AHA/ASA Guidelines for Stroke Rehabilitation and Recovery

Summary of Recommendations
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AHA/ASA Guideline

Guidelines for Adult Stroke Rehabilitation and Recovery
A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

Endorsed by the American Academy of Physical Medicine and Rehabilitation and the American Society of Neurorehabilitation

The American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists and the American Congress of Rehabilitation Medicine also affirms the educational value of these guidelines for its members

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“If possible, people who've had a stroke should be sent directly to inpatient rehabilitation after their hospital discharge. This would be instead of a skilled nursing facility or nursing home, according to new guidelines by the American Heart Association/American Stroke Association (AHA/ASA).”

AHA/ASA Stroke Rehabilitation

• Purpose: To provide a synopsis of best clinical practices in the rehabilitative care of adults recovering from stroke

• Methods: A panel reviewed relevant articles on adults using computerized searches of medical literature through 2014.
AHA/ASA Stroke Rehabilitation

• Results: Stroke rehabilitation requires a sustained and coordinated effort from a large team, including the patient and his or her goals, family and friends, other caregivers, physicians, nurses, physical and occupational therapists, speech-language pathologists, recreational therapists, psychologists, nutritionists, social workers, and others. Communication and coordination among these team members are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie this entire guideline. Without communication and coordination, isolated efforts to rehabilitate the stroke survivor are unlikely to achieve their full potential.
AHA/ASA Guideline for Stroke Rehabilitation and Recovery

• New guideline published in Stroke journal on May 5, 2016

• Highest level of evidence supports that stroke patients receive IRF care “in preference to a SNF.”

• Highest level of evidence supports that a functional assessment by a clinician with expertise in rehabilitation is recommended for patients with an acute stroke with residual functional deficits.
AHA/ASA Guideline for Stroke Rehabilitation and Recovery

- Highest level of evidence supports that stroke patients receive “organized, coordinated, interprofessional care.”

- The guidelines conclude that assessment of rehabilitation needs are best performed by an interdisciplinary team, that can include a physician with experience in rehabilitation, nurses, physical, occupational and speech therapists, psychologists and orthotists.
Definition of Classes and Levels of Evidence Used in AHA/ASA recommendations

- **Class I**: Conditions for which there is evidence for and/or general agreement that the procedure or treatment is useful and effective.

- **Class II**: Conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment.

  - Class IIa: The weight of evidence or opinion is in favor of the procedure or treatment.
Definition of Classes and Levels of Evidence Used in AHA/ASA recommendations

• Class IIb: Usefulness/efficacy is less well established by evidence or opinion

• Class III: Conditions for which there is evidence and/or general agreement that the procedure or treatment is not useful/effective and in some cases may be harmful.
Definition of Classes and Levels of Evidence Used in AHA/ASA recommendations

- Therapeutic recommendations:
  - Level of Evidence A: Data derived from multiple randomized, clinical trials or meta-analysis
  - Level of Evidence B: Data derived from a single randomized trial or nonrandomized studies
  - Level of Evidence C: Consensus opinion of experts, case studies of standards of care
Definition of Classes and Levels of Evidence Used in AHA/ASA recommendations

• Diagnostic recommendations:
  – Level of Evidence A: Data derived from multiple prospective cohort studies using a reference standard applied by a masked evaluator
  – Level of Evidence B: Data derived from a single grade A study, greater than or equal to 1 case control studies or studies using a reference standard applied by an unmasked evaluator
  – Level of Evidence C: Consensus opinion of experts,
Recommendations: Rehabilitation in the Inpatient Hospital Setting

- Class I, Level of Evidence A: It is recommended that early rehabilitation for hospitalized stroke patients be provided in environments with organized, interprofessional stroke care.

- Class I, Level of Evidence B: It is recommended that stroke survivors receive rehabilitation at an intensity commensurate with anticipated benefit and tolerance.

- Class III, Level of Evidence A: High-dose, very early mobilization within 24 hours of stroke onset can reduce the odds of a favorable outcome at 3 months and is not recommended.
Recommendations: Prevention of Skin Contractures

• Class IIa, Level of Evidence C: Positioning of hemiplegic shoulder in maximum external rotation while the patient is either sitting or in bed for 30 minutes daily is probably indicated.

