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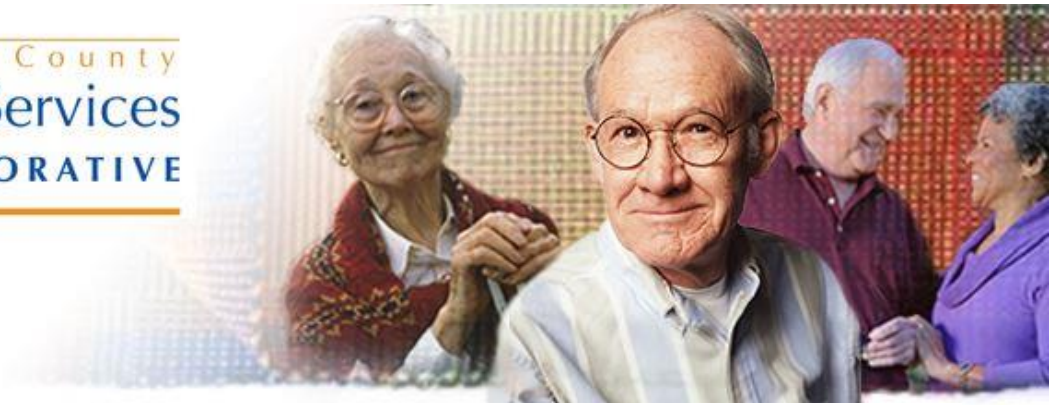
Orange County Aging Services COLLABORATIVE



The Language of Senior Care

The language for health care services can be overwhelming and confusing, especially in this age of healthcare reform. This document can be used as a tool to understand many of the common terms used in senior care. For additional helpful resources visit us at: www.ocagingservicescollaborative.org.

Acute Hospital - A hospital or medical center that treats any condition that requires either an unexpected stay due to an emergency situation such as an accident or disease-related incident (heart attack, etc.), or a planned surgery requiring a minimum of one overnight stay. The average length of stay in an acute hospital is 3-5 days. Medicare and/or insurance covers all or some of this type of stay; pre-authorization by the hospital is sometimes required for insurance coverage.

Adult Day Program (ADP) - These centers offer a non-medical model of care through a day-time program for elderly and younger adults with a focus on protective supervision by trained aides, structured activities, health monitoring, meals, out-of-home respite and support for the caregiver. They are licensed by the California Department of Social Services Community Care Licensing Division. Payment is generally private pay. Check with your insurance provider for more information. Definition from http://www.caads.org/

Adult Day Health Care (ADHC) -These centers offer a medical model of care through an out-patient day program for older persons and adults with chronic medical, cognitive or mental health conditions and/or disabilities that are at risk of needing institutional care. A coordinated team of licensed professionals, including nurses, social workers and physical, speech and occupational therapists, focus on medical, preventive and social care to improve health outcomes for high cost / high risk patients. Also provided are activities, personal care, hot meals, nutritional counseling, and transportation to and from the center. The majority of participants are Medi-Cal beneficiaries. Effective April 1, 2012, Medi-Cal beneficiaries are subject to the state's eligibility criteria for Community Based Adult Services (CBAS) and must be in Medi-Cal managed care where available and required. Payment is generally private pay. Check with your insurance provider for more information. Definition from http://www.caads.org/

Assisted Living – These facilities are more like an apartment complex. Rooms can be shared, private or suites, depending on the property and what it offers. Usually, but not always, the fee structure is a base fee with different add-on levels depending on the amount of care and supervision a person needs. Meals and activities are provided as part of the base fee, with additional assistance and dementia supervision costing more. Some facilities have "memory care," which is a section secured for dementia residents that guards against wandering and provides activities designed for this type of resident. This is never a service covered by Medicare; this is almost always private pay. Some Long Term Care Insurance policies may pay benefits, generally after a waiver period (each policy is different, contact your insurance provider for more information). These facilities are licensed by the California Department of Social Services, Community Care Licensing Division.

Board and Care - This is a facility that is usually a converted private home with no more than 6-8 units or beds. It is an another form of Assisted Living, designed for those needing more care than can be provided at home but do not need skilled nursing care. All rooms are shared rooms, unless the resident has the funds to pay for a private room. Payment is almost always private pay. Some Long Term Care Insurance policies may pay benefits, generally after a waiver period (each policy is different, contact your insurance provider for more information). Care is to be provided by one or two unlicensed caregivers, depending on the size of the facility. The Administrator or Owner of the home must be licensed. Activities of Daily Living (ADLs) are provided such as bathing, dressing, medication management, limited activities and meals. Some have more secure settings and can accept dementia residents. They are licensed by the California Department of Social Services Community Care Licensing Division.

Community Based Adult Services (CBAS) - A state program paid for by Medi-Cal to deliver Adult Day Health Care (ADHC). *See definitions for Medi-Cal and Adult Day Health Care.* The majority of participants are Medi-Cal beneficiaries. Effective April 1, 2012, Medi-Cal beneficiaries became subject to the state's eligibility criteria for Community Based Adult Services (CBAS) and must be in Medi-Cal managed care where available and required. Some ADHC accept Veteran's Affairs (VA) benefits as well. Those not covered by Medi-Cal or Veteran's Affairs will be primarily private pay. Definition from http://www.caads.org/

Dementia Care Centers – Licensed Adult Day Programs or Adult Day Health Care / Community Based Adult Service centers offering specialized Alzheimer's care for the moderate to late stage Alzheimer's patient or persons with similar conditions. A highly trained team applies a philosophy of care emphasizing dignity and respect, while fostering optimal independence according to each patient's level of functioning. Payment is generally private pay. Check with your insurance provider for more information. Definition from http://www.caads.org/

Home Care - This service consists of anything from assistance with grocery shopping and light housekeeping to assistance with bathing and dressing, to total 24-hour care in the home. Please note Home Care does **not** provide medical assistance in the home – please see definition for *Home Health Care*. Frequency of service can vary based on need. Usually you contract with a Home Care company for what you need and you pay privately per hour. This is never covered by Medicare; however, in certain instances it may be minimally covered under Medi-Cal (qualification/restrictions apply). Some Long Term Care Insurance policies may pay benefits, generally after a waiver period (each policy is different, contact your insurance provider for more information).

