Editorial

After the Discharge

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I was recently helping out in a family health care crisis and was reminded how difficult it is for someone to navigate the health care system if they are seriously ill, do not know how to access services or are simply overwhelmed with what needs to be accomplished. What do you do if you are frail and sick and need transportation to health care? What if the home health nurse schedules a visit at 10 a.m. does not show until after 11 and you have a radiation treatment 2 hours away scheduled at 1 p.m.? What happens if the doctor says you need physical therapy but you get home and find that the nearest physical therapist is an hour away, you cannot drive, there is no public transportation and you have no idea how you will get to the appointments?

These dilemmas happen with elders but can be a problem at any age. They happen in urban areas but are even more difficult to solve if you live in a rural setting. These problems are a lot simpler to deal with if you have adequate financial resources; however, if the service is extremely limited in a rural community it often still requires a lot of planning and knowledge or luck in navigating the system to be able to access the services needed. Of course if the service is not available you may not be able to get the service no matter your resources. Ancillary needs that go beyond the acute care setting are often some of the hardest to meet. Discharge planning helps but in my experience a discharge from an urban facility back to a rural community often does not translate into the services being delivered as planned.

In part, the problem is a fragmented health care system. The newly discharged patient is told to schedule an appointment with the surgeon, the oncologist or other specialist yet the treatments and home health or specialty nursing visits also need to take place in that same time

period. The home health nurse has your diagnosis but may not know that you have radiation scheduled every day for a week after your discharge from the hospital and that you have a long travel time to get to that appointment. The home health nurse of course is most likely seeing more patients than optimal and schedules are easily thrown off, delaying the time of their visit. Some health care systems do a better job than others at trying to coordinate care, particularly when there are involved treatment plans. When I have assisted family or friends to deal with complex health issues, I often wonder what do people do who do not have a nurse to ask or do not have family who are able to help. Even with family and other resources navigating the health care system can be daunting. I think that for those of us who provide health care, research health issues, or work on health policy as part of our professional lives, it is humbling and a bit scary to see the system through the eyes of someone who needs the system but where the system is not meeting the needs of the individual. Can we translate these personal experiences into action to help improve the system? Clearly communication within the system and discharge planning that incorporates ancillary as well as direct health care needs is a start. Some systems have a "nurse navigator" and I have heard that this type of position can be of great help. Whoever is navigating the system needs to be aware of some of the unique challenges of accessing services either within or from rural locations. Logic would suggest that meeting these ancillary needs has a bearing on the ability for someone to heal at home and avoid re-hospitalization.