



Senior Care Today

From Mount Vernon Nursing and Rehabilitation Center

Fall 2006

www.mvnrc.net

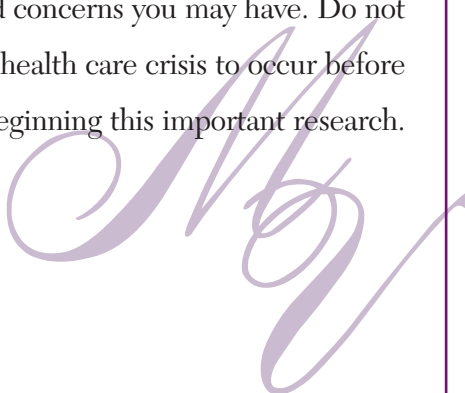
When an accident or illness leads to hospitalization, it can be a frightening, often confusing experience.

Add a period of rehabilitation and recovery to the equation and the situation can become even more difficult— physically, emotionally and financially.

In order to promote greater understanding of the factors related to this process, we have compiled three true-to-life case studies illustrating how seniors successfully navigated the unfamiliar territory of post-hospital rehabilitation, including dealing with disability, loss of independence and insurance issues.

Please keep in mind that the circumstances and situations described are by no means universal and are meant only to provide a useful overview. Should you find yourself or a loved one faced with hospitalization, rehabilitation or the need to consider long-term care, it is critically important to seek advice from knowledgeable sources related to your specific needs and circumstances. For your convenience, on page 3 of this issue of *Senior Care Today*, we have included a listing of several such resources.

We suggest you contact the appropriate agencies and organizations to discuss any questions and concerns you may have. Do not wait for a health care crisis to occur before beginning this important research.



Mount Vernon Nursing & Rehabilitation Center is a locally owned and operated 130 bed skilled and intermediate nursing facility that has served the Alexandria/Mount Vernon community for over 20 years. Conveniently located between Alexandria and Mount Vernon, it is part of a medical community including physicians' offices and the Mount Vernon Hospital.

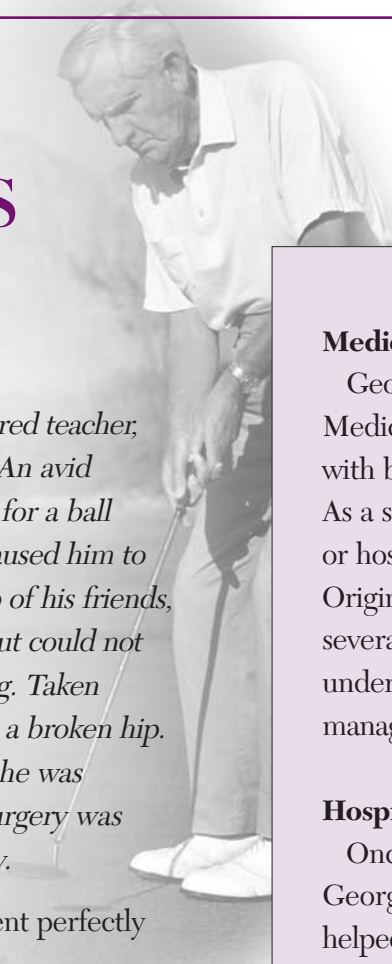
George's story...

George, a 78-year-old retired teacher, has always been active. An avid golfer, he was searching for a ball in the rough when a misstep caused him to stumble and fall. With the help of his friends, he was able to get to his feet, but could not bear any weight on his right leg. Taken to the hospital, x-rays revealed a broken hip. With his physician's approval, he was admitted to the hospital and surgery was scheduled for the following day.

Happily, George's surgery went perfectly and his recovery was off to an excellent start.

After spending 5 days in the hospital, George's doctor recommended that he continue his recovery with a period of rehabilitation. Given his age and multiple medical conditions, including high blood pressure, a history of heart disease, and diabetes, his hospital discharge planner referred George to a nearby skilled nursing facility whose capabilities included short-term rehab and specialized support services.

George spent a total of 30 days rehabilitating his hip, after which he returned home to his family and a much-anticipated round of golf.



Understanding benefits & eligibility

Medicare eligibility

George is a subscriber to the Original Medicare Plan for people age 65 or older, with both Part A and Part B coverage. As a subscriber, he can go to any doctor or hospital that accepts Medicare. The Original Medicare Plan is just one of several health plan choices available under the Medicare program, which is managed by the Federal Government.

