How can you get started with FHN Complex Care Management?

You may be referred to Complex Care Management by your healthcare provider, or you may contact us yourself.

Once we're connected, the Complex Care Manager will set up a time for your initial interview process, where you'll go over questions that will help us assess your current situation and determine what we can do to help support you.

The initial interview may take place over the phone, in your home, or at your healthcare provider's office before or after a scheduled appointment. Select a time that works for you when you can dedicate about 45 minutes to the Complex Care Manager.

After that, the Complex Care Manager will contact you at least every week or two. These calls can be set up in advance and may only take 10-15 minutes.

Of course, you may always contact your Complex Care Manager, too, if you have questions, concerns, or changes in your health.

At the end of the three-month period, your Complex Care Manager will work with you to help you transition back to the office setting or to other programs within the network that will provide longer term support.

If you are interested in participating in the Complex Care Program, please speak with your provider or contact us.

FHN
Complex Care Management

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COMPLEX CARE MANAGEMENT

Caring for our community is a team effort

FHN
Complex Care Management

What is Complex Care Management?

The Complex Care Management program was developed to help individuals with two or more chronic illnesses who could benefit by being with support from a wide variety of community services.

Chronic Conditions include:

- Heart disease, such as Congestive Heart Failure (CHF)
- Lung Disease, such as Chronic Obstructive Pulmonary Disease (COPD)
- Kidney disease
- Autoimmune issues
- Cancer
- Many others

If you become part of the program, we will provide case management services over a period of three months to help you understand your condition better and learn more about the many resources you may wish to utilize. At the end of that time, your Complex Care Manager will help you transition back to your healthcare office setting or to other programs within FHN, such as Supportive Care or Hospice, that will provide longer-term support.

What can you expect from your Complex Care Manager?

Your Complex Care Manager…

- Will assist you in reviewing your medications and make sure that you are familiar with your prescriptions.
- Will make referrals on your behalf to community resources that may be able to assist you, including transportation services, home delivered meals, the Illinois Division of Rehabilitation Services (DORS), the RAMP Center for Independent Living, the Senior Resource Center, or any others that may be able to help.
- Will help you in setting goals that are important to you and assist you in moving towards those goals by being your Health Coach.
- May set up a time with you to visit your home to review how you can be as safe and healthy as possible there.
- Will work with your primary care provider and specialty providers to coordinate your care.
- May attend doctor's visits with you, at your request, to help you better navigate your care.

What is your role when you participate in the Complex Care Program?

Your participation in FHN's Complex Care Management program is a partnership between you and your Complex Care Manager. To begin, please let your Complex Care Manager know about what goals you would like to work on to improve your health.

In addition, it's important for your Complex Care Manager to…

- Know about any changes in your health.
- Have your most current contact information.
- Have a list of all your prescribed medications including over-the-counter, herbal, and dietary supplements.
- Know about any conflicts in your schedule that may prevent you from working with your Complex Care Manager on a weekly basis (your manager can work with your schedule).