LIVEWELL HEALTH

your partner in successful aging

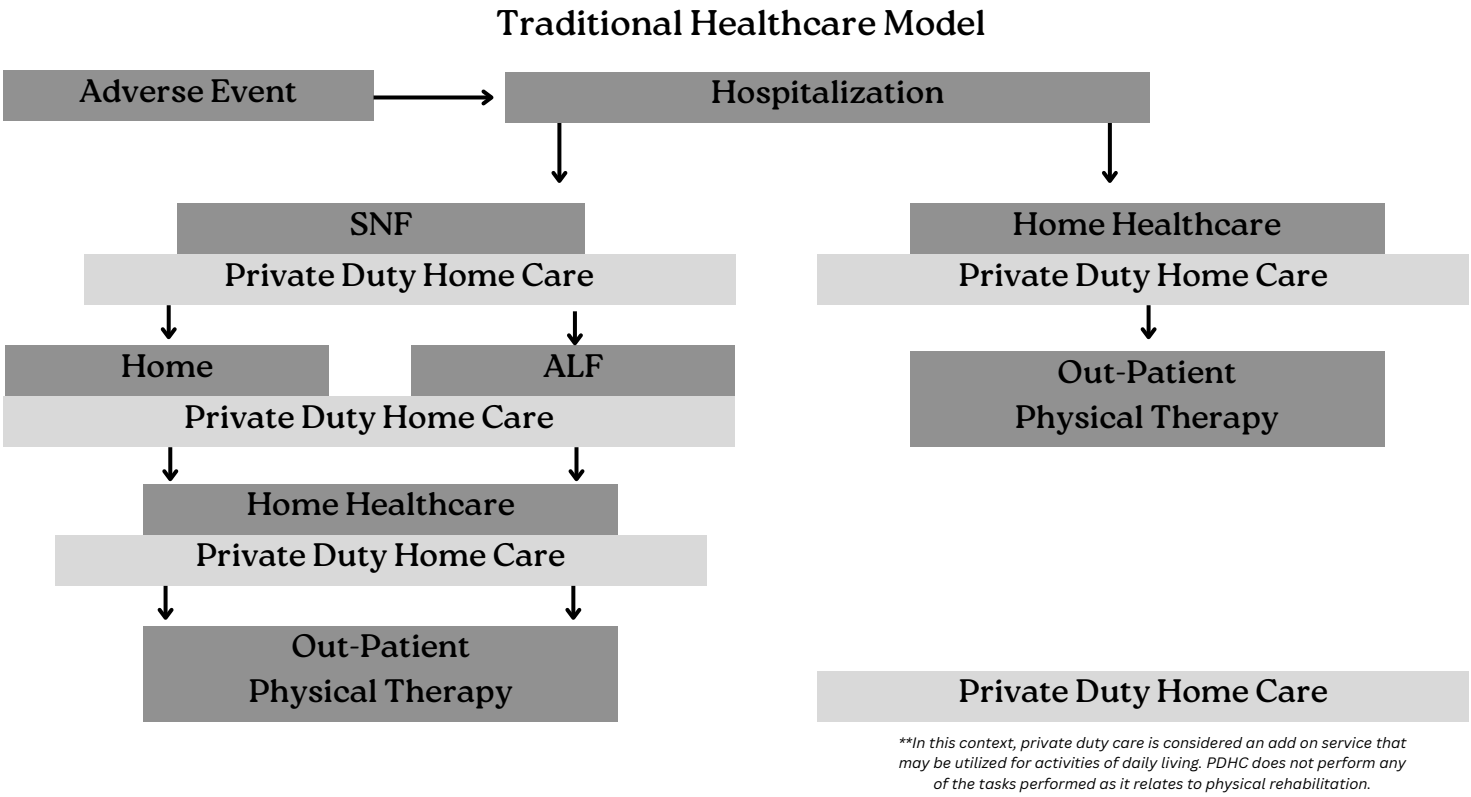
Filling the Gaps Where Medicare Falls Short: The Where, When and How LiveWell Fits Into Various Adverse Events

Where? When? And How do we at LiveWell fit in to the healthcare process?

We fill the gaps.

In our infancy we saw ourselves 'down the healthcare line', that is we would be the final stage in the rehabilitation process, we would continue the progress. While that still holds true, we have also come to be a provider at each and every level of the rehabilitation process. The first illustration shows what the traditional patient will move through should they incur an adverse event such as a fall and ultimately hospitalization, we aim to provide insight into where LiveWell can fit in.

In this sense we compare our services to much of the physical therapy services provided. Keep in mind, we are not a physical therapy clinic, we provide a strength based rehabilitative approach that patients benefit beyond the traditional model. We have included private duty home care into each situation as a secondary service. We do not provide home care, nor are we a private duty provider.



