

# PATHWAY HOME PROGRAM

Supporting Patients with a Safe Transition from Hospital or Subacute Care to Home

***30-Day Back Home Stabilization Program***

**$1500 REBATE**

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## OVERVIEW

***The first 30 days after discharge are the highest-risk period for falls, medication errors, and hospital readmission.***

Leaving the hospital or a subacute rehabilitation facility can be overwhelming for patients and families. The Unicity Care Management Pathways Home Program is designed to ensure a safe, smooth, and well-coordinated transition home with professional guidance every step of the way.

Our team of Licensed Social Workers and Registered Nurses provides personalized discharge planning, coordination of homecare services, and ongoing care management to help patients recover safely at home while giving families peace of mind.

***We collaborate directly with hospital discharge teams, rehabilitation facilities, and healthcare providers to ensure continuity of care.***

## A TRUSTED RESOURCE

*A Trusted Transition Resource for Hospitals & Subacute Facilities*

The Pathways Home Program supports discharge planners, case managers, and social workers by helping patients successfully transition home with coordinated services in place.
Our program helps:

- ✓ Ensure safe discharge transitions
- ✓ Reduce avoidable hospital readmissions
- ✓ Coordinate homecare services prior to discharge
- ✓ Provide professional oversight during the transition home
- ✓ Support families navigating complex care needs

888.609.8008
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## SERVICES

**Homecare Coordination & Scheduling**
We coordinate reliable homecare services and create a schedule tailored to support the patient's recovery and daily needs.

**Expert Recommendation:**
To ensure a safe transition and adequate support during recovery, we recommend a minimum of 6+ hours of daily homecare assistance during the first 30 days after returning home.

**Home Safety Assessment**
Our team evaluates the home environment to identify safety risks and recommend modifications to reduce fall risks and improve recovery outcomes.

**Full-Day Discharge Door-to-Door Support**
- Coordination of ambulette or medical transportation
- Oversight of the hospital discharge process
- Safe arrival and home transition support
- Coordination of caregivers and homecare services

**Medication Management Assistance**
We help organize medications, review discharge instructions, and ensure patients understand their medication schedule to prevent complications.

**MD Appointment Scheduling & Coordination**
Our team assists with scheduling and coordinating follow-up appointments with physicians and specialists to ensure continuity of care.

## TO CLAIM REBATE

To support families during this important transition, Unicity Care Management offers a **$1,500** rebate through the Pathways Home Program.

**Rebate Requirements**
To qualify for the $1,500 rebate, the following must be met:
- **A minimum of 80 hours of homecare services must be utilized within the first 30 days**

Once the required hours are completed, the $1,500 rebate will be applied according to program guidelines.

## CARE MANAGEMENT SERVICES

*Unicity Care Management provides professional support to help families navigate complex healthcare needs.*

**Services may include:**
- Ongoing care planning and monitoring
- Coordination of medical care and providers
- Communication with physicians and healthcare teams
- Advocacy for patients and families
- Resource referrals and support

*Care Management Services are billed at an hourly rate*