

READMISSIONS COLLABORATIVE

COLLABORATING TO REDUCE PREVENTABLE READMISSIONS TO IMPROVE HEALTH OUTCOMES



FHA What to Expect Guides Toolkit

Practical Tools to Help Patients and Families Navigate
Post-Acute Care Options

June 2026

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Introduction

Most patients are not ready to go straight home without any type of support, but many times patients and their families refuse post-acute services primarily because of lack of understanding on how it supports recovery. Working with the Quality Improvement Network/Quality Improvement Organization (QIN/QIO) for the 12th Scope of Work (SOW), FHA partnered with [Alliant Health Solutions](#) to develop tools for Florida hospitals to use in educating patients about their options for post-acute care.

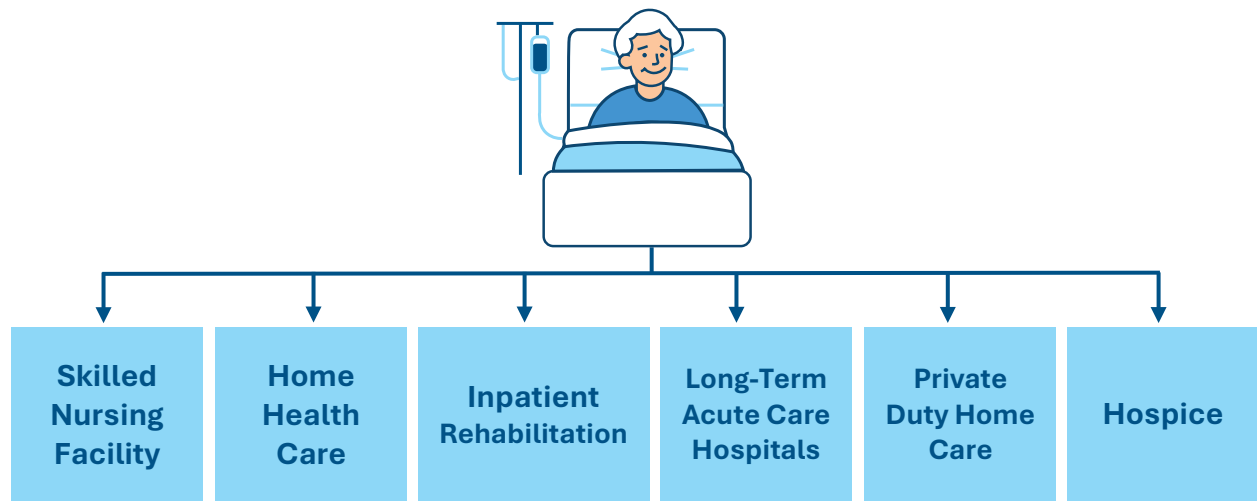
As a case manager or discharge nurse, you play a vital role in ensuring patients experience a safe, informed, and well-coordinated transition from hospital to the next phase of care. Patients and families often face unfamiliar terminology, new care environments, and time sensitive decisions—especially when navigating post-acute care options. Clear, consistent education during the discharge process helps reduce anxiety, improves patient engagement, and supports smoother transitions across settings.

This toolkit was created to support you in that mission. It offers ready-to-use materials designed to help patients and families understand the full range of post-acute care options, including skilled nursing facilities, home health, inpatient rehabilitation, long-term acute care hospitals, private duty home care, and hospice. Each resource provides plain-language explanations of what to expect, typical services offered, and the factors that may influence eligibility or appropriateness. These guides allow patients and their families to understand the services provided by each of the post-acute providers, the benefits associated with that care setting, dispel common myths, provide facts about the care they can expect, answer frequently asked questions, and provide helpful information on safely transitioning to the post-acute setting.

By using this toolkit, you can:

- Strengthening communication with patients and caregivers
- Promote informed decision making and realistic expectations
- Support safe, timely, and patient-centered discharge planning
- Reduce avoidable readmissions by improving understanding of care needs after hospitalization

Post-Acute Care Options



Whether you are introducing options early in the stay or guiding families through decisions at discharge, these tools are designed to help you deliver consistent, compassionate, and effective education. Your expertise and guidance are essential in helping patients continue their recovery with confidence—and this toolkit is here to support you in every step of the way.

What to Expect Guides

- What to Expect from Skilled Nursing Facilities
- What to Expect from Home Health Care Services
- What to Expect from Inpatient Rehabilitation Facilities
- What to Expect from Long-Term Acute Care Hospitals
- What to Expect from Private Duty Home Care Services
- What to Expect from Hospice Care

Who Should Use What to Expect Guides

Anyone who is assisting patients and families through the care continuum should utilize these guides. Examples of role types within healthcare that may find these resources beneficial are:

- Case Managers
- Discharge Coordinators and Planners
- Patient Care Coordinators
- Transition Services
- Primary Care Providers
- Hospitalists
- Nurses
- Social Workers

How to Use What to Expect Guides

These resources are easy to read, tri-fold pamphlets, that should be given to patients and their family members prior to discharge or while discussing discharge options. Reviewing each section of the appropriate guide(s) helps ensure patient and family understanding and allows you to answer questions that may arise. This may also be a great opportunity to utilize the teach-back method to be certain you have answered all questions, eased any hesitations, and educated the patient on the importance of continuing their care as they progress in their healthcare journey.

Results and Outcomes

Using these standardized “What to Expect Guides” can increase the willingness and acceptance of patients and families of post-discharge resources and settings. More successful referrals to the appropriate levels of care can lead to reduced preventable readmissions!

Co-Branding Resources

These resources are free for everyone to use and can be co-branded with your company logo. While you cannot remove any existing logos, you are welcome and encouraged to include your logo with the logos on the back page of the resource.

How the What to Expect Guides were Developed

A focus area under the CMS 12th Scope of Work was to establish community health coalitions to encourage providers to work together to improve care transitions. Alliant Health Solutions, the Quality Improvement Organization for Florida, partnered with FHA to engage Florida communities and to work with key stakeholders to set up local community coalitions to focus together on improving care transitions with the goal of reducing readmissions.

Review of the readmission data by discharge location and learning about challenges faced by the health care providers in the community, the need for tools and education to help patients and their families understand their options for post-acute care and what they can expect from the different post-hospital settings.

FHA and Alliant created multi-stakeholder workgroups to identify the types of questions and information patients needed about the various levels of post-acute care. These workgroups consisted of hospital discharge planners, social workers, SNF, home health, rehabilitation, hospice and private duty agencies to identify what should be included in the “What to Expect Guides”. * The What to Expect from Inpatient Rehabilitation Facilities was developed after the CMS 12th SOW by members of the FHA Rehab Council. The What to Expect from Long-Term Acute Care Hospitals Guide was developed in partnership with Kindred Hospitals Empowered by Scion Health.

Skilled Nursing Facility (SNF) – What to Expect Guide

Recovering after a hospital stay can require continued medical support, therapy, and close monitoring. A Skilled Nursing Facility (SNF) provides short-term, 24-hour nursing care and rehabilitation for patients who are not ready to return home safely. This guide helps patients and families understand what SNF care offers, how daily routines may look, and what services—such as physical, occupational, or speech therapy—they may receive. It also outlines typical expectations around length of stay, care planning, and involvement in the recovery process.

