



Preparing to go home after a COVID-19 hospital stay

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*Access the other sections of [this workbook](http://michmed.org/ng2Wl) by visiting: <http://michmed.org/ng2Wl>



What is the discharge process?

To leave a hospital or care facility, you must go through a process called **discharge**. The discharge process has 3 parts:

1. Alerting you that the discharge process has started
2. Holding a discharge planning meeting
3. Sending you home on discharge day

All the work done in preparation to leave a healthcare facility is called **discharge planning**. The doctor decides when you can be discharged, but nurses, social workers, discharge planners, and others also play a role in creating the discharge plan. Together, these people make up your **discharge team**. Your discharge team may provide you with a discharge packet that includes information such as medications, future appointments, and diet restrictions.

University of Michigan Care Management

At the University of Michigan, you may also receive assistance from Care Management. **Care Management** is a team led by a registered nurse and a social worker. The Care Management team can connect you with services and resources to support you during your hospital stay, as well as after discharge.

Care Management will:

- Offer counseling on how illness, disability, and grief can impact you and your family
- Problem-solve with you on social and financial barriers that impact your medical care
- Provide community resources, information, and referrals
- Connect you with the following services:
 - Home care services, such as:
 - Visiting nurses
 - Physical therapy
 - Occupational therapy
 - Speech therapy
 - Private duty nursing
 - Out-of-hospital placement referrals, such as: skilled nursing facilities and acute rehab facilities
 - Durable medical equipment, such as: wheelchairs, oxygen, medical supplies



How are caregivers involved in the discharge process?¹

This document addresses anyone who is providing care to someone during or after a hospital stay as a “caregiver.” This may be the first time you find yourself in a caregiving role, or you may have been a caregiver to this person (or others) for a long time. The purpose of this section is to help you and the patient navigate the transition home, whether from the hospital or from a different healthcare facility.

During the discharge process, your discharge team should:²

- **Include** you and the patient in conversations
- **Discuss** key areas to prevent problems at home
- **Educate** you and the patient on their condition, the discharge process, and next steps
- **Assess** how well the information above was explained and understood
- **Listen** to your and the patient’s goals, preferences, observations, and concerns

When starting the discharge process, talk to the discharge team about your willingness and ability to provide care. You may have physical, financial, or other limitations that affect your caregiving capabilities. You may have other obligations such as a job or childcare that impact the time you have available. It is extremely important to tell the discharge team about these limitations.

How has COVID-19 changed the discharge process?

Because of COVID-19, the process of leaving the hospital or care facility may be faster than usual. You may not be able to enter the hospital or care facility for safety reasons. You should advocate to:

- Have the most accurate information about the steps it takes to be discharged
- Be involved in discharge planning and conversations with the discharge team
- Have your questions and concerns addressed before the patient is sent home

Some of the care the patient needs might be quite complicated. It is essential that you get any training you need in special care techniques, such as wound care, feeding tube or catheter care, or transferring someone from a bed to a chair.¹ To make sure you get the information you need:

- Ask that conversations about going home be scheduled at times that you can attend
- Use phone or video calls to attend conversations when you are unable to go in person
- Ask for written documents and summaries of plans for care at home and ask for a phone number to call if you have any questions

¹ Adapted from: Family Caregiver Alliance. Hospital Discharge Planning: A Guide for Families and Caregivers. <https://www.caregiver.org/hospital-discharge-planning-guide-families-and-caregivers>. Published 2009. Accessed December 5, 2020.

² Adapted from: Agency for Healthcare Research and Quality. IDEAL Discharge Planning Overview, Process, and Checklist. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklist_508.pdf. Accessed December 5, 2020.



What should be included in the discharge plan?

A basic discharge plan should include:³

- **Evaluation** of your current health status and ongoing issues
 - Ask for a written list of all tubes/lines/drains so you know what the different bumps and bruises and holes are from and what to look for regarding healing/infection risk
- **Planning** for your return home
- **Review** of medications and equipment you may need
- **Determination** of whether you need training or other support
- **Referrals** to home care agencies or other support organizations
- **Arrangements** for follow-up appointments or tests

Remember that the discharge team will not be familiar with all aspects of the patient's situation. As a caregiver, you may be able to help by providing information about the patient's medical history and home environment. Sharing this information with the discharge team can help them make a safe and effective discharge plan.

