Partners in Your Patient's Road to Recovery

The professional and compassionate care your patients received during their stay at the hospital or a facility continues when you direct them to Caraday Home Health.

Caraday Home Health shares your commitment to providing your patients with the best skilled care and therapy. A streamlined process helps develop personalized care plans and matches patients up with a care team quickly, saving you valuable time and ensuring your patients of the highest level of care.

An extension of your clinical team

As partners in delivering person-centered care, Caraday Healthcare is one of the only long-term, post-acute care systems led by a Chief Medical Officer who is a nationally recognized geriatrician. Our team has a legacy of having built some of the most reputable and exceptional quality home health companies in the country.

This clinical expertise drives the commitment to deliver quality outcomes in home health care so that your patients achieve optimal health. While in our care, Caraday Home Health keeps physician's current on their patient's recovery.

Caraday Home Health is an integral part of our Caraday Safe Discharge Home program which manages the transition of care from the discharging medical provider during that critical period between discharge and resumption of care under the primary medical provider. Caraday Home Health is a foundational step in a system-wide approach to a long-term and post-acute continuum of care focused on outcomes. Data will be compiled to demonstrate effectiveness in reduced readmissions and lower care costs.

The convenience of home health care is further augmented with options for telemedicine and remote patient monitoring, further extending your clinical team. This continuous care experience provides additional assurance and immediate access using the latest technology for virtual health care.

Who will benefit from home health care?

Determining eligibility is an important first step and Caraday team members can work with your patients to verify eligibility for home health care. Patients with Medicare are covered if they meet the following requirements:

- Must be under the care of a physician and receiving services as part of a care plan created and reviewed by a physician
- Certified by a physician that they need any of the following services:
  - Intermittent skilled nursing care (other than drawing blood)
  - Physical therapy, speech language pathology, or occupational therapy that are necessary for recovery from an illness or injury or as part of ongoing care
- Must meet homebound criteria, leaving infrequently for approved outings. Examples of exceptions are leaving home for medical appointments, Adult Day Care, and religious observances

Referring patients

Our simple communication and referral system is a quicker and easier way to get your patients the care they need. To make a referral:

- **Call 747-250-7570**
- **Fax 830-947-4114**

Please direct the discharge referral to Caraday Home Health when writing discharge orders.

A comprehensive menu of services assures patients that all of their needs are taken care of *in the comfort of their homes.*

Skilled Nursing

- Post-Surgical Care
- Chronic Disease
- CVA/Stroke
- CHF
- COPD
- Diabetes Care
- Parkinsons
- Behavioral Health
- Wound Care
- Pain Management
- Catheter Care
- Tube Feeding
- Antibiotic Therapy
- Infusion Therapy
- New or Changed Medication Teaching

Rehabilitation Therapy

- Physical Therapy
- Occupational Therapy
- Speech Therapy

Home Health Aides

- Bathing
- Grooming
- Dressing
- Personal Care
- Ambulation
- Light Housekeeping

Virtual Care

- Telehealth Visits
- Remote Patient Monitoring

Social Services

- Social Work Services

747-250-7570
homehealth@caradayhealth.com
caradayhomehealth.com