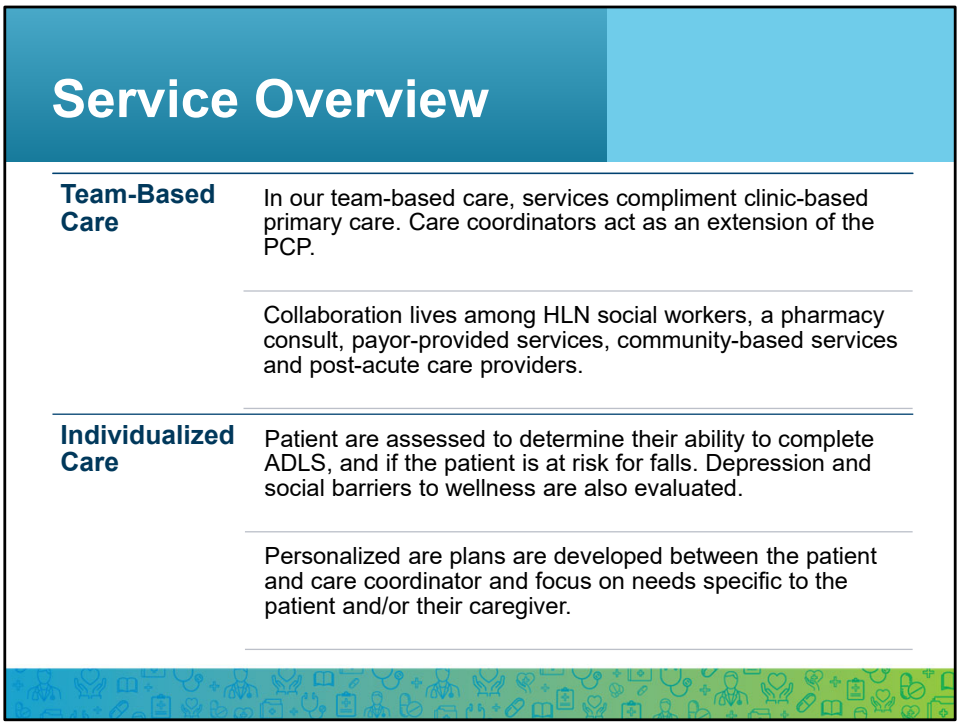
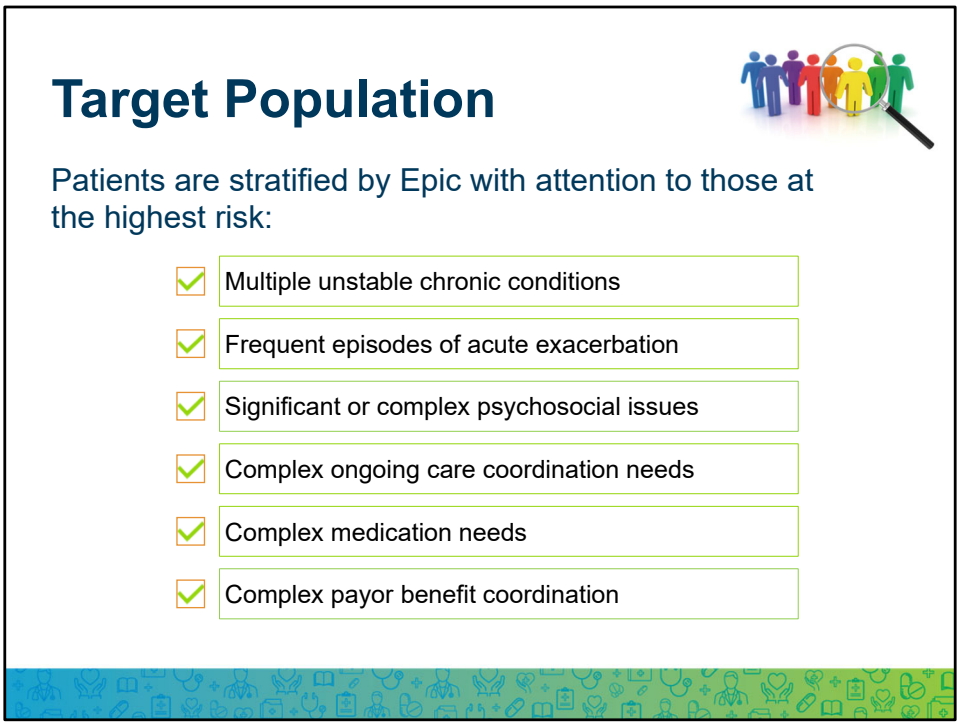
Hello and welcome to HLN's Intensive Case Management orientation course. Our intensive case management services are provided by HLN's Care Coordination department which is staffed by registered nurses, licensed clinical social workers, and patient care partners.