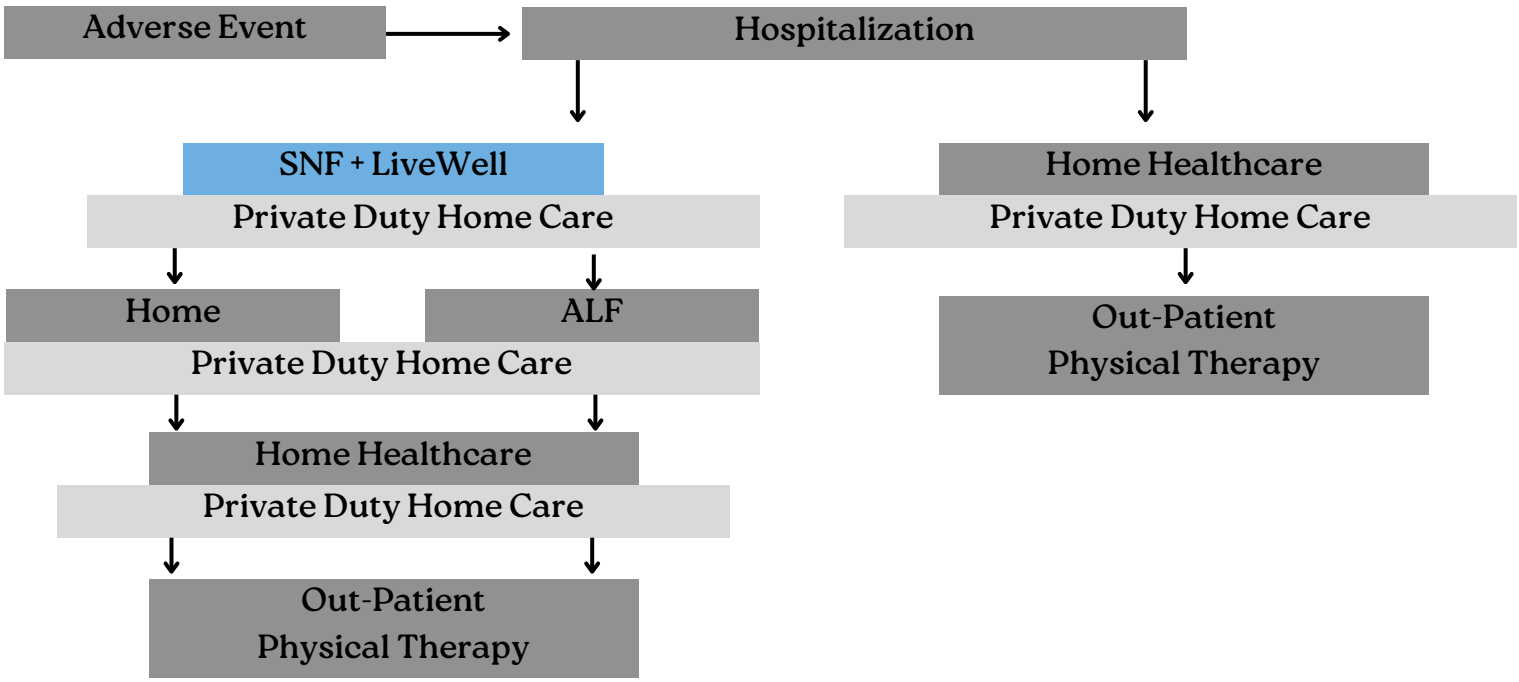
***In this context, private duty care is considered an add on service that may be utilized for activities of daily living. PDHC does not perform any of the tasks performed as it relates to physical rehabilitation.*

Scenario #1

At LiveWell, we offer essential support to patients who have experienced a qualified hospital stay and are transitioning to a skilled nursing facility (SNF). Our services aim to address the recurring theme we've observed in Naples - the strong desire among patients to recover quicker and more effectively.

While SNFs already provide daily therapy, we collaborate with various facilities to offer supplemental services. Our role comes into play after patients have received therapy through traditional Medicare-provided means on a daily basis. Typically, patients receive therapy from the onsite staff in the morning, and we step in to provide our supplementary services in the afternoon.

It's important to highlight that our intention was not to compete with or replace existing healthcare services but to complement and enhance patient outcomes. While we did not foresee this to be a vertical in which we would venture towards, approximately 10% of our members benefit from this therapy support, which we believe is a testament to the value we add to the recovery process.



