Concierge Case Management and Advocacy

Certified case managers are specialists who assist seniors, people with special needs and their families in planning for and implementing ways to allow for the greatest degree of health, safety, independence, and quality of life.

Our Concierge Services

- Available 24/7 for emergencies and 7 days a week by appointment
- Customized to meet your unique needs
- Provided at your place of residence
- Focused on Assessment, Care Plan Development and Care Coordination
- Advocacy services offered in the ER, Hospital, short term rehab, assisted living, skilled nursing facility, and hospice
- Diverse menu of services to select

Seniors and people with special needs often face multiple challenges, and require a team approach.

If you think of this team as an orchestra, the team consists of multiple members; doctors, physical therapist, occupational therapist, counselor, or agencies providing services such as caregivers, transportation, etc.)

"Helping Seniors, Persons with Special Needs & Their Families"

Typical Calls We Receive

- Daughter needs advocacy services for dad who's in the hospital
- Son questions whether mom is safe to live at home alone
- Man seeks help to coordinate his partner's multiple care providers
- Family needs help to find services for a teen with schizophrenia
- Senior wants to remain in her home. but is struggling
- Couple want help to move from FL to a CT assisted living facility
- Husband seeks help for his wife who had a recent stroke

Serving the Community since 1990

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What You Need to Know Before Leaving the Hospital

"Discharge Planning Aids Recovery and Reduces Readmission"

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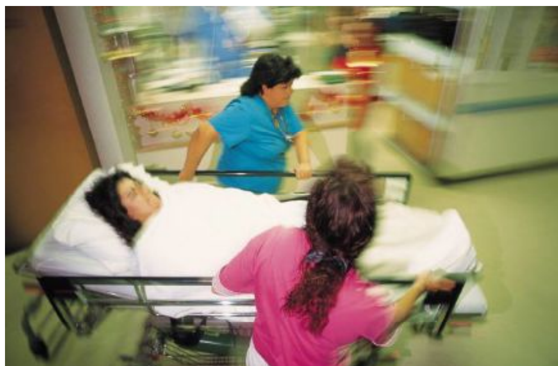
Discharge Planning

There is a lot more involved in being discharged from the hospital, than just walking out the door.

Just The Facts:

- 20% of Medicare patients discharged from the hospital are readmitted within 30 days
- 33% of Medicare patients are readmitted to the hospital within 90 days



Research Shows:

- 20% to 30% of adverse events following discharge that lead to readmission, are preventable
- Another 30% of these events, could at least be minimized

Source: Medicare

Some factors that are attributed to patient readmissions include:

- Fragmented system of care
- Lack of patient understanding about their diagnosis, care plan, or follow up instructions
- Confusion about medications that were prescribed while in the hospital
- Lack of understanding whether to continue medications taken before the hospital visit
- Absence of a discharge plan that addresses patient issues and provides needed services
- Poor coordination of care between hospital staff and primary care physician
- Uncertainty about which doctor to see for follow up (e.g. primary care or specialist)

Source: The Revolving Door, Feb 2018

Discharge Planning Meeting

The goal of the discharge planning meeting is to have everyone in the room at the same time, in order to make sure that there is a clear understanding of the patient's needs and the appropriate plan of action once the patient leaves the facility

Participants in the meeting usually include the patient, family members, and members of the patient's care team (e.g. physician, nurse, physical therapist, social worker).

The Value of Case Management

Care for seniors and people with special needs often requires a multi-disciplinary team approach that encompasses many aspects of life such as:

- Health and Mental Health
- Activities of Daily Living (ADLs)
- Transportation
- Finances
- Social Opportunities
- Emotional Well Being

This process needs to focus on a person's:

- Hopes and Desires
- Short and Long Term Goals
- Abilities and Needs
- Spectrum of Resources to address current and evolving needs

Case management is a collaborative process that consists of four steps:

1. Needs Assessments
2. Development of a customized Care Plan (road map)
3. Implementation & Monitoring of the Plan
4. Ongoing Review and Modification of Care Plans as client needs change

For more information, contact:

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