A Guide to Understanding Your Discharge Options After Hospitalization

Helping our patients to put the pieces together.

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Note: All asterisked terms may be found in the glossary
Discharge from the hospital can be a stressful time for patients and their families. This booklet will help to answer questions that you or your family may have regarding available discharge options.

The staff at Dartmouth-Hitchcock Medical Center wants to be sure that patients are discharged safely when their condition no longer requires a hospital stay. Many medical or surgical conditions need home care follow-up or a stay at another facility to complete recovery.

Hospital stays are often short; so it is very important that planning for discharge and follow-up be done as early as possible. At the same time that your team of caregivers are planning the tests, treatments, and procedures that you may receive, they are also planning for the time that you will be ready to leave the hospital. We encourage you to talk about this aspect of your hospital stay with your doctor and other caregivers.

Decisions about when you are ready to leave, and the best place to go, can be complex. It is not unusual for patients and their families to be surprised when they hear that you are leaving the hospital. You may not feel ready to leave. This means that you and your family may need to respond quickly to discharge decisions.
The Office of Care Management has Clinical Resource Coordinators (CRC)*, Social Workers (SW)*, Continuing Care Managers (CCM)*, and Resource Specialists*, who will assist in pulling together a discharge plan that is right for you. We suggest that you have a family member, or person that you trust be involved in this process so that you have support when making decisions regarding your care after hospitalization.

We also ask that you consider all the possible discharge choices with the guidance of your support person, medical team, CRC and/or SW. Often the best choice can be hard, but it may be the best for you to complete your recovery.
Hospital to Home with Home Care

How will I know if I qualify for Home Care?

People who need part-time nursing services or rehabilitative services and are not able to get this care in any other setting such as an out patient clinic might qualify for home care. Your CRC can help you look into the many state and local community social services that may support you at home. Examples are Meals on Wheels, Adult Day Care and transportation assistance.

How is Home Care paid for?

- **Medicare**: Medicare fully covers professional services as long as the care is necessary and ordered by your doctor. There is a 20% insurance co-payment for equipment.

- **Medicaid**: Medicaid will pay for Home Care as long as the Home Care Agency is a state contracted Medicaid provider. There may be some restrictions.

- **Commercial Insurance**: Coverage varies by policy. Your Care Manager, (CRC or SW), can help you find out what coverage you might have. Most insurance policies have a home care benefit and professional care is covered. You may be responsible for a co-payment.

- **No Insurance**: You pay or you may be able to get assistance (such as Medicaid). Your social worker can help you apply for assistance.

How is Home Care arranged?

Your Care Manager, (CRC or SW) will work with you and your family to select the right agency for you. The Care Manager will contact the agency and provide them with the necessary clinical, social, and insurance information for them to meet your needs.
When you leave the hospital you will receive discharge instructions that will include a list of your medications, and the name and number of the agency that will provide your service.

**How long can I expect to receive Home Care?**

Your doctor orders a treatment plan. Your goals and progress will determine how long you will qualify for home care services.

Supportive social services will be looked at on a regular basis and are dependent on the resources in your area.

**What else do I need to know?**

- Home care is part-time care. It does not provide 24-hour care, and in many cases will not provide daily care. If that is what is required in order for you to stay at home you will need to supplement the services with family, friends or private help.

- Your care needs may mean that more than one agency will be involved in your care at home. One agency may deliver supplies and equipment while another may provide the professional staff.

  **Resources are limited and it takes time to plan, so starting early is important!**

*NOTE: A section of Care Management is called Lifeline. This service can summon 24-hour assistance by pressing a small personal help button. Your Care Manager can give you more information or help you to subscribe to this service.*
**Hospice Care**

**What is Hospice care?**

Hospice is a special way of caring for the person who is dying. Care is given in their home, a hospital or a nursing home. This care includes physical care and counseling. It is for all age groups during their final stages of life. The goal of Hospice is to comfort and care for you and your family and not to cure your illness.