• Class IIb, Level of Evidence C: Resting hand splints, along with regular stretching and spasticity management in patient lacking hand movement, may be considered.

• Class IIb, Level of Evidence B: Resting ankle splints used at night and during assisted standing may be considered for prevention of ankle contracture in the hemiplegic limb.
Recommendations: Prevention of DVT

- **Class I, A:** In ischemic stroke, prophylactic-dose subcutaneous heparin (UFH or LMWH) should be used for the duration of the acute and rehabilitation hospital stay or until the stroke survivor regains mobility.
- **Class IIa, A:** In ischemic stroke, it is reasonable to use prophylactic-dose LMWH over prophylactic dose UFH for prevention of DVT.
- **Class III, B:** In ischemic stroke, it is not useful to use elastic compression stocking.
- **Class III, C:** In ICH, it is not useful to use elastic compression stockings.
Recommendations: Treatment of Bowel and Bladder Incontinence

- Class I, B: A history of urological issues before stroke should be obtained.

- Class I, B: Assessment of urinary retention through bladder scanning or intermittent catheterizations after voiding while recording volumes is recommended for patients with urinary incontinence or retention.

- Class I, B: Removal of Foley catheter (if any) within 24 hours after admission for acute stroke is recommended.
Recommendations: Assessment, Prevention, and Treatment of Hemiplegic Shoulder Pain

• Class I, C: Patient and family education (ROM, positioning) is recommended for shoulder pain and shoulder care after stroke, particularly before discharge or transition of care.

• Class IIa, A: Botulinum toxin injection can be useful to reduce severe hypertonicity in hemiplegic shoulder muscles.

• Class IIa, C: It is reasonable to consider positioning and use of supportive devices and slings for shoulder subluxation.

• Class IIb, B: Usefulness of subacromial or glenohumeral corticosteroid injection for patients with inflammation in these locations is not well established.

• Class III, C: The use of overhead pulley exercises is not recommended.
Recommendations: Central Pain after Stroke

- Class IIa, B: Amitriptyline and lamotrigine are reasonable first-line pharmacological treatments.
- Class IIa, C: Interprofessional pain management is probably useful in conjunction with pharmacotherapy.
- Class IIb, B: Pregabalin, gabapentin, carbamazepine, or phenytoin may be considered as second line treatments
- Class III, B: TENS has not been established as an effective treatment
- Class III, B: Deep brain stimulation has not been established as an effective treatment.
Prevention of Falls

- Class I, B: It is recommended that individuals with stroke discharged to the community participate in exercise programs with balance training to reduce falls.
- Class I, A: It is recommended that individuals with stroke be provided a formal fall prevention program during hospitalization.
- Class IIa, B: It is reasonable that individuals with stroke be evaluated for fall risk annually with an established instrument appropriate to the setting.
- Class IIb, B: Tai Chi training may be reasonable for fall prevention.
Recommendations: Seizures

• Class I, C: Any patient who develops a seizure should be treated with standard management approaches, including a search for reversible causes of seizure in addition to potential use of antiepileptic drugs.

• Class III, C: Routine seizure prophylaxis for patients with ischemic or hemorrhagic stroke is not recommended.
Recommendations: Post-stroke Depression, including Emotional and Behavioral State

- Class I, B: Administration of a structured depression inventory such as the Patient Health Questionnaire-2 is recommended to routinely screen for poststroke depression.
- Class IIa, A: A therapeutic trial of an SSRI or dextromethorphan/quinidine is reasonable for patients with emotional lability or pseudobulbar affect causing emotional distress.
- Class IIb, B: An exercise program of at least 4 weeks duration may be considered as a complementary treatment for post-stroke depression.
- Class III, A: No recommendation for the use of any particular class of antidepressants is made SSRIs are commonly used and generally well tolerated in this patient population.
Recommendations: Post-stroke Osteoporosis

• Class I, A: It is recommended that individuals with stroke residing in long-term care facilities be evaluated for calcium and vitamin D supplementation.

• Class I, B: It is recommended that US Preventive Services Task Force osteoporosis screening recommendations be followed in women with stroke.

