Discharge Planning

Care Transitions and How We Can Assist You:

The Care Transitions Team at New England Baptist Hospital is comprised of a team of registered nurses and licensed social workers who will assist you and your care partner with important decisions which impact your recovery process and for planning care that may be needed following hospitalization. At NEBH, we encourage patients to be actively involved in their own care. This is known as shared decision making. The team along with your physician, will develop a discharge plan which may include no services, home care (physical therapy or nursing care in your home), outpatient therapy, or inpatient rehabilitation at a skilled nursing facility and/or rehabilitation hospital.

You are a key member of the team and you can help prepare for your upcoming surgery by becoming an informed decision maker.

Helpful Hints to Successfully Transition from the Hospital

Be proactive! Create a plan with your care partner upon which you both agree.

For your surgical pre-operative visit:

- Be informed, ask your physician about your surgical status, inpatient versus outpatient as you may have varying copays.
- Remember to provide your surgeon's office with time sensitive documents i.e.: disability forms, handicap plate, FMLA and worker's compensation forms.

For your hospital procedure/stay:

- Most patients progress quickly and are as safe to go home from the hospital, having met their goals usually the day of or morning after surgery
- You should be prepared and arrange for transportation home
- If Medicare is your primary insurance, www.medicare.gov is your best resource
- For commercial insurances, contact your primary insurer's customer service pre-operatively
- Request information regarding copays for hospitalization, home care, outpatient services, or inpatient rehab and non-emergent ambulance transport.

  Be aware Medicare may only cover 30 miles of an ambulance ride at 80% with no guarantee of payment. It is determined based on medical necessity.
- Request a list of in-network covered skilled nursing facilities (SNF) rehabs
- Research and visit your rehab choices. Be prepared to provide us with 2 or 3 choices and your preferred home care agency/Visiting Nurse Association (VNA)

- If the care team recommends rehab:
    - o There are two levels of rehab; acute (rehab hospital) and sub-acute (SNF).
    - o Bed offers are based on medical necessity, bed availability, and insurance approval.
    - o For both, approval is based on post-op clinical documentation.
    - o Acute rehab hospital admission criteria requires an active unstable medical diagnosis, requiring 24/7 physician care in addition to the surgical procedure.
- Transport by private car to a rehab needs physician approval

- Traveling from out of state, please be aware that most VNA services outside of Massachusetts requires a primary care physician (PCP) from that state to order therapy to provide services. Check with your local VNA in advance.

Based on your choices and our recommendations we will develop mutual discharge planning goals.