



Medical Resources
Home Health Corp

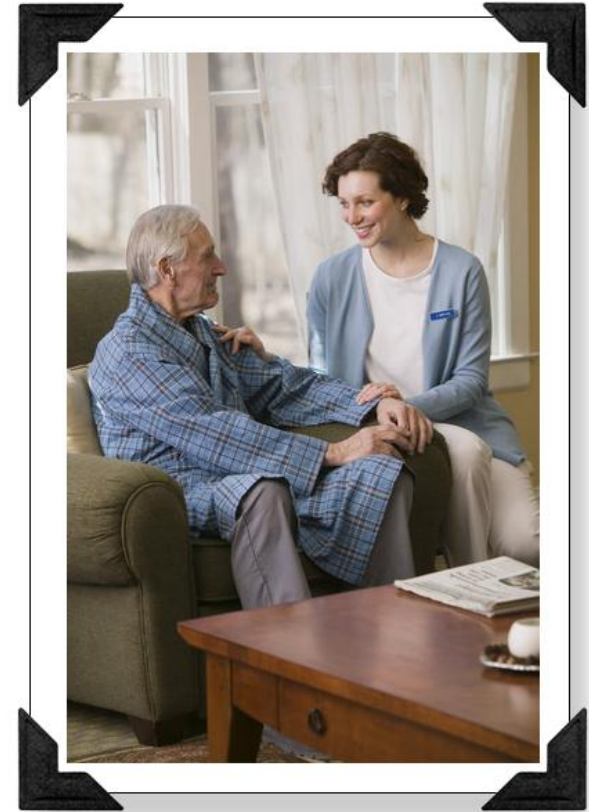
Medicare Certified / Medicaid Licensed

Healthy  Home

A P P R O A C H

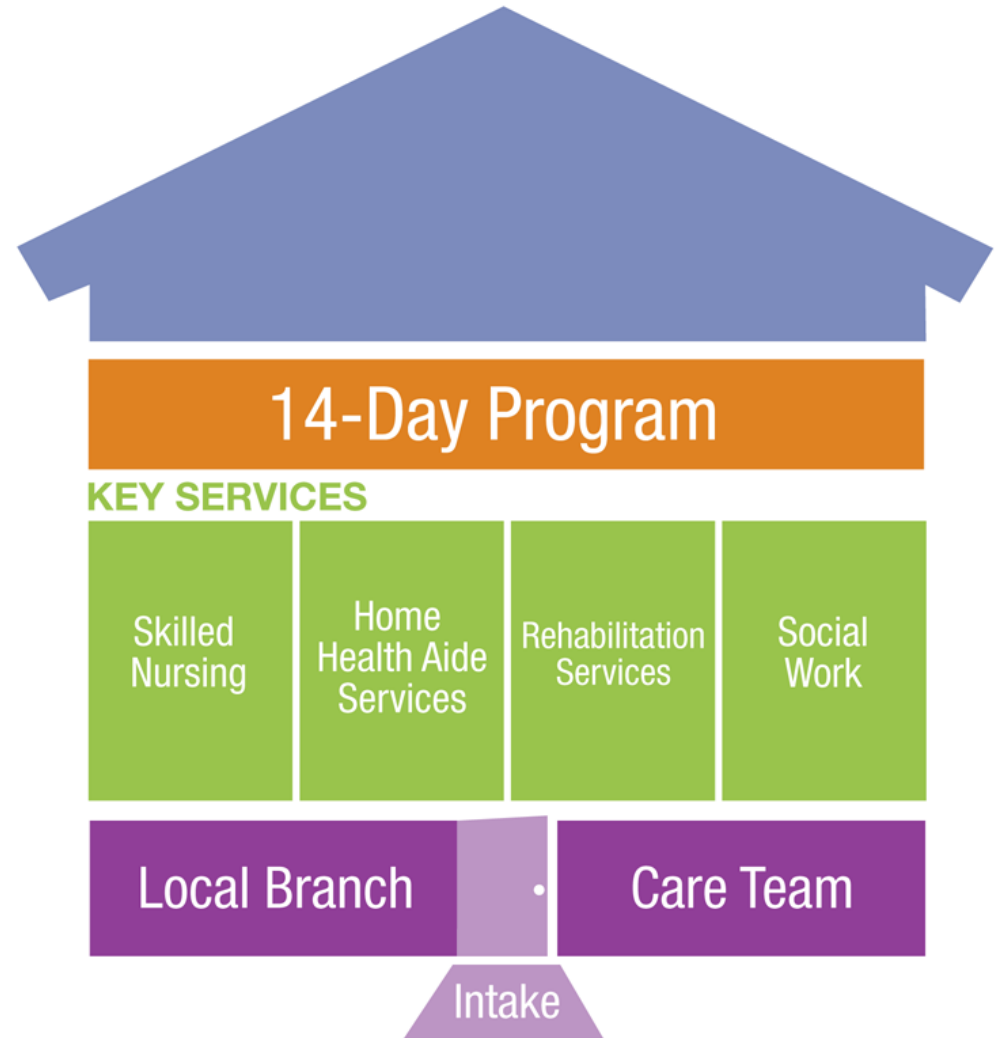
A Medical Resources Home Health System

Medical Resources Home Health
outcome data reveals that keeping the patient home with intensified services for a 14-day post-acute period of time markedly decreases the possibility of acute-care re-hospitalization.



