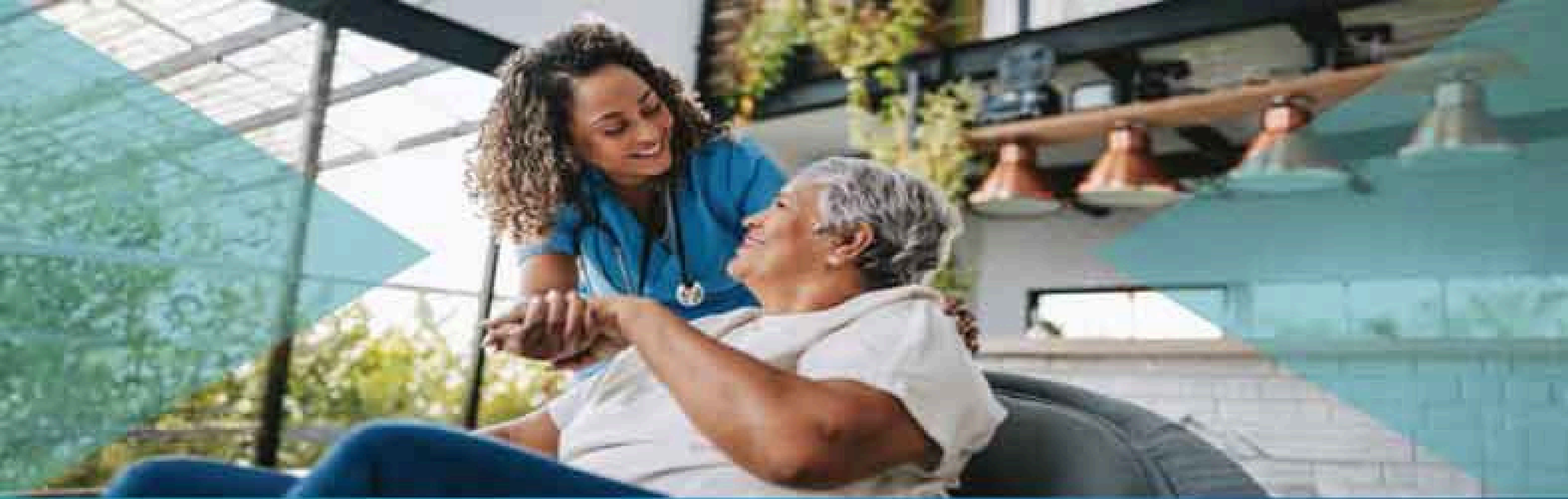


WHY FACILITIES PARTNER WITH US

WHY RCFE, ARF AND RESIDENTIAL CARE FACILITIES SHOULD PARTNER WITH US

- ***We keep your residents healthy at home by monitoring their health and chronic illnesses.***
- ***We help residents to age in place at home whenever possible while improving quality of life. reducing hospitalizations, emergency room visits, and urgent care utilization.***
- ***Prompt response to referrals, great bedside manners.***
- ***No more looking for many different medical professionals for different needs.***
- ***We are your one stop complete, compassionate and comprehensive care.***
- ***We manage all your residents' chronic illnesses to keep them safely at home.***
- ***Prompt visits in 24 hours for urgent and 48 hrs-5 days depending on type of referrals***
- ***You just make one call and get all needed services.***
- ***Stabilize your residents and keep them safe and healthy at their residence.***

EXPERIENCED IN COMPLEX CARE TRANSITIONS

Post-Discharge Evaluation · *Medication Reconciliation* · *Continuity of Care*

Providing comprehensive geriatric primary care and chronic disease management for medically complex patients.

ACCESSIBLE MOBILE HEALTHCARE

Bringing Comprehensive Compassionate Care Home to You

YOUR **ONE-STOP HEALTHCARE** PARTNER

Comprehensive Mobile Primary Care, Advanced Wound Care, Transitional Care Management, and Chronic Disease Management Delivered Directly to Your Residents

Most patients seen within 24-48 hours

OUR PROMISE

From primary care and advanced wound care to chronic disease management, transitional care, and ongoing follow-up, we bring timely medical services directly to the patient's home—helping residents stay healthier, safer, and where they want to be most: at home."

