Transitions in Care
Skilled Nursing Facility Information

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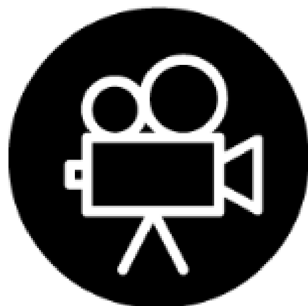

Your Hospital Stay: Moving to Another Care Facility (02:05)

Your health professional recommends that you watch this short online health video.

Learn how your discharge plan can help you feel more confident about moving to a care facility.

How to watch the video

Scan the QR code

OR

Visit the website

https://hwi.se/r/Efjag5j1yz5zl

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What is a Skilled Nursing Facility?

A skilled nursing facility (SNF) is a place where you can go after an injury, illness, or hospital stay. A team of healthcare workers will work with you to continue your recovery. Assistance is available around the clock.

Why is the team at the hospital recommending I go to a SNF?

The hospital team feels you are making progress, but still need more care. You are not ready to return home. The hospital team recommends you have help day and night. This suggestion comes after thinking about many factors. The hospital team reviews the reason you came to the hospital (diagnosis) and medical needs. These needs include medicines and treatments. The team also discusses your care needs for nursing and therapy. Therapies may include physical, occupational, and speech. How much help you need and how long you might need the help are also important.

What is the goal of care at a SNF?

There are two main goals of care during your stay. The first is to improve your health. The second is to increase your independence as much as possible. You will set your own goals with the SNF team. The goals will depend on what is best for you. The SNF team will work with you to meet them. Some examples might be:

- To increase strength in your arms and legs
- To help you learn to walk better
- To help you care for your wound
- To help you learn new skills to care for yourself

Who will help me find a SNF?

A case manager (CM) is the main team member at the hospital who will help you. He or she will work with you and your family to find a SNF.

What steps need to occur for me to go to a SNF?

1. A CM will talk to you about discharge from the hospital.
2. You will hear what the hospital team recommends for you after the hospital.
3. Your CM will give you a list of SNF options.
4. You should give 3 to 4 choices to the CM.
5. Your family has the option to visit the SNFs. We recommend you go early in the process.
6. The CM will send information about you and your needs to the SNFs.
7. The SNF will review the information to see if they can meet your needs.
8. If the SNF can meet your needs and if space is available, the SNF will let the CM know.
9. Your CM will update you.
10. You can choose from the SNFs, which can meet your needs and have a bed on the day that you are ready for discharge.
11. Your CM will update you on your offers.

What should I consider when selecting a SNF?

There are several things to consider when selecting a skilled nursing facility. Here are some questions:

- How long do I expect to be in the SNF?
- Do I have a family member who can help choose the right SNF for me?
- Would a family member or friend be able to visit SNFs for me?

- The Official Medicare website at www.medicare.gov has information about skilled nursing facilities. Your case manager can help you find this information.
- Is the SNF clean, well kept, quiet, and a comfortable temperature?
- Does the staff at the SNF speak my language? Are interpreter services available?
- Will the SNF be able to meet my diet and cultural needs?
- Is the location convenient?
- Will my family and friends be able to visit after I get there?

How will I know that I am ready for discharge?

Many things will determine if you are ready to leave the hospital. There are three key steps.

1. The hospital doctor and team decide you are ready to leave the hospital.
2. The SNF is ready for you.
3. The communication between the teams before discharge.

What should I expect when I get there?

A nurse will meet with you when you get to the SNF. He or she will begin to get to know you. This includes looking at your medical records and asking questions. He or she will also examine you. If your doctor has recommended therapy, the therapists will complete a similar review. Therapies may include physical, occupational and/or speech. You will also complete paperwork. A family member should come with you to the facility. Both of you can hear information about the SNF such as policies and procedures.

What happens during a typical day?

There is not really a typical day at a SNF. Your schedule is set based on your needs and treatments. The SNF team will review your schedule with you. Some common daily activities might include

- Getting up out of bed
- Dressing
- Bathing
- Participating in rehab
- Eating meals
- Taking medicines
- Nursing treatments
- Learning about your care needs

What do I need to bring?

