WHY CHOOSE CARE AROUND THE BLOCK FOR POST-HOSPITALIZATION CARE?

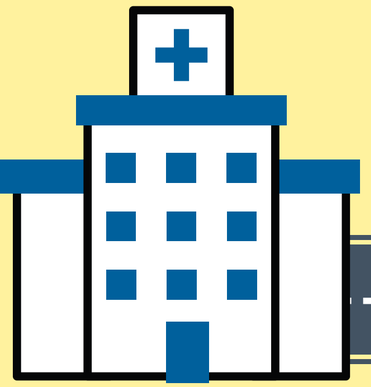
Partners in an exceptional aging journey

(865) 444-6787

1. Finding the Right Solution:

Our Client Liaison is alerted when an inquiry is received. She contacts the potential client or family member to:

- Provide a free consult while the potential client is still in the Hospital or Short-Term Rehabilitation Center (S-T Rehab), or at the client's home prior to hospitalization for planned procedures.
- Explore the potential client's anticipated challenges with their return home.
- Suggest several solutions to address the potential client's needs.



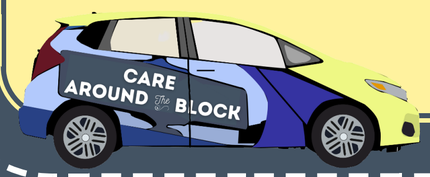
2. Creating the Right Plan:

All clients receive a comprehensive assessment from a CAB nurse Care Manager near discharge from the Hospital/S-T Rehab, or at home immediately following discharge. The assessment assists us to:

- Identify areas of concern, challenges, and needs post-discharge.
- Set up a plan of care and services, including Care Management and Caregiving schedules.
- Figure out how our partnership can help make the client's life easier as concerns are addressed.

3. Providing the Right Care:

- The client's primary nurse Care Manager will oversee the CAB in-home personal care team once discharged to home.
- We work to match our clients with the right Care Partners.
- The Care Manager helps coordinate services post-discharge provided by the client's Home Health Care Agency.
- We ensure the client's physician follow-up is scheduled and the Care Manager attends appointments to advocate for the client, keeping all involved in the communication loop.
- Our on-call response team is available 24/7 in case of emergent needs.



4. Finding the Right Time for care plan updates:

- Our client's primary Care Manager will provide continued oversight and evaluation, making any needed adjustments to the care plan.
- Our Care Partners monitor for any changes and compliance issues, and report back to the Care Manager to assist with these challenges.
- Client services will continue as needs continue.
- Services can transition to ongoing Care Management as sub-acute needs resolve.
- Care Partnering services may continue or be tapered as status improves.

5. All these steps = the client's ideal outcome, whatever their goal might be…

Whether the client's goal is to be more active, cook for themselves, reduce unnecessary hospitalization, or other discussed objective, our integrated Care Manager-Care Partner team can help each client create their best "big picture" outcome.

Our client families have peace of mind knowing their loved one has an individualized plan of care following a Hospital or S-T Rehab stay to reduce the chance of re-hospitalization.