• Class IIa, B: Increased levels of physical activity are probably indicated to reduce the risk and severity of post-stroke osteoporosis.
Recommendations: Assessment of Disability and Rehabilitation Needs

- Class I, B: It is recommended that all individuals with stroke be provided a formal assessment of their ADLs and IADLs, communication abilities, and functional mobility before discharge from acute care hospitalization and the findings be incorporated into the care transition and the discharge planning process.

- Class I, B: It is recommended that all individuals with stroke discharged to independent community living from postacute rehabilitation or SNFs receive ADL and IADL assessment directly related to their discharge living setting.

- Class IIa, B: It is reasonable that individuals with stroke discharged from acute and postacute hospitals/centers receive formal follow-up on their ADL and IADL status, communication abilities, and functional mobility within 30 days of discharge.
Recommendations: Assessment of Motor Impairment, Activity and Mobility

- Class IIb, C: Motor impairment assessments (paresis/muscle strength, tone, individuated finger movements, coordination) with standardized tools may be useful.
- Class IIb, C: The use of standardized questionnaires to assess stroke survivor perception of motor impairments, activity limitations, and participation may be considered.
- Class IIb, C: The use of technology (accelerometers, stepactivity monitors, pedometers) as an objective means of assessing real-world activity and participation may be considered.
Recommendation: Assessment of Communication Impairment

- Class I, B: Communication assessment should consist of interview, conversation, observation, standardized tests, or nonstandardized items; assess speech, language, cognitive-communication, pragmatics, reading, and writing; identify communicative strengths and weaknesses; and identify helpful compensatory strategies.

- Class IIa, A: Telerehabilitation is reasonable when face-to-face assessment is impossible or impractical.
Recommendations: Assessment of Cognition and Memory

• Class I, B: Screening for cognitive deficits is recommended for all stroke patients before discharge home.

• Class IIa, C: When screening reveals cognitive deficits, a more detailed neuropsychological evaluation to identify areas of cognitive strength and weakness may be beneficial.
Recommendation: Sensory Impairments, Including Touch, Vision and Hearing

- Class IIa, B: Evaluation of stroke patients for sensory impairments, including touch, vision, and hearing, is probably indicated.
Recommendations: Dysphagia Screening, Management, and Nutritional Support

- **Class I, B:** Early dysphagia screening is recommended for acute stroke patients to identify dysphagia or aspiration, which can lead to pneumonia, malnutrition, dehydration, and other complications.
- **Class I, B:** Assessment of swallowing before the patient begins eating, drinking, or receiving oral medications is recommended.
- **Class IIa, B:** An instrumental evaluation is probably indicated for those patients suspected of aspiration to verify the presence/absence of aspiration and to determine the physiological reasons for the dysphagia to guide the treatment plan.
- **Class I, B:** Oral hygiene protocols should be implemented to reduce the risk of aspiration pneumonia after stroke.
- **Class I, A:** Enteral feedings (tube feedings) should be initiated within 7 days after stroke for patients who cannot safely swallow.
- **Class I, B:** Nasogastric tube feeding should be used for short term (2–3 weeks) nutritional support for patients who cannot swallow safely.
- **Class IIa, C:** Incorporating principles of neuroplasticity into dysphagia rehabilitation strategies/interventions is reasonable.
Recommendations: Nondrug Therapies for Cognitive Impairment, Including Memory

- Class I, A: Enriched environments to increase engagement with cognitive activities are recommended.
- Class IIa, B: Use of cognitive rehabilitation to improve attention, memory, visual neglect, and executive functioning is reasonable.
- Class IIa, B: Use of cognitive training strategies that consider practice, compensation, and adaptive techniques for increasing independence is reasonable.
- Class IIb, B: Errorless learning techniques may be effective for individuals with severe memory impairments for learning specific skills or knowledge, although there is limited transfer to novel tasks or reduction in overall functional memory problems.
Recommendations: Use of Drugs to Improve Cognitive Impairments

• Class IIb, B: The usefulness of donepezil in the treatment of poststroke cognitive deficits is not well established.

• Class IIb, B: The usefulness of rivastigmine in the treatment of poststroke cognitive deficits is not well established.

