HOSPICE AT HOME

PATIENT CASELOAD: Patients with a life-limiting illness who need comfort and symptom management

RESPONSIBILITIES:
• Conduct a face-to-face encounter, utilizing knowledge of hospice criteria to assess at recertification whether the patient continues to meet hospice criteria for enrollment
• Collaborate and communicate findings to the hospice care manager and Medical Director when applicable
• Contribute to the IDT discussion whenever there is a complicated patient or when a patient may no longer meet criteria

WHY IS CLEVELAND CLINIC CENTER FOR CONNECTED CARE A GREAT PLACE TO WORK?

• Dynamic people
• Team-oriented environment
• Competitive salary
• Pension plan
• Savings and investment plan (403(b))
• Paid time off
• Medical, dental and vision insurance
• Life and disability benefits
• Tuition reimbursement
• Continuing education programs

Cleveland Clinic Center for Connected Care
6801 Brecksville Road
Suite 10
Independence, OH 44131
216.444.4663, 800.263.0403
clevelandclinic.org/connectedcare

For more information on current jobs, please visit: www.clevelandclinic.org/CCCjobs
For questions, please contact Ryan Mayer at 216.448.8205.

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Cleveland Clinic is a nonprofit multispecialty academic medical center that integrates clinical and hospital care with research and education. More than 3,000 staff physicians and researchers represent 120 medical specialties. Cleveland Clinic health system includes a main campus near downtown Cleveland, eight community hospitals and more than 75 outpatient locations in northern Ohio, including 16 family health centers. Cleveland Clinic also has locations in Florida, Nevada, Toronto and Abu Dhabi. U.S. News & World Report consistently names Cleveland Clinic as one of the nation’s best hospitals in its annual “America’s Best Hospitals” survey.
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Join Us as an Advanced Practice Nurse

Cleveland Clinic Center for Connected Care offers exceptional opportunities to work in a specialty environment and gain invaluable experience.

Some of our APN openings include:

**SKILLED NURSING FACILITY (SNF) CONNECTED CARE**

**PATIENT CASELOAD:** Patients discharged from Cleveland Clinic main campus with multiple co-morbidities to a collaborating Connected Care Program SNF.

**PATIENTS WE HELP:**
- Those discharged to a SNF with an expected length of stay of 30 days or less. This will include patients with serious acute/chronic diagnoses and those who are at risk for readmission to the acute care setting.

**PHYSICIAN COLLABORATION MODEL:**
- Partnered with staff physician assigned to Connected Care Program SNF

**RESPONSIBILITIES:**
- Will attend approximately 20+ patients at one or two facilities regularly – with expectation that a medical visit occurs daily (weekdays). Possible coverage required at other nearby CCU facilities and/or for Heart Care at Home as needed or scheduled in advance.

**HEART CARE AT HOME**

**PATIENT CASELOAD:** Primarily 65 years and older

**PATIENTS WE HELP:**
- Those who have been discharged from acute care setting with primary diagnosis of heart failure or an acute MI; have difficulty with getting to an office; considered high risk for readmission to hospital due to disease process, cognitive issues and lack of social support

**PHYSICIAN COLLABORATION MODEL:**
- Primarily work with patients’ individual physicians to discuss changes in plans of care. Also, collaborate with Heart Care at Home medical director when needed.

**RESPONSIBILITIES:**
- Perform chart reviews and EMR monitoring of patients to assess need for actual face-to-face visit
- Transitional coaches handle first-line triage and communicate to NP via email, and/or cell phone
- Laptop devices used to document in EMR in home/electronic prescription processing

**MEDICAL CARE AT HOME**

**PATIENT CASELOAD:** Primary care – predominately geriatric patients

**PATIENTS WE HELP:**
- Primarily older adults who are at risk and live in the community; have serious chronic conditions; have difficulty getting to an office; recently discharged from acute or sub-acute setting; have fall, balance or mobility problems; late-life depression, memory disorders or behavioral concerns

**PHYSICIAN COLLABORATION MODEL:**
- NP typically partnered with one physician co-managing a set patient case load
- Covers urgent visits for other physicians in the practice

**RESPONSIBILITIES:**
- Practice has weekly multi-disciplinary team meetings
- Nursing support/triage occurs in the medical practice office
- Laptop devices used to document in EMR in home/electronic prescription processing

**HIGHLY DESIRABLE PRACTICAL EXPERIENCE:**
- Working with seniors

**MUST HAVE:**
- Ability to work autonomously under the guidance of a collaborating physician

**MEDICAL CARE AT HOME**

**PATIENT CASELOAD:** Primarily 65 years and older

**PATIENTS WE HELP:**
- Primarily older adults who are at risk and live in the community; have serious chronic conditions; have difficulty getting to an office; recently discharged from acute or sub-acute setting; have fall, balance or mobility problems; late-life depression, memory disorders or behavioral concerns

**PHYSICIAN COLLABORATION MODEL:**
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**MUST HAVE:**
- Ability to work autonomously under the guidance of a collaborating physician