

2024 Lunch & Learn

CT Teachers Retirement Board



Post-Acute Care Settings



Skilled Nursing Facility

 Nursing care or rehab services following illness, injury, or surgery



Long-Term Acute Care Hospital

 Specialize in treatment of patients with serious medical conditions that require care on an ongoing basis



Inpatient Rehab Facility

 Provide intensive rehabilitation services to patients after illness, injury, or surgery



Home Health Care

 In-home support services to assist patients who suffer from injuries or health conditions that impair their ability to perform activities of daily living



Palliative / Hospice Care

 Services provided to beneficiaries in their home for palliative and support services for terminally ill patients

What's the difference between Skilled Nursing Care and Long-Term Acute Care?

	Skilled Nursing Care		Long-Term Acute Care
•	Nursing-driven care plans	•	Daily physical bedside visits, with sub-specialists on staff
•	Physician visits as rarely as every 60 days, sub specialists seen offsite	•	ICU-and CCU-level nurses and physicians
•	Care for moderately ill patients who do not need acute-level treatment	•	Specialty in medically complex and critically ill patients
•	Limited respiratory therapy, unless required for pulmonary patients	•	24/7 respiratory therapy onsite
•	Standard rehabilitation services	•	Specialized rehab programs and early mobilization of critical care patients, including those on ventilators
•	Radiology, pharmacy, and lab services accessibility, but not onsite	•	Onsite telemetry, radiology, pharmacy

How is it Covered?

	Skilled Nursing Facility	Long Term Acute Care / Inpatient Rehabilitation	Home Health Care Services	Palliative/ Hospice Care
Medicare Advantage	 No inpatient hospitalization required Days 1-100: \$0 copay 	• \$200 copay per stay	• \$10 copay	 Covered by Original Medicare
Senior Supplement	 3 day inpatient hospitalization required Days 1-20: \$0 copay Days 21-100: \$250 per admission 	• \$250 per admission	\$0 copay after Part B deductible	Covered by Original Medicare

Post Discharge Transitions

Advocacy and Support

- Determine safe discharge plan
- Identify needs and connect to appropriate programs



Post Discharge Outreach

- Reinforce understanding of discharge instructions
- Review and ensure access to medications
- Schedule follow up appointments
- Coordinate treatment plan

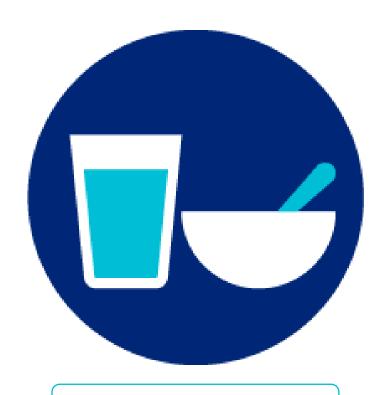


Improve Health Outcomes

- Reduce avoidable admissions
- Caregiver and retiree resources

Healthy at Home

Post-Discharge Meal Delivery, Transportation, and In-home Personal Care



28 meals



6 hours of in-home personal care



Up to 12 one-way rides





