer training (car, toilet, bed) • Functional goals tied to home environment

SLP Speech-Language Pathology	Addresses complex communication and swallowing needs: • Instrumental swallowing studies (MBSS/FEES) • Tracheostomy management & speaking valve trials • Ventilator weaning communication support • Cognitive-communication for ICU-related deficits • Dysphagia diet modification & feeding strategies • AAC (alternative communication) devices if needed	Supports swallowing safety and communication for daily life: • Instrumental swallowing studies (FEES) available in select SNF facilities Swallowing therapy and diet texture advancement • Oral motor exercises for speech and swallowing • Aphasia treatment (language recovery after stroke) • Memory and cognitive strategy training • Voice and articulation therapy • Family education on communication strategies • AAC (alternative communication) devices (insurance dependent)

Insurance & Coverage: What Families Should Know

LTACH Coverage	SNF Coverage
• Billed under Medicare Part A as a hospital benefit • Separate from SNF benefit, does not use SNF days • Medicare patients require a 3-day qualifying hospital stay • Prior authorization often required by Medicare Advantage and commercial plans	• Medicare Part A uses “Skilled Nursing Days,” requires 3 day inpatient hospital stay. Up to 100 days available per benefit period however must continue to demonstrate skilled need. • Prior authorization often required by Medicare Advantage and other commercial insurances. • Coverage requires continued skilled care need

Speak with facility business office or insurance provider to better understand your particular insurance coverage.

Questions to Ask the Rehabilitation Team

About the Setting & Plan	About Therapy & Discharge
• Why is LTACH (or SNF) recommended for my family member? • What are the short-term and long-term therapy goals? • How will progress be communicated to our family? • How often will the therapy team and doctors meet? • What is the estimated length of stay?	• What will therapy look like on a weekly basis? • How can we as family members support therapy goals? • What milestones need to be met before going home? • What home modifications or equipment might be needed? • Will home health or outpatient therapy be needed after discharge?

Tips for Families During the Rehab Process

- Attend care conferences whenever possible, you are part of the team.
- Ask the therapists to show you exercises or techniques so you can encourage practice.
- Bring familiar items from home (photos, music, favorite clothing) to support morale.
- Keep a notebook of questions and progress observations to share with the team.
- Understand that progress may be gradual, celebrate small victories.
- Ask the case manager about community resources, support groups, and post-discharge planning early.
- Make sure the therapy team knows your loved one's prior level of function and home setup.