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November 20, 2015

**SERVICES OFFERED TO ALL STATE AND COUNTY EMPLOYEES AND
RETIREES UNDER EUTF'S MEDICAL PLANS FOR CARE
WHEN TRANSITIONING FROM HOSPITAL TO HOME**

EUTF's medical plans (HMSA, Kaiser, and UnitedHealthcare) offer services when a patient transitions from the hospital to home.

Here are some of the services that are available under EUTF's both active and retiree plans:

HMSA

HMSA has a "Post-Discharge Team". Heading this Team is a Case Manager Registered Nurse (RN) that is assigned to the patient once he/she gets home. This RN Case Manager conducts a comprehensive needs assessment and develops a plan of care in conjunction with your primary care physician. The plan of care includes:

- Educating members and caregivers/family on discharge instructions from the hospital;
- Verifying and calendaring the primary care physician follow up appointments;
- Education on proper usage of your medications;
- Working with your primary care physician to make sure all of your medications don't conflict with each other;
- Coordinating your health care and social services needs;
- Coordinating your follow up appointments.

Kaiser Permanente

Kaiser Permanente has a Patient Care Coordinator who coordinates with the medical staff, hospital departments, and your caregiver/family to assure you have everything you need when you get home. This includes:

- Follow up appointments with your physician;
- Follow up tests and therapy;
- Other medically necessary services that your physician determines can best be provided in your home and can be safely and effectively provided in your home. These services are provided at no charge, except physician house calls which are \$15 per visit for the Comprehensive Plan and \$20 for the Standard Plan;
- A handy brochure of instructions and resources that ensure a smooth transition from hospital to home.

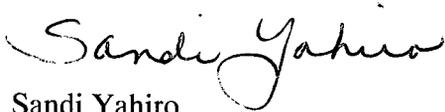
EUTF's Mission: We care for the health and well being of our beneficiaries by striving to provide quality benefit plans that are affordable, reliable, and meet their changing needs. We provide service that is excellent, courteous, compassionate, and informative.

UnitedHealthcare (for EUTF Medicare retirees only)

UHC has an Inpatient Care Management Nurse who, prior to or at the time of discharge, assesses your discharge needs and identifies if you will require transitional case management outreach after discharge. Transitional case management focuses on medication self-management, follow up with your primary care and specialist follow up, and understanding and knowledge of signs and symptoms. Another service available is the Solution for Caregivers program. This program is a comprehensive program designed to support family caregivers in helping aging family members stay healthy, function as independently as possible, live with dignity and remain in the community for as long as possible and is available during transition periods. The program offers professional assessment, consultation and care management services to people who have long term or advanced illness, are older, or have disabilities, while providing support and consultant to their caregivers.

Also attached is a discharge planning checklist when transitioning from hospital to home. I think you and your caregiver/family will find it very helpful if you become hospitalized.

Aloha,

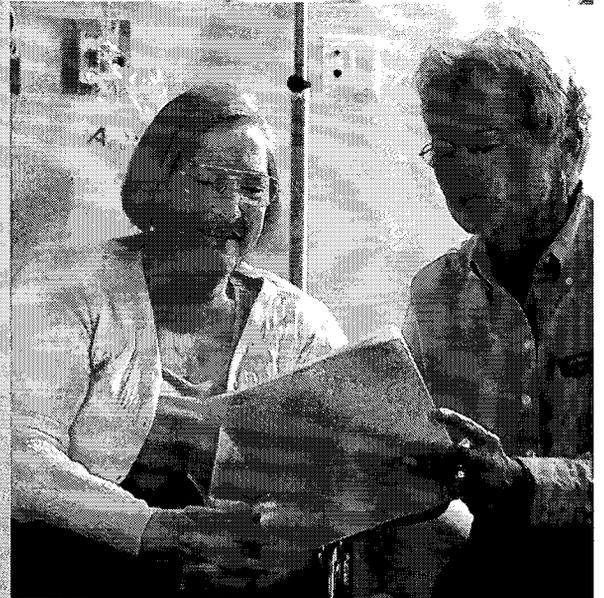
A handwritten signature in cursive script that reads "Sandi Yahiro".

Sandi Yahiro
EUTF Administrator

Attachment

Your Discharge Planning Checklist:

For patients and their caregivers
preparing to leave a hospital, nursing home,
or other care setting



Name: _____

Reason for admission: _____

During your stay, your doctor and the staff will work with you to plan for your discharge. You and your caregiver (a family member or friend who may be helping you) are important members of the planning team. You and your caregiver can use this checklist to prepare for your discharge.

Instructions:

- Use this checklist early and often during your stay.
- Talk to your doctor and the staff (like a discharge planner, social worker, or nurse) about the items on this checklist.
- Check the box next to each item when you and your caregiver complete it. 
- Use the notes column to write down important information (like names and phone numbers).
- Skip any items that don't apply to you.

Action items	Notes
What's ahead?	
<input type="checkbox"/> Ask where you'll get care after you leave (after you're discharged). Do you have options (like home health care)? Be sure you tell the staff what you prefer.	
<input type="checkbox"/> If a caregiver will be helping you after discharge, write down their name and phone number.	
Your health	
<input type="checkbox"/> Ask the staff about your health condition and what you can do to help yourself get better.	
<input type="checkbox"/> Ask about problems to watch for and what to do about them. Write down a name and phone number of a person to call if you have problems.	

Action items

Notes

- Use "My drug list" on page 5 to write down your prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.
- Review the list with the staff.
- Tell the staff what drugs, vitamins, or supplements you took before you were admitted. Ask if you should still take these after you leave.
- Write down a name and phone number of a person to call if you have questions.