Hospitalization

Once he was admitted to the hospital, George's Medicare Part A insurance helped cover many of his inpatient costs,

including his semi-private room, meals, general nursing, lab tests, inpatient prescription drugs and other medically necessary services and supplies provided in the hospital. Like most people, George does not pay a monthly premium for Part A because he already paid for this coverage through his

payroll taxes while he was working.

George's surgeons' and doctors' fees, certain diagnostic tests and other services not covered by Part A were included under Medicare Part B. Since enrollment in Part B is voluntary, subscribers must pay a monthly premium as well as an annual deductible before Medicare starts to pay its share of medically necessary costs.

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Medicare benefits are not automatic. You must apply and meet certain requirements for coverage.

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MOUNT VERNON NURSING & REHABILITATION CENTER

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Alice's story...

Understanding benefits & eligibility

Now 68 years old, Alice began to experience knee problems about ten years ago. A tennis player since her youth, over the years she suffered several traumas to her left knee, including a dislocation and a fractured knee cap. Although she no longer played tennis, degeneration of the knee joint had progressed to the point that she was experiencing difficulty walking and considerable pain. On the advice and approval of her orthopedist, Alice underwent knee replacement surgery.

At the end of her hospital stay, Alice's doctor recommended a period of rehabilitation in a local skilled nursing facility. However, Alice chose to return home, preferring to attempt to complete her recovery with the aid of a visiting therapist.

After just 10 days, Alice began to reconsider her decision. Except for her twice weekly visits by the therapist, she was without help. A widow, she had no family member able to assist her with daily needs and her condition made it impossible for her to leave the house. She also found that she was unsteady climbing stairs and was constantly afraid of falling and re-injuring herself. It was clear she needed more care than was available at home.

After talking the situation over with her doctor, Alice agreed that the best course of action was to enter a senior care facility for short-term rehabilitation as was originally suggested.

Alice completed her 20-day rehab stay and was scheduled to be discharged, but she still felt the need for a few additional days of professional care. As a result, Alice made the decision to remain in the facility for transitional care. There, with all of her daily needs met and 24-hour nursing care available, she was able to continue her rehabilitation and fully restore her strength and confidence. In a little more than a week's time, Alice was ready to return home and resume her normal activities, including regular walks with her grandchildren. *Mj*

CONSIDER THIS...

Costs that the patient must pay while in a hospital or long-term care facility, such as co-insurance, co-payments and deductibles are called "gaps" in Original Medicare Coverage. You may want to buy a health insurance policy from a private insurance company to cover these potential expenses. Referred to as Medigap policies, some of these plans also cover benefits not included under Medicare, such as vision and dental services and emergency care when traveling outside the country.

Medicare and Medicaid are forms of insurance, each with special terms and conditions.

Medicare eligibility

As a subscriber to both Medicare Parts A and B, Alice's hospitalization and knee replacement surgery were fully covered, after an initial deductible. Covered benefits included her semi-private room, meals, general nursing, all surgeons' and doctors' fees, inpatient therapies, wound care, medication and other medically-necessary services and supplies.

Home Care

After her discharge from the hospital, Alice's initial period of physician-authorized home care was fully covered under

Medicare, as were the services of a home health aide assigned to help Alice twice each week with personal care and household chores.

Inpatient Short-Term Rehab

Like Alice, people who choose not to immediately enter physician-approved Medicare Part A rehab, or those who leave rehab before the prescribed period of care has ended, can return to care within 30 days.

Thus, Alice's inpatient rehab stay, as it began only 10 days after her hospital discharge, was included under her Medicare coverage.

Transitional care

Since Alice herself elected to remain in the long-term care facility for an additional temporary stay after her Medicare approved rehab had ended (additional inpatient care was determined not to be medically necessary by her doctor), her transitional care was not paid for by Medicare. While under certain circumstances some services provided during a transitional care stay may be covered by private insurance, transitional care is generally paid for with personal funds, as it was in Alice's case.

This raises an important point: insurance and health plan coverage, benefits, limitations and eligibility requirements vary widely. It is vitally important that you review your individual situation with your plan representative before committing to a course of action.

When it comes to benefits and eligibility, each individual's situation is unique. We will be happy to help you better understand this often complex subject. Please call 703-360-4000 or visit www.mvnrc.net.

What is it like to live in a senior care facility?

