Being discharged from a hospital is a welcome event, but it is not without challenges. This video has information about the discharge plan, whether the person you care for is going home or to a facility for more care. Other aspects of discharge, such as safety at home, are important topics. As a family caregiver you also need to consider your own situation and abilities to provide the needed care, especially if you are the only or main caregiver. As you plan for discharge, remember what you have learned about the “4Ms”: What Matters, Medications, Mentation, and Mobility. All are as important at home as in the hospital.

### Hospital Discharge to a Rehabilitation or Skilled Nursing Facility

Home is typically the first choice after discharge, but that is not always the most appropriate destination. If the person you care for needs rehabilitation therapy or continued medical treatment, the health care team may advise going to an acute rehabilitation facility or a short-term skilled nursing facility (SNF, pronounced “sniff”). These facilities are designed to provide the level of care your family member or friend needs to be safe at home. In some cases, however, older adults do not make enough progress in these facilities to go home and are moved to long-term care facilities.

If discharge to a SNF or rehab facility is advised, the hospital will provide you with a list of facilities that can provide the needed care. Because of the coronavirus pandemic and its impact on hospitals, the Centers for Medicare & Medicaid Services (CMS) waived some new regulations that would have given patients and family caregivers more specific facility information from the health care team (see article in Additional Resources). You should plan to do some research on your own, often with short notice. Go to CMS for resources to finding and comparing facilities: [https://www.cms.gov/nursing-homes/patients-caregivers/finding-home](https://www.cms.gov/nursing-homes/patients-caregivers/finding-home). Try to visit the facilities on the list and talk to people whose relatives or friends have been at those facilities. Ask about staffing, visiting policies, and activities available to patients. Studies show that most people choose a facility based on location, which is understandable, but it is not the only factor to consider.

If your family member or friend is going to a facility, the hospital staff should send documentation summarizing the care provided, medications prescribed, and other details. Staff will also give you contact information in case questions arise. In the frequently rushed discharge process, this step may be cut short, so make sure that it is done fully.

### Hospital Discharge to Home

By comparison, it may seem simple to go straight home after discharge. But there are many things that you as the family caregiver need to consider. The health care team may use terms like supervision to describe your caregiving responsibilities at home, but this can mean just being watchful or, alternately, being totally immersed in the person’s care.

Before the discharge, ask the nurse or pharmacist to go over the current medication list with you so that you can catch any inadvertent errors. This process is called medication reconciliation and is important because medications or doses may have been changed. Also ask about when and what doctor’s visits should be arranged, and who to call if there is an emergency.

You should think realistically about what types of care you can provide and for how long. Consider your other responsibilities, such as your own health, employment, childcare, or care of other family member or friends. Think about whether you can manage changing dressings, administering multiple medications, transfers from bed to chair or toilet, and the many other tasks that need to be done. This may be familiar territory and you might know
what to expect, although some details might be different if there’s been a change in the person’s health or a new diagnosis. If you are new to caregiving, you may not even know what kinds of help you will need and haven’t yet had to ask for help from family and friends or community groups. If this is the case, ask the social worker or care manager about the possibility of some in-home health care help to get started. Depending on insurance, some short-term help may be covered.

Be sure to ask for instructions on any tasks that are new or that have changed since the illness and hospitalization. Tell the health care team about any impediments to safe care in the patient’s home, such as limited space for equipment, lack of Internet access that might be needed for telehealth visits, difficulty in navigating stairs, or other problems. Some alterations may be needed to make the home safer and more accessible, such as adding a grab bar in the bathroom and improving the lighting.

If equipment is needed at home, such as oxygen, a walker, or a raised toilet seat, the staff will advise you about how to obtain it. Some items may be rented, but others will need to be purchased. Medical equipment is usually provided by a company that sends a technician to set up the device and instruct you in its use.

Transportation
If your family member or friend is going to a facility, the hospital will arrange transportation. However, if the person is going home, generally hospitals will not provide transportation. If the person needs a wheelchair or there is no suitable car available, the hospital can arrange the service. Insurance may or may not cover this charge.

If the person can be safely transported by car, a staff member will accompany him or her to the hospital entrance and meet the driver. If needed, that staff member can help the person get into the car.

It’s a good idea to have someone at home to greet you and your family member or friend. That person can make sure you have supplies and groceries to ease the transition. Preparing in advance and being aware of issues that may arise will help you and your family member or friend make a smooth re-entry.

Additional Resources


> The United Hospital Fund has also published a series of reports called *Difficult Decisions about Post-Acute Care*, including one report based on family caregiver interviews. Go to [https://uhfnyc.org/our-work/initiatives/quality-institute/post-acute-care/](https://uhfnyc.org/our-work/initiatives/quality-institute/post-acute-care/).


For more information, go to [www.AARP.org/nolongeralone](http://www.AARP.org/nolongeralone).

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