

Hospital discharge planning

Hospitals provide discharge planning to assist patients and their families arrange care after a hospitalization. Discharge planners are social workers, nurses or other appropriately qualified persons, who can help arrange services after a hospitalization. Medicare defines discharge planning as “a process used to decide what a patient needs for a smooth move from one level of care to another.” The discharge plan may be to home, a relative’s home, rehabilitation hospital, skilled nursing and rehabilitation facility (nursing home) or other place.

Advancements in medicine enable discharge from the hospital when someone is not fully recovered. Insurance regulations may necessitate a shorter stay, before a course of treatment is totally clear. Your physician determines when your condition is stable and no longer requires hospital level of care. If you disagree with this decision and you have Medicare, you may appeal it through MassPRO (Peer Review Organization) – the hospital will provide you with a notification entitled “*An Important Message from Medicare*” which includes the appeal process and telephone numbers. Medicare states that the discharge plan must be “safe and adequate” This unfortunately does not mean that you can stay in the hospital until you are happy with the plan.

The discharge plan addresses only the short term and does not predict or anticipate future needs. Only a physician can discharge a patient, but others can be instrumental in working out a discharge plan including the patient and her family, health care professionals and the discharge planner.

If you require home health services, your doctor must order these services. Other services can be arranged by the discharge planner. Patients are often surprised to learn that some services and medical equipment is not covered by their health insurance. Coverage will depend on your condition and progress. If you have specific questions about Medicare coverage, call 1-800-MEDICARE. For other insurance companies, call the Member Services number on the back of your insurance card. Keep a record of your calls – date, name of person spoken to and answers received.

If you are going home, you may think about informal services – family, friends & neighbors. It is important to be realistic: can your daughter-in-law, who lives 75 miles away, come daily to help you prepare meals? Do you have a back-up plan in case your driver or shopper is sick?

If you are thinking of going to a skilled nursing or rehabilitation facility, it is important that you or your family do your homework – research the facilities, tour them and then return at a mealtime hour. You don’t have to accept a bed at facility “A” if you prefer facility “B” **and** facility “B” has a bed and will accept you.

It is often difficult to make these decisions during an acute phase of an illness – it is helpful to have an advocate – your Health Care Proxy, family member or friend – assist you in developing this discharge plan. If you have questions or would like additional information, call Kathy Laufer at the Newton Senior Center 617-796-1660.