Guide Content:

- Introduction (Page 1)
 - We know that going to a skilled nursing facility can be challenging. We strive to provide you with a home away from home experience during your stay. There are many aspects of care to adjust to during this time. Safety and dignity are the basis for many facility policies and recommendations. This pamphlet will assist you in answering many frequently asked questions and more. We want to ensure you have a pleasant experience and feel comfortable with your transition.
- What to Bring (Page 2)
 - Insurance and ID Cards (including social security)
 - Comfortable clothing and nonskid shoes
 - List of any allergies you have
 - Most other items will be provided by the facility, or they will let you know what else to bring.
- Doctor Visits (Page 2)
 - The facility will assign a physician who will oversee your specific care needs during your stay. You may also see a Nurse Practitioner, Physician Assistant, and/or Clinical Nurse Specialist that works with the facility physician. Depending on your individual needs, the doctor will determine the frequency of visits. Follow up appointments from your hospital stay will be managed by the facility. If you have other appointments, please inform the facility so that they can be rescheduled if necessary.

- Room Assignments (Page 2)
 - You may have a roommate. Most insurances do not pay for a private room, but a private room may be available for an additional charge.
- Medications (Page 2-3)
 - The facility policies for managing your medications will be reviewed with you. It is very important to tell the facility about all of the medications, including over-the-counter medications, supplements, and herbs that you take. Your family may be asked to bring in your medications from home for the facility to review.
- Advance Directives (Page 3)
 - It is important to inform the facility of your advance directive choices, for example, code status, living will, healthcare decision maker, etc. Please bring copies of these items to the facility upon admission
- Paperwork /Consents (Page 3)
 - There will be paperwork for you to complete and sign, which includes facility specific information and Resident Rights. Be prepared to answer questions from multiple staff members. They will be requesting your permission and consent to treat you in the facility. There will also be financial paperwork for you to complete and sign.
- Personal Care (Page 3-4)
 - During your stay, a certified nursing assistant will assist you with your activities of daily living which may include bathing, dressing, toileting, and other services. You will have a regular shower schedule, and your linens will be changed based on that schedule and as needed. Certified Staff will provide your medications, as well as any treatments ordered by your physician. You will have a full body skin assessment upon arrival to the facility so that any issues can be immediately addressed.
- Discharge Goals and Planning (Page 4)
 - Your goals are very important to the facility. The team will work to help you meet those goals. The facility will discuss these goals with both you and your family/caregiver. It is important that you give the team honest and real answers so that they can determine what support, supplies, equipment, and services you will need when you are ready to discharge.

- Individualized Care Plan (Page 4)
 - The management team will be developing a specific plan of care for you. This plan will be tailored to your individual needs and goals during your stay. You and your family will be asked to participate in this plan.
- Meals/Diets (Page 5)
 - The facility will be providing your meals during your stay. Most facilities are able to accommodate special dietary needs and/or restrictions. It is important for you to notify the facility of these needs. The facility may encourage you to eat your meals in their dining area. They may also offer alternative choices to meals.
- Life Enrichment Activities (Page 5)
 - The facility offers an activity program with many opportunities for you to get involved during your stay. These may include bingo, crafts, exercise groups, beauty services, live entertainment, etc. The activity staff will speak with you about your preferences during your stay.
- Laundry (Page 5)
 - The facility will provide laundry services for you unless you prefer otherwise. Your family may elect to do your laundry for you.
- Family Visits (Page 5)
 - Unless restricted, you will be allowed visitors according to the facility policies. Visitation times and the number of visitors at one time may be limited.
- Therapy (Page 5-6)
 - The facility will provide you with therapy services during your stay as directed by your physician up to seven days per week. This may include Physical, Occupational, and/or Speech therapy. You will be evaluated by the therapy staff, and a treatment plan will be initiated that is specific to your individual needs. Your therapy services will begin following the evaluation and creation of your specific plan.

What to Expect from Skilled Nursing Facilities (English / Spanish)



Meals/Diets

The facility will be providing your meals during your stay. Most facilities are able to accommodate special dietary needs and/or restrictions. It is important for you to notify the facility of these needs.

The facility may encourage you to eat your meals in their dining area. They may also offer alternative choices to meals.

Life Enrichment Activities

The facility offers an activity program with many opportunities for you to get involved during your stay. These may include bingo, crafts, exercise groups, beauty services, live entertainment, etc. The activity staff will speak with you about your preferences during your stay.

Laundry

The facility will provide laundry services for you unless you prefer otherwise. Your family may elect to do your laundry for you.

Family Visits

Unless restricted, you will be allowed visitors according to the facility policies. Visitation times and the number of visitors at one time may be limited.

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The facility will provide you with therapy services during your stay as directed by your physician up to seven days per week. This may include

Physical, Occupational, and/or Speech therapy.

You will be evaluated by the therapy staff and a treatment plan will be initiated that is specific to your individual needs.

Your therapy services will begin following the evaluation and creation of your specific plan.



Visit www.medicare.gov for more information on quality star ratings and nursing home comparisons published by Medicare.

This material was prepared by Alliant Health Solutions, a Quality Improvement Network – Quality Improvement Organization (QIN – QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 1250W-AHS-QIN-QIO-TOI-NH-3713-05/06/23

ALLIANT HEALTH SOLUTIONS
QIN-QIO
Quality Improvement Network
Quality Improvement Organization
QUALITY IMPROVEMENT & INNOVATION GROUP
quality.allianthealth.org

What to Expect WHEN GOING TO A SKILLED NURSING FACILITY



We know that going to a skilled nursing facility can be challenging. We strive to provide you with a home away from home experience during your stay.

There are many aspects of care to adjust to during this time. Safety and dignity are the basis for many facility policies and recommendations.

This pamphlet will assist you in answering many frequently asked questions and more.

We want to ensure you have a pleasant experience and feel comfortable with your transition.

What to Bring

- **Insurance and ID cards** (including social security).
- **Comfortable Clothing and nonskid shoes.**
- List of any **allergies** you have.

Most other items will be provided by the facility or they will let you know what else you might need to bring.

Doctor Visits

The facility will assign a physician who will oversee your specific care needs during your stay.

You may also see a Nurse Practitioner, Physician Assistant, and/or Clinical Nurse Specialist that works with the facility physician. Depending on your individual needs, the doctor will determine the frequency of visits.

Follow up appointments from your hospital stay will be managed by the facility. If you have other appointments, please inform the facility so that they can be rescheduled, if necessary.

Room Assignment

You may have a roommate. Most insurances do not pay for a private room, but a private room may be available for an additional charge.

Medications

The facility policies for managing your medications will be reviewed with you. It is very **important** to tell the facility about all of the medications, including



over-the-counter medications, supplements, and herbs that you take. Your family may be asked to bring in your medications from home for the facility to review.

Advanced Directives

It is important to inform the facility of your **advance directive choices**, for example; code status, living will, healthcare decision maker, etc. Please bring copies of these items to the facility upon **admission**.

Paperwork/Consents

There will be paperwork for you to **complete and sign**, which includes facility specific information and Resident Rights. Be prepared to **answer questions** from multiple staff members. They will be requesting your **permission and consent** to treat you in the facility. There will also be **financial paperwork** for you to complete and sign.

Personal Care

During your stay, a **certified nursing assistant** will assist you with your

activities of daily living which may include **bathing, dressing, toileting**, and other services.

You will have a regular **shower schedule** and your linens will be changed based on that schedule and as needed.

Certified Staff will provide your **medications**, as well as any **treatments** ordered by your physician.

You will have a **full body skin assessment** upon arrival to the facility so that any issues can be immediately addressed.

