HOSPITAL TO HOME

Non-Medical Home Care: Helping Prevent Hospital Readmissions

One in nine hospital admissions is actually a readmission when a patient returns within the first 30 days of discharge. Patients may experience falls, medication problems, pressure wounds, and infections that often send them back into the hospital within days or weeks of discharge. Reducing hospital readmissions is a key strategic initiative for hospitals. Readmissions are costly, affect patient outcomes, quality of service and profitability.

Non-medical home care can help reduce readmissions by providing a low-cost supplement to medical-based care transitions.

1 in 5
Medicare patients is readmitted to the hospital within 30 days of discharge.

Non-Medical Home Care Can Reduce Readmissions

Home care can help reduce unplanned hospitalizations for high-risk clients in the comfort of their own homes. Non-medical homecare may include:

- Alerting family members of potential changes in the client’s condition
- Educating clients and families on health warning signs or potential complications that can be a critical link to raise red flags with other caregivers
- Identifying potential dangers in the home that may cause falls and accidents
- Encouraging clients to keep follow-up visits with physicians and specialists
- Providing transportation services to doctor’s appointments and pharmacies
- Providing personal care services such as bathing and grooming that can help prevent infections
- Providing ambulatory care so that clients can safely navigate their home and surroundings
- Providing bed-turning services to prevent bed sores
- Providing respite services to family caregivers so that they can mentally and physically re-charge

The elderly and vulnerable patients are the ones most often re-hospitalized, and patients in Kentucky are at increased risk because of the prevalence of chronic diseases and lack of outpatient facilities in rural areas.
Lifeline Homecare – Your Partner in Non-Medical Home Care

Lifeline Homecare as a Care Transition Partner
Bringing quality non-medical homecare services to your patients starts when case managers and discharge planners refer patients to our Care Coordinators. Once we receive a referral, our Care Coordinator will schedule a FREE home care assessment to determine the level of non-medical care needed in the home. During this initial home visit, hazards are noted that could increase the risk for falls, medications are reviewed, daily routines are noted, and client goals are established. In addition, the Care Coordinator will document any other concerns of the client or family members. A care plan is developed and personalized for each client with the Care Coordinator’s name and contact information.

We often work in tandem with medical home-health agencies to ensure continuity of care as patients transition home.

Lifeline Caregivers
At Lifeline Homecare, we understand the important role caregivers have in facilitating the transition from hospital to home. Utilizing our BetterCare Screening Process, we are able to continuously select the highest quality caregivers. The standards of excellence we employ help ensure quality and consistency in the services we provide to clients. We also participate with the Caregiver Quality Assurance™ program, the industry leading program for recruiting, selecting, and retaining the best caregivers. Every potential caregiver must participate in a mandatory caregiver assessment that utilizes advanced psychological testing to help ensure that the caregivers we send into a client’s home are trustworthy, dependable and qualified to provide top quality care.

Using our CareFit Matching System, we match client preferences (personality, values, behaviors) and client needs with our detailed caregiver profiles to ensure the best care possible for our clients.

To make a referral call 1-844-LIFELINE (1-844-543-3546)

“Patients who lived alone and had no in-home care were readmitted more than twice as often as those discharged patients who had in-home care assistance.”
- Sequoia Blog (February 2010)

Health care in the United States is faced with many issues: quality, cost, access and continuity of care are just a few. At the same time, the U.S. population is living longer, many with chronic diseases that impact the transition of patients back home. According to the Centers for Medicare and Medicaid Services:

75% of those age 65+
They account for 72% of doctor visits
They are 100X more likely to experience a preventable hospitalization.

76% of hospital readmissions