Case management services are provided to align with HLN's tenant of team-based care while developing individualized care plans tailored to specific patient needs and barriers to care.

Care coordinators and case management services compliment clinic-based primary care by extending physician and APP directed services into the patient's home. In addition to working with a patient's primary care provider, care coordinators collaborate with a patient's entire care team including family and friends assisting the patient in the home and various payor and community-based services outside of the home.

Patients who participate in HLN's intensive case management services are assessed to determine their ability to provide self-care and to identify any barriers that may be preventing the patient from meeting their healthcare goals. Individualized care plans are then developed to meet program and patient specific goals.



Intensive case management services are offered to patients who are at the highest risk for ongoing medical complications. Algorithms have been built into Epic to identify service appropriate patients; this comes out to approximately 15% of those at the highest risk. Factors that influence a patient's risk factor include (review the above list).

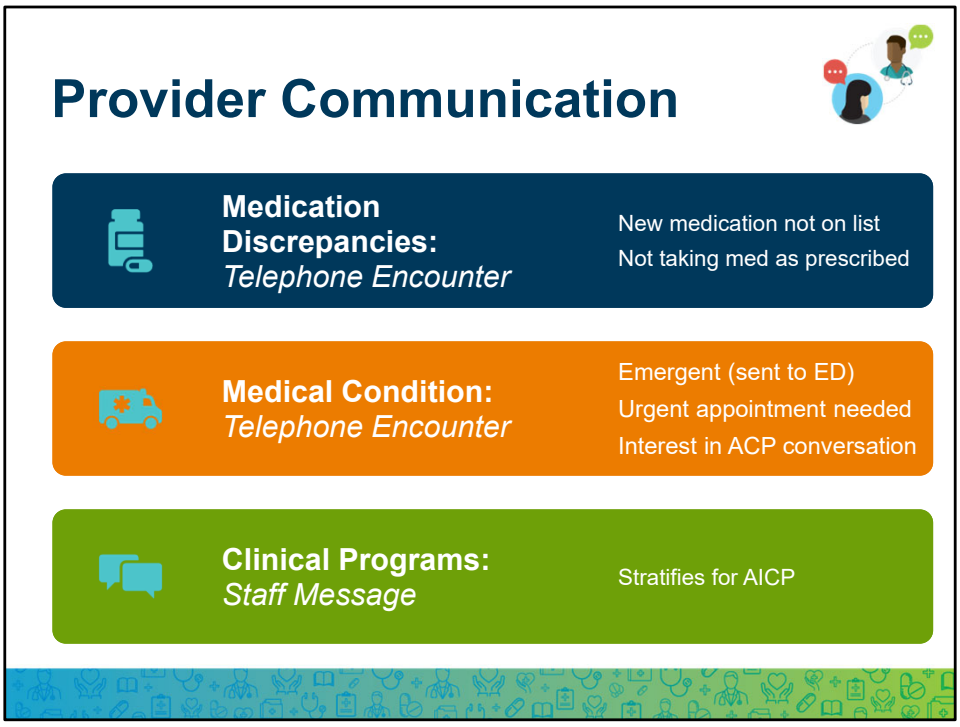
Care coordination leadership runs potential candidate listings on a daily and weekly schedule based on the three case management programs offered.

NOTE: TCP candidate list is run every business day; CCP and AICP candidate lists are run weekly.