Discharge Goals and Planning

Your **goals** are very important to the facility. The team will work to help you meet those goals. The facility will discuss these goals with both you and your family/caregiver. It is important that you give the team honest and real answers so that they can determine what **support, supplies, equipment, and services** you will need when you are ready to discharge.

Individualized Care Plan

The management team will be developing a specific **plan of care** for you. This plan will be tailored to your individual **needs and goals** during your stay.

You and your family will be asked to **participate** in this plan.

Home Health Care Services – What to Expect Guide

Many patients continue their recovery at home with support from home health services. Home health provides skilled nursing and therapy in the comfort of the patient's home, helping them regain strength, manage medications, and transition safely back to daily activities. This guide explains who may qualify, what services are commonly provided, how visits are scheduled, and what patients and caregivers can expect during the first weeks after discharge.

Guide Content:

- Introduction (Page 1)
 - Choosing home health care is an important decision in your recovery journey, and there are many benefits to using this service.
 - Home health care is delivered by medical professionals who treat your medical condition. They do not cook, clean or serve as sitters.
 - Many people transition to home health care after a stay in the hospital, rehab center or skilled nursing facility. The primary goals are to help you recover and stay as independent as possible.
 - This pamphlet will help you in answering many questions and more.
- Home Health Care Is (Page 2)
 - Short-term intermittent services– such as skilled nursing, physical therapy, occupational therapy, speech therapy and a medical social worker – are provided in the comfort of your home. Skilled clinicians work with your physicians to establish a plan of care based on your individual needs.
- What Does “Homebound” Mean (Page 2)
 - Homebound means the patient's condition prevents them from safely leaving the home without assistance from others or assistive devices (e.g., canes, walkers, crutches, or wheelchairs). In most cases, patients are considered homebound even if they leave home for medical treatments that cannot be provided at home. Brief and occasional non-medical absences, such as going to church, the beauty shop or special family events, may also be allowed.
- What Can Home Health Care Provide? Services Chart Compared to Private Duty (Page 3)
 - Does Provide:
 - Skilled Nursing

- Wound Care
 - Pain Management
 - Medication Administration
 - Medication Reminders
 - Disease Management
 - Medical Tests
 - Health Monitoring
 - Social Worker
 - Durable Medical Equipment
 - Rehabilitation Therapies (PT, OT, ST)
 - Patient & Caregiver Education
- Does Not Provide:
 - Help with Bathing/Dressing
 - Bathroom Support
 - Cleaning
 - Sitter/Companion
 - Meal Prep or Delivery
 - Transportation
- *Disclaimer: Services may vary by Provider, Insurance, and State
- Benefits of Home Health Care (Page 4)
 - Care is delivered directly in your home where you are most comfortable.
 - Medical services are provided by skilled professionals.
 - Home health staff follow your physician-prescribed plan.
 - You regain independence and self-sufficiency at home.
 - Home health care provides safety, comfort, and convenience by reducing the risk of infections, falls and hospitalizations.
 - Home health care prevents avoidable trips to the hospital by monitoring and managing health conditions at home.
- Your Plan of Care (Page 4)
 - Family members are encouraged to assist in the planning process to help set and meet your goals while working with home health care professionals for your benefit.
- Myths and Facts of Home Health Care (Page 5)
 - Myth: Home health care is for people without family support. I have a family caregiver.

- Fact: Home health care professionals can lower the stress placed on loved ones to create a comfortable and healing environment for the patient.
- Myth: I can't trust a stranger in my house.
 - Fact: Home health care companies perform fingerprinting, background checks, and competency tests on staff before they interact with patients, thereby ensuring patients are matched with a quality professional who can meet their needs and be trustworthy and reliable.
- Myth: I don't want to lose my independence.
 - Fact: You will regain your independence quicker and have a better quality of life.
- Myth: Home health care is too expensive.
 - Fact: Home health care is covered by Medicare, Medicaid and most private insurance companies. Non-medical care, such as meal prep, cleaning, sitter, and transportation, are typically not covered. That is Private Duty Care.
- Known Fact (Page 6)
 - People who accept home health care tend to recover quickly and are less likely to be readmitted to the hospital due to complications. Let our team help in your recovery.
- Visit www.medicare.gov/care-compare/ for more information on quality star ratings and home health care comparisons published by Medicare.

What to Expect from Home Health Care Services (English / Spanish)



MYTHS AND FACTS OF HOME HEALTH CARE

Myth: Home health care is for people without family support. I have a family caregiver.

Fact: Home health care professionals can lower the stress placed on loved ones to create a comfortable and healing environment for the patient.

Myth: I can't trust a stranger in my house.

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KNOWN FACT

People who accept home health care tend to recover quickly and are less likely to be readmitted to the hospital due to complications. Let our team help in your recovery.



Visit www.medicare.gov/care-compare/ for more information on quality star ratings and home health care comparisons published by Medicare.



This material was prepared by Alliant Health Solutions, a Quality Innovation Network - Quality Improvement Organization (QIN - QIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 1250W-AHS-QIN-QIC-TCI-PCH-5588-04/2024

What to Expect from Home Health Care Services



Choosing home health care is an important decision in your recovery journey, and there are many benefits to using this service.

Home health care is delivered by medical professionals who treat your medical condition. They do not cook, clean or serve as a sitter.

Many people transition to home health care after a stay in the hospital, rehab center or skilled nursing facility. The primary goals are to help you recover and stay as independent as possible.

This pamphlet will help you in answering many questions and more.

HOME HEALTH CARE IS:

Short-term intermittent services – such as skilled nursing, physical therapy, occupational therapy, speech therapy and a medical social worker – are provided in the comfort of your home. Skilled clinicians work with your physician to establish a plan of care based on your individual needs.



WHAT DOES "HOMEBOUND" MEAN?

Homebound means the patient's condition prevents them from safely leaving the home without assistance from others or assistive devices (e.g., canes, walkers, crutches, or wheelchairs). In most cases, patients are considered homebound even if they leave the home for medical treatments that cannot be provided at home. Brief and occasional non-medical absences, such as going to church, the beauty shop or special family events, may also be allowed.

WHAT CAN HOME HEALTH CARE PROVIDE?

Home-based services	Home Health Care	Private Duty
Skilled Nursing	✓	✗
Wound Care	✓	✗
Pain Management	✓	✗
Medication Administration	✓	✗
Medication Reminders	✓	✓
Disease Management	✓	✗
Medical Tests	✓	✗
Health Monitoring	✓	✗
Social Worker	✓	✗
Durable Medical Equipment	✓	✗
Rehabilitation Therapies (PT, OT, ST)	✓	✗
Patient & Caregiver Education	✓	✗
Help with Bathing/Dressing	✗	✓
Bathroom Support	✗	✓
Cleaning	✗	✓
Sitter/Companion	✗	✓
Meal Prep or Delivery	✗	✓
Transportation	✗	✓

Disclaimer: Services may vary by Provider, Insurance and State.

BENEFITS OF HOME HEALTH CARE:

- Care is delivered directly in your home where you are most comfortable.
- Medical services are provided by skilled professionals.
- Home health staff follow your physician-prescribed plan.
- You regain independence and self-sufficiency at home.
- Home health care provides safety, comfort, and convenience by reducing the risk of infections, falls and hospitalizations.
- Home health care prevents avoidable trips to the hospital by monitoring and managing health conditions at home.

YOUR PLAN OF CARE

Family members are encouraged to assist in the planning process to help set and meet your goals while working with home health care professionals for your benefit.