Home Health Care - In order to be eligible for this service as covered under Medicare, your doctor must decide that you need medical care in your home and write orders stating such. Also, you must need at least one of the following: intermittent (but not full time) skilled nursing care, or physical therapy or speech language pathology services. You must be homebound, meaning that you are normally unable to leave home (being homebound means that leaving home is a major effort). When you leave home, it must be infrequent, for a short time, or to get medical care. And a very important point - the home health agency caring for you must be approved by the Medicare program. If you are covered by some other insurance or managed care plan, you need to check for any variations in these requirements. Also, it is important to note that any services or therapies are only given for limited hours within a week – this is not home care.

Hospice - This is a special concept of care designed to provide comfort and support to patients and their families when a life-limiting illness no longer responds to cure-oriented treatments. While it is usually accessed as an "end of life" service, it isn't necessarily limited to that time period. Hospice providers address all symptoms of a disease while focusing on pain management and limiting discomfort. They also address the emotional and spiritual impact of the disease on the patient and the family, and offer bereavement counseling before and after a patient's death. When a patient elects to enroll in hospice, if they are Medicare eligible, no matter the insurance they are disenrolled from that insurance and Medicare takes over for payment of hospice services. This is important to note because that means that the patient (or family) has full freedom to choose whatever hospice company they wish – there are no restrictions, as long as that company is recognized by Medicare. Hospice services are covered by Medicare Part A, Medi-Cal, and most private insurances. In addition, many hospice companies will not turn away a patient if they lack a payer source for hospice benefit.

Independent Living - A community that allows for residents to live in their own bungalows or apartments but that have a communal dining area and activities. Kitchenettes may exist in the living quarters, but communal dining is encouraged for at least 1-2 meals a day. Other amenities may be offered on the campus. This is never a covered option under Medicare; this is always private pay.

Long Term Acute Hospital (LTAC) – If the incident requiring acute hospitalization has been stabilized, but the person still requires extensive care not available at a skilled nursing facility (SNF) level, the attending physician may choose to discharge he/she to an LTAC. Average length of stay is 21 days. Daily physician rounds are still required and therefore this care is paid for out of the same Medicare designation as an acute stay.

Skilled Nursing or "Rehab" Facility (SNF) - This care is utilized for someone who has had an acute illness or planned surgery which required a minimum stay of 3 midnights in an acute hospital, is stable but still requires more extensive rehabilitation or supervision than is available in a private home. The physician is not required to visit daily, but instead directs care through physician orders that are then managed by the nursing and rehabilitation staff at the SNF. The goal of a SNF is to get the patient well enough to go back to their prior level of functioning; however, when that is not possible, many SNFs also offer long term care. When a patient is admitted under skilled care or rehab, and Medicare is your primary form of payment, the rules are the same as with sub-acute care; your first 20 days will be covered 100%; from day 21-100, you will have a co-pay. You will only continue to be covered as long as you meet Medicare guidelines for this type of care, so NONE of this coverage is automatic. It is reviewed and submitted for approval to CMS (Center for Medicare and Medicaid Services) on a regular basis. If you have insurance or managed care (Medicare Advantage, HMO, etc) coverage, the requirements may vary slightly, but overall, they will follow these same guidelines. Check your policy carefully for any co-payment amounts. If long term care is required, this is NOT covered under Medicare. Some patients may hold long term care policies that may cover for a set period of time, but often there is a co-payment involved. If you have no long term care insurance, then this will be private pay only; or, if the patient qualifies, Medi-Cal can be accessed for this care. These facilities are licensed by the California Department of Public Health.

Sub-acute Unit - Sometimes called a "step-down unit" when located inside an acute hospital. There are sub-acute units also offered outside of acute hospitals, often as a separate wing in a skilled nursing facility. This level of care may be accessed when someone in a hospital may need more supervision than available at a SNF, but only for a short interim period and therefore an LTAC wouldn't be appropriate. Or, this may be accessed for someone who has been stabilized but will require more specialized long term care, such as someone on a ventilator. Following current Medicare guidelines, in order to access Medicare as payment, the patient will have had to spend 3 midnights in an acute hospital as an admitted patient (not just "under observation") within the past 30 days. This level of care does not use the same Medicare payment days as an acute hospital or LTAC. If Medicare is your primary form of payment, your first 20 days will be covered 100%; from day 21-100, you will have a co-pay. You will only continue to be covered as long as you meet Medicare guidelines for this type of care, so NONE of this coverage is automatic. It is reviewed and submitted for approval to CMS (Center for Medicare and Medicaid Services) on a regular basis. If you have insurance or managed care (Medicare Advantage, HMO, etc.) coverage, the requirements may vary slightly, but overall, they will follow these same guidelines. Check your policy carefully for any co-payment amounts.

See anything you would like us to include on this sheet?

Please email Christine@ocagingservicescollaborative.org