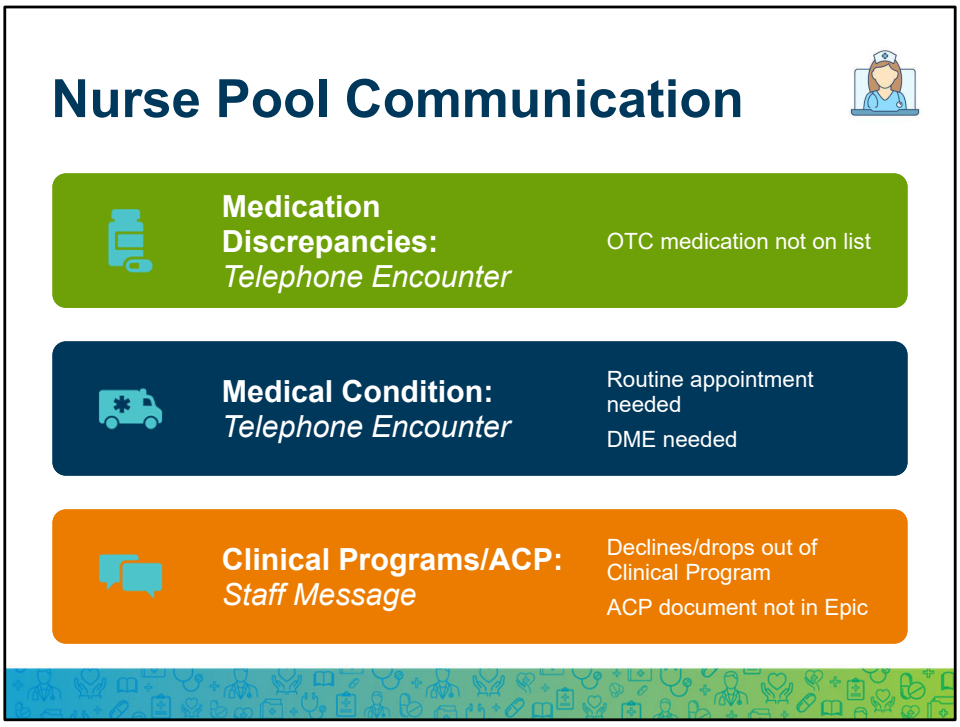
The first program case management program in operation is the Transition Care Program or TCP which focuses on patients who have been discharged from the acute setting and are at high risk for having an unplanned readmission to the acute setting within 30 days of discharge. Patients stay in this program for approximately 30 days and during this time, care coordinators provide care advising to improve the patient's transition to their home setting. TCP accepts both pediatric and adult patients.

Our second program is the Complex Care Program or CCP. CCP patients have two or more chronic conditions which have become difficult to manage in their home setting. Care coordinators focus on identifying and overcoming health care barriers and closing care gaps. Services include health education and improving health literacy, behavioral health support, and medication reconciliation. Patients average approximately 120 days in the complex care program. Both pediatric and adult patients can participate in this program.

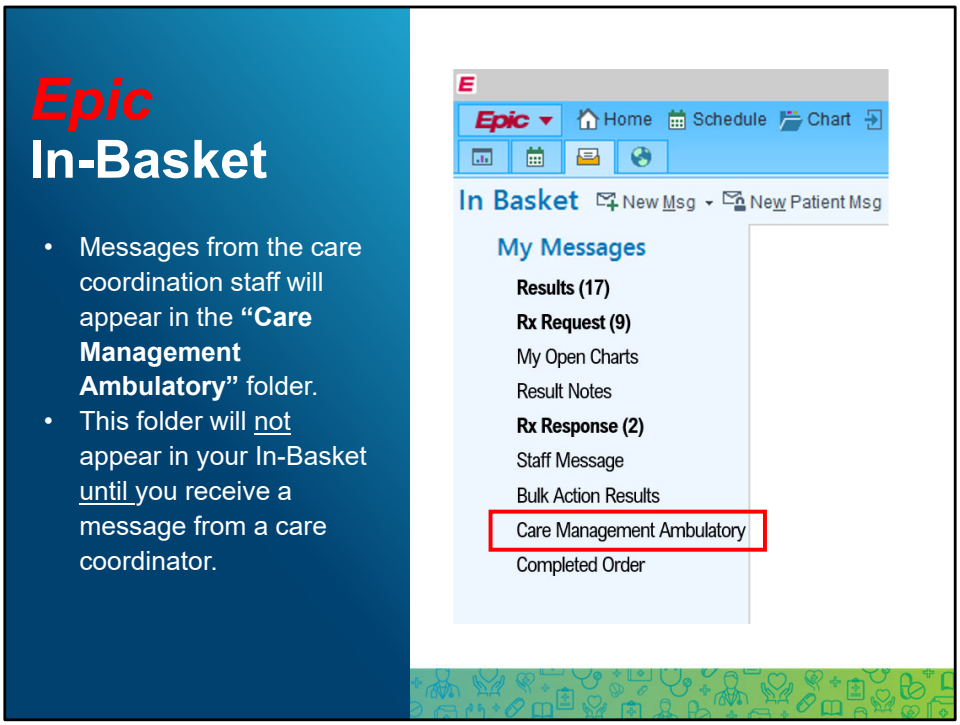
Lastly, our care coordination team offers the Advanced Illness Care Program or AICP for patients with serious or advancing illness. Patients have an average program duration of 90 days and care coordinators focus on exploring a patient's goals, values and preferences in regard to biopsychosocial spiritual wellness. Care coordinators help patients identify a symptom response plan and complete advanced care planning documents. AICP is the only program that accepts patients based on risk stratification and provider referral.