ONE CALL. ONE TEAM. ONE TRUSTED PARTNER. COMPREHENSIVE CARE DELIVERED TO YOUR HOME.

CONTACT US

ACCESSIBLE MOBILE HEALTHCARE

Address: 2979 Mumford Ct, Riverside CA 92503; **Tel:** (951) 977- 0573 **Fax:** (951) 475 - 6488

Email: info@accessiblemobilehealthcare.com **Website:** Accessiblemobilehealthcare.com

WHY SNFS AND HOSPITALS SHOULD PARTNER WITH OUR TEAM

No more struggling to find where to discharge patients with complex wounds or delicate fragile health
Your discharge team will not need to look for more professionals; we are a one-stop team to reduce your discharge burden.

EXPERIENCED IN COMPLEX CARE TRANSITIONS

- *Post-Discharge Evaluation*
- *Medication Reconciliation*
- *Continuity of Care*

OUR PROVIDER HAS EXPERIENCE WORKING WITH MEDICALLY COMPLEX PATIENTS THROUGH:

HOMEBASE MEDICAL

A SCAN-affiliated medical group focused on high-risk seniors and home-based care.

OPTUM / UNITEDHEALTHCARE

Providing comprehensive geriatric primary care and chronic disease management for medically complex patients.

.

TRANSITIONAL CARE MANAGEMENT

FOLLOWING **DISCHARGE** FROM:

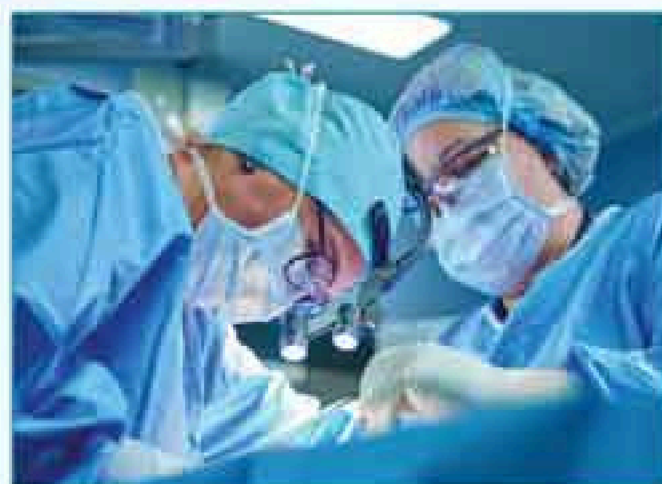
Hospitals
Skilled Nursing Facilities (SNFs)
Rehabilitation Centers
Emergency Departments
Urgent Care Centers

WHY PATIENTS, CAREGIVERS AND FAMILIES SHOULD PARTNER WITH US

√ We are a one-stop comprehensive and compassionate team.
√ Faster Access to Medical Care
√ Improved Resident Outcomes
√ Reduced Emergency Room Visits
√ Reduced Urgent Care Utilization
√ Reduced Caregiver Burden
√ Improved Family Satisfaction
√ One Trusted Healthcare Partner
√ No more frustration and confusion of looking for different professionals.

We provide TCM and Continuity of Care Services

√ Extensive Transition Care Management experience.
√ Extensive Continuity of care services experience.
√ Comprehensive post-discharge assessment
√ Review discharge instructions
√ Review Specialist recommendations
√ Evaluate current health status
√ Reduced Hospitalizations
√ Improved Communication
√ Reduced Hospital Readmissions
√ Experienced transition care management
√ Reduced ER and Urgent care visits
√ Med reconciliation to reduced medication errors
√ Care coordination gaps
√ Chronic Disease monitoring
√ Care Coordination
√ Most Patients Seen Within 24–48 Hours



We help reduce caregiver burden and simplify healthcare by minimizing the need to search for and coordinate multiple medical professionals.