Inpatient Rehabilitation Facility (IRF) – What to Expect Guide

For patients who need intensive therapy to regain function, an inpatient rehabilitation hospital provides a highly structured, specialized environment focused on recovery. Patients typically participate in multiple hours of therapy each day with an interdisciplinary team, including physicians, nurses, and therapists. This guide outlines the eligibility criteria, daily therapy schedule, team-based approach, and the active role patients and families play in achieving rehabilitation goals.

Guide Content:

- Introduction (Page 1)
 - We know choosing to work with Inpatient Rehabilitation Services is an important decision in your recovery journey. Treatment is provided to patients who require hospital-level care combined with intensive rehabilitation. This pamphlet will provide you with information to assist you in your recovery.
- Inpatient Rehabilitation Care (Page 2)
 - What:
 - Patients receive comprehensive therapy, delivered by an interdisciplinary care team to restore function and support the highest possible quality of life after injury, illness, or surgery.
 - Physical therapy
 - Occupational therapy
 - Speech therapy
 - Who:
 - Care is provided for patients recovering from complex injuries and medical conditions, including:
 - Stroke
 - Brain injury
 - Spinal cord injury
 - Neurological conditions (Parkinson’s disease, multiple sclerosis)
 - Amputation
 - Complex orthopedic conditions
 - Cardiac conditions

- Pediatric rehabilitation
- How:
 - Care is led by a physician specializing in physical medicine and rehabilitation.
- Why:
 - The goal is to help patients regain independence and return to their community with the highest possible level of functional ability following injury, illness, or surgery
- How are Inpatient Rehabilitation Facilities Different than Nursing Homes? (Page 3)
 - Physician Visits
 - IRF- 3x/week minimum
 - SNF- 1x/month minimum
 - Rehabilitation Services
 - IRF- 15 hours/week minimum
 - SNF- Not required
 - Inter-Disciplinary Team Approach
 - IRF- Required
 - SNF- Not required
 - MD or DO Rehabilitation Director
 - IRF- Required
 - SNF- Not required
 - Nurse to Patient Ratio
 - IRF- 1 Nurse to 6-8 Patients
 - SNF- 1 Nurse to 15 Patients (Industry Average)
 - Industry Average Discharge to Home
 - IRF- 77.4%
 - SNF- 39.5%
- Benefits (Page 4)
 - Focused support throughout recovery helps patients achieve the best possible outcomes.
 - Physician-led team providing rehabilitation care for patients
 - Care tailored to each individual based on needs and goals
 - Supports increased independence and mobility for daily life
 - Reduces risk of medical complications during and after rehabilitation process
 - Promotes emotional well-being and enhances overall mental health

- Helps patients return home sooner
- Improves overall quality of life
- Home evaluations provided to help patients safely navigate their living environment
- Coordinates durable medical equipment and community resources to support continued care
- Manages all post-discharge care for a smooth, safe recovery transition
- Plan of Care (Page 4)
 - Each patient receives a personalized plan of care, with family members encouraged to be actively involved throughout the recovery process. This collaborative approach helps support better outcomes and a smoother transition home.
- Myths & Facts (Page 5-6)
 - Myth: Medicare patients must have a 3-day hospitalization before transferring to an inpatient rehabilitation facility
 - Fact: Patients can be admitted any time once they are medically appropriate and able to participate in, and benefit from, intensive therapy, has a need for daily physician management and has a need for 24-hour rehab nursing care. IRFs can even admit patients directly from home if warranted.
 - Myth: Cost is more expensive than other forms of post-acute care.
 - Fact: Inpatient rehabilitation facilities are paid for the medical rehabilitation services they provide by: commercial insurance, Medicare Part A, workers' compensation and other sources. The hospital will let you know if there will be any patient responsibility.
 - Myth: Rehabilitation hospitals only accept patients of a certain age.
 - Fact: All ages are welcome.
 - Myth: A certain diagnosis is required to be admitted.
 - Fact: Admittance is not limited by diagnosis
 - Myth: Inpatient rehab is only for severe cases.
 - Fact: Inpatient rehab is tailored to various conditions and needs, from those with major injuries to those requiring intensive therapy after medical and surgical conditions.
- * Disclaimer: insurance benefits may vary and your hospital will call for prior authorization

What to Expect from Inpatient Rehabilitation Facilities (English)



MYTHS & FACTS

MYTH

Medicare patients must have a 3-day hospitalization before transferring to an inpatient rehabilitation facility.

FACT

Patients can be admitted any time once they are medically appropriate and able to participate in, and benefit from, intensive therapy, has a need for daily physician management and has a need for 24-hour rehab nursing care. IRFs can even admit patients directly from home if warranted.

MYTH

Cost is more expensive than other forms of post acute care.

FACT

Inpatient rehabilitation hospitals are paid for the medical rehabilitation services they provide by: commercial insurance, Medicare Part A, workers' compensation and other sources. The hospital will let you know if there will be any patient responsibility.

MYTH

Rehabilitation hospitals only accept patients of a certain age.

FACT

All ages are welcome.

MYTH

A certain diagnosis is required to be admitted.

FACT

Admittance is not limited by diagnosis.

MYTH

Inpatient rehab is only for severe cases.

FACT

Inpatient rehab is tailored to various conditions and needs, from those with major injuries to those requiring intensive therapy after medical and surgical conditions.

Disclaimer: Insurance benefits may vary and your hospital will call for prior authorization.



FHA FLORIDA HOSPITAL ASSOCIATION

Created in conjunction with the Florida Hospital Association Rehab Council.



INPATIENT REHABILITATION WHAT TO EXPECT



We know choosing to work with inpatient rehabilitation services is an important decision in your recovery journey. Treatment is provided to patients who require hospital-level care combined with intensive rehabilitation.

This pamphlet will provide you with information to assist you in your recovery.

OVERVIEW

WHAT

Patients receive comprehensive therapy, delivered by an interdisciplinary care team to restore function and support the highest possible quality of life after injury, illness, or surgery.

- Physical therapy
- Occupational therapy
- Speech therapy

WHO

Care is provided for patients recovering from complex injuries and medical conditions, including:

- Stroke
- Brain injury
- Spinal cord injury
- Neurological conditions (Parkinson's disease, multiple sclerosis)
- Amputation
- Complex orthopedic conditions
- Cardiac conditions
- Pediatric rehabilitation

HOW

Care is led by a physician specializing in physical medicine and rehabilitation.

WHY

The goal is to help patients regain independence and return to their community with the highest possible level of functional ability following injury, illness, or surgery.

CARE COMPARISON

How **inpatient rehabilitation hospitals** differ from **nursing homes**.

	Inpatient Rehabilitation Hospital	Nursing Home (Skilled Nursing Facility, Short-Term Rehab)
Physician Visits	3x/week minimum	1x/month minimum
Rehab Services	15 hrs/week minimum	Not required
Inter-Disciplinary Team Approach	Required	Not required
MD or DO Rehab Director	Required	Not required
Nurse to Patient Ratio	1 nurse to 6-8 patients	1 nurse to 15 patients (industry avg)
Discharge to Home	77.4%	39.5%

BENEFITS

Focused support throughout recovery helps patients achieve the best possible outcomes.