This section provides basic information about discharge planning. For other tools and conversation starters, visit:

- **Agency for Healthcare Research and Quality:** [IDEAL “Be Prepared to Go Home Booklet”](http://michmed.org/O5J70) (<http://michmed.org/O5J70>)
- **Medicare:** [Your Discharge Planning Checklist](http://michmed.org/Ylw75): For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting (<http://michmed.org/Ylw75>)

What if I feel it's too soon to leave the hospital?³

If you feel it's too soon to leave the hospital, you have the right to appeal the decision. The hospital must let you know how to get your case reviewed. Here are some steps you can take:

- Talk to your doctor and other discharge team members about your worries
- Ask to talk to a Patient Advocate
- Contact Medicare, Medicaid, or your insurance company

³ Adapted from: Family Caregiver Alliance. Hospital Discharge Planning: A Guide for Families and Caregivers. <https://www.caregiver.org/hospital-discharge-planning-guide-families-and-caregivers>. Published 2009. Accessed December 5, 2020.



Preparing for discharge: safety

How do I get the patient home from the hospital?

The patient may go home by themselves, with you, or with another family member, friend, or transportation resource or service. If the patient needs help getting home, please let your discharge team know.

If the patient is still contagious and will be driving or riding in a personal vehicle, take appropriate precautions:

- Wash or sanitize your hands before and after entering and exiting the vehicle
- Bring cleaning supplies (such as wipes and hand sanitizer) to wipe down commonly touched areas in the vehicle
- Go directly home (do not go on errands along the way)
- Wear a mask (note: masks should not be worn by those having difficulty breathing, children under 2 years old, or those unable to take off their own mask)
- Sit as far away from other people in the vehicle as possible
- Open the car windows and turn your fan on to outside air to increase air flow
- Clean and disinfect surfaces you have touched

How do I prepare the patient's home?

The patient's physical ability when they leave the hospital will be different than when they were admitted to the hospital. They may need time and help to regain their strength and ability to do daily activities. Additionally, the patient may need to isolate once they are home. Before discharge day, ask the care team whether or not the patient will need to isolate and ask the patient's physical and occupational therapists for advice on preparing the home.

You may need to:

- **Clear the path from the bed to the bathroom.** Check that doorways and hallways are completely clear. You may need to move furniture around to make this possible. You may also need to temporarily put a bed on the first floor.
- **Reduce trip hazards.** Remove clutter from the floor and securely fasten or remove rugs.
- **Increase lighting.** Increase lighting in areas the patient will frequently use, such as entrances or staircases.
- **Install grab bars.** Grab bars are important in the bathroom, especially around the toilet and the shower.
- **Check any steps or stairs.** Add rails or bannisters next to all steps that don't have them. You may need to add a ramp or slope up to the front door.

Talk to the patient's physical and occupational therapists, and visit HealthinAging.org for [instructions on setting up a room and assisting a frail person](https://michmed.org/axgG1) in bed and in the bathroom (<http://michmed.org/axgG1>).



Preparing for discharge: safety

How do I keep myself and others safe once the patient is home?

Depending on the discharge team's instructions, the patient may be asked to isolate. For a guide to quarantining and isolating, visit the workbook section "[Navigating COVID-19 Exposure, Testing, and Quarantine](http://michmed.org/ng2WI)": (<http://michmed.org/ng2WI>).

