Caring for Our Community

Hammond-Henry Hospital Discharge Planning

We are here for you!

Sometimes it seems as though discharge from the hospital happens all at once, and in a hurry. Remember that discharge planning is a process, not a single event.

As a result of that process, the discharge plan may be to send you to your own home, a rehabilitation facility, a nursing home, or some other place outside the hospital. A discharge plan should be based on a careful review of all the available options.

Discharge from the hospital does not mean that you are fully recovered. It simply means that a physician has determined that your condition is stable and you do not need hospital-level care.

Once your level of care changes and you no longer need acute or skilled care, you can expect to be discharged. Discharge planning is a short-term plan to get you out of the hospital. No one can predict future needs, as your condition may improve or even worsen over time. It is important for you to think about the long term as much as possible, this brochure will help you get started.

The Basics of a Discharge Plan

Ideally the Discharge Planning process begins on the day of admission to the hospital. If the hospital stay was unplanned, as in the case of an accident or sudden illness, you may not have a clear idea of how long you will be hospitalized or what your condition will be. Still, it is a good idea to start thinking about the options as soon as possible.

Once you are admitted your Case Manager will meet with you to identify potential discharge needs. The Case Manager will also coordinate any services with your insurance company and Medicare.

Your Discharge Planning team will do everything possible to assist with the entire process. It is important for you to know who they are, so they can plan, educate and refer as needed. The Discharge Planning Team meets everyday Monday through Friday and includes a Social Service worker, Registered Nurses, Rehabilitation Services, Home Care Nurses, Patient Accounts and Registered Dieticians. The outline below explains the specific roles on how discharge planners, social services, patients, family members and other involved in the process should work together.

Planning Before discharge a Case Manger will determine Medicare and/or insurance eligibility for services such as visiting nurses or home care aides when needed. Arrange for transfers to an alternate level of care such as a skilled nursing unit. Assist in obtaining home care needs, supplies or rental equipment.

Patient Education Before discharge a health care professional will provide you and your family with applicable education such as a written medication list with dosing instructions, techniques such as bed to chair transfers, the use of special Durable Medical Equipment and the recognition of symptoms and other elements of patient care.

Referrals Before discharge the Discharge Planning Team will explore available support services and community services available to assist you such as agencies that provide equipment maintenance, transportation, respite and home care.

Only a physician can authorize a hospital discharge. However, many other people are involved in working out the details of the discharge plan. Two important Discharge Planners that you will be speaking with you are the Case Manager and Social Service worker. Their phone numbers are listed on the back.

What Will Insurance Pay For?

Most people do not have a good idea of what medical insurance will pay for until the need arises. It can be a shock to find that insurance will not pay for many items and services needed at home that are routinely paid for in the hospital.

Unless you or your relative has specific long-term care insurance, many services, especially home care aides or attendants, will not be covered at all or beyond an initial short-term period.

Your social worker and case manager will work with you to coordinate any services that you may need before discharge.

For more information about Hospital Discharge Planning call:

Case Manager

extension 2400 or (309) 944-9140

Social Service worker

extension 1470 or (309) 944-9170

Online Information Resources

- ✓ www.aoa.gov - Caregiver resources from the Administration on Aging
- ✓ www.caregiving.com - Online support groups and articles on caregiving
- ✓ www2.careplanner.org - Online decision support tool for seniors, individuals with physical impairments, and their caregivers
- ✓ www.healthfinder.gov - Free internet guide to consumer health information from the U.S. Department of Health and Human Services
- ✓ Children of Aging Parents: 800-227-7294 www.caps4caregivers.org - Information, referrals and support for caregivers of the elderly
- ✓ Eldercare Locator: 800-677-1116 www.eldercare.gov - Help with locating aging services in every U.S. community
- ✓ Medicare: 800-MEDICARE www.medicare.gov - Official U.S. government site for people with Medicare.
- ✓ National Alliance for Caregiving: www.caregiving.org - Support for family caregivers & professionals who serve them

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Hospital Discharge Planning

At Hammond-Henry we serve our community's health care needs by contributing to the quality of life and well being of people living within our service area through a cost effective continuum of preventative, diagnostic, therapeutic, rehabilitative services.

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Here for you.