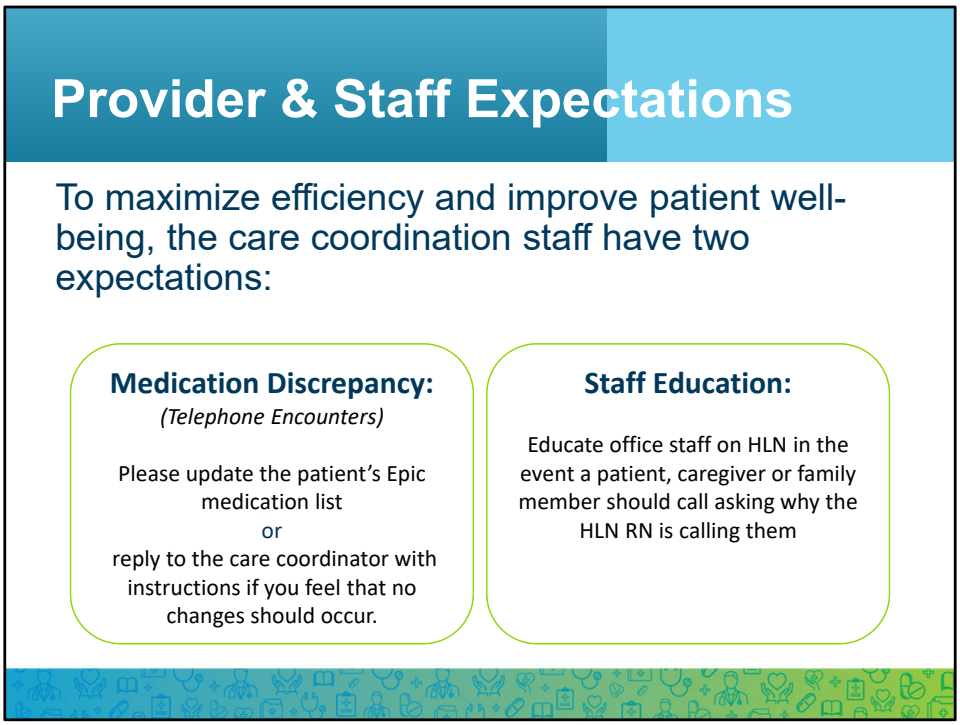
Care coordinators will communicate with primary care providers using Epic In Basket. Telephone encounter messages will be sent for medication discrepancies and medical conditions and will be sent with routine importance unless the patient's status has declined. A staff message will be used if the patient stratifies for the advanced illness care program.



