



Planning for Your Discharge

Answers to common questions

Every patient at Eden Medical Center will have a discharge plan. This is the term we use to speak about the end of your hospital stay and your care after you leave the hospital.

This brochure explains your role in the process, and provides answers to questions about discharge planning.

Eden Campus Case Management

20103 Lake Chabot Road
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(510) 889-5040

San Leandro Hospital Campus Case Management

13855 East 14th Street
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(510) 667-4508



Eden Medical Center

A Sutter Health Affiliate

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www.edenmedcenter.org

Frequently Asked Questions

How does the discharge planning work at Eden Medical Center?

You and your family are our partners in planning a safe, smooth and prompt discharge. We start early in your hospital stay so that you and your family can have time to gather information and resources and to review options for what you will need after you leave the hospital.

Who can help with discharge planning?

The doctor, nurse, case manager, rehabilitation therapist and pharmacist all have roles in discharge planning. The case manager will help coordinate your discharge process. The case manager helps to find a skilled nursing facility, a home care or home health agency and can provide you with information about community resources.

How can I help with my discharge plan?

To help with your discharge plan:

- Ask your doctor how long you are expected to stay in the hospital and what assistance she or he recommends.
- Tell your nurse the medications you already have at home and where you plan to fill your prescriptions.
- Talk with your family and support system about how they are able to help at home upon discharge. Tell your nurse if you do not have someone who can help you at home.
- Talk with your nurse about getting home. If there are restrictions on how you can travel, the nurse will help you make plans.
- In general, your discharge time is at 11:00 a.m. (or as scheduled). Please confirm your discharge time with your nurse or doctor and arrange your ride in advance. We will make every effort to have everything ready for your planned discharge time.

- Your case manager will discuss transportation options with you if you're transferred to another facility instead of home.

What do I need for my hospital stay that will help with planning for discharge?

- Health insurance card
- Pharmacy or drug benefit card (this is part of many insurance cards)
- Legal papers about your health care, such as a Health Care Directive (Living Will) and Power of Attorney, if you have them.
- Phone numbers of family or friends you may want contacted during your stay.
- Glasses, hearing aids, dentures or any other health aids that you may use.
- It is best to leave valuables at home, but please plan how you will pay for prescriptions and/or a ride home.

How is a skilled nursing facility (SNF) arranged?

If you and your doctor determine that you need the specialized services of a skilled nursing facility, the case manager will meet with you and your family to provide a list of facilities and ask you to decide on your top three or four choices. Your choices may be affected by the medical care you require, acceptance by or the availability of the facility or agency you select, and your insurance.

We make every effort to arrange care in one of your preferred choices, but this may not always be possible.

Due to the demand for hospital services, we cannot allow you to stay once you no longer need to be in the hospital.

What if I need rehabilitation services at discharge?

Rehabilitation can occur in an inpatient or outpatient setting, a skilled nursing facility or in the home, depending on your needs. Inpatient rehabilitation admission at a skilled nursing or acute rehab facility is based on:

- your diagnosis and medical condition
- your expected progress
- your insurance coverage
- bed availability

What if I need help at home?

Home health means the skilled services of a nurse or physical, occupational, or speech therapist. It requires that you be home bound (unable to leave your home) and it requires a doctor's order. Home health is often covered by insurance, and will be arranged by your case manager.

Home care programs generally provide non-skilled or homemaker type services and are not covered by insurance. These programs may include help with:

- transportation
- bathing
- dressing
- feeding
- housework
- cooking

The case manager can provide you with a list of agencies or community resources so you and your family can arrange for this help if you need it.

How will I pay for my after care?

If you qualify for these services, case management staff will assist you in obtaining authorization from your insurance provider. The case manager can advise you about who can assist you with applying for MediCal.

Some services that you may need at home may not be covered by your insurance plan. Case Management staff will help you sort this

out and will let you know if there are other resources available to you.

The Case Management Department works with your insurance company to ensure your medical needs will be addressed when you're preparing for discharge. This can include, discharge to skilled nursing or acute rehabilitation facilities, home health and medical equipment.

We're here to help...

Just as every patient has a discharge plan, you also have a care plan for your hospital stay. Ask your nurse to review it with you so that you will know the goals for your stay.

Your nurse, doctor or case manager can answer any questions that you or your family may have or they can direct you to the person who will know the answer.

At the Eden Campus, contact (510) 889-5040.

At the San Leandro Hospital Campus, contact (510) 667-4508.

Questions?

Your questions are important. Call your doctor or health care provider if you have questions or concerns.

For a social worker or case manager, ask your nurse or health care provider for a referral.



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