SUB-ACUTE REHAB/SKILLED NURSING FACILITY (SAR/SNF)

What service(s) will be provided by this level of care?

- Nursing care
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Clinically Complex Conditions such as wound care, IV antibiotic therapy, and clinical nutritional therapy.

How is this level of care different from being in the hospital?

- SNF provides a different staffing ratio than the hospital because patients no longer require acute care
- In the SNF, your care will include a higher level of individual participation because the SNF focuses on your independence.
- Most likely, your SNF stay will require a longer period of time than your hospitalization required.

How does the referral process work? Does this level of care require a physician order?

- The case manager or social worker at the hospital will submit referral information to your SNF choice SNF admissions staff will review clinical documentation and coordinate your admission from that point.
- A physician's order is required to transition to the SNF.

How long will I need to stay at this level of care?

- The average length of stay in SAR/SNF varies and is determined by a number of factors including: your clinical condition, your care needs and your progress in rehab therapy

Will my insurance pay for this level of care? What happens when insurance no longer covers this level of care?

- Medicare and most Medicare Replacement Plans pay the first 20 days in full; then a co-insurance amount is applied to days 21 – 100.
- There are no benefits beyond 100 days in a benefit period and patients must continue to make functional improvement for Medicare to continue coverage.
- Commercial insurance payments vary by policy and coverage plans. Questions regarding insurance coverage should be directed to the patient's insurance company.
- Most insurance providers require a preauthorization before admission to a SNF. The SNF works with your insurance company for continued authorization for your stay
- Once your SNF care team and insurance company determine you no longer require SAR/SNF level of care, the care team at the SNF will work with you and your family on your discharge plan
- Social Services at the SNF will arrange your home health services, any durable medical equipment, and any needed community services to begin once you are discharged from the facility.

What should I expect from this level of care? Who will take care of me? How often will I be seen by a physician or healthcare professional? What happens if I have medical issues?

- For rehab (SAR) patients, rehab services will consist of a 5-7 day per week therapy regimen; nursing services, dietary services, and the medical/physician staff approach your care from an interdisciplinary approach.
- On-site medical oversight will not occur daily as in a hospital setting.
- A physician will conduct your initial assessment followed by subsequent visits as may be deemed necessary (physician on-call covers all after-hours, including nights, weekends, and holidays).
- Patients admitted from the hospital to SNF/SAR are seen by the physician or advanced practice provider (APP) upon admission and generally weekly, unless there is a change in condition.

Who will supervise and coordinate my care once I am at this facility? Does one of my current doctors need to and agree to continue to manage my care?

- Medical staff will consist of a Medical Director and Attending physicians.
- Nurse Practitioners and Physicians' Assistants often provide additional patient care in the SNF.

- Physician oversight is provided by your attending physician, not outside physicians; however, he/she will usually consult with your outside physician if your level of care warrants it, or if you request it.

What is expected of me at this level of care?

- Your full participation and compliance is expected throughout the clinical process.
- Your engagement determines your clinical outcomes such as positive / excellent, as well as any negative results.

What must I be able to do on my own or with family support to safely discharge from this level of care?

- Goals are set with you in order to transition back to your prior functional level (prior to hospitalization).
- You are likely require support and/or supervision from friends or family members when you are discharged from this level of care.
- Each patient is different, but the SAR/SNF multi-disciplinary will provide guidance and education to prepare you and your family for your next transition.

What happens when I no longer need this level of care? Do I go to another level of care?

- The multi-disciplinary team at the SAR/SNF will work with you to coordinate your discharge plan
- This may include arranging home health services or durable medical equipment in your home

Why and how likely might I be readmitted to the hospital? Will I have to go through the Emergency Department to get readmitted to the hospital from this facility?

- If you experience a change in condition beyond the capability of the SAR/SNF, your physician will have you transferred to the hospital, usually through the emergency department.
- If you become stabilized and hospitalization is not warranted, you will return to the SNF.
- In some situations, your physician may arrange for direct admission.
- It is important to know the SNF's re-hospitalization rate; the lower the rate, the greater the chance the SNF can manage your acute need in the facility, without transitioning you to the hospital.