In addition to providing an optional period of care and support in a professionally supervised, restful environment, for some people, transitional care also represents a unique opportunity to "preview" long-term senior care and evaluate a particular facility. In fact, transitional care guests enjoy all of the same services, features, activities and amenities that are available to the facility's long-term residents. Thus, should the time come when age or changing health conditions make long-term care a necessity, the prospective resident is uniquely able to make a truly informed decision.

To request a free, informative pamphlet on transitional care, call **703-360-4000**.

George's story...

Continued from page 1

Understanding benefits & eligibility

Post-Hospital Rehab

Medicare also covered the costs involved with his rehabilitation. While in the hospital, his early physical therapy was covered under Part A. Once he moved to a separate rehab unit within a skilled nursing facility, his Medicare coverage paid in full for the first 20 days of his care. Beginning on day 21, George was required to pay a co-payment amount for each day of the remainder of his stay. Had it been deemed medically necessary, George's stay could have been extended up to 100 days, during which time Medicare would have paid all but a daily co-payment amount.

Returning home

After his 30-day period of rehabilitation, George was able to return home.

In cases where additional therapy or rehab-related care is determined to be medically necessary, physical and occupational therapy, as well as speech and language therapy, may often be provided on an outpatient basis or through home health care. Both must be ordered by the doctor and provided by certified therapists in order to be covered under Medicare.

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CONSIDER THIS...

The need for assistance with tasks of everyday living, like bathing, dressing and other types of custodial care cannot, in itself, qualify an individual for Medicare coverage. However, if a person has been admitted to a long-term care facility for skilled nursing or rehabilitation, Medicare will pay for all of the care he or she needs while in the facility, including help with activities of daily living.

HELPFUL RESOURCES

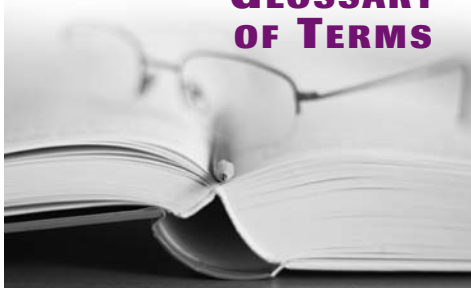


Traveling the physical, emotional, and financial pathways to recovery should not be done alone. In addition to the support of family and friends, there are many valuable resources that can make the journey less frightening, more understandable, and ultimately, more effective. Here are just a few:

- **The Virginia Department for Aging** www.vda.virginia.gov
- **AARP** aarp.org/health/medicare
- **Medicare** www.medicare.gov, or telephone 1-800-MEDICARE

For professional advice and assistance with your specific Medicare or other insurance issues, you may also contact a **Mount Vernon Nursing & Rehabilitation Center senior care advisor at 703-360-4000.**

GLOSSARY OF TERMS



• **Benefit Period** This is the way that Medicare measures your use of hospital and/or skilled nursing facility services. A benefit period begins the day you go into a hospital or skilled nursing facility. It ends when you have not received any care in either facility for 60 days in a row from the date of your discharge. If you are admitted to a hospital or skilled nursing facility after one benefit

period has officially ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

- **Co-insurance** The amount you may be required to pay for medical services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage of the Medicare approved amount, and applies after you have paid the deductible for Part A and/or Part B.
- **Co-payment** In some Medicare plans, you will need to pay this set amount for each medical service, such as a doctor's office visit. Co-payments also apply to some hospital outpatient services under the Original Medicare Plan.
- **Deductible** The amount you must pay for health care services before Original Medicare or other insurance begins to pay. With Original Medicare Part A, you pay a new deductible for each benefit period. There is an annual deductible for Part B.
- **Medically Necessary** Service or supplies that are required for the diagnosis or treatment of your medical condition and that meet the standards of good medical practice for your local area.
- **Medicare Approved Amount** The amount Medicare will pay a doctor or supplier for a specified service, plus any deductible, co-insurance or co-payment that you pay.
- **Premium** The periodic payment to Medicare, an insurance company, or managed care plan for healthcare coverage.

Paying for long-term care

Long-term care can be very expensive, which makes it extremely important to plan ahead, long before the need occurs. There are several ways that people pay for long-term care; one may be right for you.