**How will I know if I qualify for Hospice?**

Your Doctor and the hospice medical director confirm that your illness will not get better and you probably have less than six months to live.

**How are Hospice services paid?**

- **Medicare:** Hospice is covered under Medicare Part A, (hospital insurance). You must sign a statement choosing hospice care instead of routine Medicare covered benefits. You must also receive care from a Medicare approved hospice program. Medicare fully covers a number of services you will need. You will only have to pay part of the cost for outpatient drugs and inpatient respite care. You will pay no more than $5 for each prescription drug and other similar products. Your Care Manager can provide you and your family with more detailed information about your coverage.

- **Medicaid:** Medicaid will pay for Hospice/Home Care as long as the Agency is a state contracted Medicaid provider. There may be some restrictions.
• **Commercial Insurance:** Coverage varies by policy. Your Care Manager, (CRC or SW), can help you find out what coverage you might have. You may be responsible for a co-payment.

• **No Insurance:** You pay or you may be able to get assistance (such as Medicaid). Your social worker can help you apply for assistance.

**How are Hospice services arranged?**

Your Care Manager (CRC or SW) will work with you, your family and your health care team to identify the agency to provide the services. A plan of care will be set up to meet your needs.

**How long can I expect to receive Hospice services?**

Under Medicare, Hospice services are provided in “periods of care”. Once Hospice services are initiated, you can receive hospice care for two 90 day periods followed by an unlimited amount of 60-day periods. Your doctor must confirm your need for continued hospice care at the start of each period.

**What else do I need to know?**

• Volunteers are trained to help you with everyday tasks. Members of the hospice team will make regular visits.

• If you are on Medicare, you will continue to use your Medicare Insurance for any health problems not related to your illness for which you are receiving hospice care.
**Skilled Nursing Facility**

What is Skilled Care?

Skilled care is health care given when you no longer need hospital care but are not yet ready to go home. You may need skilled nursing or rehabilitation staff to manage, observe and evaluate your care.

How will I know if I qualify for a Skilled Nursing Facility?

You have a medical need that can only be provided for in a Skilled Nursing Facility (SNF).

If you are a Medicare patient, you must have a 3-day qualifying hospital stay within 30 days of going to a Skilled Nursing Facility. Your Care Manager (CRC or SW) will discuss this with you.

How is Skilled Care paid for?

- **Medicare**: Medicare covers 100% of the first 20 days and you pay a co-payment for days 1-100. If you have supplemental insurance it may cover the co-payment for days 21-100.

- **Medicaid**: Medicaid will pay for skilled care as long as the facility is a state contracted Medicaid provider. There may be some restrictions.

- **Commercial Insurance**: Coverage varies by policy. Your Care Manager, (CRC or SW), can help you find out what coverage you might have. You may be responsible for a co-payment.

- **No Insurance**: You pay or you may be able to get assistance (such as Medicaid). A social worker can help you apply for assistance.
How is a SNF transfer arranged?

Your Care Manager, (CRC or SW) will discuss with you the facilities near your home, however some patients may need to stay near the hospital for follow-up treatments. Referrals will be made to facilities that will meet your needs. Every effort will be made to get you into the facility of your choice; however, options and bed availability may be limited. You will be informed when the SNFs have an available bed. Your CRC will assist in setting up travel to the facility; (you may need an ambulance, wheelchair van, or may be able to go by car).

How long can I expect to receive Skilled Care?

Your stay at a SNF could be a few days or several weeks. Your length of stay depends on your personal needs and how well your recovery is coming along.

Sometimes a person will choose to stay in a SNF because they simply cannot return home after their Medicare skilled days are complete. They would then change to a different type of care: “custodial”, or long term. This is another level of care and is not covered by Medicare. Payment for custodial care is made privately or Medicaid may cover the cost.

What else do I need to know?

• Medicare may deny your stay at the hospital if you do not accept a bed offer that meets your needs.

• You will not be seen by a doctor daily, however you will have 24 hour nursing care in the SNF.

