What Gets *Missed* After Discharge.

Arosa
Care Elevated

A strong discharge plan only works if life at home can support it.

Leaving the hospital is only one part of the transition. Once home, the person returning from a hospital or rehab stay, along with the family members or trusted supports helping them, may be managing medications, follow-up appointments, changing symptoms, mobility limitations, new routines, and evolving care needs, often while feeling overwhelmed or underprepared.

Common Gaps After Discharge

- The person returning home or their family may not fully understand the plan.
- Medication changes can create confusion.
- Follow-up care can be hard to coordinate.
- Warning signs may be missed or minimized.
- Mobility and safety issues can make the home environment risky.
- Family caregivers and trusted supports may feel overwhelmed quickly.
- Communication between providers, the individual, family, and support systems can break down.

How Arosa Helps

Care Management	Helps coordinate the moving parts after discharge.
Caregiving	Provides hands-on support with routines, safety, and day-to-day follow-through.
Concierge Nursing	Can provide added clinical support where available.
Integrated Care	Helps individuals and families move from confusion to clarity with one coordinated approach.
Ongoing Oversight	Helps identify concerns early before they become bigger problems.

The discharge plan is the starting point. We help individuals and families carry it forward at home.

Arosa helps bridge the gap between hospital discharge and what comes next by supporting the person returning home, guiding families and trusted supports, reinforcing the plan, and helping reduce the breakdowns that too often happen once someone gets home.

(866) GO-AROSA 462-7672
startcare@arosacare.com
arosacare.com

Let's talk about how Arosa can support safer, smoother transitions home.