Additionally, many people who have had COVID-19 have questions about whether or not they can get sick from COVID-19 again (**reinfection**). Currently, there is not enough information available about COVID-19 reinfection.⁵ Unless you have been told to isolate, the best way to prevent infection or reinfection is to take steps to protect yourself:

- Wear a mask in public places
- Stay at least 6 feet away from other people
- Wash your hands
- Avoid crowds and confined spaces

For the latest [information about COVID-19 reinfection](https://www.cdc.gov/coronavirus/2019-ncov/your-health/reinfection.html), visit:

<https://www.cdc.gov/coronavirus/2019-ncov/your-health/reinfection.html>

⁵ Centers for Disease Control and Prevention. Reinfection with COVID-19. <https://www.cdc.gov/coronavirus/2019-ncov/your-health/reinfection.html>. Published 2020. Accessed December 9, 2020.



Preparing for discharge: equipment and supplies

What medical equipment and supplies do I need?

After a COVID-19-related hospital stay, the patient may need medical equipment at home that they do not already use or have. You may also need certain supplies for their care, such as bandages for bed sores, masks, and gloves. Your discharge team can help you understand what medical equipment and supplies you will need, as well as how to get these items.

Equipment prescribed by your doctor is called **durable medical equipment (DME)**. Examples of DME include wheelchairs, oxygen, and devices for exercising breathing. Equipment must meet these criteria in order to be considered DME:⁶

- Can withstand repeated use (**durable**)
- Used for a medical reason
- Not usually useful to someone who isn't sick or injured
- Used in your home
- Generally has an expected lifetime of at least 3 years

Before discharge day, ask your discharge team these questions about equipment and supplies:

- What durable medical equipment will the patient need at home?
- What equipment will help the patient move around more easily?
- What supplies will I need in order to care for the patient?
- What equipment and supplies will the patient come home with?
- How do I get the equipment and supplies the patient does not come home with?
- Can you show or tell me how to use the equipment and supplies properly?
- What happens if there is an issue with the equipment I receive?
- How do I return equipment once I am done using it?

⁶ U.S. Centers for Medicare & Medicaid Services. Durable Medical Equipment (DME) Coverage. <https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage>. Accessed December 9, 2020.



Preparing for discharge: equipment and supplies

How do I get the equipment and supplies I need?

To find out how much your equipment will cost, talk to the patient's doctor and insurance company. The specific amount owed may depend on several things:⁶

- The type of insurance the patient has
- Where you get the equipment and supplies

Many times, orders will be placed for the DME that you need. A social worker can also help you identify places to get your DME and resources to help with the cost. Ask if there will be a cost to you. You can contact that company directly or contact your discharge team to assist.

At Michigan Medicine, a social worker may also help you through the Guest Assistance Program. The **Guest Assistance Program** can connect you with several types of resources (all based on eligibility) for social needs related to medical care at Michigan Medicine:

- Communication with government and community organizations
- Pharmacy assistance for prescriptions
- Costs for medications, supplies and equipment
- Lodging assistance
- Meal Assistance and Food Insecurity
- Transportation assistance
- Durable medical equipment/supplies
- Parking



Guest Assistance Program:

Phone: 800-888-9825

Hours: Monday-Friday 9 a.m.-5 p.m.,

Visit: michmed.org/q4kRz (scan the QR code)

⁶ U.S. Centers for Medicare & Medicaid Services. Durable Medical Equipment (DME) Coverage. <https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage>. Accessed December 9, 2020.



Preparing for discharge: medications

How do I manage medications?

It is likely that the patient will be discharged home with a list of new or changed medications. Ahead of time, decide who will pick up their medications, what pharmacy you will use, and when you will pick them up. Making a plan will help you avoid missing a dose of important medications or taking the dose late.

Before or on discharge day, ask the discharge team these questions about medications:

- What medication(s) should they be taking at home?
- Should they take the medications they were taking before their hospital stay?
- What is this medicine for? How and when should they take it?
- What are potential side effects? How do I look for them?
- Is this medicine safe to take with their other medications and supplements?
- Is there a way to minimize the number of medications or supplements?
- What alternative therapies are available?

For questions about your medications, call your healthcare provider.

How can I keep track of medications?

