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.
• 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 COVID-19

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

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

What do you want us to know?
References