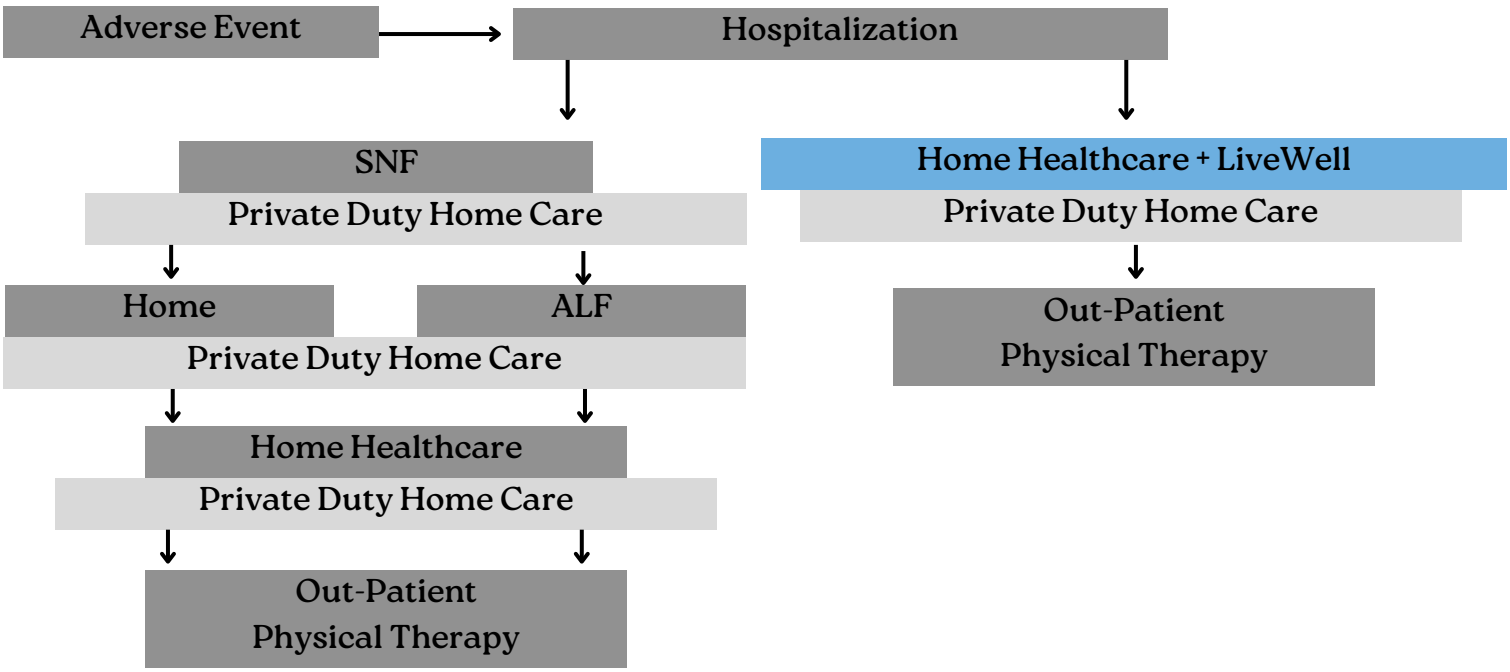
Scenario #2

After hospitalization, some patients may be recommended to go to a skilled nursing facility (SNF) for their recovery. However, many individuals prefer to recuperate at home, especially if they are unable to secure a spot in their preferred SNF. The challenge with avoiding SNFs is the limited therapy available in home healthcare nowadays, with physical and occupational therapy being less prevalent than before.

Typically, home healthcare offers two weeks of occupational therapy, scheduled once a week, and physical therapy lasting two to four weeks, with two weekly visits. Unfortunately, this might not be sufficient for certain patients. To address this gap, we collaborate closely with home healthcare agencies to provide supplementary rehabilitation services.

By working together, we can enhance the therapy regimen for patients who choose home recovery. While the home healthcare team might visit twice a week, our team can provide additional sessions, with up to three, four, or even five visits per week. This enables us to offer rehabilitation services on a daily basis, effectively mirroring the therapy services provided within a skilled nursing facility, but in the comfort and familiarity of the patient's own home.

This unexpected yet valuable partnership has proven to be a game-changer for our members. Approximately 20% of the patients who begin their recovery journey with us simultaneously receive home healthcare, allowing them to benefit from the best of both worlds and experience a more robust and accelerated rehabilitation process.