- ✓ Physician-led team providing rehabilitation care for patients
- ✓ Care tailored to each individual based on needs and goals
- ✓ Supports increased independence and mobility for daily life
- ✓ Reduces risk of medical complications during and after rehabilitation process
- ✓ Promotes emotional well-being and enhances overall mental health
- ✓ Helps patients return home sooner
- ✓ Improves overall quality of life
- ✓ Home evaluations provided to help patients safely navigate their living environment
- ✓ Coordinates durable medical equipment and community resources to support continued care
- ✓ Manages all post-discharge care for a smooth, safe recovery transition

PLAN OF CARE

Each patient receives a personalized plan of care, with family members encouraged to be actively involved throughout the recovery process. This collaborative approach helps support better outcomes and a smoother transition home.

Long-Term Acute Care Hospital (LTACH) – What to Expect Guide

Some patients require ongoing hospital-level care after a serious illness, injury, or extended hospitalization. A Long-Term Acute Care Hospital (LTACH) provides specialized medical treatment for patients with complex conditions who need a longer recovery period and daily physician oversight. This guide helps patients and families understand what LTACH care offers, how daily routines may look, and what services—such as respiratory therapy, wound care, intravenous medications, or rehabilitation therapies—they may receive. It also outlines typical expectations around length of stay, care planning, and the role patients and families play in supporting recovery and transition to the next level of care.

Guide Content:

- Introduction (Page 1)
 - After a sudden illness or accident, most patients in a traditional hospital will be able to go home or to a lower level of care within a few days. Patients with complex conditions, however, may need additional time to recover in an acute care setting. That’s where long-term acute care hospitals, or LTACHs, come in. With physician-led care teams, LTACHs provide specialized acute care and rehabilitation to critically ill and injured patients who are facing an extended recovery after an initial hospital stay. This pamphlet will help you in answering many questions you have about care in an LTACH.
- Frequently Asked Questions (Page 2-3)
 - Why wouldn’t I stay in a traditional hospital instead of an LTACH?
 - The goal of a traditional hospital is to diagnose and stabilize your condition, which may occur in a few days or a week. However, if your condition is medically complex, you may need the specialized care of a long-term acute care hospital to recover as fully as possible. Your physician will determine whether care at an LTACH is appropriate for you. A referral is then required for admission.
 - Why would I be referred to an LTACH as an option when I leave the hospital?
 - A process called discharge planning begins immediately upon admission to any hospital to ensure that the patient is in the most appropriate care setting for their medical needs. An LTACH may have been suggested because:

- You need more recovery time in a hospital setting
 - Your diagnosis requires specialized care
 - You require daily monitoring by physicians
 - You require team-based care
- How long do patients typically stay in an LTACH?
 - Lengths of stay may vary, but the average stay is 25 days as patients recover and transition to home, or the next appropriate level of care.
- What types of conditions are treated in LTACHs?
 - Patients come to LTACHs with serious conditions such as respiratory failure and complex pulmonary conditions, infectious disease and sepsis, congestive heart failure, renal failure, complex wounds, stroke, traumatic brain injuries, or even a combination of these. Their diagnoses are often complicated by existing health problems like diabetes or COPD. Ventilator management and weaning are specialties of LTACHs.
- Do LTACHs provide rehabilitation therapy?
 - Yes. In addition to receiving specialized medical care, LTACH patients have access to in-hospital physical and occupational therapy, and speech-language pathology. This early access to rehabilitation can improve outcomes for all patients.
- What kind of care team is involved?
 - Long-term acute care is provided by a multidisciplinary team that may include:
 - Physicians (including specialists such as pulmonologists, neurologists, cardiologists, and surgeons)
 - Nurses
 - Respiratory therapists
 - Physical therapists
 - Occupational therapists
 - Speech-language pathologists
 - Dietitians
 - Pharmacists
 - Case managers
- What happens after a patient leaves an LTACH?
 - Patients may transition to inpatient rehabilitation, a skilled nursing facility, or return home, depending on their recovery and care needs.

- Benefits of Long-Term Acute Care Hospitals (Page 3)
 - Specialized care for complex medical conditions
 - Extended recovery time with hospital-level support
 - Daily physician oversight and advanced medical equipment
 - Coordinated, team-based approach to care
 - Focused rehabilitation and therapy services
 - Individualized treatment plans tailored to each patient
 - Ongoing communication and involvement for families
- What Services Does an LTACH Provide? (Page 4)
 - Services can include, but are not limited to:
 - 24/7 hospital-level nursing care
 - Daily physician oversight and medical management
 - Respiratory therapy, including ventilator weaning and support
 - Complex wound care and wound management programs
 - Intravenous (IV) therapy and medication management
 - Post-ICU and post-surgical recovery care
 - Physical therapy to improve strength, mobility, and endurance
 - Occupational therapy to support activities of daily living
 - Speech therapy for communication and swallowing support
 - Infection management and long-term antibiotic therapy
 - Nutritional support, including feeding tube management when needed
 - Diagnostic testing and advanced monitoring services
 - Case management and discharge planning coordination
 - Patient and family education and support throughout recovery
- Myths & Facts of LTACHs (Page 5)
 - Myth: Long-term acute care hospitals (LTACHs) aren't "real" hospitals.
 - Fact: LTACHs are licensed as acute care hospitals and certified by the Centers for Medicare and Medicaid Services (CMS). LTACH patients receive daily physician visits and specialist consults, as needed, in pulmonology, cardiology, nephrology, and more. LTACHs also have hospital services such as radiology, laboratory, pharmacy, and dialysis.
 - Myth: LTACHs are the same as skilled nursing facilities (SNFs).
 - Fact: LTACHs are very different from SNFs. Long-term acute care hospitals provide physician-led acute care for critically ill patients

with complex conditions. Skilled nursing facilities are lower-level care settings for patients who do not require hospital-level care.

- Myth: LTACHs are the same as long-term care (LTC) facilities, or nursing homes.
 - Fact: Their names may sound similar, but LTACHs and LTC facilities are very different. LTACHs provide hospital-level acute care for medically complex patients. Long-term care facilities provide custodial care to help residents complete day-to-day activities as independently as possible.
- Myth: Insurance won't cover LTACH stays.
 - Fact: Many insurance plans, including Medicare (when criteria are met), cover LTACH care based on medical necessity. Verification of insurance will likely be part of the admission process.
- Known Fact (Page 6)
 - Medically complex patients who transfer to long-term acute care hospitals from a traditional hospital are 3X more likely to discharge home than those who do not transfer.*
 - <https://www.tandfonline.com/doi/full/10.3111/13696998.2010.551163>
- LTACH Care after an ICU or PCU Stay (Page 6)
 - After three or more nights in an intensive care unit (ICU) or progressive care unit (PCU), which is also sometimes called a “step-down unit”, critical patients may be appropriate candidates for admission to a long-term acute care hospital, which can continue the treatment that began in the ICU and provide specialized rehabilitation for medically complex patients. Key indicators* that a patient may be appropriate for a transfer to an LTACH include:
 - An ICU or PCU stay of 3 midnights or greater
 - Mechanical ventilation for 96+ hours
 - Complex wounds and/or infections
 - Multiple complications indicating a prolonged hospital course

* Based on Medicare eligibility criteria; not intended to be a complete list of indicators for all patients

What to Expect from Long-Term Acute Care Hospitals (English)



Myths & Facts of LTACHs

Myth: Long-term acute care hospitals (LTACHs) aren't "real" hospitals.

Fact: LTACHs are licensed as acute care hospitals and certified by the Centers for Medicare and Medicaid Services (CMS). LTACH patients receive daily physician visits and specialist consults, as needed, in pulmonology, cardiology, nephrology, and more. LTACHs also have hospital services such as radiology, laboratory, pharmacy, and dialysis.