• Most SNFs do not have televisions or telephones in the room. These services are usually available in common rooms, or you can provide your own.
**Acute Rehabilitation**

**What is Acute Rehab?**

Acute Rehabilitation is designed to:

- Help improve your condition within a pre-set time period; or
- Set up a program designed to maintain your current condition and prevent it from getting worse.

**How will I know if I qualify for Acute Rehab?**

Patients needing constant physical, occupational or speech therapy in order to regain or improve their level of independence after an accident or illness may be right for an acute rehabilitation program.

Admission to acute rehabilitation generally requires that you are able to take part in three or more hours of therapy a day. You must also be able to return home after an average stay of 2-6 weeks. Family members will need to plan for the patient’s return to home once this care has ended.

**How is Acute Rehab paid for?**

- **Medicare:** Medicare will usually pay for acute rehab if you meet their medical criteria for that level of care.
- **Medicaid:** Medicaid will pay Acute Rehab as long as the facility is a state contracted Medicaid provider. You may need prior approval and there may be some restrictions.
- **Commercial Insurance:** Coverage varies by policy. Your Care Manager, (CRC or SW), can help you find out what coverage you might have. You may be responsible for a co-payment.
• **No Insurance:** You pay or you may be able to get assistance (such as Medicaid). A social worker can help you apply for assistance.

**How is Acute Rehab arranged?**

Your Care Manager, (CRC or SW) will meet with you soon after admission to begin the process. He/She will give you names and locations of Acute Rehabilitation agencies in your area. Many Acute Rehabilitation agencies will send their own representative to the hospital to meet you and do an evaluation for admission.

**How long can I expect to receive Acute Rehab?**

The length of stay depends on your needs and how you progress through your personal program. Your rehabilitation team will work with you to set goals and create a safe discharge plan.

**What else do I need to know?**

• There are three accredited acute rehabilitation programs in Vermont and four in New Hampshire. We encourage family members/significant others to tour the facilities. Every effort will be made to get you into the facility of your choice; however, options and available beds may be limited.
**Long Term Acute Care Facilities**

**What is Long Term Acute Care?**

Long Term Acute Care (LTAC) is a Medicare Designated level of Acute Care Services. It is appropriate when your condition has stabilized (no longer requiring invasive testing or surgeries), yet your needs continue to be at an acute level. Therefore, your needs may be greater than what can be addressed at home, a skilled nursing facility or a rehabilitation center.

Examples of needs addressed at LTAC facilities include ventilator and tracheostomy support, complex wound care, multiple drains or IVs which require close observation and ongoing evaluation. An LTAC facility provides intensive nursing care in addition to rehabilitation services in order to assist in facilitating your independence.

**How will I know if I qualify for LTAC?**

Your condition has stabilized (as described above) and you continue to have medical needs that can only be provided in a setting with nursing and medical oversight similar to that of the hospital. Your team will collaborate with potential LTAC facilities to review your readiness for transfer.

If you are a Medicare patient, Medicare covers this level of care as a part of your overall benefit within your benefit period. Your Care Manger (CRC or SW) will discuss this with you.

**How is LTAC paid for?**

- **Medicare:** Medicare covers LTAC just as it would a hospital stay. Your Care Manger (CRC or SW) will discuss any coverage limitations with you.
• **Medicaid**: Medicaid will pay for Long Term Acute Care as long as the facility is a state contracted Medicaid provider. There may be some restrictions.

• **Commercial Insurance**: Coverage varies by policy. Your Care Manager, (CRC or SW), can help you find out what coverage you might have. You may be responsible for a co-payment.

• **No Insurance**: You pay or you may be able to get assistance (such as Medicaid. A social worker can help you apply for assistance.

**How is a transfer to LTAC facility arranged?**

Your Care Manager, (CRC or SW), will discuss with you the facilities in our region. We do not have LTAC facilities in NH or VT. With your consent, referrals will be made to LTAC programs that will meet your needs. You will be informed when a facility has an available bed. Your CRC will assist in setting up an ambulance to transport you to the facility.