• Class IIb, B: The usefulness of antidepressants in the treatment of poststroke cognitive deficits is not well established.
Recommendations: Limb Apraxia

- Class IIb, B: Strategy training or gesture training for apraxia may be considered.
- Class IIb, C: Task practice for apraxia with and without mental rehearsal may be considered.
Recommendations: Hemispatial Neglect or Hemi-Attention

- Class IIa, A: It is reasonable to provide repeated top-down and bottom-up interventions such as prism adaptation, visual scanning training, optokinetic stimulation, virtual reality, limb activation, mental imagery, and neck vibration combined with prism adaptation to improve neglect symptoms.
- Class IIb, B: Right visual field testing may be considered.
- Class IIb, B: Repetitive transcranial magnetic stimulation of various forms may be considered to ameliorate neglect symptoms.
Recommendations: Cognitive Communication Disorders

• Class IIa, B: Interventions for cognitive-communication disorders are reasonable to consider if they are individually tailored and target:
  – The overt communication deficit affecting prosody, comprehension, expression of discourse, and pragmatics.
  – The cognitive deficits that accompany or underlie the communication deficit, including attention, memory, and executive functions.
Recommendations: Aphasia

• Class IIa, A: Intensive treatment is probably indicated, but there is no definitive agreement on the optimum amount, timing, intensity, distribution, or duration of treatment.

• Class IIb, B: Pharmacotherapy for aphasia may be considered on a case-by-case basis in conjunction with speech and language therapy, but no specific regimen is recommended for routine use at this time.

• Class III, B: Brain stimulation techniques as adjuncts to behavioral speech and language therapy are considered experimental and therefore are not currently recommended for routine use.
Recommendations: Motor Speech Disorders and Apraxia of Speech

- Class I, B: Interventions for motor speech disorders should be individually tailored and can include behavioral techniques and strategies that target:
  - Physiological support for speech, including respiration, phonation, articulation, and resonance
  - Global aspects of speech production such as loudness, rate, and prosody.
Recommendations: Spasticity

- Class I, A: Targeted injection of botulinum toxin into localized upper limb muscles is recommended to reduce spasticity, to improve passive or active range of motion, and to improve dressing, hygiene, and limb positioning.
- Class I, A: Targeted injection of botulinum toxin into lower limb muscles is recommended to reduce spasticity that interferes with gait function.
- Class IIa, A: Oral antispasticity agents can be useful for generalized spastic dystonia but may result in dose-limiting sedation or other side effects.
- Class IIb, A: Physical modalities such as NMES or vibration applied to spastic muscles may be reasonable to improve spasticity temporarily as an adjunct to rehabilitation therapy.
- Class IIb, A: Intrathecal baclofen therapy may be useful for severe spastic hypertonia that does not respond to other interventions.
- Class IIb, C: Postural training and task-oriented therapy may be considered for rehabilitation of ataxia.
- Class III, B: The use of splints and taping are not recommended for prevention of wrist and finger spasticity after stroke.
Recommendations: Balance and Ataxia

- Class I, A: Individuals with stroke who have poor balance, low balance confidence, and fear of falls or are at risk for falls should be provided with a balance training program.
- Class I, A: Individuals with stroke should be prescribed and fit with an assistive device or orthosis if appropriate to improve balance.
- Class I, C: Individuals with stroke should be evaluated for balance, balance confidence, and fall risk.
Recommendations: Mobility

• Class I, A: Intensive, repetitive, mobility-task training is recommended for all individuals with gait limitations after stroke.
• Class I, A: An AFO after stroke is recommended in individuals with remediable gait impairments (eg, foot drop) to compensate for foot drop and to improve mobility and paretic ankle and knee kinematics, kinetics, and energy cost of walking.
• Class IIa, A: Group therapy with circuit training is a reasonable approach to improve walking.
• Class IIa, A: Incorporating cardiovascular exercise and strengthening interventions is reasonable to consider for recovery of gait capacity and gait related mobility tasks.
• Class IIb, A: Robot-assisted movement training to improve motor function and mobility after stroke in combination with conventional therapy may be considered.
• Class IIb, B: The usefulness of electromyography biofeedback during gait training in patients after stroke is uncertain.
• Class IIb, B: Virtual reality may be beneficial for the improvement of gait.
• Class IIb, B: The effectiveness of levodopa to enhance motor recovery is not well established.
Recommendations: Upper Extremity Activity, including ADLs, IADLs, Touch and Proprioception

