



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

For more information on current jobs, please visit:
www.clevelandclinic.org/CCCjobs

For questions, please contact
Ryan Mayer at 216.448.8205.



[Cleveland Clinic Center for Connected Care](http://clevelandclinic.org/connectedcare)

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9500 Euclid Avenue, Cleveland, OH 44195

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. clevelandclinic.org

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Advanced Practice Nursing Opportunities



Connected Care

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:



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



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

HIGHLY DESIRABLE PRACTICAL EXPERIENCE:

- Cardiovascular or cardiothoracic practice setting experience, especially treatment and knowledge of heart failure management

MUST HAVE:

- Ability to work autonomously under the guidance of a collaborating physician, must be flexible with ability to alter and change schedule/assignment at last minute as needed for patient care
- Ability to assist in facilitation of regular case presentations of high-risk/readmitted patients to team

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.

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.

PHYSICIAN COLLABORATION MODEL:

- Partnered with staff physician assigned to Connected Care Program SNF

RESPONSIBILITIES:

- Laptop devices or designated desktops at the facility used to document in EPIC EMR

HIGHLY DESIRABLE PRACTICAL EXPERIENCE:

- Skilled nursing and interest in post-acute; geriatrics is a plus; any specialty in disease or chronic care management
- Will participate in the facility Joint Quality Committee, any projects that spin off of the JQC, the facility interdisciplinary care plan meetings, and regular meetings with the Connected Care Program team on Cleveland Clinic main campus.

MUST HAVE:

- Ability to work autonomously under the guidance of a collaborating physician