Myth: LTACHs are the same as skilled nursing facilities (SNFs).

Fact: LTACHs are very different from SNFs. Long-term acute care hospitals provide physician-led acute care for critically ill patients with complex conditions. Skilled nursing facilities are lower-level care settings for patients who do not require hospital-level care.

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KNOWN FACT

Medically complex patients who transfer to long-term acute care hospitals from a traditional hospital are 3X more likely to discharge home than those who do not transfer.*

*[landonline.com/doi/full/10.3111/13696998.2010.551163](https://doi.org/10.3111/13696998.2010.551163)

LTACH Care after an ICU or PCU Stay

After three or more nights in an intensive care unit (ICU) or progressive care unit (PCU), which is also sometimes called a "step-down unit", critical patients may be appropriate candidates for admission to a long-term acute care hospital, which can continue the treatment that began in the ICU and provide specialized rehabilitation for medically complex patients. Key indicators* that a patient may be appropriate for a transfer to an LTACH include:

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What to Expect from Long-Term Acute Care Hospitals

After a sudden illness or accident, most patients in a traditional hospital will be able to go home or to a lower level of care within a few days. Patients with complex conditions, however, may need additional time to recover in an acute care setting.

That's where long-term acute care hospitals, or LTACHs, come in. With physician-led care teams, LTACHs provide specialized acute care and rehabilitation to critically ill and injured patients who are facing an extended recovery after an initial hospital stay.

This pamphlet will help you in answering many questions you have about care in an LTACH.

Frequently Asked Questions

Why wouldn't I stay in a traditional hospital instead of an LTACH?

The goal of a traditional hospital is to diagnose and stabilize your condition, which may occur in a few days or a week. However, if your condition is medically complex, you may need the specialized care of a long-term acute care hospital to recover as fully as possible. Your physician will determine whether care at an LTACH is appropriate for you. A referral is then required for admission.

Why would I be referred to an LTACH as an option when I leave the hospital?

A process called discharge planning begins immediately upon admission to any hospital to ensure that the patient is in the most appropriate care setting for their medical needs.

An LTACH may have been suggested because:

- You need more recovery time in a hospital setting
- Your diagnosis requires specialized care
- You require daily monitoring by physicians
- You require team-based care

How long do patients typically stay in an LTACH?

Lengths of stay may vary, but the average stay is 25 days as patients recover and transition to home, or the next appropriate level of care.

What types of conditions are treated in LTACHs?

Patients come to LTACHs with serious conditions such as respiratory failure and complex pulmonary conditions, infectious disease and sepsis, congestive heart failure, renal failure, complex wounds, stroke, traumatic brain injuries, or even a combination of these. Their diagnoses are often complicated by existing health problems like diabetes or COPD. Ventilator management and weaning are specialties of LTACHs.

Do LTACHs provide rehabilitation therapy?

Yes. In addition to receiving specialized medical care, LTACH patients have access to in-hospital physical and occupational therapy, and speech-language pathology. This early access to rehabilitation can improve outcomes for all patients.

What kind of care team is involved?

Long-term acute care is provided by a multidisciplinary team that may include:

- Physicians (including specialists such as pulmonologists, neurologists, and cardiologists, and surgeons)
- Nurses
- Respiratory therapists
- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Dietitians
- Pharmacists
- Case managers

What happens after a patient leaves an LTACH?

Patients may transition to inpatient rehabilitation, a skilled nursing facility, or return home, depending on their recovery and care needs.

Benefits of Long-Term Acute Care Hospitals

- ✓ Specialized care for complex medical conditions
- ✓ Extended recovery time with hospital-level support
- ✓ Daily physician oversight and advanced medical equipment
- ✓ Coordinated, team-based approach to care
- ✓ Focused rehabilitation and therapy services
- ✓ Individualized treatment plans tailored to each patient
- ✓ Ongoing communication and involvement for families

What Services Does an LTACH Provide?

Services can include, but are not limited to:

- 24/7 hospital-level nursing care
- Daily physician oversight and medical management
- Respiratory therapy, including ventilator weaning and support
- Complex wound care and wound management programs
- Intravenous (IV) therapy and medication management
- Post-ICU and post-surgical recovery care
- Physical therapy to improve strength, mobility, and endurance
- Occupational therapy to support activities of daily living
- Speech therapy for communication and swallowing support
- Infection management and long-term antibiotic therapy
- Nutritional support, including feeding tube management when needed
- Diagnostic testing and advanced monitoring services
- Case management and discharge planning coordination
- Patient and family education and support throughout recovery

Private Duty Home Care – What to Expect Guide

While patients continue their recovery at home, they may need additional non-medical support. Private duty home care provides personalized, non-medical support to individuals in their homes, helping them maintain independence, safety, and quality of life. Services are tailored to each client's needs and may include assistance with activities of daily living, companionship, medication reminders, mobility support, and respite for family caregivers. This guide explains what services are commonly provided, the benefits of this service, and clarifies the role of private duty home care in addition to home health care.

Guide Content:

- Introduction (Page 1)
 - We know choosing to work with a private duty home care provider is an important decision in maintaining your independence and remaining in your home environment.
 - Private duty home care is delivered by individuals who perform meal prep and housekeeping, escort you to appointments, serve as a sitter, and more. Many people supplement with private duty home care after a stay in the hospital, rehab center or skilled nursing facility for additional home assistance, allowing them to recover and maintain their independence. This pamphlet addresses many of your questions and provides more information.
- What is Private Duty Home Care? (Page 2)
 - A service that assists individuals who need a little extra help to remain independent in their home—whether a private residence, assisted living facility, skilled nursing facility, etc.—for as long as possible. Services include, but are not limited to:
 - Medication reminders
 - Assist with medication self-administration
 - Pick up prescriptions
 - Escort to Dr. Visits
 - Transportation
 - Assist with getting in and out of bed
 - Moving safely around the house
 - Assist with bathing and dressing
 - Incontinence care
 - Safety supervision

- Meal planning and preparation
 - Light housekeeping
 - Laundry services
 - Change linens
 - Help with pet care
 - Family respite care
 - Companionship
- Frequently Asked Questions (Page 3)
 - How is Private Duty Homecare paid for?
 - It is most often paid for with private funds. If you have long-term care insurance or Veteran's benefits, ask your provider if they accept those plans
 - Are private duty home care and home health care the same thing?
 - No. Private duty home care is non-medical and assists with services that are not provided by home health.
 - Will I have the same person helping me every time?
 - That is always the goal, it is not a guarantee. The home care provider will do its best to find a good, permanent match as soon as possible
 - What is personal care?
 - All things related to activities of daily living. This includes personal hygiene, toileting, dressing, meal prep and medication reminders to name a few.
- Benefits of Private Duty Home Care (Page 4)
 - They partner with home health and hospice providers to fill a gap by offering customized, non-medical services to help you maintain your independence where you live.
 - Care is flexible and can range from a few hours per week to 24/7 coverage, depending on your needs.
 - The length of service is determined by the client or their family rather than by a physician or insurance company.
 - Their goal is to keep you safe in your home and reduce hospitalization.
 - They offer comprehensive services not typically provided by other levels of care.
 - There is no referral or prescription needed for services.
 - They aim to reduce hospital admissions and readmissions
- Myths and Facts of Private Duty Home Care (Page 5)

- Myth: Private duty home care is too expensive.
 - Fact: While it can be costly, it may save you money in the long run by helping you stay in your home longer and safely. Additionally, there are various payment options available. Be sure to explore these options with your private duty care provider.
- Myth: Private duty home care is for people without family support. I have a family who can help me.
 - Fact: Private duty home care staff can reduce stress on loved ones by providing services and allowing them to enjoy quality time with you
- Myth: I can't trust a stranger in my house.
 - Fact: Private duty home care agencies and registries perform fingerprinting, reference and background checks on their staff before they interact with clients. In addition, they are licensed by AHCA to ensure compliance with regulations. The agencies also provide staff training and supervision to ensure their employees are competent to meet clients' needs.
- Myth: I will lose my independence.
 - Fact: Allowing professionals to assist with your needs improves your independence, enabling you to stay in your home.
- Private Duty Home Care Agencies/Nurse Registries VS. Private Hire (Page 6)
 - Private Duty Home Care Agencies/Nurse Registries conduct:
 - Reference checks on staff
 - Background checks on staff
 - Carry liability insurance
 - Supervision of staff (Agency)
 - Staff training (Agency)
 - Vacation/emergency coverage
 - It is the responsibility of the client to verify these services when hiring private individuals.