**How long can I expect to be at an LTAC facility?**

The length of stay depends on your needs and how you progress through your individualized treatment program. Your team at the LTAC facility will work with you and your family to set goals and create a safe discharge plan.

**What else do I need to know about LTAC?**

There are no facilities in NH or VT. There are several facilities in Massachusetts. We encourage family members and significant others to tour the facilities. Every effort will be made to get you into the facility of your choice; however options and available beds may be limited.
**Respite Care**

**What is Respite Care?**

Respite care is temporary relief for caregivers and families. It is a service in which care is provided to:

- Persons with disabilities and other special needs.
- Persons suffering from a long term illness or an illness that will lead to their death.
- Persons at risk of abuse or neglect.

Respite can occur in out-of-home and in-home settings for any length of time depending on the needs of the family and available resources. Your Care Manager, (CRC or SW) can assist you in investigating these resources.

**How will I know if I qualify for Respite Care?**

If you have Medicare and are receiving Hospice Care, you are eligible for Respite Care.

For other types of respite care, it will depend on your level of need and the resources in your area.

**How is Respite Care paid for?**

- **Medicare:** If you have Medicare and you are a hospice patient, during a period of respite care, you will be cared for in a Medicare approved facility, hospital or nursing home. You will have to pay 5% of the Medicare payment amount for inpatient respite care. The amount you pay for respite care can change each year.

- **Medicaid:** There are limits as to the hours of respite care that can be received. These limits will vary by state.
• **Commercial Insurance:** Coverage varies by policy. Your Care Manager, (CRC or SW), can help you find out what coverage you might have. You may be responsible for a co-payment.

• **No Insurance:** You pay or you may be able to get assistance (such as Medicaid). A social worker can help you apply for assistance.

**How is Respite Care arranged?**

If you are in the hospital, your Care Manager, (CRC or SW) can assist you. If you are receiving hospice care, the hospice staff can help with setting up respite care. You can also contact your local social service agencies for help.

**How long can I expect to receive Respite Care?**

If you are a Medicare patient you can stay in a Medicare-approved hospital or nursing home up to five days each time you get respite care. There is no limit to the number of times you can get respite care. All other insurance coverage will vary by policy.

**Long Term Planning**

If you are considering a long-term nursing home stay or an Assisted Living* situation, the Office of Care Management can provide you with a list of resources that will allow you and your family to investigate these options.
**Glossary**

**Acute Hospital Care:** When medical needs are met in a hospital and are provided by 24-hour professional staff with daily doctor intervention.

**Assisted Living:** Residents are generally independent, but need help with a small number of tasks such as cooking, laundry, or housekeeping/maintenance.

**CCM:** Continuing Care Managers. A registered nurse or social worker that plans care for patients who have complex medical and social needs and who are getting their care in the outpatient clinic.

**CRC:** Clinical Resource Coordinator. A registered nurse who follows patients from hospital admission through discharge and assists with coordination of care and discharge planning.

**Medicare:** Medicare is the federal health insurance program for people age 65 and over, and certain disabled persons. It is not based on financial need.

**Medicaid:** Medicaid is health insurance provided by the state in which you reside. It is a medical assistance program for people with low income and limited financial assets. It is important to know that Medicaid is administered by each individual state, so there may be some variation in coverage.

**Resource Specialist:** Staff who can help patients and care managers get a variety of specialized services, such as admission to a Skilled Nursing Facility, medication assistance, and government programs.
SNF: Skilled Nursing Facility. SNFs provide short term, rehabilitative and convalescent care, which is delivered by professional staff 24 hours a day.

SW: Social Worker. Helps patients and families with effects of illness or injury by providing grief counseling and helping patients get resources available to them. Covers both inpatient and outpatient services.
Dartmouth-Hitchcock Medical Center is a charitable organization and has a financial assistance policy.