Patients who leave a hospital or care facility after a lengthy stay often have changes to their medications. Depending on their health conditions, it is not unusual for someone to take 15 medications or more after an extended hospital stay. During the first few weeks home, it is common for a doctor, nurse, or pharmacist to change which medications the patient takes, how often they take them, and how much they take.

As a caregiver, you can help the patient keep track of these medication changes:

- Use a journal to keep track of medications. See example on the next page.
- Use a pill organizer to make it easier to prepare medications in advance.
- Use a pill splitter to cut larger pills into smaller dosages (amounts).
- Try a free mobile app, such as [Medisafe \(www.medisafeapp.com\)](http://www.medisafeapp.com)*, to remind both you and the patient when it's time for them to take their medications.

* Note: Michigan Medicine has no connection to Medisafe and has not reviewed its services. This is intended as an example for informational purposes only, not an endorsement of Medisafe services.



Preparing for discharge: care coordination

Who should I tell that the patient is home?

When the patient is coming home, you should make sure you notify their primary care doctor and any other specialists. These people can help you with the transition of care.

What care services do I need at home?

After discharge, the responsibility of coordinating the patient's care often transfers from the hospital to you. At this point, you may first feel the weight of being a caregiver. Talk to your discharge team about what home care services are available to help you. For some of these services, the patient must be referred by a doctor.

At Michigan Medicine, home care services include:

- **HomeMed:** A home infusion provider and licensed pharmacy that provides a range of services in the comfort of your home. For more information about HomeMed, visit: <https://homecare.med.umich.edu/HomeMed>
- **HouseCalls:** A team that provides care to patients that are homebound or have limited mobility. For more information about HouseCalls, visit: <https://homecare.med.umich.edu/HouseCalls>
- **Michigan Visiting Nurses (MVN):** A home care provider of skilled nursing and rehabilitation services to patients. For more information about Michigan Visiting Nurses, visit: <https://homecare.med.umich.edu/Michigan-Visiting-Nurses>
- **Patient Monitoring @ Home:** A team that works closely with your doctor to ensure your plan of care helps you to remain healthy and happy in the comfort of your home. For more information about Patient Monitoring @ Home, visit: <https://homecare.med.umich.edu/PatientMonitoringAtHome>
- **Wheelchair Seating Service:** A leading provider of custom mobility products in the area. For more information about Wheelchair Seating Service, visit: <https://homecare.med.umich.edu/Wheelchair-Seating-Service>



Preparing for discharge: care coordination

U-M PULSE Clinic

Services for COVID-19 patients after leaving the intensive care unit (ICU)

The University of Michigan Post-ICU Longitudinal Survivor Experience (U-M PULSE) Clinic works with post-ICU patients and their caregivers, including COVID-19 patients, to help streamline all of the services you might need after leaving the ICU.

The U-M PULSE team works to:

- Identify the changes that are most disruptive to the patient's life.
- Identify the patient's strengths and supports.
- Develop a comprehensive care plan that addresses the patient's goals.
- Assess the impact of the patient's illness on you as a caregiver.
- Help you access additional services and support.

For [more information](http://med.umich.edu/cvc/pdf/UM-Pulse.pdf) visit <http://med.umich.edu/cvc/pdf/UM-Pulse.pdf> or call 1-888-287-1084 and ask for Dr. Jakob McSparron.



What can I expect during the care transition?

When the patient first comes home, coordinating their care may seem like a full-time job. You may be balancing new caregiving responsibilities on top of employment, childcare, and self-care. You may also be wondering how to help the patient and at the same time encourage, motivate, and enable them to care for themselves. During this time, you may feel a wide range of emotions. You may feel:

- **Euphoric** that the patient survived
- **Anxious** or fearful that the patient may get sick again
- **Worried** over the patient's well being and the need to constantly check that they are okay
- **Unsettled** due to disruption of normal schedules and routines
- **Relieved** when changes to medications reduces symptoms
- **Overwhelmed** from coordinating appointments, medications, and other care
- **Concerned** about how to manage dietary needs that may have changed