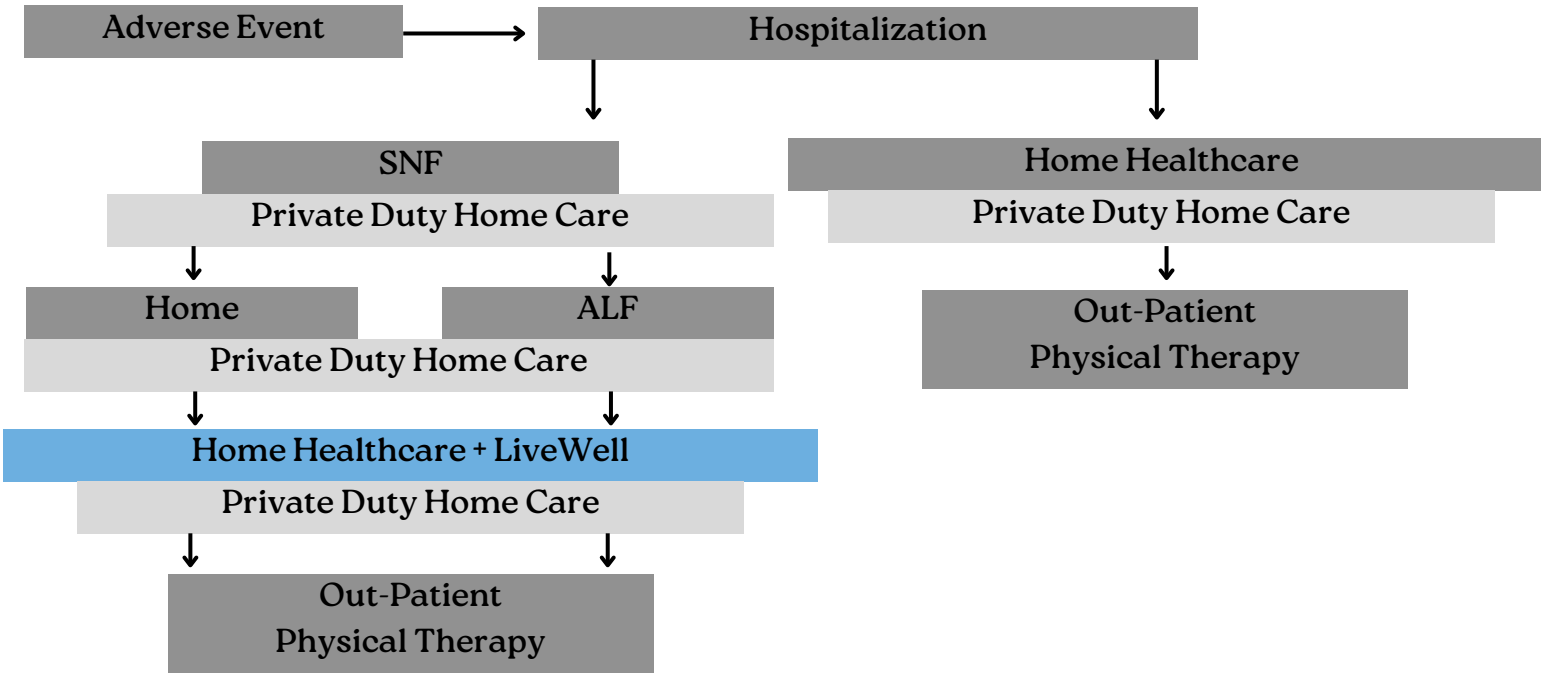


Scenario #3

In the third scenario, we continue to provide valuable support to patients who have had a stay in a skilled nursing facility (SNF) and are now transitioning back home under home health care. This situation proves to be especially beneficial for individuals who may be approaching their Medicare-allotted time within the SNF or for those who simply prefer to recover in the comfort of their own homes.

By combining the services of home health care and LiveWell, we can effectively mimic the therapy that was provided during their stay at the SNF. This collaborative approach allows us to offer comprehensive and continuous rehabilitation support, even after the patient has returned home.

For those nearing the end of their Medicare-covered SNF stay, this partnership becomes crucial in ensuring a seamless transition without compromising on the quality and frequency of therapy needed for a successful recovery. Additionally, for those who have opted to go back home directly from the SNF, our combined services enable them to continue receiving consistent and effective therapy in their familiar surroundings.

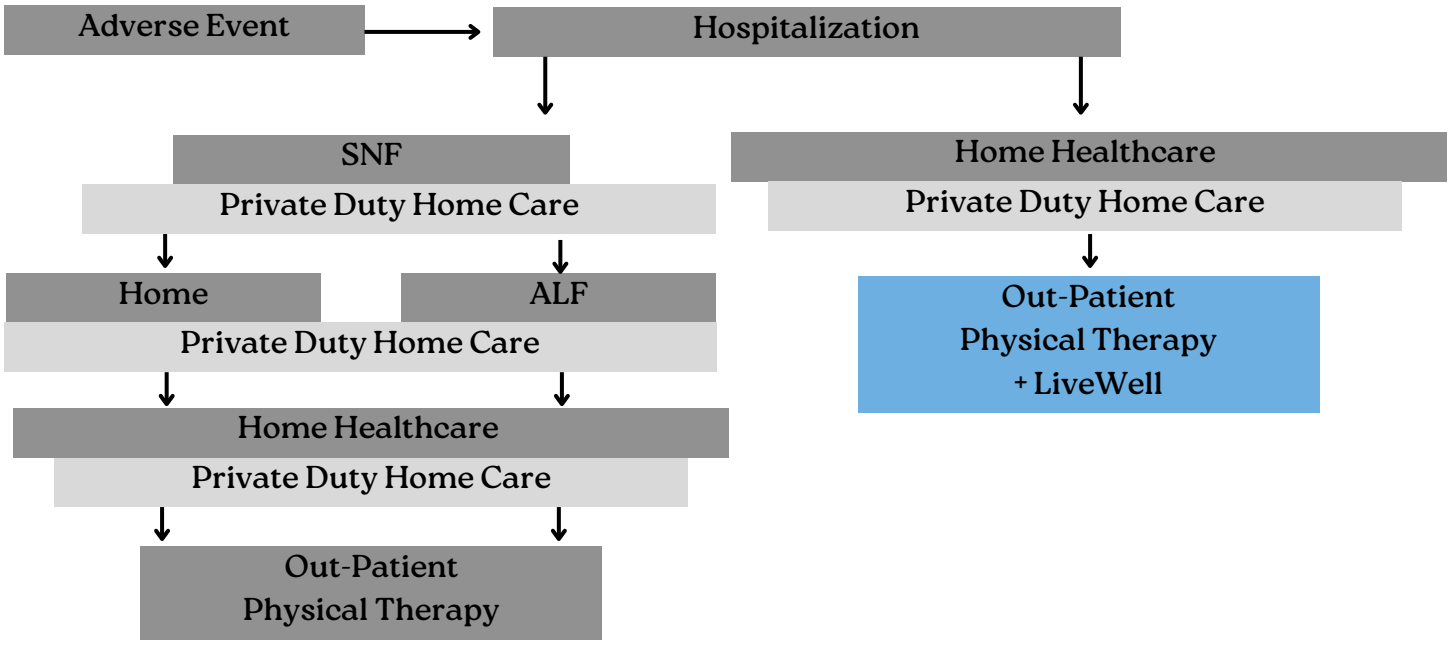


Scenario #4 & 5

The synergy between our services and outpatient physical therapy is a powerful combination that bridges the gap between traditional physical therapy and our strength-based approach. By integrating these two services, we emphasize the importance of ongoing movement and exercise beyond the formal physical therapy period.

