



The Advantage Care CoachSM

Coordinating and managing the ongoing care of seniors living at home.

Helping Patients & Families

Coordinating the ongoing care of an elderly family member can be overwhelming. To help, Advantage Home Health Services offers its Advantage Care CoachSM Service.

First we identify a patient's medical and support needs, next we create an action plan to meet those needs and then we proactively manage the ongoing care. As an offering of Advantage Home Health Services, our geriatric care managers have direct access to our interdisciplinary team of healthcare professionals and can integrate any of our services into the care plan at any time, as needed.

Advantage Home Health professionals:

- Skilled Nurses
- Physical, Occupational & Speech Therapists
- Medical Social Workers
- Registered Dieticians
- Home Health Aides



Advantage Care Coach:

- Collaborates with community organizations to obtain needed and available services
- Builds client's self management skills, assists with medication management and schedules appointments
- Reminds client of upcoming appointments and arranges transportation to and from the appointments if necessary
- Facilitates accurate and effective communication between the client, doctors, family members, and service providers
- Provides access to needed social support and delivers preventative care education

Advantage Care Coach Services Overview

Getting Started

Referral and Introductory Phone Call

- Introductory phone call to patient and/or family on the day that we receive the referral or inquiry to learn about the patient's general needs, provide an overview of Advantage Home Health, introduce the Advantage Care Coach and explain available services

Initial & Follow-up Home Visit

- Perform an initial home visit to complete the patient's Personal Health Information Profile, set-up the Advantage HealthCheckSM telehealth monitor system and review our Open Packet Information
- Establish the overall goals for care and support
- Perform a follow-up home visit the next week to review the patient's status and comfort with the Advantage HealthCheckSM telehealth monitor and to ensure that the Medication Card is completed and clearly displayed.

Care Coordination with Primary Caregiver

- Contact the primary caregiver to review the patient's Personal Health Information Profile, discuss patient's history and care, identify any overlooked items or medications and update the patient's Personal Health Information Profile accordingly

Ongoing Care

Care Coordination & Support

- Place follow-up phone calls to patient, at minimum of once weekly or at least 3 times in the month
- Review the patient's progress toward goals, discuss encounters with health care



professionals, review medications, and establish a schedule of upcoming doctor visits

- Ensure patient's doctor visits are maintained, attend patient doctor appointments whenever feasible, and provide telehealth reports for the physician

Empower & Educate Patients & Family Members

- Assist patients with techniques and increased awareness for improved medication self-management
- Educate patients and family members about the red flag symptoms of the patient's physical diagnosis and serve as a training resource

Discharge

When and if the patient and/or family feels that all of the care goals have been achieved, discharge from the service will occur. The Advantage Care Coach will review self-management techniques and education as part of the discharge check list. The patient and/or family can choose to continue with the Advantage HealthCheckSM Service to have the patient's vitals tracked by a trained healthcare professional on a daily basis to provide additional on-going care support even after discharge.



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