The SNF team wants you to be comfortable. You will be able to have your own belongings at the SNF to make it feel more like home. You might want to bring:

- Comfortable Clothes
- Pajamas
- Shoes
- Personal Care Items
- Magazine or Books
- Photos
- Items that bring comfort, like a favorite quilt
- Insurance Cards
- You do ***NOT*** need to bring your medicines unless the SNF tells you otherwise.

How can my family and I play an active role during the stay?

It is important for you to be involved in your care. You are an important member of the team. You are encouraged to:

- Ask questions
- Learn what is expected of you during your stay
- Work together with the team
- Set goals
- Work hard towards your goals
- Let the providers know how you are feeling
- Attend scheduled care plan meetings
- Look for ways to participate in activities that interest you

Who are members of the SNF team who may be working with me?

A doctor or physician (MD) will direct the care provided by the SNF team. Nurse practitioners (NP) and Physician Assistants (PAs) may also provide your medical care. MDs, PAs and NPs are called providers. How often you see the providers will not be the same as when you were in the hospital. Each SNF has a different schedule for provider visits. A provider will be available if you need him or her. You can speak to the staff at the SNF to learn more.

Nursing services will be available around the clock. The nurses may be Registered Nurses (RNs) or Licensed Practical Nurses (LPNs). Nursing assistants (NAs) will work with the RNs and LPNs to meet your care needs.

You will likely go to a SNF to get therapy. In this case, you may work with Physical Therapists (PT), Occupational Therapists (OT) and/ or Speech Therapists (SLP). You may hear them called “rehab” people. PTs may help you gain skills such as walking, moving to a chair and balance. OTs may work with you on things you do every day such as bathing, dressing, eating, and writing. SLPs focus on speaking, thinking and swallowing.

In addition, you may have a dietician, social worker, counselor, recreational therapist, or other providers working with you.

What nursing services might I receive in a SNF?

Skilled nursing is a service provided under the direction of a licensed nurse. Nurses work with all the team members to carry out your treatment plan. The nursing staff will monitor your health and provide direct care. The exact type of care will be based on what brings you to the SNF. Some examples might include complex wound care, complex medicines, monitoring your overall health or teaching you to care for yourself at home.

What is rehab?

Rehab is a short form of the word rehabilitation. Your illness, injury, or surgery may have caused some changes in your body. You may have lost some ability to care for yourself. This might include chores such as bathing, dressing, or walking. You might also have a hard time talking, thinking, or eating. Rehabilitation is a program that helps you learn to do as much as possible for yourself.

How is rehab in a SNF different from the hospital?

There is a change in the goal of your care from hospital to SNF. The new goals are to help you get stronger and learn how to care for yourself. You may see some members of your health team more and some less in the SNF than in the hospital. For example, you will not need to see your SNF doctor as much as you saw the doctor in the hospital. You will see some SNF team members on a daily basis.

The SNF is a stop on your road to recovery. You will do more home like activities. For example, getting up and dressed in regular clothes will happen on a daily basis. You may go to a dining room to eat, just as you would at home. You will also be "working out" on a regular basis with your therapists. The therapy session will more likely occur in the facility gym, treatment room, or hallways instead of your room. The therapy

sessions are also likely to last longer. These differences in rehab will allow you more opportunity to gain strength and ability to care for yourself.

What are some key points of rehab?

- You, the patient, are an important part of the team.
- The reason for rehab is to help you get better and gain independence.
- While you are getting rehab, the SNF provides care for your illnesses and/or injury.
- Rehab activities help you learn to do as much as possible for yourself.
- You will need to share your needs with the team.
- You will need to work hard with the SNF therapists during your therapy sessions. Generally, a rehab stay is short-term. This means that your stay lasts weeks, not months.
- Most insurance will help cover your rehab expenses, but additional expenses might occur. You can talk to the business office or the admissions coordinator at the SNF to get your questions answered.

How will I get from the hospital to the SNF?

The CM at the hospital will work with you to arrange transportation. Some options include private vehicle, wheelchair van, or ambulance. You may be financially responsible for some portion of your transportation.

Does insurance cover SNF services?

