# Navigating a Short-Term Stay in a Skilled Nursing Facility: Key Strategies for Caregivers

Presented by

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# Alzheimer’s Texas

A privately funded voluntary health organization formed in 1982 to serve Central Texans with Alzheimer’s disease and their caregivers.

**MISSION**

To eliminate Alzheimer's disease and related disorders through the advancement of research and to enhance care and support for individuals, their families, and caregivers.

**VISION**

To create and sustain a dementia capable Texas in which persons with Alzheimer’s and related disorders, and their families, receive quality care, effective treatments, and meaningful support.

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# Learning Objectives

- Understand key aspects of a short-term rehabilitation stay, including admission, patient needs, and discharge planning.
- Learn strategies for self advocacy and effective communication with various individuals and departments within a skilled nursing facility.
- Formulate key questions to help caregivers develop a well-informed discharge process for their loved one with dementia.
- Think about and share ways we are supporting ourselves or others who are experiencing a short-term stay in a skilled nursing facility.

# Medicare Part A: Skilled Nursing Facility Care

- Must meet medical criteria for rehabilitation therapy (able to participate)
- 3 midnight hospital stay rule and you must enter the SNF within 30 days of discharge from the hospital
- Short-term stay/inpatient rehab: PT, OT, ST, Skilled Nursing, Dietary, SW, recreational activities
- Must be able to continue participating to remain covered
- Long-term care in skilled nursing is only covered by Medicaid or a patient's individual LTC insurance.
- **Benefit Period:** Starts on day one in a skilled nursing facility
- **Days 1-20: 100%**
- **Days 21-100: 80%**
  - Many pts use supplemental insurance or Medicaid for coinsurance after day 20
  - Copayment per day of each benefit period-varies per year and usually increases slightly each year
- **Days 100+: 0%**
  - pts can utilize their Part B benefit for rehab at this point but room and board is no longer covered
- **Benefit period resets after 60 days of no hospital or SNF admission**
- **Once a patient has been discharged from the SNF for 30 days, they must have a new 3 night hospital stay to qualify for a new benefit period.**

# Changes Due to COVID19

Some people may be able to get renewed SNF coverage without first having to start a new benefit period.

If you're not able to be in your home during the COVID-19 pandemic or are otherwise affected by the pandemic, you can get SNF care without a qualifying hospital stay.

**1-800-MEDICARE & Medicare.gov**

# Selecting a Skilled Nursing Facility

- Referrals from the hospital social worker or case manager
- Visiting facilities to assess patient to caregiver ratio, staff interactions, appearance of residents, activities offered, and overall impressions
- Compare 5 star ratings of skilled nursing facilities on Medicare.gov
  - https://www.medicare.gov/care-compare/
  - Reflects health inspections, staffing, and overall quality measures
- Unfortunately, caregivers are often given less than 48 hours to make this decision

# Helpful Information for Caregivers To Access

| | | |
|---|---|---|
| Visiting policies, especially COVID specific policies | Meal schedules | Rehab schedules |
| Various activities offered | Assistance with completing advance directives and Referrals to Community Resources | Names of nurses and nurse aides working with the patient |
| Names of Facility Administrator, Social Worker, Director of Nursing, Dietary Director, Housekeeping Director | Additional services available to patient: psychological, psychiatric, music therapy, pet therapy, etc.? | When the first care plan meeting will be held with the interdisciplinary team |

# How Can Caregivers Access Information?

- ✓ Request an Interdisciplinary Care Plan Meeting
  - **Social worker**
  - **Physician/Nurse Practitioner/Charge Nurse**
  - **Rehab Therapists (Physical, Occupational, Speech Therapy)**
  - Activities Director/Aide
  - Nurse Aide
  - Dietician/Food Service Manager
  - Psychologist/Psychiatrist
- ✓ Request a meeting with the social worker
- ✓ Plan ahead with health care providers (Home Health, Hospice, Durable Medical Equipment Company, Assisted Living, Personal Care Home)

# Why is the Discharge Happening?

- Rehabilitation therapy is ending
- Patient and/or caregiver wishes for the patient to return home
- Patient is moving to a different level of care or another facility
- The skilled nursing facility can no longer meet the patient's needs

# What are the Patient's Needs at Discharge?

- ❑ Medication regimen
- ❑ Appropriate level of care

  (Skilled Nursing-24 hour care, Assisted Living/Memory Care, Personal Care Home, Long Term Acute Care, Home Health, Hospice/Palliative care, Outpatient Rehab)
- ❑ Assistance with Activities of Daily Living (ADLs): bathing, incontinence care, etc.
- ❑ Equipment needs: walker, wheelchair, Hoyer lift . . .
- ❑ Wound care/infection control
- ❑ Mobility restrictions/activity level (weight bearing status, exercise, driving . . .
- ❑ Mental health/emotional support needs
- ❑ Dietary needs/restrictions
- ❑ Level of care covered by Medicare/Medicaid/insurance
- ❑ Care needs not covered by Medicare/Medicaid/insurance

# Which Level of Care is Most Appropriate?

***Depends on level of care needed, patient/caregiver preferences, and insurance coverage**

**Inpatient/Acute:**

- Skilled Nursing Facility (SNF)
- Inpatient Hospice Care
- Long-term Acute Care
- Inpatient Psychiatric Care
- Free standing Short-Term Rehab Centers

**Outpatient:**

- Independent Living/Retirement Community
- Assisted Living/Memory Care (AL/MC)
- Personal Care Home (PCH)
- Home with attendant care and/home health or hospice care services as needed

# My Loved One is Going Home. Which Services Do They Need?

***Depends on level of care needed, patient/caregiver abilities & preferences, and insurance coverage**

- Home Health
- Hospice
- In Home Attendant Care
- Mental Health Services: Psychological/Psychiatric Care
- Outpatient Rehabilitation Therapy

***Who will tend to each caregiving task?**

# How Does the Discharge Process Happen?

- ✓ Interdisciplinary team recommends that patient be discharged or patient/family requests discharge
- ✓ Interdisciplinary Care Plan meeting is held with patient and/or caregiver
- ✓ Physician writes orders for discharge, health care services and medical equipment
- ✓ Orders for health care services and medical equipment are sent to health care agencies and durable medical equipment providers
- ✓ Health care agencies and durable medical equipment provider contact patient or caregiver to coordinate start date for services or equipment delivery
- ✓ Patient and caregiver are notified of date and time of discharge
- ✓ Charge nurse prepares discharge instructions, medications and other equipment to go home with patient
- ✓ Charge nurse goes over discharge instructions and medication list with patient and/or caregiver prior to discharge
- ✓ Caregiver or medical transport brings patient to home or receiving facility

# SNF Discharge Planning Toolbox

- ❑ **Why** is the patient being discharged?
- ❑ May we have an **interdisciplinary care plan meeting** to discuss the discharge?
- ❑ What are the **patient's care needs** at this time?
- ❑ What is the **appropriate level of care** that meets the patient's needs, honors the patient's wishes and is covered by the patient's insurance or private funding?
- ❑ What **health care services** are being ordered by the physician, what care needs are covered by the patient's insurance and when will they begin?
- ❑ **Which health care service providers** will be contacting me?
- ❑ **When will the patient be discharged** and what will happen on the day of discharge?
- ❑ **What medical equipment is being ordered** by the physician, what percentage of the equipment cost is covered by insurance, and when will it be delivered?
- ❑ **What care needs will the patient and/or caregiver be responsible for?**

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# Questions?

# What do you want us to know?

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