While outpatient physical therapy provides essential rehabilitation during the recovery phase, our strength-focused approach encourages patients to continue their journey towards improved health and mobility. Our goal is to make it evident to the patient that being discharged from physical therapy does not mean they are out of the woods. Continued exercise is imperative for sustaining and further enhancing the progress achieved during physical therapy. By combining our services with outpatient physical therapy, we reinforce the message that ongoing exercise is a non-negotiable aspect of maintaining and building upon the gains made during formal rehabilitation.

This collaborative approach empowers patients to take ownership of their health and well-being, making them active participants in their recovery journey. It also fosters a sense of continuity and support as they transition from formal therapy settings to more independent exercise routines.



Scenario #4 & 5

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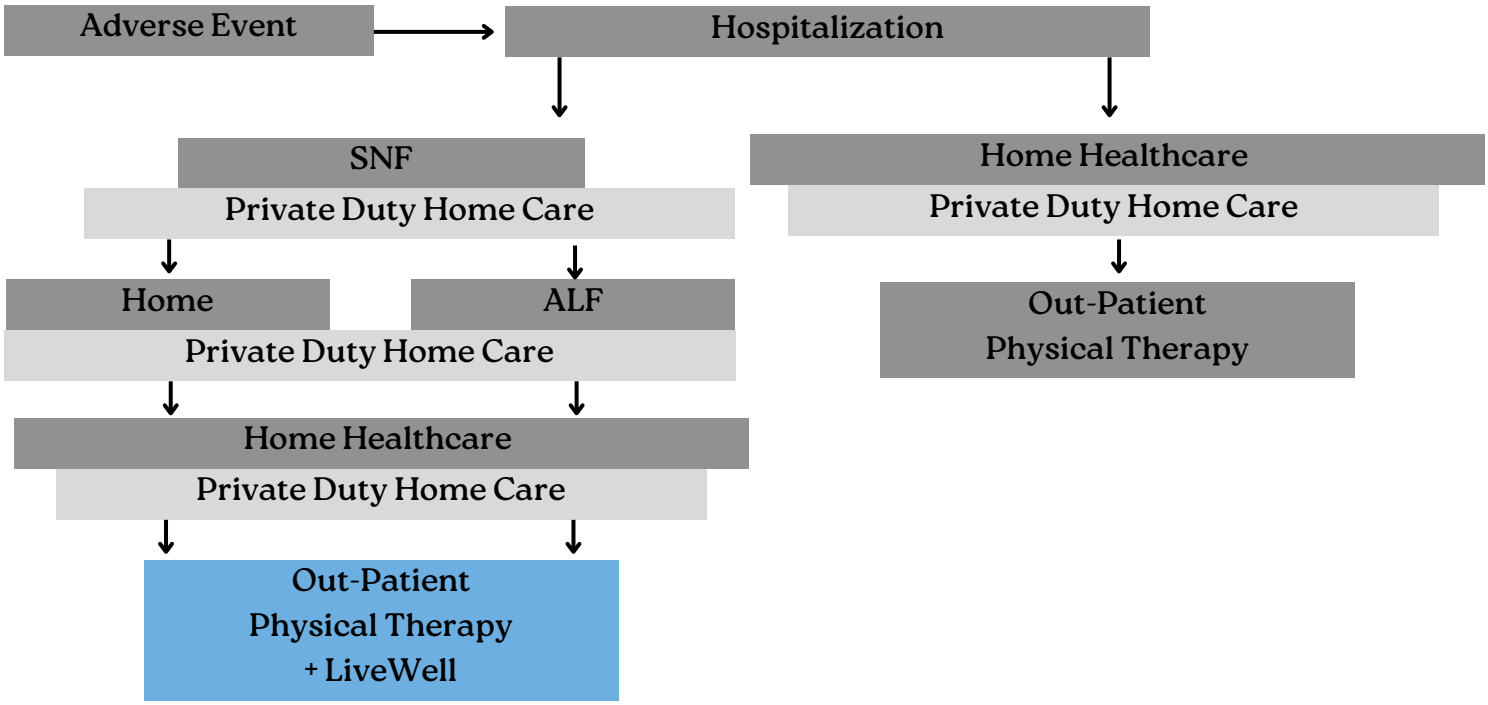
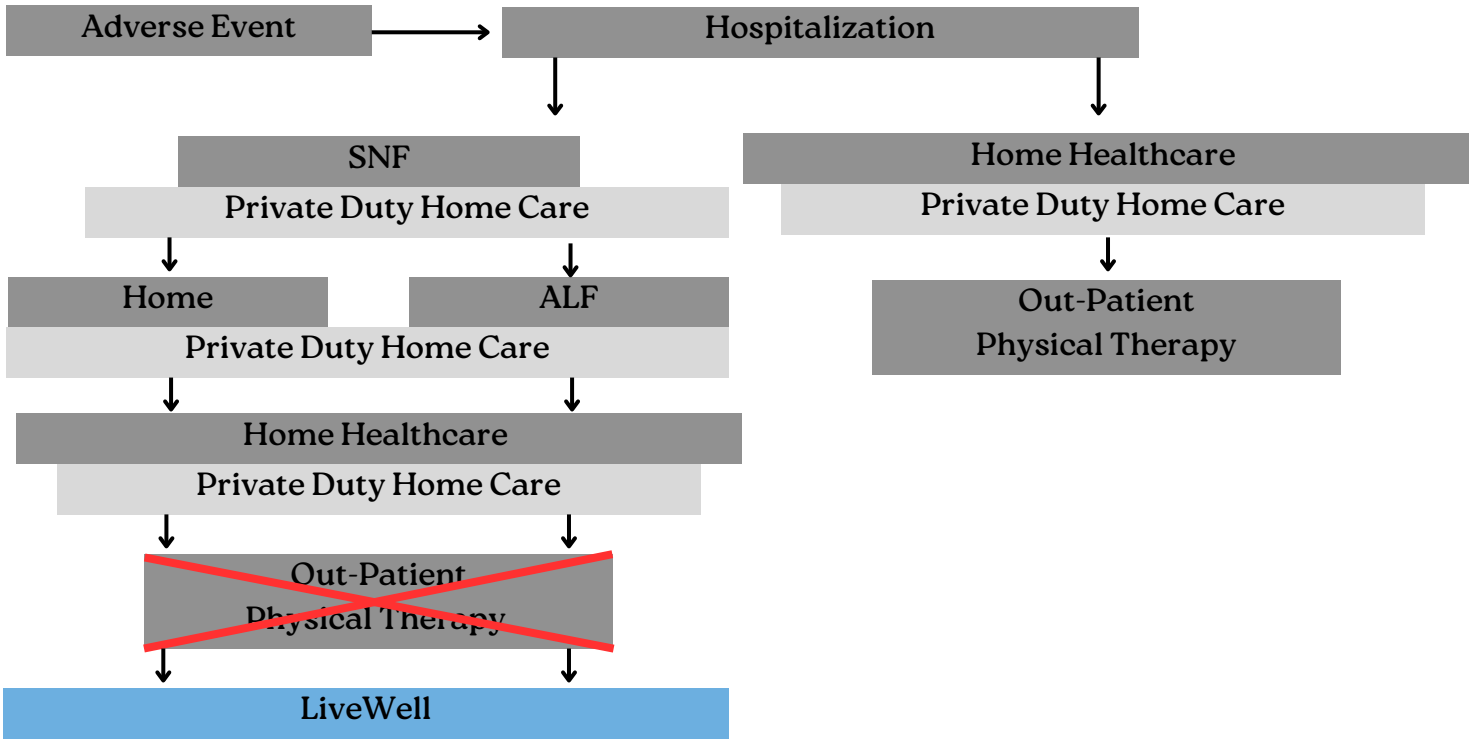


