Smooth Transition Care

Preferred Care at Home®

A Safe and Caring Transition from Hospital to Home

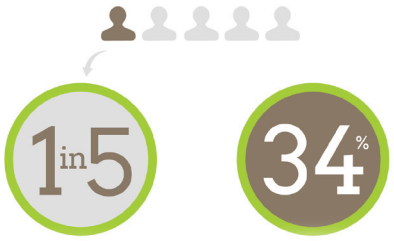
A program that complements the discharge process, ensures home safety and enables continued recovery

Preventing Readmission and Supporting Recovery

When a patient is discharged, readmission risk depends largely on what patients do at home. Seniors and families are often overwhelmed with medication changes, follow-up appointments and preparing the home for arrival.

What if they had a resource that implements discharge plans and supports continued wellness and recovery at home, while reducing the risk of hospital readmission? And what if it was not only effective, but affordable?

At Preferred Care at Home we offer an evidence-based recovery program that addresses the top reasons patients return to the hospital. Our 30-day *Smooth* Transition Care program ensures medication compliance, follow-up with physicians, monitors chronic illness symptoms ("red flags") and helps prevent falls.



After leaving the hospital, 1 in 5 seniors will be readmitted within the first month and 34% will be back in 90 days.

[CMS.gov]

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Celebrating life, dignity and independence. ™

Macomb and Grosse Pointes 586-298-1044
Oakland 248-430-6688
www.PreferHome.com

Four Readmission Risks

...and How Smooth Transition Care Can Prevent Them

1 Medication errors and non-compliance

After discharge, the most common complication is an adverse drug event. *Smooth* Transition Care includes our electronic Personal Health Record which your transition coach uses to reconcile medications and ensures prescriptions are filled and taken as prescribed.

2 No follow up with health-care providers

Half of Medicare patients who are readmitted have not seen a doctor within the last 30 days. We coordinate a schedule that assures follow-up with all post-hospital appointments and provide transportation if necessary.

3 Missing chronic illness "Red Flags"

80% of seniors have at least 2 chronic illnesses but do not recognize the warning signs. With proper education and monitoring, the *Smooth* Transition coach can identify any "red flags" before they progress too far, and help prevent unnecessary emergency room visits and rehospitalization.

4 Lack of fall-prevention measures

After a hospital stay, patients are more prone to falls. The *Smooth* Transition Coach performs a home assessment to help create a fall-free environment and encourages the patient to follow physical therapy programs and range of motion exercises.

Family surrogates need an advocate to help reduce the risks of readmission

The University of Colorado conducted a study using a program very similar to Smooth Transition Care. The study showed a 30% reduction in rehospitalization rates within 30 days of discharge.

By 180 days, 38% fewer patients had been readmitted for the same diagnosis.

The study was published in Archives of Internal Medicine in 2006.

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Smooth Transition Care

Proven Success in Preventing Rehospitalization

Empowering the patient and family after hospital discharge, while providing care and support during this critical time

The 30-Day Smooth Transition Care Program includes:

A Smooth Transition Coach

- Pre-Discharge Assessment at Hospital
- Home and Fall Prevention Survey
- Discharge Instructions Review
- Medication Reconciliation and Management
- Electronic Personal Health Record (PHR)
- Medical Equipment Assessment and Set Up
- 3 Weekly Home Visits to Review Progress
- Weekly Phone Follow-Up
- Vitals Monitoring and Documentation
- Illness Symptoms and "Red Flag" Reporting
- Communication and Progress Reporting

40 Hours of Home Care*

- Alzheimer's and Dementia Care
- Toileting and Incontinence Care
- Bathing, Hygiene and Dressing
- Transfers and Fall Prevention
- Transportation and Errands
- Night Time Supervision
- Medication Reminders
- Light Housekeeping
- Meal Preparation
- Companionship

Smooth Transition Care is available for $750

** The 40 hours of home care services must be used within the first 30 days of discharge and are available in 4 hour minimum blocks. A complete list of services are listed on the back of this brochure.*

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Let Our Family Care for Your Family

Improving Quality of Life ... Safeguarding Dignity and Independence

Owners: Bob, Jason and Mike

As professional Firefighters and Paramedics, caregiving comes naturally to us. Every day we are called to serve seniors who sometimes have trouble living on their own. This invaluable experience and our natural instinct as caregivers are the foundation that our company is built upon.

We are driven to provide the services and compassion needed to help your loved one remain safely in their home for as long as possible.

Our case managers work closely with your family, caregivers and medical professionals to establish and monitor a care plan for the client. We ensure our caregivers are qualified, trained and pre-screened with reference and background checks.

Case Managers: Lisa, Debbie and Melissa

Hourly Rates

24 hour live-in.....$8/$9
4 hours or more.....$16.50
40+ hours/week.....$15.50
24 hour care.....$14.50
(in 12 hour shifts)

Smooth Transition Care $750

Home Care Services

- Alzheimers and Dementia
- Medication Reminders
- Meal Preparation
- Bathroom Assistance
- Incontinence Care
- Dressing Assistance
- Bathing and Hygiene
- Transfers/Fall Prevention
- Light Housework
- Transportation/Errands
- Companionship
- Night Time Supervision

All Services are Insured and Bonded

24/7 Service

Assisted Living in Your Home

Our 24/7 service offers round-the-clock peace of mind while providing all the services needed for your loved one to remain at home safely.

Each client is evaluated by our staff and a custom care plan is developed. Our case managers assign and monitor two to three experienced live-in caregivers to each client.

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