- If you have original Medicare, SNF services are covered if you meet Medicare's requirements:
  - You need to be in the hospital for at least 3 days as an inpatient.
    - Each day starts at midnight. At least 3 midnights as an inpatient in a hospital is required.
  - The need for a professional to provide skilled care.
    - Generally, Medicare pays for the first 20 days of a SNF stay in a benefit period.
    - After the first 20-day period, you will be paying a portion of the bill out of your own pocket unless you have additional insurance. This does not guarantee you will get 20 days automatically. Your number of days is based on your needs and progress.
- Please see http://medicare.gov to review your specific benefits and coverage. Your admissions coordinator at the SNF can help answer questions related to Medicare criteria, coverage and any items or services not covered in the first 20 days.
- If you have a Medicare Advantage plan, please review your specific benefit plan. Each plan is different.
- If you have Medicaid, your benefits will depend on which state you live in. You can contact your local Medicaid Office. Your CM can also help answer questions.
- If you have private insurance, you may or may not have coverage for a SNF stay. Please refer to your insurance plan benefits. The admissions coordinator can also answer questions for you.

What will happen after my SNF stay?

After discharge from the SNF, you will likely need ongoing rehab therapy. This will help you continue to recover from your illness, injury, or surgery. An outpatient rehab center or home health agency can provide ongoing therapy. These services could include PT, OT, SLP, nursing, or social work. You and the SNF care team will work together to determine the best plan for you. You may feel much better and improve more quickly when you are in your own home.

You may need a different living situation than before you went to the hospital. Some examples may be staying with a family member or friend, staying in an assisted living facility, or staying in a long-term care area of a SNF. Please be aware of this possibility and work closely with the SNF care team. Share your feelings and concerns. The team can help you determine the best discharge solution for you based on your needs and caregiver situation.

Wherever you decide to live after discharge from the SNF, you will need to see a doctor for primary care. This might be a doctor you already know, or the SNF may help you find a new doctor if you need one. You should see your doctor within a few weeks of discharge from the SNF. This appointment is very important to make sure that your doctor knows if any of your medicines have changed, that you have all of the equipment and help that you need, and to make a plan to keep you healthy. Staff at the SNF may help you schedule this doctor's appointment. If they do, make sure you know the date and time of the appointment and that you have transportation if you need it.

Resources

The following educational information includes links to Non-Duke University Health System Internet resources including web sites. However, DUHS does not moderate these sites and is not responsible for the accuracy or content of information contained in these sites. Links from DUHS to third-party sites and resources do not constitute an endorsement by DUHS of the parties or their products and services. The appearance of advertisements and product or service information on these 3rd party sites does not constitute an endorsement by DUHS and DUHS has not investigated the claims made by any advertiser.

Benefits Check Up: This site is a service of the advocacy group, National Council on Aging. It provides information about programs that help pay for prescription drugs, utility bills, meals, health care, and more. Their phone number is 202-479-1200. The web address is www.benefitscheckup.org

Long-Term Care (LTC) Ombudsman Program: This site is funded by the Administration on Aging. It is managed by Consumer Voice. The site provides support to the Ombudsman Programs in the states. The program also hopes to increase the quality of life of long-term care residents. The phone number is 202-332-2275. The email address is info@theconsumervoice.org. The web address is http://ltcombudsman.org

Senior Pharm Assist: This organization assists senior adults in reviewing their medicine options in Durham County, North Carolina. The phone number is 919-688-4772. The email address is info@seniorpharmassist.org . The web address is http://seniorpharmassist.org

Governmental Agencies (Insurance based)

Medicaid for Long Term Care: This website provides information on who is eligible for the long-term Medicaid program. It has links to Community Alternative Programs and Program for All-Inclusive Care for the Elderly (PACE). Website: http://www.ncdhhs.gov/dma/medicaid/ltc.htm#nursinghome

Medicare: This is the official website for Medicare. It covers information about costs, what is covered, forms, provider comparisons and much more. It also has a link to compare skilled nursing facilities at Nursing Home Compare: http://www.medicare.gov/nursinghomecompare/search.html For more information call 1-800-MEDICARE or visit www.medicare.gov.