Scenario #6 &7

In scenarios 6 and 7, we have observed a common trend among individuals in the Naples area who may not be officially homebound but find it inconvenient or prefer not to leave their homes for outpatient therapy. These patients choose to forgo Medicare-provided outpatient therapy services and opt to have us bring our services to them in the comfort of their homes.

For these individuals, continuity and convenience are essential factors in their decision-making process. Having experienced the benefits of home healthcare services, they desire to maintain a similar level of care and attention by having our team come directly to their homes.

At LiveWell, we understand the significance of providing personalized and flexible care that aligns with our patients' preferences and lifestyles. By offering our services in-home, we cater to the unique needs of these individuals, ensuring they receive the same level of expertise and attention that they have become accustomed to through home healthcare. This approach also empowers patients to stay committed to their therapy and exercise routines, as they no longer need to deal with the inconvenience of traveling to a physical location for treatment. By eliminating barriers to accessing care, we aim to foster a positive and productive rehabilitation experience for our patients.



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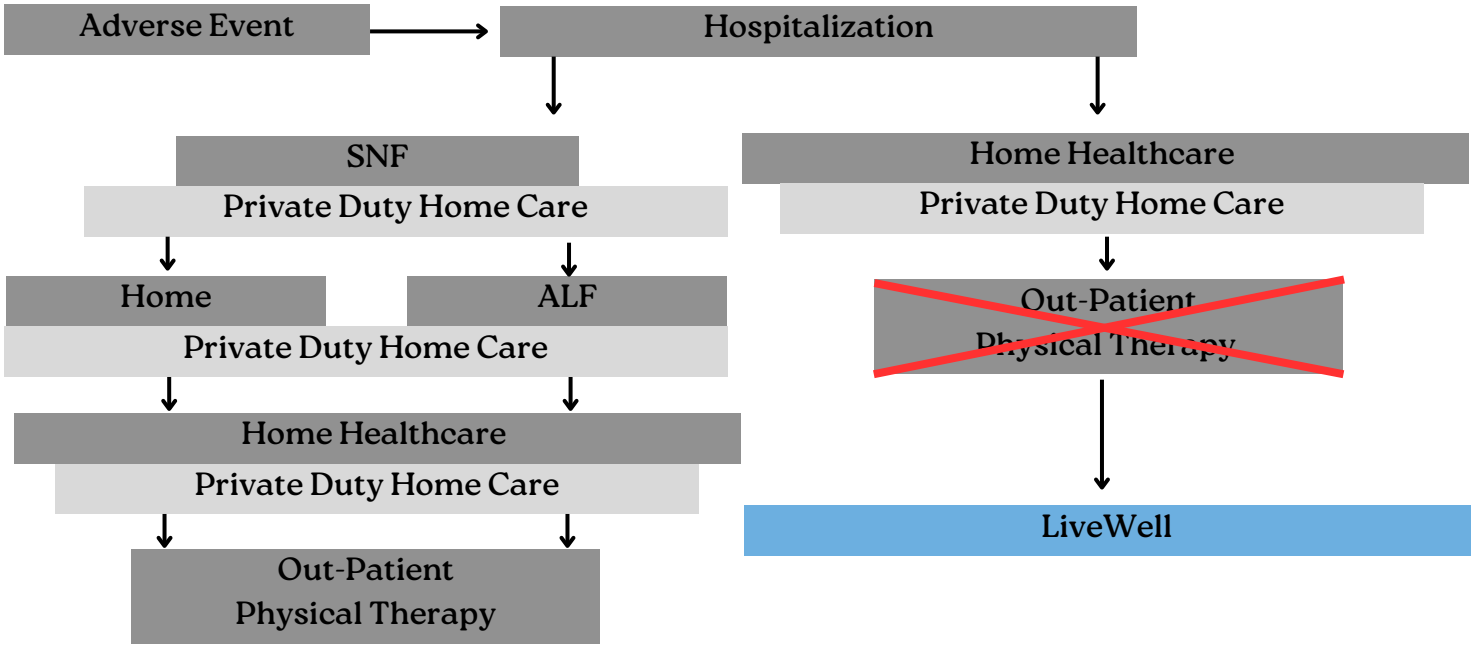

Adverse Event
Hospitalization
SNF
Private Duty Home Care
Home
ALF
Private Duty Home Care
Home Healthcare
Private Duty Home Care
Out-Patient
Physical Therapy
Home Healthcare
Private Duty Home Care
Out-Patient
LiveWell

Scenario #8 & 9

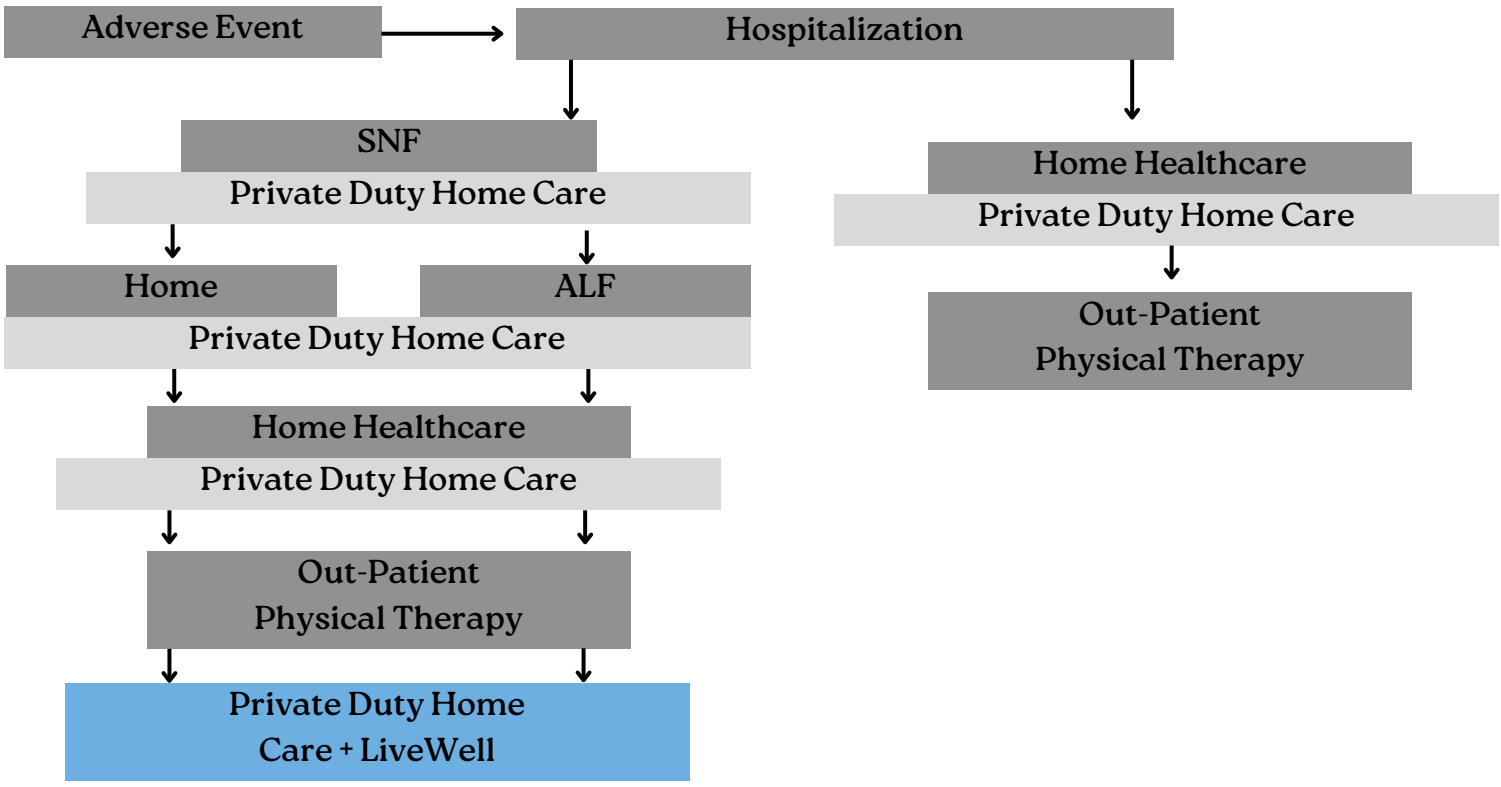
In scenarios 8 and 9, we highlight our commitment to providing continuity of care for individuals with chronic conditions. After successfully navigating the rehabilitation process, our focus shifts to preventing future setbacks and building resilience against extended hospitalizations. Our approach revolves around pushing each individual beyond the limits of traditional physical therapy, fostering improved strength, balance, and overall function.