Through our comprehensive mobile healthcare model, we bring primary care, advanced wound care, chronic disease management, transitional care management, continuity of care, medication reconciliation, and care coordination directly to the patient's home.

COMPREHENSIVE SERVICES

MOBILE PRIMARY CARE

√ New Patient Visits
√ Routine Follow-Ups
√ Annual Wellness Visits
√ Preventive Care
√ Medication Management
√ Medication Reconciliation
√ Health Maintenance

SCREENING SERVICES

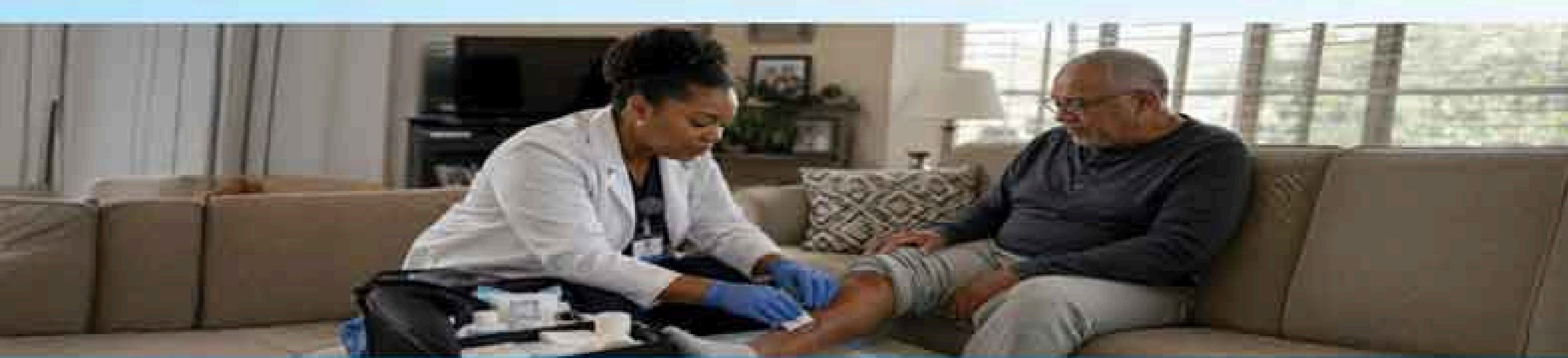
√ PHQ-9 Depression Screening
√ Mini-Cog Cognitive Screening
√ Fall Risk Assessment
√ Functional Assessment
√ Advance Care Planning

CHRONIC DISEASE MANAGEMENT

√ Congestive Heart Failure (CHF)
√ COPD
√ Asthma
√ Diabetes
√ Hypertension
√ Chronic Kidney Disease
√ Dementia
√ Parkinson's Disease
√ Stroke Recovery
√ Complex Geriatric Conditions

LABORATORY IMAGING COORDINATION

√ Routine Labs
√ Acute and routine imaging
√ Preventive Screening Labs
√ Wound swabs and culturing
√ Chronic Disease Monitoring



ADVANCED WOUND CARE PROGRAM

SPECIALIZED WOUND CARE SERVICES

Evaluation and management of:

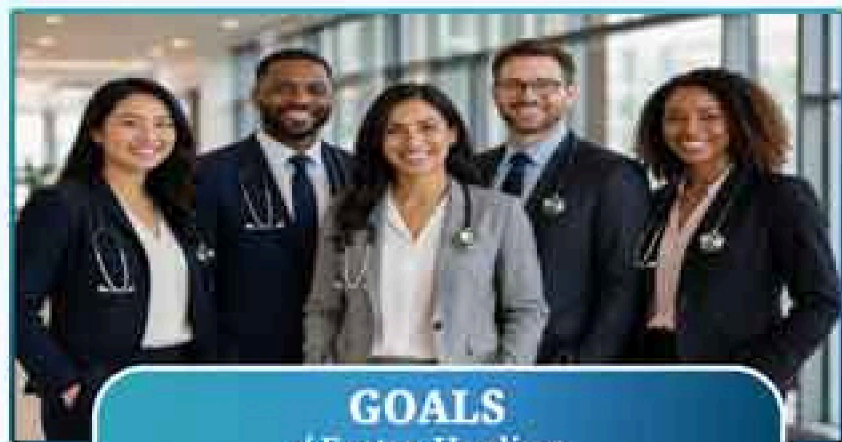
√ On-site debridement
√ On-site incision and drainage with wound packing
√ Wound Vac Placement
√ ABI/TBI for vascular integrity evaluation
√ Grafting
√ Vascular referral for compromised ABI/TBI
√ Pressure Injuries
√ Diabetic Foot Ulcers
√ Venous Ulcers
√ Arterial Ulcers
√ Skin Tears
√ Surgical Wounds
√ Traumatic Wound

PRESSURE INJURY PREVENTION

√ Early Identification
√ Offloading Recommendations
√ Prevention Programs
√ Caregiver Education

WOUND CARE COLLABORATION

Coordination with:
√ Home Health
√ Hospice
√ Physical Therapy
√ Occupational Therapy
√ DME Providers
√ Facility Staff
√ Family Caregivers



GOALS

√ Faster Healing
√ Fewer Wound Complications
√ Reduced Hospitalizations
√ Reduced Emergency Room Visits
√ Improved Quality of Life

TRANSITIONAL CARE MANAGEMENT & CONTINUITY OF CARE

EXPERIENCED IN COMPLEX CARE TRANSITIONS

Our provider has experience working with medically complex patients through:

Homebase Medical

A SCAN-affiliated medical group focused on high-risk seniors and home-based care.

Optum / United Healthcare

Providing comprehensive geriatric primary care and chronic disease management for medically complex patients.

TRANSITIONAL CARE MANAGEMENT

Following discharge from:

√ Hospitals
√ Skilled Nursing Facilities (SNFs)
√ Rehabilitation Centers
√ Emergency Departments
√ Urgent Care Centers

WE PROVIDE TCM AND CONTINUITY OF CARE SERVICES

√ Post-Discharge Evaluation
√ Medication Reconciliation
√ Continuity of Care
√ Chronic Disease Monitoring
√ Care Coordination
√ Family Education
√ Ongoing Follow-Up

OUR GOALS:
Reduce

Hospitalizations
Readmissions
Emergency Room Visits
Urgent Care Visits
Medication Errors
Care Coordination Gaps

CARE COORDINATION & COLLABORATIVE CARE

COMPREHENSIVE CARE TEAM APPROACH

We work closely with:
Home Health Agencies
Hospice Agencies
Palliative Care Teams
Physical Therapy
Occupational Therapy
Respiratory Therapy
Nutritionist
Specialists
DME Providers
Caregivers & Families
Facility Staff

ONE CALL. ONE TEAM.

Instead of searching for multiple healthcare providers, facilities and families can rely on one coordinated team to help manage the residents' healthcare needs.
Our integrated approach helps reduce delays in care, improve communication, and ensure continuity of treatment.

IDEAL PATIENTS & OUTCOMES

WE ARE IDEAL FOR RESIDENTS WITH:

√ Frequent Hospitalizations
√ Multiple Chronic Conditions
√ Recurrent Wounds
√ CHF
√ COPD
√ Diabetes
√ CKD
√ Dementia
√ Parkinson's Disease
√ Functional Decline
√ Polypharmacy
√ Post-Hospital Discharge Needs

EXPECTED OUTCOMES

√ Reduced Readmissions
√ Reduced Hospital Utilization
√ Reduced Emergency Room visits
√ Reduced Urgent Care Visits
√ Improved Medication Compliance
√ Better Chronic Disease Control
√ Faster Wound Healing
√ Improved Resident Satisfaction
√ Improved Family Satisfaction
√ Reduced Caregiver Burden