Recovery & support

- Ask if you'll need medical equipment (like a walker). Who will arrange for this? Write down a name and phone number of a person you can call if you have questions about equipment.
- Ask if you're ready to do the activities below. Circle the ones you need help with, and tell the staff:
 - Bathing, dressing, using the bathroom, climbing stairs
 - Cooking, food shopping, house cleaning, paying bills
 - Getting to doctors' appointments, picking up prescription drugs
- Make sure you have support (like a caregiver) in place that can help you. See "Resources" on page 6 for more information.
- Ask the staff to show you and your caregiver any other tasks that require special skills (like changing a bandage or giving a shot). Then, show them you can do these tasks. Write down a name and phone number of a person you can call if you need help.
- Ask to speak to a social worker if you're concerned about how you and your family are coping with your illness. Write down information about support groups and other resources.
- Talk to a social worker or your health plan if you have questions about what your insurance will cover, and how much you'll have to pay. Ask about possible ways to get help with your costs.

Action items

Notes

- Ask for written discharge instructions (that you can read and understand) and a summary of your current health status. Bring this information and your completed "My drug list" to your follow-up appointments.
- Use "My appointments" on page 5 to write down any appointments and tests you'll need in the next several weeks.

For the caregiver

- Do you have any questions about the items on this checklist or on the discharge instructions? Write them down, and discuss them with the staff.
- Can you give the patient the help he or she needs?
 - What tasks do you need help with?
 - Do you need any education or training?
 - Talk to the staff about getting the help you need before discharge.
 - Write down a name and phone number of a person you can call if you have questions.
- Get prescriptions and any special diet instructions early, so you won't have to make extra trips after discharge.

More information for people with Medicare

If you need help choosing a home health agency or nursing home:

- Talk to the staff.
- Visit Medicare.gov to compare the quality of home health agencies, nursing homes, dialysis facilities, and hospitals in your area.
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048.

If you think you're being asked to leave a hospital or other health care setting (discharged) too soon:

You may have the right to ask for a review of the discharge decision by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) before you leave. A BFCC-QIO is a type of quality improvement organization (a group of doctors and other health care experts under contract with Medicare) that reviews complaints and quality of care for people with Medicare. To get the phone number for your BFCC-QIO, visit Medicare.gov/contacts, or call **1-800-MEDICARE**. You can also ask the staff for this information. If you're in a hospital, the staff should give you a notice called "Important Message from Medicare," which contains information on your BFCC-QIO. If you don't get this notice, ask for it.

For more information on your right to appeal, visit Medicare.gov/appeals, or visit Medicare.gov/publications to view the booklet "Medicare Appeals."

My drug list

Filled out on: _____

Fill out this list with all prescription drugs, over-the-counter drugs, vitamins, and herbal supplements you take. Review this list with the staff.

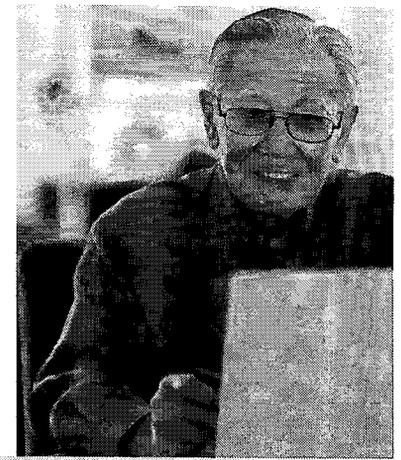
If you have Medicare and limited income and resources, you may qualify for Extra Help to pay for your Medicare prescription drug coverage. For more information about Extra Help, visit Medicare.gov/publications to view the booklet "Your Guide to Medicare Prescription Drug Coverage."

Drug name	What it does	Dose	How to take it	When to take it	Notes

My appointments

Appointments and tests	Date	Phone number

Resources



The agencies listed here have information on community services, (like home-delivered meals and rides to appointments). You can also get help making long-term care decisions. Ask the staff in your health care setting for more information.

Area Agencies on Aging (AAAs) and Aging and Disability Resource Centers (ADRCs): Help older adults, people with disabilities, and their caregivers. To find the AAA or ADRC in your area, visit the Eldercare Locator at eldercare.gov, or call 1-800-677-1116.

Medicare: Provides information and support to caregivers of people with Medicare. Visit Medicare.gov.

Long-Term Care (LTC) Ombudsman Program: Advocate for and promote the rights of residents in LTC facilities. Visit ltcombudsman.org.

Senior Medicare Patrol (SMP) Programs: Work with seniors to protect themselves from the economic and health-related consequences of Medicare and Medicaid fraud, error, and abuse. To find a local SMP program, visit smpresource.org.

Centers for Independent Living (CILs): Help people with disabilities live independently. For a state-by-state directory of CILs, visit ilru.org/html/publications/directory/index.html.

State Technology Assistance Project: Has information on medical equipment and other assistive technology. Visit resna.org, or call 1-703-524-6686 to get the contact information in your state.

National Long-Term Care Clearinghouse: Provides information and resources to plan for your long-term care needs. Visit longtermcare.gov.

National Council on Aging: Provides information about programs that help pay for prescription drugs, utility bills, meals, health care, and more. Visit benefitscheckup.org.

State Health Insurance Assistance Programs (SHIPs): Offer counseling on health insurance and programs for people with limited income. Also help with claims, billing, and appeals. Visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227) to get your SHIP's phone number. TTY users should call 1-877-486-2048.

Medicaid: Helps with medical costs for some people with limited income and resources. To find your local office, visit Medicare.gov/contacts, or call 1-800-MEDICARE.

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The information in this booklet describes the Medicare program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users should call 1-877-486-2048. "Your Discharge Planning Checklist" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.