- Class I, A: Functional tasks should be practiced; that is, task-specific training, in which the tasks are graded to challenge individual capabilities, practiced repeatedly, and progressed in difficulty on a frequent basis.
- Class I, A: All individuals with stroke should receive ADL training tailored to individual needs and eventual discharge setting.
- Class IIa, A: CIMT or its modified version is reasonable to consider for eligible stroke survivors.
- Class IIa, A: Robotic therapy is reasonable to consider to deliver more intensive practice for individuals with moderate to severe upper limb paresis.
- Class IIa, A: NMES is reasonable to consider for individuals with minimal volitional movement within the first few months after stroke or for individuals with shoulder subluxation.
- Class IIa, A: Mental practice is reasonable to consider as an adjunct to upper extremity rehabilitation services.
- Class IIa, B: Strengthening exercises are reasonable to consider as an adjunct to functional task practice.
- Class IIa, B: Virtual reality is reasonable to consider as a method for delivering upper extremity movement practice.
Recommendations: Adaptive Equipment, Durable Medical Devices, Orthotics and Wheelchairs

• Class I, B: Ambulatory assistive devices (eg, cane, walker) should be used to help with gait and balance impairments, as well as mobility efficiency and safety, when needed.

• Class I, B: AFOs should be used for ankle instability or dorsiflexor weakness.

• Class I, C: Wheelchairs should be used for nonambulatory individuals or those with limited walking ability.
Recommendations: Chronic Care Management: Home- and Community-Based Participation

- Class I, A (for improved fitness); B (for reduction of stroke risk): After successful screening, an individually tailored exercise program is indicated to enhance cardiorespiratory fitness and to reduce the risk of stroke recurrence.

- Class I, A: After completion of formal stroke rehabilitation, participation in a program of exercise or physical activity at home or in the community is recommended.
Recommendations: Treatments/Interventions for Visual Impairments

• For deficits in eye movements:
  – Class I, A: Eye exercises for treatment of convergence insufficiency are recommended.
  – Class IIb, C: Compensatory scanning training may be considered for improving scanning and reading outcomes.
Recommendations: Treatments/Interventions for Visual Impairments

• For deficits in visual fields:
  – Class IIb, B: Yoked prisms may be useful to help patients compensate for visual field cuts.
  – Class IIb, B: Compensatory scanning training may be considered for improving functional deficits after visual field loss but is not effective at reducing visual field deficits.
Recommendations: Treatments/Interventions for Visual Impairments

- For visual-spatial/perceptual deficits:
  - Class I, B: Multimodal audiovisual spatial exploration training appears to be more effective than visual spatial exploration training alone and is recommended to improve visual scanning.
  - Class IIb, B: There is insufficient evidence to support or refute any specific intervention as effective at reducing the impact of impaired perceptual functioning.
  - Class IIb, B: The use of virtual reality environments to improve visual-spatial/perceptual functioning may be considered.
Recommendations: Hearing Loss

• Class IIa, C: If a patient is suspected of a hearing impairment, it is reasonable to refer to an audiologist for audiometric testing.

• Class IIa, C: It is reasonable to use some form of amplification (eg, hearing aids).

• Class IIa, C: It is reasonable to use communication strategies such as looking at the patient when speaking.

• Class IIa, C: It is reasonable to minimize the level of background noise in the patient’s environment.
Recommendation: Ensuring Medical and Rehabilitation Continuity Through the Rehabilitation Process and Into the Community

• Class IIa, B: It is reasonable to consider individualized discharge planning in the transition from hospital to home.

• Class IIa, B: It is reasonable to consider alternative methods of communication and support (eg, telephone visits, telehealth, or Web-based support), particularly for patients in rural settings.
Recommendations: Social and Family Caregiver Support

• Class IIb, A: It may be useful for the family/caregiver to be an integral component of stroke rehabilitation.

• Class IIb, A: It may be reasonable that family/caregiver support include some or all of the following on a regular basis: education, training, counseling, development of a support structure, financial assistance.