Our primary objective is to set a new standard for our patients, one that goes beyond merely restoring previous function. We strive to help them achieve enhanced strength and mobility levels that contribute to greater independence and a higher quality of life.

By closely following the steps of previous physical therapy modalities, we build on the progress made during rehabilitation. We aim to create a reserve of strength and mobility that acts as a protective barrier against potential future challenges.

Through our specialized strength-based approach, we empower individuals to go beyond what they thought possible, surpassing the limitations of traditional therapy. This approach fosters self-belief and confidence in our patients, instilling in them the understanding that their potential for growth and improvement is boundless.

Our mission is not just to treat chronic conditions but to equip our patients with the tools and resources they need to proactively manage their health. By raising the bar and setting new standards for strength and balance, we help them take charge of their well-being and reduce the risk of setbacks.



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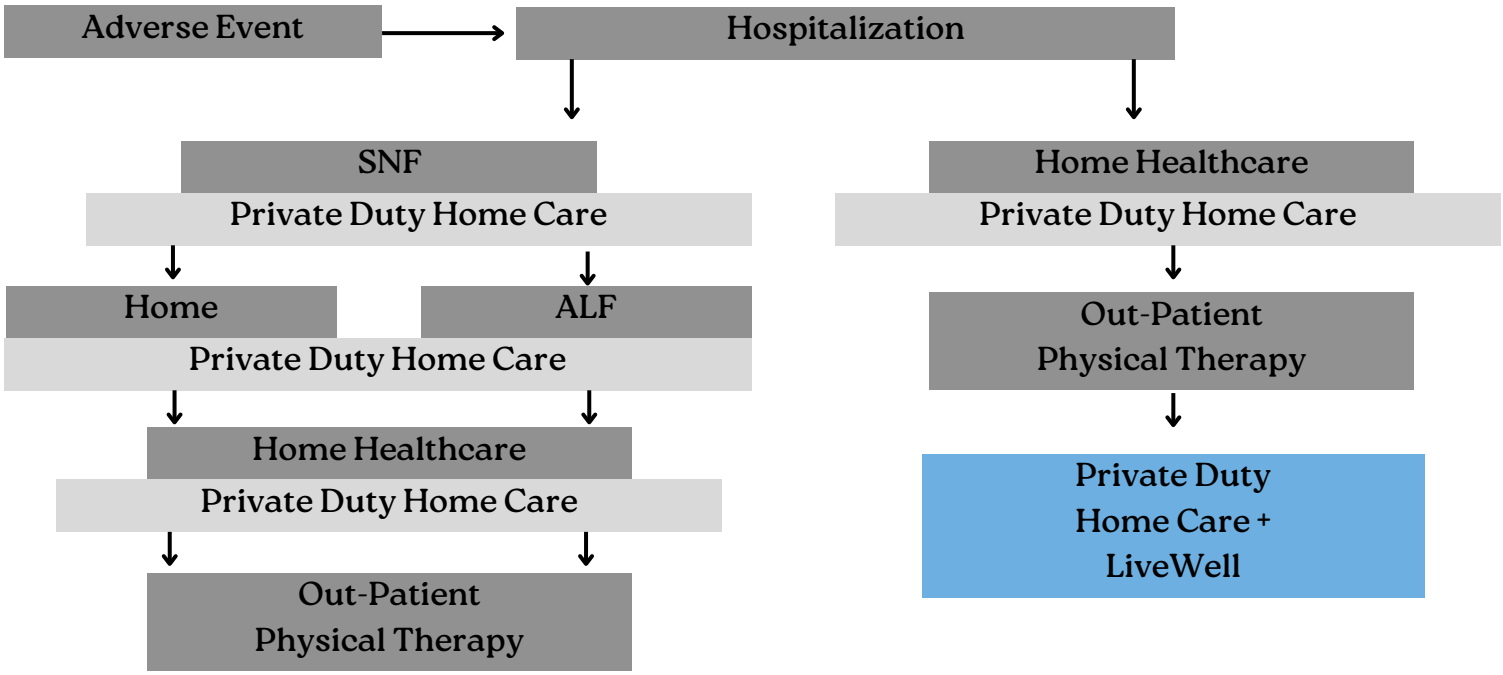
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