Building a Solid Foundation

- Integrated approach to total well being for Behavioral Health patients
- Intensely trained team of expert, multi-lingual health care professionals
- Clinical solutions to manage the patient's complete spectrum of care mental health to physical health



Branch/Care Team

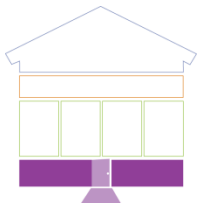
“More Collaboration = Better Outcomes”

- Patient’s care team established and introduced to patient and family
- Network of compassionate specialized nursing professionals, therapists and paraprofessionals provide care

Local Branch

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Care Team



Key Services



Skilled Nursing

- Re-hospitalization risk assessment
- Medication reconciliation
- Nutritional & safety assessments
- Assessment of the client's criticality/severity prompts timely referrals to other disciplines
- Psychiatric nurses to provide the plan of care developed in collaboration with the care team



Key Services

Home Health Aide Services



- Specialized rehabilitation services – physical, occupational and speech therapy
- Services initiated within 48 hours
- Comprehensive functional evaluation addressing specialized safety needs
- **Fall Prevention Program** - comprehensive assessments and interventions based on the latest clinical research



Key Services



Rehabilitation Services

- Durable Medical Equipment (DME) - assessments, ordering and training
- Assess, monitor and address patient's level of pain during treatments
- Continual communication with Primary Care Nurse and the rest of the patient's "team"
- Therapists help bring patient back to their maximum level of functional mobility



Key Services

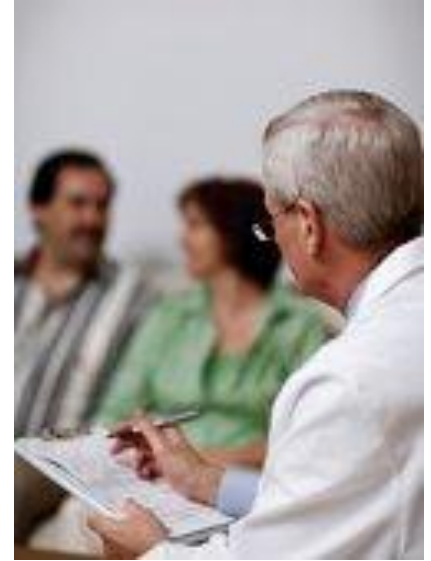


Rehabilitation Services

- Reliable in-home support provides assistance with everyday home living
- HHAs receive 15 hours of orientation
- National background checks, OIG, Sex Offender Registry & drug testing, for all HHAs
- Supervision by PCN done on-site within 48 hours
- Patients are called on the third business day to assess satisfaction and address questions.



Key Services



Social Work

- Provides short-term supportive counseling
- Facilitates improvement of family communication
- Assess for appropriateness and linkage to community resources
- Helps patients explore options for financial assistance or support



14-Day Program

“Intensity of Care”

- Resources are “front-loaded” to reduce risk of re-hospitalization
- Extensive patient/team interaction – frequent visits at beginning of program and lessen as need decreases
- Streamlined program focuses on communication and education of patient and caregivers



14-Day Program

Week 1

Day 1

- Comprehensive patient assessment by care team leader (RN)
- Mutual setting of goals and expectations
- Medication reconciliation, review and teaching
- Communication with M.D. and other providers
- Hospital risk assessment

Day 2

- Re-visit patient/implementation of plan
- Follow-up assessment
- Initiation of additional services (therapy, HHA, social work, dietician)
- Follow-up visits occur 7 days/week



14-Day Program



Day 3

Telephone triage to assess:

- Compliance and response to medications
- Appetite, meal management
- Reoccurrence of symptoms
- Blood glucose, weights, temp, etc.

Day 4

- Re-visit patient
- Evaluation of plan/interventions
- Assessment of services/modification of plan
- Care coordination



14-Day Program



Days 5/6/7

- Daily phone calls to evaluate compliance with plan of care and assess need for PRN visit
- Education of the accessibility of the agency in case of problems, concerns, etc.



Goals **Week Two**

Foster independence

Focus on health & wellness

Addition of supportive services

14-Day Program

Week 2



- Re-visit patient
- Assessment of compliance, response to medications
- Modification of plan dependent on patient status and management of disease process
- Phone calls with patient – frequency dependent on results of assessments
- Provide emotional support to restore independence and quality of life



14-Day Program

Beyond Week 2



- Telephone communication as indicated, interspersed with home visits according to plan of care
- Transition to independence
- Assess achievement of goals



Healthy @ Home

- Comprehensive care and emotional support for the patient
- Peace of mind for the patient's family
- Successful collaboration and outcomes for the physician, health care provider or discharge specialist
- **A vision – and a plan –** *for the future of home health care*





Healthy@Home empowers individuals to take control of their health care by providing the **knowledge, resources** and **assistance** they need to remain at home.

Resources

¹Wilkins K, Park E. Home care in Canada. *Health Rep.* 1997;9:27–36.

²http://seniorliving.about.com/od/lawpolitics/a/senior_pop_demo.htm

³<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1188058#B2>

⁴National Center for Chronic Disease Prevention and Health Promotion, CDC. Chronic disease notes and reports: special focus. *Healthy Aging* 1999;12:3.

⁵Kinsella K, Velkoff V. U.S. Census Bureau. *An Aging World: 2001*. Washington, DC: U.S. Government Printing Office, 2001; series P95/01-1.



To refer your patients to *Healthy@Home*
call **866-672-2273**

Healthy @ Home

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