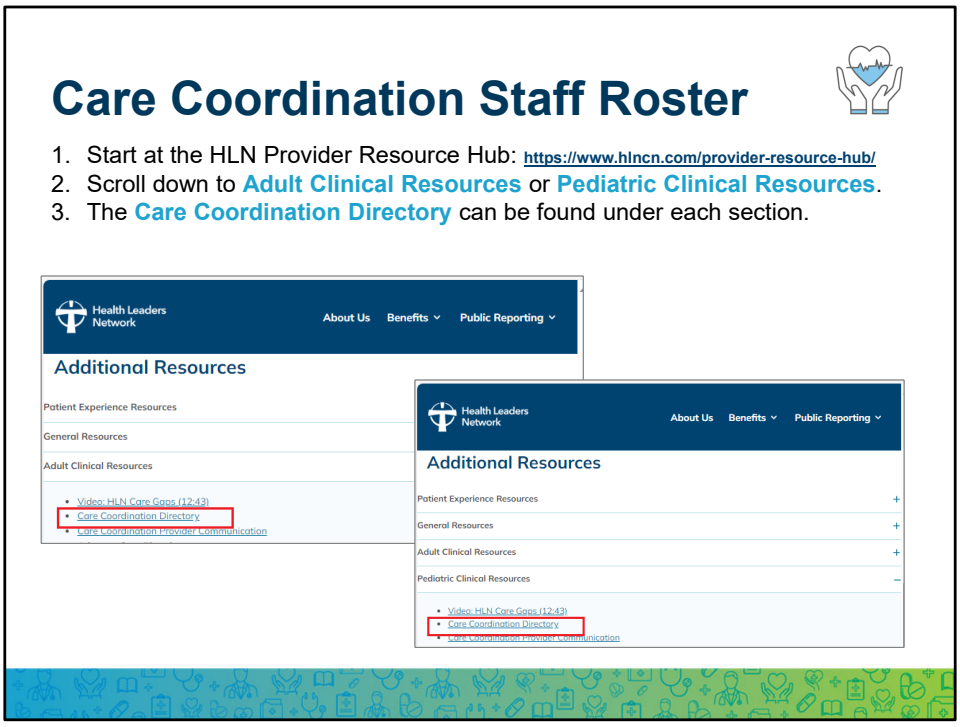
As with providers, care coordinators will also send telephone encounter message to the nurse pool in basket for medication discrepancies and medical conditions with staff messages being sent for clinical program status and advanced care planning documents.



Telephone encounter messages will appear in the Care Management Ambulatory folder of the provider's In Basket but the folder will not appear until the provider receives a message as shown in this screen shot.



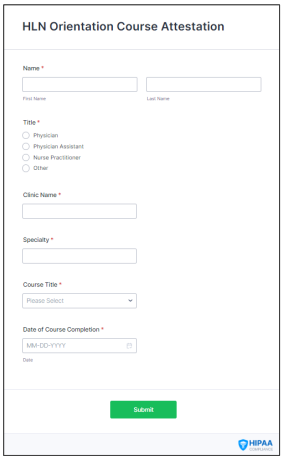
And lastly regarding communication, we ask that providers keep patient medication lists updated and to please respond promptly if a care coordinator reaches out with questions regarding medication changes. It is also helpful to remind nurses and office staff on the role of HLN care coordinators play in patient care to minimize miscommunication to patients.



HLN providers can access the care coordination staff roster through our HLN Provider Resource Hub, then scroll down to Adult Clinical Resources or Pediatric Clinical Resources at the bottom of the web page as shown in the screenshot above. The Care Coordination Directory can be found under each section.

Course Attestation

1. Take out phone
2. Select **Camera** application on phone
3. Scan QR Code
4. Select Website banner
5. Fill out form
6. Course title is **Intensive Case Mgmt.**
7. Click **Submit** Form*



***Credit will not be issued until you complete the attestation form.**

This will conclude HLN's Intensive Case Management orientation course. Please take out your smart phone and use the camera function to scan the QR code and complete the course attestation form linked to it. Credit for course completion will only be issued if you complete and submit the form.

Finally, on your hand-out you will see an additional slide which has the contact information for Maggie Taylor-Menard who is the Director of Care Management for HLN. Please feel free to reach out to Maggie if you have any questions about this course or about the services provided by the care coordination staff.

Thank you and have a wonderful day.

Questions

Maggie Taylor-Menard, RN, BSN, CCM
Director, Care Management
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