- **Long-Term Care Insurance** Sold by private insurance companies, you can receive a wealth of valuable information on this important financial tool by downloading a copy of "A Shopper's Guide to Long-Term Care Insurance." Simply go to www.ltcfeds.com/documents
- **Reverse Mortgages** This option allows homeowners to use the equity they have in their home as a source of income, without losing ownership. Speak with a lawyer or financial advisor about the appropriateness of this option relative to your particular circumstances.
- **Life Insurance** Life insurance policies may be used to pay for long-term care in some instances. Ask your insurance agent for details.
- **Personal Funds** Of course, you can use your own resources to pay for long-term nursing care. Once you have used most of your resources, you may qualify for Medicaid coverage. Income and asset limits vary from state-to-state, so it's important to check with the Virginia Department of Medical Assistance Services. Call 804-786-7933.

Martha's story...

Understanding benefits & eligibility

Martha, an 81-year-old grandmother of five, suffered a serious stroke that left her unable to speak and paralyzed on her left side. After several weeks in the hospital, Martha was sent to a nursing facility to continue her recuperation and begin rehabilitation. While there was no way to predict the extent of her recovery, her doctors remained hopeful that, in time, she would make sufficient progress to return to a higher level of functioning.

After receiving as much therapy as her capabilities allowed, and completing her full allocation of Medicare-covered rehabilitation days, Martha's condition had improved only marginally. It became clear that she would not be able to live independently and would require 24-hour supervision.

Given her condition, Martha's senior care options were limited. Her husband, Bob, was himself not in good health and unable to care for her at home. Moreover, the assisted living facility where they lived was not qualified to provide the special services or constant supervision Martha needed. Consequently, the most appropriate, safest and best choice for Martha was a residential skilled nursing facility. There, she continued to receive the full-time nursing care and supervision she required, as well as ongoing physical, occupational and speech therapy.

Martha and her husband's savings and other shared assets made her ineligible for Medicaid long-term care coverage, however, they are sufficient to allow the couple to pay privately for skilled nursing care for the foreseeable future. *Mj*

Medicare eligibility

Martha is a member of a Medicare Preferred Provider Plan, one of several Medicare Advantage Plans. Under her plan, she is entitled to all of her regular Medicare-covered services, as well as certain extra benefits, such as vision care and preventive health services. Each month Medicare pays a set amount of money directly to her plan and Martha pays a monthly premium that includes Part A and B benefits, prescription drug coverage and a range of additional health and wellness services. She must, however, use doctors and hospitals included on the plan's list of preferred providers in order to receive full coverage and realize maximum savings.

Hospitalization

After her stroke, Martha was admitted to a hospital that was a member of her plan's provider network. Likewise, the doctors and specialists that treated her during her

stay were also part of the plan. As a result, virtually all of Martha's hospital and physician-related costs were covered by her Medicare Advantage Plan during her lengthy hospital stay.

Inpatient Rehabilitation

Medicare covered the full cost of Martha's subacute care in a skilled nursing facility during the first 20 days of her rehabilitation stay. From days 21 to 100, Medicare paid for a portion of her care. Martha was required to pay the balance of the charge personally. Fortunately, Martha and her husband have a Medigap (Medicare Supplemental Insurance) policy that covered all of her co-payments.

Long-Term Care

When it was determined that Martha needed constant nursing supervision, she was admitted to a long-term care facility as a permanent resident. Long-term care in a nursing facility is not covered by Medicare Part A and Part B.

In Martha's case, she and her husband's effective financial planning allowed them to pay privately for Martha's care in her new home.

When it comes to benefits and eligibility, each individual's situation is unique. We will be happy to help you better understand this often complex subject. Please call 703-360-4000 or visit www.mvnrc.net.

CONSIDER THIS...

Purchasing long-term care insurance requires careful shopping. Coverage and costs vary widely and depend on the benefits you choose and other factors. For example, premiums increase as you age. A plan that costs a 50-year-old \$1600 annually will cost a 60-year-old \$3100. A 70-year-old will pay over \$7500 for the same policy. While it is clear that buying young will lower premium costs, the average age of people admitted to nursing facilities is 83. This means that a younger person may pay premiums for many years without knowing whether he or she will ever need the policy.

Look for a well-established insurer. Since it's likely to be many years before you need the benefits of your plan, consider only insurers that receive high financial safety marks from insurance ratings companies.

Policies have limitations, usually in the form of "elimination periods" of from 20 to 100 days, during which you must pay for nursing care out of your own pocket.



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Inside:

Understanding senior care benefits and using the healthcare system to your best advantage.

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