What to Expect from Private Duty Home Care Services (English / Spanish)



MYTHS & FACTS OF PRIVATE DUTY HOME CARE

Myth: Private duty home care is too expensive.

Fact: While it can be costly, it may actually save you money in the long run by helping you stay in your home longer and more safely. Additionally, there are various payment options available. Be sure to explore these options with your private duty care provider.

Myth: Private duty home care is for people without family support. I have a family who can help me.

Fact: Private duty home care staff can reduce stress on loved ones by providing services and allowing them to enjoy quality time with you.

Myth: I can't trust a stranger in my house.

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Fact: Allowing professionals to assist with your needs improves your independence, enabling you to stay in your home.

PRIVATE DUTY HOME CARE AGENCIES/NURSE REGISTRIES VS. PRIVATE HIRE

Private Duty Home Care Agencies/ Nurse Registries Conduct:

- Reference checks on staff
- Background checks on staff
- Carry liability insurance
- Supervision of staff (Agency)
- Staff training (Agency)
- Vacation/emergency coverage

It is the responsibility of the client to verify these services when hiring private individuals.

Thank you to the organizations that collaborated with us on this resource:

Affinity Home Health
American In-home Care
Assisting Hands Home Care
Brookdale at Home
Classique Concierge Home Health Care
ComForCare Home Care
Heart Body & Mind Home Care
Orlando Health
TheKey



www.quality.allianthealth.org

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What to Expect From Private Duty Home Care Services



We know choosing to work with a private duty home care provider is an important decision in maintaining your independence and remaining in your home environment.

Private duty home care is delivered by individuals who perform meal prep and housekeeping, escort you to appointments, serve as a sitter, and more.

Many people supplement with private duty home care after a stay in the hospital, rehab center or skilled nursing facility for additional home assistance, allowing them to recover and maintain their independence.

This pamphlet addresses many of your questions and provides more information.

WHAT IS PRIVATE DUTY HOME CARE?

A service that assists individuals who need a little extra help to remain independent in their home—whether a private residence, assisted living facility, skilled nursing facility, etc.—for as long as possible. Services include, but are not limited to:

Home-Based Services	Private Duty Home Care
Medication reminders	✓
Assist with medication self-administration	✓
Pick up prescriptions	✓
Escort to Dr. Visits	✓
Transportation	✓
Assist with getting in and out of bed	✓
Moving safely around the house	✓
Assist with bathing and dressing	✓
Incontinence care	✓
Safety supervision	✓
Meal planning and preparation	✓
Light housekeeping	✓
Laundry services	✓
Change linens	✓
Help with pet care	✓
Family respite care	✓
Companionship	✓

FREQUENTLY ASKED QUESTIONS

❖ How is private duty home care paid for?

It is most often paid for with private funds. If you have long-term care insurance or Veteran's benefits, ask your provider if they accept those plans.

❖ Is private duty home care and home health care the same thing?

No. Private duty home care is non-medical and assists with services that are not provided by home health.

❖ Will I have the same person helping me every time?

Although that is always the goal, it is not a guarantee. The home care provider will do its best to find a good, permanent match as soon as possible.

❖ What is personal care?

All things related to activities of daily living. This includes personal hygiene, toileting, dressing, meal prep and medication reminders to name a few.



BENEFITS OF PRIVATE DUTY HOME CARE

- They partner with home health and hospice providers to fill a gap by offering customized, non-medical services to help you maintain your independence where you live.
- Care is flexible and can range from a few hours per week to 24/7 coverage, depending on your needs.
- The length of service is determined by the client or their family rather than a physician or insurance company.
- Their goal is to keep you safe in your home and reduce hospitalization.
- They offer comprehensive services not typically provided by other levels of care.
- There is no referral or prescription needed for services.
- They aim to reduce hospital admissions and readmissions.

Hospice – What to Expect Guide

Hospice care focuses on comfort, dignity, and quality of life for patients facing a serious or life-limiting illness. It provides compassionate medical, emotional, and spiritual support for both patients and their families. This guide helps families understand the philosophy of hospice, the services available at home or in a facility, the role of the hospice care team, and how hospice can support symptom management and family needs during this stage of care.

Guide Content:

- Introduction (Page 1)
 - Choosing hospice is an important decision in your journey. Working with hospice has many benefits for you and your loved ones.
 - Knowing the differences between hospice and palliative care can help you decide what type of care is best for you. If your health changes, the type of care being received can be changed.
 - Palliative care focuses on maintaining the highest quality of life while managing treatment and other needs. Hospice care specifically focuses on the last six months of life.
 - When a patient elects hospice, the goals of care change from curative or life-extending therapies to comfort and quality-of-life therapies. These include medical goals for the patient and the psychosocial, emotional, and spiritual needs of the patient and loved ones.
- What is Hospice Care? (Page 2)
 - Hospice is a program of care and support for people who are terminally ill and their loved ones. Important facts about hospice:
 - The focus is on comfort (palliative care), not curing an illness.
 - Services typically include physical care, counseling, drugs, equipment, and supplies for the terminal illness and related conditions.
 - Specially trained teams of professionals and caregivers provide care for the whole person, including physical, emotional, social and spiritual needs.
 - Care is generally given where the patient resides.
 - Caregiver support and training.
 - Any person diagnosed with a terminal illness or condition where, under normal course of the disease, the person who is expected to live six months or less is eligible for hospice.
- How is Hospice Care Paid For? (Page 2)
 - Hospice is often paid for as a defined benefit of Medicare. However, hospice may also be paid for under Medicare Advantage plans, state Medicaid and

some private insurance plans. The hospice philosophy is to provide access regardless of ability to pay. This is possible through fundraising, donations and grants.