State Health Insurance Assistance Programs (SHIPs): Offers counseling on health insurance and programs for people with limited income. They help with claims, billing, and appeals. Visit www.Medicare.gov/contacts , or call 1-800-MEDICARE (1-800-633-4227) to get your SHIP's phone number. TTY users should call 1-877-486-2048.

State Medical Assistance (Medicaid) Office: Provides information about Medicaid. To find your local office, visit www.Medicare.gov/contacts , or call 1-800-MEDICARE.

Governmental Agencies (Non-insurance)

Administration on Aging (AoA): It is agency of the United States Department of Health and Human Services. It has links to Office of Support and Caregiver Services, Office of Nutrition and Health Promotion, Office of Elder Protection, Office for American Indian Alaska Natives and Hawaiian Natives, Older American Act and Aging Network and Office of Long-term Care Ombudsman Program. The agency can be reached at Public Inquiries: (202) 619-0724. Website: http://www.acl.gov/About_ACL/Contact_Us/Index.aspx.

Administration for Community Living: This is a government agency that helps individuals live in the community. The agency works with people of all ages. The phone number is Office of the Administrator, Administration for Community Living: (202) 401-4634. Visit: http://www.acl.gov/Index.aspx

Area Agencies on Aging (AAAs): This website can help adults age 60 and older and their caregivers. To find the AAA in your area, call The Eldercare Locator at 1-800-677-1116 weekdays from 9:00 a.m. to 8:00 p.m. (EST) or visit www.eldercare.acl.gov

Eldercare Locator: This site is run by the Department of Health and Human Services. It seeks to connect elders with resources. The phone number is 1-800-677-1116. The web address is http://www.eldercare.acl.gov/Eldercare.NET/Public/Index.aspx

National Long-Term Care Clearinghouse: This site is part of the US Department of Health and Human Services. It provides information and resources to plan for your long-term care needs. Visit www.longtermcare.gov

North Carolina Division of Health Service Regulation: This website provides multiple links to listings of nursing homes, adult care homes, hospitals, and home care agencies licensed by the state. You can visit the web at http://www.ncdhhs.gov/dhsr/index.html

*** You can also speak to your CM or SNF Discharge Planner about resources.

Skilled Nursing Facility (SNF) Checklist

(From Medicare.gov)

You or someone you trust is encouraged to visit several SNFs. This checklist can help you compare the skilled nursing facilities (SNFs) that you visit. Look at the checklist before you go on your visit or tour. Sample questions to ask are available below. This list also provides suggestions on what to look for as you tour the facility and see the staff and the residents. Some of these questions may be more personally important to you and your family. Some items are more important to find out about the quality of care the residents get. Use a new checklist for each SNF you visit.

Use your completed checklist with the quality of care information from www.medicare.gov to help you compare the SNFs.
You can find this information by visiting www.medicare.gov/nhcompare/ .

"Nursing Home Compare" at www.medicare.gov on the web includes:

- ✓ The number of beds at the facility. How many beds are used (occupied)
- ✓ Nursing staff hours per resident per day
- ✓ SNF inspection summary results
- ✓ Problems and complaint information
- ✓ Quality measures for each nursing home

Name of skilled nursing facility (SNF):

____

Date of visit: _________________________

Basic information	**Yes**	**No**	**Comments**
The SNF is Medicare-certified?			
The SNF is Medicaid-certified?			
The SNF provides the skilled care you need, and a bed is available.			
The SNF has special services if needed in a separate unit (like dementia, ventilator, or rehabilitation), and a bed is available.			

Resident information	**Yes**	**No**	**Comments**
Residents are clean, appropriately dressed for the season or time of day, and well groomed.			

Living Spaces	Yes	No	Comments
The SNF is free from overwhelming unpleasant odors.			
The SNF appears clean and well kept.			
The temperature in the SNF is comfortable for residents.			
The SNF has good lighting.			
Noise levels in the dining room and other common areas are comfortable.			
Smoking is not allowed or may be restricted to certain areas of the SNF.			
Furnishings are sturdy, yet comfortable and attractive.			

Today I spoke with: ____________________________

His/her job title is:______________________________

His/her phone number is: ______________________

Questions/Notes

In the hospital, we encourage you to talk to your health team about your questions and concerns.