Strengthen Care Beyond the Hospital

Healthy Connect
Powered by RCP Remote Care Partners

Introducing the HealthyConnect Program

Significantly improve patient outcomes post-discharge with the inclusion of HealthyConnect CMS approved services including transition care, remote patient monitoring, and chronic care management. You are not responsible for the service or billing and HealthyConnect handles everything needed with the support of its partner home health care agency. It's simple, it works, and you can start immediately.

How HealthyConnect Works

With HealthyConnect, your discharged patient can be set up in less than 48 hours with devices including our innovative watch, a care plan, and nurse coach that monitors the data received and works often with the Medicare Home Care agency working with the patient along with the patient's physician or our virtual clinic physician that sets up the account.

HIGHLIGHTS INCLUDE:

surescripts

- Prescriptions
- Dates
- Refills Picked up
- Drug Info
- Adherence

Specialized Devices

We can provide patients with relevant monitoring devices - including a Dexcom continuous glucose monitor, thermometer, pulse oximeter, blood pressure cuff, scale, and more.

Personalized Patient Care

Seamlessly transition patients into personalized care programs designed to meet their individual needs. We provide health alerts and prioritize the ones that need medical attention, reducing the reliance on patients to reach out or schedule appointments.

Medication Adherence

HealthyConnect uses SureScripts to track medications prescribed, pickups, refills, and more. Patients enrolled in care management programs also have nurse coaches track over-the-counter medications and supplements.

The HealthyConnect Difference

With HealthyConnect, you can transform post-discharge care through our innovative features and benefits tailored for hospitals and medical professionals:

KEY FEATURES:

Personalized Care Plan Implementation

Seamlessly transition patients into personalized care programs designed to meet their individual needs.

Collaboration with Home Health Care Agencies

Enable home health agencies to efficiently manage patient care and deliver consistent, high-quality support.

Enhanced Patient Monitoring

Improve care continuity with tools that ensure patients remain on track with their care plan, reducing readmission rates.

TARGET OUTCOMES FOR YOUR FACILITY:

Improved Patient Care Quality

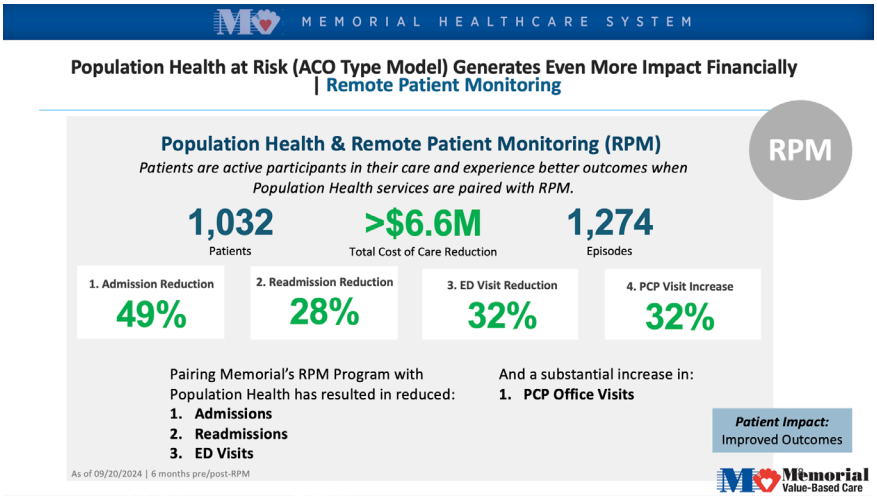
Empower patients with more personalized care, leading to healthier outcomes and higher satisfaction.

More Assignments for Home Health Agencies

Drive better collaboration with home care providers for smoother patient transitions and greater referral opportunities.

Higher Quality Scores

Enhance your facility's reputation and ratings with better care tracking and demonstrated outcomes.



Patient Care is Ongoing

The patient may cancel the service at anytime but many will elect to continue the care management programs when the Medicare Home Care agency care period ends. The following charts show how effective these programs can be in reducing hospitalizations and emergency room visits.

How to Get Started

If you are working with a contracted HealthyConnect Home Care Agency, you don't need to do anything, they'll handle the implementation with the normal set up of the patient under their care.

If you have other patients you would like to enroll in the HealthyConnect program, we can handle by phone, fax, or if we provide you with a user ID and password, a simple data entry form and we will take care of the rest.

Healthy Connect