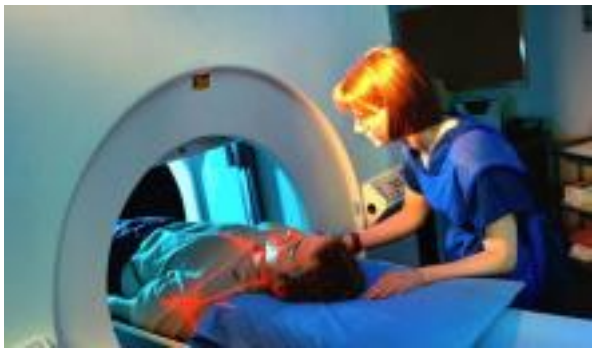
Using Personal Safety Nets to Help Patients Recover and Reduce Hospital Re-Admissions

~~The Centers for Medicare and Medicaid Services~~ (CMS) recently ~~**reported**~~ **that up to 75 percent of hospital re-admissions are potentially preventable, and "by encouraging providers to reduce preventable re-admissions**, the US government expects cost savings of over $26 billion in the next ten years."



[1]This has lead to the rapid growth of ~~hospital discharge planners~~," and to the creation of "discharge" departments within hospitals and clinics. As helpful as these services may be, implementation is commonly referred onward to private home care agencies with the idea of saving the government, hospitals and health insurers money. **Unfortunately, no matter where patients derive these services, they most frequently come at a cost - although probably less than a continued hospital stay.** What CMS and others often overlook is the value of actively engaging patients themselves in designing their own discharge desires and supports. **Discharge planners (private and public) know that if the following assistance is provided, it will cut the chances of re-admission. In their job ~~descriptions~~:**

- Meeting the patient at the hospital or rehabilitation facility and providing safe transportation home for them and their equipment and belongings;
- Picking up prescriptions, groceries and supplies;
- Helping prepare meals and ensure proper nutrition;
- Monitoring medication compliance;
- Assisting with activities of daily living while a person may be continuing to build strength;
- Assisting with strengthening exercises per physical therapist;
- Transporting client to follow-up appointments

Read the list again, slowly, please. These are common tasks - although not easy for all those leaving a facility. They are also tasks that can certainly be done by friends, family members and volunteers who may be willing to give a bit of their time to come together to help another. **Using a team approach and tactics, this can be very effective. We all have a human need to help others. Urging patients, before discharge, to identify and create a support base addresses this need, while supporting healthy discharges and reduced readmission rates.**

This is the incredibly simple concept known as creating a personal safety net (PSN): organizing a team to help accomplish goals or help with needs that one cannot by oneself. Having a network will minimize isolation or bouts of depression while helping ensure better regimented homecare.

If you know a patient looking toward discharge, here are two sources of assistance: 1) the chapters of Personal Safety Nets book - to remind or help you deal with the processes of creating, building and using a PSN team; and 2) A checklist (on this site) called "A Hospital Discharge Planning Checklist"- with a series of questions and actions that safety net friends/teams can ask and follow to help.

Remember, if you know someone is in need of help and you think you might help:1) A little help is better than none at all and 2) if your help is declined, it's not personal. So, use your intuition - leaving a hospital is strenuous, but for some, asking for assistance is even tougher. Offer to help.

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Links
[1] https://personalsafetynets.org/file/92