• Class IIb, B: It may be useful to have the family/caregiver involved in decision making and treatment planning as early as possible and throughout the duration of the rehabilitation process.
Recommendations: Referral to Community Resources

• Class I, C: It is recommended that acute care hospitals and rehabilitation facilities maintain up-to-date inventories of community resources.
• Class I, C: Patient and family/caregiver preferences for resources should be considered.
• Class I, C: It is recommended that information about local resources be provided to the patient and family.
• Class I, C: Follow-up is recommended to ensure that the patient and family receive the necessary services.
Recommendations: Rehabilitation in the Community

- Class I, A: Patients with stroke receiving comprehensive ADL, IADL, and mobility assessments, including evaluation of the discharge living setting, should be considered candidates for community or home-based rehabilitation when feasible. Exclusions include individuals with stroke who require daily nursing services, regular medical interventions, specialized equipment, or interprofessional expertise.

- Class IIa, B: It is reasonable that caregivers, including family members, be involved in training and education related directly to home-based rehabilitation programs and be included as active partners in the planning and implementation or treatment activities under the supervision of professionals.
Recommendation: Sexual Function

- Class IIb, B: An offer to patients and their partners to discuss sexual issues may be useful before discharge home and again after transition to the community. Discussion topics may include safety concerns, changes in libido, physical limitations resulting from stroke, and emotional consequences of stroke.
Recommendations: Recreational and Leisure Activity

- Class IIa, B: It is reasonable to promote engagement in leisure and recreational pursuits, particularly through the provision of information on the importance of maintaining an active and healthy lifestyle.

- Class IIa, B: It is reasonable to foster the development of self-management skills for problem solving for overcoming barriers to engagement in active activities.

- Class IIa, B: It is reasonable to start education and self-management skill development about leisure/recreation activities during and in conjunction with in-patient rehabilitation.
Recommendations: Return to Work

• Class IIa, C: Vocationally targeted therapy or vocational rehabilitation is reasonable for individuals with stroke considering a return to work.

• Class IIb, C: An assessment of cognitive, perception, physical, and motor abilities may be considered for stroke survivors considering a return to work.
Recommendations: Return to Driving

• Class I, C: Individuals who appear to be ready to return to driving, as demonstrated by successful performance on fitness-to-drive tests, should have an on-the-road test administered by an authorized person.

• Class IIa, B: It is reasonable that individuals who do not pass an on-the-road driving test be referred to a driver rehabilitation program for training.

• Class IIb, C: A driving simulation assessment may be considered for predicting fitness to drive.
IRFs provide hospital-level care to stroke survivors who need intensive, 24-hour-a-day, interdisciplinary rehabilitation care that is provided under the direct supervision of a physician. Medicare (Centers for Medicare & Medicaid Services) regulations specify that admission to IRFs should be limited to patients for whom significant improvement is expected within a reasonable length of time and who are likely to return to a community setting (rather than being transferred to another setting such as a SNF or long-term care facility). Medicare regulations also generally dictate that IRFs provide at least 3 hours of rehabilitation therapy (defined as PT, OT, and SLT) per day for at least 5 d/wk. Physicians are expected to have training or experience in rehabilitation, and daily physician visits are typical. Registered nurses are present on a continuous basis and commonly have specialty certification in rehabilitation nursing. An IRF can be located as a geographically distinct unit within an acute care hospital or as a free-standing facility.
SNFs (also known as subacute rehabilitation) provide rehabilitation care to stroke survivors who need daily skilled nursing or rehabilitation services. Admission to SNFs may be requested for patients who the rehabilitation team determines may not reach full or partial recovery or if skilled nursing services are required to maintain or prevent deterioration of the patient. SNFs are required to have rehabilitation nursing on site for a minimum of 8 h/d, and care must still follow a physician’s plan, although there is no requirement for direct daily supervision by a physician. SNFs can be stand-alone facilities, but when located within an existing nursing home or hospital, they must be physically distinguishable from the larger institution (e.g., a separate designated wing, ward, or building).
the findings in favor of IRF referral suggests that stroke survivors who qualify for IRF services should receive this care in preference to SNF-based care.

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<th>Recommendations: Organization of Poststroke Rehabilitation Care (Levels of Care)</th>
<th>Class</th>
<th>Level of Evidence</th>
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<td>It is recommended that stroke patients who are candidates for postacute rehabilitation receive organized, coordinated, interprofessional care.</td>
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<tr>
<td>It is recommended that stroke survivors who qualify for and have access to IRF care receive treatment in an IRF in preference to a SNF.</td>
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