Strategies that can help:⁷

- **Acknowledge that the patient has the right to make decisions about their life.** Respect that right unless your loved one is no longer capable of making decisions or could put themselves or others in danger through their behavior.
- **Whenever possible, offer choices.** Making choices is a basic freedom and enables us to express ourselves. Provide choices for your loved one when possible.
- **Do only those things your loved one can't do.** If your loved one is still capable of performing certain activities, such as paying bills or cooking meals, encourage them to do so. Helping your loved one feel some independence will make them feel better about being in a care-receiving situation.
- **Take care of yourself so you can take care of others.** Caregivers often exhaust themselves due to the caregiving responsibilities on top of normal daily routines. Take time to sleep and to do things you enjoy so you can be there for the long haul.
- **Don't be afraid to ask for help.** There can be deep emotional currents when a loved one becomes ill. Relatives and friends can do a lot to ease your caregiving burden. You can also ask a faith leader, social worker, or therapist for support processing your thoughts and feelings.

⁷Adapted from: Leukemia & Lymphoma Society. Caregiver Workbook Chapter 1: Introduction to Caregiving. Rye Brook; 2019. https://www.lls.org/sites/default/files/National/USA/Pdf/Publications/Caregiver_Workbook_Ch1_Introduction_to_Caregiving_2019.pdf. Accessed December 9, 2020.



Preparing for discharge: care coordination

How can I keep track of upcoming appointments?⁸

Patients who leave a hospital or care facility after an extended stay often have many follow-up appointments with healthcare providers. These healthcare providers may be specialists the patient has never talked to before.

As a caregiver, you can help the patient keep track of their new healthcare providers and upcoming appointments using a paper calendar or calendar app. Below is a blank calendar template and a logbook to write down healthcare provider contact information.

How do I access online health records?

If you are a patient

You can contact your care team and view your health records through the [MyUofM-Health Patient Portal](http://michmed.org/xoWYR) (<http://michmed.org/xoWYR>). Select “For myself only” to make an account for yourself, or select “Adult granting access to another adult” to give your caregiver access.

If you are a caregiver

With the patient’s permission, you can also contact the care team and view the patient’s health records. See the contact information below for help.



For questions or information about the MyUofMHealth Patient Portal:

Email: HIM-PatientPortal@med.umich.edu,

Phone: 734-615-0872 (Monday-Friday 7:00 am - 7:00 pm, Saturday and Sunday 8:00 am - 5:00 pm), or

Visit: <http://michmed.org/xoWYR> (or scan the QR code)



Preparing for discharge: care coordination

Monthly Appointment Calendar⁸

Month: _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

⁸ Leukemia & Lymphoma Society. Caregiver Worksheet 6a: Appointment Calendar, By Month. Rye Brook; 2019. https://www.lls.org/sites/default/files/National/USA/Pdf/Publications/Caregiver_Worksheet_6a_AppointmentsMonth_2019.pdf. Accessed December 7, 2020.



Healthcare team contact information⁹

Type of healthcare provider:
Name:
Phone:
Email:
Address:
Notes:

Type of healthcare provider:
Name:
Phone:
Email:
Address:
Notes:

Type of healthcare provider:
Name:
Phone:
Email:
Address:
Notes:



Healthcare team contact information⁹

Type of healthcare provider:
Name:
Phone:
Email:
Address:
Notes:

Type of healthcare provider:
Name:
Phone:
Email:
Address:
Notes:

⁹ Leukemia & Lymphoma Society. Caregiver Worksheet 5: Healthcare Team Contact List. Rye Brook; 2019. https://www.lls.org/sites/default/files/National/USA/Pdf/Publications/Caregiver_Worksheet_5_HCPcontacts_2019.pdf. Accessed December 7, 2020.



Help improve these materials:

Please help make these materials better for other patients and caregivers.

[Share your feedback here \(http://michmed.org/pxwgb\)](http://michmed.org/pxwgb), or scan the QR code.

This Quality Assurance/Quality Improvement effort was reviewed under IRB-Med #HUM00190878 and determined not to require IRB approval (Not Regulated - non-research).

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