ACCESSIBLE MOBILE HEALTHCARE REFERRAL REQUEST

(Please scan QR code on the back to fill out form online)

Facility Name: ______________________________

Contact Person: ______________________________

Phone: ______________ Fax: ______________

Resident Name: ______________________________

DOB: ______________________________

Room #: ______________________________

Insurance: ______________________________

REASON FOR REFERRAL (check all that apply)

- ☐ New Patient Primary Care
- ☐ Annual Wellness Visit
- ☐ Chronic Disease Management
- ☐ Hospital Follow-Up
- ☐ SNF Discharge Follow-Up
- ☐ Wound Care Evaluation
- ☐ Pressure Injury
- ☐ Diabetic Foot Ulcer
- ☐ Skin Tear
- ☐ Medication Review
- ☐ Hospice Collaboration
- ☐ Palliative Care Collaboration
- ☐ Other ______________

URGENCY

☐ **Routine**
(Chronic illness management, monthly follow-up visits, annual wellness visits, medication review, preventive care)

☐ **Within 48 Hours**
(Post-hospitalization follow-up, post-SNF discharge follow-up, post-urgent care visit, new patient evaluation, worsening chronic condition, non-emergent wound concerns)

☐ **Urgent Same-Day Review Requested**
(Fever, chills, night sweats, rapidly worsening wound, new drainage, foul odor, increased redness, swelling, uncontrolled pain, altered mental status, shortness of breath, chest pain, oxygen decline, or acute change in condition)

CLINICAL CONCERNS

____

____

____

____

RECENT HOSPITALIZATION OR SNF STAY

Hospital/SNF:

____

Discharge Date:

____

Primary Diagnosis:

____

Referring Staff:

____

Title:

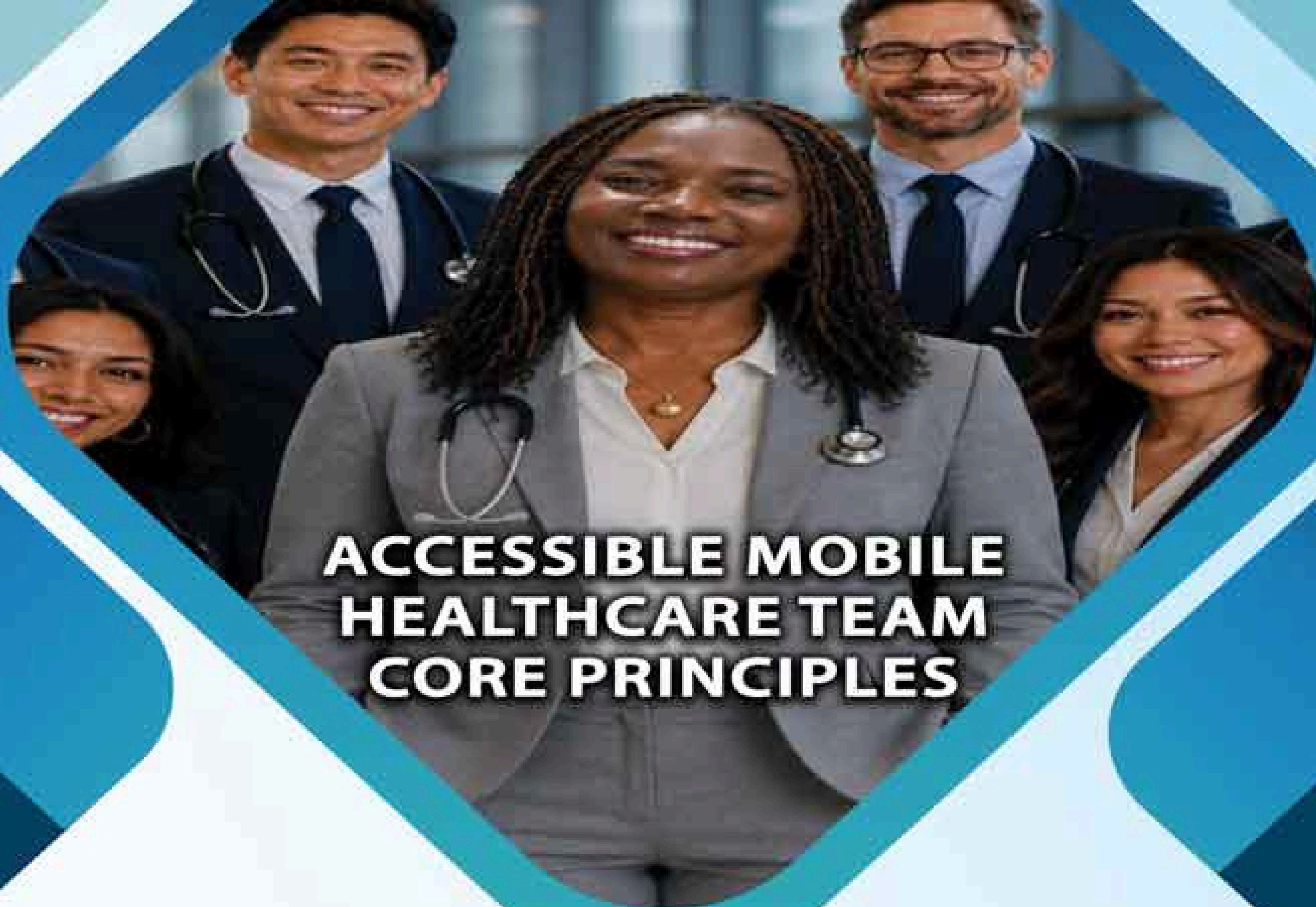
____

Signature:

____

Date:

____



COMPASSION

We are a group of compassionate and highly dedicated providers with extensive experience in geriatric medicine, internal medicine, wound care management, hospice and palliative evaluations, and mobile healthcare services.

COMPREHENSIVE PATIENT CARE

Accessible Mobile Healthcare is committed to delivering comprehensive, patient-centered medical care directly to patients in their homes, assisted living communities, residential care facilities, and underserved populations throughout Riverside County and surrounding areas.

ACCESSIBILITY AND BRIDGING HEALTHCARE GAPS

Our team is passionate about improving healthcare accessibility for seniors, homebound patients, and medically complex individuals. Our approach focuses on preserving dignity, promoting independence, reducing unnecessary hospitalizations, and helping patients achieve a better quality of life in the comfort of their own environment.

TEAM WORK AND COLLABORATION

We work as a team with all our collaborators across the medical discipline to ensure that our patients' needs are fully met. We are able to bring a comprehensive healthcare to your door steps because we work collectively in the best interest of our patients.

REDUCING THE BURDEN OF CAREGIVING

We bring a comprehensive healthcare model to reduce the complexity of searching for different medical services for primary care, wound etc. Our compassionate and quality care for your loved one will drastically reduce the burden of caregiving; allowing families to have loved ones age in place right at the comfort of their homes.

CONTACT INFORMATION

Accessible Mobile Healthcare

Primary Care • Wound Care
• Transitional Care Management
• Chronic Disease Management
• Care Coordination

ONE CALL. ONE TEAM. ONE TRUSTED PARTNER.
COMPREHENSIVE CARE DELIVERED HOME.

OUR PROMISE

"You no longer have to wait, and you no longer have to search for multiple healthcare providers. Accessible Mobile Healthcare is your one-stop healthcare partner for comprehensive, coordinated, patient-centered care.

Urgent patients are seen within 24 hours and most seen within 48-72 hours based on the scale of urgency.

FILL OUT REFERRAL FORM ON OUR WEBSITE

Accessiblemobilehealthcare.com.

ACCESSIBLE MOBILE HEALTHCARE

Address: 2979 Mumford Ct, Riverside CA 92503:
Tel: (951) 977- 0573 **Fax:** (951) 475 - 6488
Email: info@accessiblemobilehealthcare.com
Website: Accessiblemobilehealthcare.com