

Community Case Management

Use the Community Case Management subsystem to document how high-risk patients are managed across the continuum of care. Whether you identify high-risk clients upon enrollment to a health plan, perform as a clinical specialist for specific patient populations, follow clients in the community, or coordinate authorization of services and discharge planning, the Community Case Management module has what you need to ensure successful outcomes. You can associate assessments, problems, interventions, goals and outcomes with each individual case management episode to create an individualized care plan for your patient.

Using SmarTrack™ rules, the Community Case Management module automatically notifies case managers when a client re-enters the healthcare system, exceeds a recommended length of stay, or meets any number of user-defined criteria. It also allows you to transfer patients from one worklist to another and reminds you when a patient requires follow-up contact or interventions. You can create multiple case management episodes if the patient is being managed for more than one medical condition and the case management team can update the care plan frequently. With SmarTrack, you can define your own case and resource management rules and parameters for accurate data management and reporting.

Another critical benefit is an environment in which interventions are linked to projected outcomes. A plan of care, including problems, goals and projected outcomes, can be updated by the multi-disciplinary team. It also enables case managers to track specific services and referral patterns for a specified patient population by cross-referencing them with network-wide resource data.

Features and Benefits

- Manage high-risk, community-based, and inpatient populations with complete flexibility
- User-defined assessments and simultaneous problem identification initiate a case management episode
- Create an individualized patient care plan worksheet which includes goals, outcomes and interventions to meet TJC requirements
- Notifies case managers when a patient re-enters the healthcare system, exceeds a recommended length of stay, experiences a variation in a clinical pathway, or meets any number of user-defined criteria
- Populate hospital discharge planning notes or previous case management episode data into newly opened episode
- Add or delete visits to health continuum facilities from a case management episode
- Create user-defined letters to patients and physicians
- Access online agency detail lookup to match services to appropriate agencies
- Provide worklist notification when patients requires follow-up contact or intervention
- Report goals, outcomes, interventions and productivity by case manager or episode type
- Track referral sources and track patient status and needs
- Identify patient problems and track medical history

"Licking Memorial Hospital in Newark, Ohio has been able to tap into the flexibility of the MIDAS+ system. We are able to monitor our community case management population, even if they are not already in the system. Also, when we want to collect new data and there isn't already a module for it, you can create your own focus module!"

*Licking Memorial Hospital
Newark, Ohio*