



CASE MANAGEMENT



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Assisting with your care

The Case Management department will review your treatment plan and work with your doctor and insurance company to facilitate a smooth and timely transition from the hospital to your home or another health care facility, if necessary. We want to make sure you have a safe and timely discharge that address your continued care needs and ensure you will have the help you need when you leave the hospital. Case Management will also discuss your preferences with you. Every effort will be made to honor your preference, but certain insurance companies and government regulations may limit your choices or the options we may pursue on your behalf.

Please contact Case Management at 405-307-4337 if you have any questions.

Below are some of the services Case Management can help with as you leave the hospital:

- Outpatient services
- Home Health Care
- Home Medical Equipment
- Skilled Nursing Facility
- Inpatient Rehabilitation Services
- Long Term Acute Care Hospital transfers
- Palliative care
- Hospice care
- Medication Assistance Program
- Long Term Care placement
- Assisted Living
- Community Resources and Public Assistance Programs

Planning for your discharge

Discharge planning helps patients have a smooth transition of care from one level of care to another. **Discharging from the hospital does not mean a patient is fully recovered.** It simply means that the physician has determined the patient is stable and no longer requires the services of an acute care hospital.

Medical services

Outpatient services

These are medical services provided in a setting outside the hospital or your home. This includes services such as physical therapies and wound care. A patient typically receives treatment one to three times a week.

Home health care

Home health care is covered only if you are determined to be "homebound" and have care needs requiring a licensed professional, such as a physical therapist or nurse. You may be homebound for a short time after your hospital stay and then transition to outpatient services when you are no longer homebound.

Medical equipment

Most patients are discharged from the hospital with no medical equipment needs. If it is determined you will need a piece of medical equipment, your case managers will arrange for hospital or home delivery of the equipment. The cost of some medical equipment may not be covered by insurance. Check with Case Management for more information.

Skilled nursing facility (SNF)

Some patients need continued medical care or physical therapy after leaving the hospital. Staff such as nurses, therapist, and physicians will manage, observe, and evaluate your care. Medicare provides payment for care in a skilled nursing facility **if a variety of conditions have been met**. The typical stay at a skilled nursing facility is a week.

Inpatient rehabilitation facility

Some patients require intensive therapy in a hospital setting to improve their level of independence. This is usually needed after an accident or sudden decline, such as a stroke. Patients must be able to tolerate three hours of therapy for inpatient rehab and the typical length of stay is about two weeks. Norman Regional Health System has an inpatient rehabilitation facility, but it is always your choice on which facility is right for you.

Long-term acute care hospital (LTACH)

Some patients require more complex care for longer periods of time, although they are in a stable medical condition. An example is a patient who received a new tracheostomy placement or the continued need for a ventilator. The typical stay at this facility is longer than 28 days.

Palliative care

Palliative care provides relief from suffering and improves quality of life, focusing on physical, social, emotional, and spiritual health. Palliative care can be provided along with curative treatment. A patient does not have to be on hospice to receive palliative care. The goal is to improve quality of life for both the patient and their family.

Hospice care

Hospice care is a type and philosophy of care focusing on the relief of a terminally or seriously ill patient's pain and symptoms while attending to their emotional and spiritual needs. The emphasis of hospice is to shift care from curative to comfort. Hospice care can be provided at home or, in some cases, an inpatient hospice facility.

Medication assistance program

Obtaining and taking the medications prescribed by your physician is integral to a full recovery and will help prevent you from having to come back to the hospital. There are many assistance programs available for those who qualify but cannot afford certain medications. If you cannot afford a medication you are currently taking or a new prescription, please tell your case manager or contact the Medication Assistance Program at 405-307-3029. We will provide you with assistance.

All of the above services are contingent on payer restrictions and physician orders. If your discharge plan includes one of the above services, your case management team will provide you with information and options to facilitate your transition to the next level of care.

Residential services

Long-term care

A long-term care facility is a residential facility. The cost of these facilities is not covered by Medicare or insurance. It is the responsibility of the patient in most cases, but may be covered by Medicaid if the patient qualifies.

Assisted living

Assisted living facilities provide various levels of assistance from medication management to dressing, bathing, etc. The cost of these facilities is the responsibility of the patient.

Housekeeping and meal preparation

Many patients find upon leaving the hospital they can benefit from services such as housekeeping or meal preparation. Insurance companies and Medicare do not cover these services.

Community resources and public assistance programs

Your Case Management team can provide you with information for assistance programs for items such as utility bills, safety, food, etc.

Steps for planning your discharge

Step 1

Has your doctor explained your condition in terms that you and your family understand? If NOT, ask your doctor these questions before discharge:

- What is my main problem?

- What do I need to do?

- Why is it important that I do this?
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Step 2

Do you feel you are able to safely return home? If NOT, ask your nurse right away to contact Case Management to help with your discharge.

Step 3

- When your doctor has determined you can leave the hospital, your nurse will provide written instructions and discuss the signs and symptoms for you and your family to look for to keep you healthy.
- You will also be given a list of your medications to take, and a follow up appointment with your physician. If you need more explanation about your instructions, please let your nurse know.

After your doctor has ordered your discharge, it may take some time for us to get you ready to leave. At times this can take up to four hours, depending on additional treatments, tests or medications ordered by your provider. Please know we value your time and understand you want to go as soon as you can.

We are committed to getting us all to a healthier place. Please call us at 405-307-4337 if you have questions about your care after you get home.

We value your health and appreciate your opinion!

My discharge plan is _____



**NORMAN
REGIONAL**
Health System

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