In-Home Care

Don't Gamble with Your Loved One's Health!

Help avoid the high-stakes game, rely on Comfort Keepers® Hospital to Home Program.

Finally, it's time to go back home. You've received some of the finest medical treatment in the world, with technologies and procedures unthinkable, even a few decades ago. Crisis over, rehabilitation begins.

The sad fact is that for adults over 65, almost 20% can expect to find themselves back in the hospital within 30 days; 34% within 90 days. The revolving door begins.

No worries, Medicare has me covered, right? Not so much. Many hospitalizations lead to an interim stay at a rehabilitation facility to regain your footing and they're not always covered by Medicare, even if you need it. That's \$363.58 per day, on average.² Even if your hospitalization does qualify for Medicare to pick up the tab, after 20 days you'd still be on the hook for \$161.00/day.³ With the average rehab stay at 27 days,⁴ that can add up quickly. And, every time you readmit to the hospital, your odds of needing a longer rehab stay or not qualifying for Medicare rehab coverage at all get worse. Put another way - after that first hospitalization, you're stuck playing a high-stakes game of readmit roulette, with both your wallet and your independence on the table.

There is a way to help increase your odds. Studies are showing that going home with in-home support and assistance, such as Comfort Keepers®, could help reduce your chance of hospital readmission by as much as 61%!⁵ In a recent study by Duke University and Forsyth Medical, as few

as eight 3-hour visits during the critical first two weeks post-discharge, to help with homemaking, transportation, meal prep, and personal care, in conjunction with a comprehensive Care Plan and follow-up, was all it took to achieve such fantastic reductions.⁵ Let us help you **beat the dealer**.

Stay Home. Stay Independent.

(See our packages and discuss with your hospital discharge planner which one is right for you.)

Call today to schedule. 763) 786-1000





- Create a comprehensive Plan of Care or "game plan" with your discharge planner
- Coordinate home services and doctor appointments through discharge planner
- Follow up on all appointments and calls
- Review with RN or discharge planner all medications – only take those on new list
- Home Safety Review and modifications, if necessary
- Regular social interaction don't stay isolated

1 N Engl J Med. 2011 Apr 21;364(16):1582.

- 2 CMS-1351-F. Medicare Program; Prospective payment systems and consolidated billing for skilled nursing facilities for fiscal year 2012. Federal Register 76, no. 152 (August 8): 48486-48562.
- 3 http://www.medicare.gov/cost/
- 4 http://aspe.hhs.gov/daltcp/reports/2010/paltc.htm
- 5 Prof. Case Mgmt. 2011. Vol.17/No.3: 117 123