- Hospice Levels of Care (Page 3)
 - Routine Home Care
 - Most common level of care. The patient is generally stable, and the patient's symptoms are adequately controlled.
 - Continuous Home Care
 - Crisis care for short-term management of out-of-control pain and/or symptom management.
 - Always provided where the patient resides.
 - Once the period of crisis is resolved, the patient receives the appropriate level of care.
 - General Inpatient Care
 - Short-term crisis management for out-of-control pain and/or symptom management.
 - Always provided outside the home in a hospital, hospice inpatient facility or skilled nursing facility.
 - Inpatient Respite Care
 - The level of temporary care provided in a nursing home, hospice inpatient facility, or hospital so the caregiver can take up to five days off.
 - This level of care is tied to caregiver needs, not patient symptoms.
- Benefits of Hospice Care (Page 4)
 - Offers care where you need it, in addition to what your caregiver provides.
 - Patients have a sense of dignity in their comfortable environment.
 - Provides a comprehensive plan for controlling and reducing pain.
 - Provides an extra level of care to assist the caregiver.
 - Loved ones can focus on spending time with the patient.
 - Provides counseling to loved ones.
 - Community grief and bereavement support.
 - Less financial burden compared to hospital care
- What is Palliative Care? (Page 4)
 - Focuses on advanced care planning, goals of care and developing a plan of care. These accompany other therapies, including curative and life-extending therapies for chronic and serious illness.
 - Focuses on easing pain and discomfort, reducing stress and helping people have the highest quality of life possible.
 - You can receive palliative care while also receiving curative and therapeutic care for an illness, such as chemotherapy, dialysis or surgery.

- Holistic Caring approach addressing mind, body and spirit.
- Services vary by location and insurance
- Myths and Facts of Hospice Care (Page 5)
 - Myth: Hospice care only focuses on dying.
 - Fact: Hospice focuses on compassionate caring at the end of life so that you can live each day as fully as possible with dignity, choices and control.
 - Myth: Hospice requires a Do Not Resuscitate (DNR) order.
 - Fact: While many people who choose hospice care wish to have a DNR to avoid unnecessary medical interventions and hospitalization, a DNR is not required to begin receiving hospice care.
 - Myth: Once the choice is made for hospice care, there is no turning back.
 - Fact: Individuals can leave a hospice program at any time for any reason and can re-enroll.
 - Myth: Hospice is only for cancer patients.
 - Fact: Hospice is available for patients with any terminal condition or disease.
 - Myth: Hospice speeds up death.
 - Fact: People do not die faster due to hospice. Sometimes, they live longer because their quality of life has improved.
- Additional Resources (Page 6)
 - [CMS Hospice Benefit Toolkit](#)
 - [Caring Info](#)
 - [Let Hospice Help](#)
 - [American Hospice: Learning About Hospice & Debunking the Myths About Hospice](#)
 - [Florida Hospice & Palliative Care Association \(Patient Worksheet\)](#)
 - [National Hospice & Palliative Care Organization](#)
 - Visit www.medicare.gov/care-compare/ for more information on quality star ratings and Hospice Care comparisons published by Medicare

What to Expect from Hospice Care (English / Spanish)



MYTHS AND FACTS OF HOSPICE CARE

Myth: Hospice care only focuses on dying.

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Myth: Hospice speeds up death.

Fact: People do not die faster due to hospice. Sometimes, they live longer because their quality of life has improved.

ADDITIONAL RESOURCES:

CMS Hospice Benefit Toolkit
<https://www.cms.gov/medicare/medicaid-coordination/states/hospice-benefit-toolkit>

Caring Info - <https://www.caringinfo.org/>

Let Hospice Help - <https://www.letshospicehelp.org/>

American Hospice - <https://americanhospice.org/learning-about-hospice/debunking-the-myths-of-hospice/>

Florida Hospice & Palliative Care Association (Patient Worksheet) - http://floridahospices.org/Website-Files/PatientInfoWorksheet_Full.pdf

National Hospice & Palliative Care Organization
<https://www.nhpc.org/>

Visit www.medicare.gov/care-compare/ for more information on quality star ratings and Hospice Care comparisons published by Medicare.

Thank you to the organizations that collaborated with us on this resource:

AdventHealth Hospice Care
 Assisting Hands Home Care
 Broward Health
 Cornerstone Hospice
 Florida Hospice & Palliative Care Association
 VITAS Healthcare



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What to Expect from Hospice Care



Choosing hospice is an important decision in your journey. Working with hospice has many benefits for you and your loved ones.

Knowing the differences between hospice and palliative care can help you decide what type of care is best for you. If your health changes, the type of care being received can be changed.

Palliative care focuses on maintaining the highest quality of life while managing treatment and other needs. Hospice care specifically focuses on the last six months of life.

When a patient elects hospice, the goals of care change from curative or life-extending therapies to comfort and quality-of-life therapies. These include medical goals for the patient and the psychosocial, emotional, and spiritual needs of the patient and loved ones.

WHAT IS HOSPICE CARE:

Hospice is a program of care and support for people who are terminally ill and their loved ones. Important facts about hospice:

- The focus is on comfort (palliative care), not curing an illness.
- Services typically include physical care, counseling, drugs, equipment, and supplies for the terminal illness and related conditions.
- Specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social and spiritual needs.
- Care is generally given where the patient resides.
- Caregiver support and training.
- Any person diagnosed with a terminal illness or condition where, under normal course of the disease the person is expected to live six months or less is eligible for hospice.

HOW IS HOSPICE CARE PAID FOR:

Hospice is often paid for as a defined benefit of Medicare. However, hospice may also be paid for under Medicare Advantage plans, state Medicaid and some private insurance plans. The hospice philosophy is to provide access regardless of ability to pay. This is possible through fundraising, donations and grants.

HOSPICE LEVELS OF CARE:

Routine Home Care

- Most common level of care. The patient is generally stable, and the patient's symptoms are adequately controlled.

Continuous Home Care

- Crisis care for short-term management of out-of-control pain and/or symptom management.
- Always provided where the patient resides.
- Once the period of crisis is resolved, the patient receives the appropriate level of care.

General Inpatient Care

- Short-term crisis management for out-of-control pain and/or symptom management.
- Always provided outside the home in a hospital, hospice inpatient facility or skilled nursing facility.

Inpatient Respite Care

- The level of temporary care provided in a nursing home, hospice inpatient facility, or hospital so the caregiver can take up to five days off.
- This level of care is tied to caregiver needs, not patient symptoms.



Hospice ~ because every day is a gift.

BENEFITS OF HOSPICE CARE:

- Offers care where you need it, in addition to what your caregiver provides.
- Patients have a sense of dignity in their comfortable environment.
- Provides a comprehensive plan for controlling and reducing pain.
- Provides an extra level of care to assist the caregiver.
- Loved ones can focus on spending time with the patient.
- Provides counseling to loved ones.
- Community grief and bereavement support.
- Less financial burden compared to hospital care.

WHAT IS PALLIATIVE CARE:

- Focuses on advance care planning, goals of care and developing a plan of care. These accompany other therapies, including curative and life-extending therapies for chronic and serious illness.
- Focuses on easing pain and discomfort, reducing stress and helping people have the highest quality of life possible.
- You can receive palliative care while also receiving curative and therapeutic care for an illness, such as chemotherapy, dialysis or surgery.
- Holistic Caring approach addressing mind, body and spirit.
- Services vary by location and insurance.

Provide Feedback and Improve this Toolkit

Thank you for using this *What to Expect Guide* toolkit as a resource to support safe, informed, and patient-centered transitions of care. We encourage hospitals, care teams, and community partners to share how they are using these materials—whether in staff training, patient education, or social media posts that highlight successful discharge planning, collaborative workflows, or improved patient experiences.

If your team has success stories, innovative uses, or recommendations for future updates, we welcome your feedback. Your insights help us keep this toolkit current, meaningful, and aligned with the real needs of patients, families, and care providers. Please send any suggestions, examples, or stories to our team so we can continue strengthening resources that support better outcomes across the care continuum.



Share Your Feedback

Scan to [share your experience](#), ideas, or success stories. Your feedback helps refine this toolkit and strengthen patient-centered transitions of care.