Job Description

Position Title: RN Care Manager

Position Summary: The RN Care Manager is a practice-based RN who directly supports SCRFHC's highest risk patients. In collaboration with other members of the healthcare team, the RN Care Manager is responsible for organizing, coordinating, and providing care coordination and care management services to patients within the practice who are most at risk for health deterioration, sentinel events, and/or poor outcomes.
The RN Care Manager communicates with patients to assess their needs and then consults with health professionals to decide on which services to provide. Responsibilities include planning, organizing, and informing patients regarding general preventative care practices as well as individualized care plans. Work involves using health information technology to keep track of patients' records, especially electronic records, and must keep current with computer technology, software, security measures, and legislation regarding patient privacy and other issues.
Work in a manner that supports the mission and purpose of the health center and performs in accordance with system-wide competencies and behaviors, utilizing both the Patient Centered Medical Home model and the Accountable Care Organization measures.

Primary Responsibilities:

Care Management Systems:

1. Manage SCRFHC high-risk patient registry
   a) Oversee systems for identifying high risk patients through EMR, referrals, registries from health insurance payers
   b) Ensure validity of registry; collaborate with Information Technology on registry functionality.
2. Develop a tracking system for patient care coordination and care management across the continuum, including care transitions, Primary and Specialty care.
3. Act as clinical liaison for Payer Based Care Management programs, including ACO, commercial payors, Medicare advantage, managed care and Medicaid as indicated.
4. Conduct data reporting to identify gaps in care or services and conducts patient outreach to facilitate follow-up care or services.
5. Visit, educate, and serve as a resource to providers on patients with chronic and/or high-risk conditions that could benefit from extra services to provide coordination and linkage to general medical services.

6. Communicate and coordinate with medical and mental health providers concerning options, including community services; available to the patients they serve.
7. Meet with patients, primary care and behavioral health providers, and other staff as needed to develop and coordinate treatments plans; meet with patient family members as needed.
8. Interface with and refer patients to other supportive services as appropriate.
9. Serve as a linkage between SCRFHC providers and other providers that the patient is seeing to improve coordination of services and information flow.
10. Provide self-management support to patients. Work to educate, motive, and coach patients utilizing disease-specific protocols.
11. Provide patient education sessions for various health conditions; e.g., diabetes, CHF, COPD, etc.
12. Provide ongoing phone contact with patients.

Direct Patient Care:

1. Provide direct nursing care as indicated and/or provide nursing back-up in the event of staff shortage, including provision of telephone triage and provider assistance and support.
2. Follow-up with patients within 24 hours on inpatient discharge & within 48 hours of ED visit notification.
3. Conduct comprehensive assessment of patients' physical, mental, and psychosocial needs
4. Develop care plans to prevent disease exacerbation, improve outcomes, increase patient engagement in self-care, decrease risk status, and minimize hospital and ED utilization
5. Utilize behavioral strategies help patients adopt healthy behaviors and improve self-care in chronic disease management. Promote self-management goals.
6. Assist patients in navigating the health care system. Coordinate Specialty care, follow-up on test results and other care coordination needs.
7. Partner with external case management programs to coordinate care
8. Ongoing evaluation and documentation of patient progress/ risk status Document in EMR; communicate with care teams
9. Document all patient related activity in EMR, per policy

Patient-Centered Medical Home:

1. Pro-actively support PCMH initiatives related to care coordination.
2. Participate in Quality Improvement Committee activities, trainings, and participate in professional development activities
3. Pro-active member of care teams in team-based care initiatives
4. Practices team-based care
5. Involved in huddles on daily basis per huddle procedure
6. Stay up to date with trends in healthcare to develop/ revise integrated care management programs

**Performs other duties as requested or assigned.

Qualifications:

1. Valid RN licensure. 3-5 years of relevant experience preferred.
2. Experience working in case management, disease management, home health care nursing, hospital nursing or intensive outpatient education and/or self-management support skills
    a) Ability to work with a variety of people from different professions
    b) Relationship building with patients, staff, and providers
    c) Comprehensive nursing assessment, problem identification and care plan development
    d) Disease management
    e) Ability to interact with physicians and other health care professionals in a professional manner.
    f) Working knowledge of physical health and behavioral health medications.
    g) Screening for developmental issues, depression, other psychological conditions, and frailty.
    h) Behavioral strategies including motivational interviewing and self-management support
3. Ability to communicate effectively orally and in writing
4. Ability to initiate and implement procedures and to evaluate their effectiveness
5. Ability to use a personal computer or computer terminal
6. Visual/hearing ability sufficient to comprehend written/verbal communications and work with documents and reports.
7. Proficient in Microsoft Office and Excel.
8. Ability to travel to required meetings and conferences.
9. Clinical system design and development
10. Project and time management skills
11. Solid computer skills including excel, word, and PowerPoint.
12. Organized and resourceful self-starter; strong ability to work in a team
13. Excellent written, oral and interpersonal communication skills

Working conditions: office-based with the ability to do home visits on a limited basis

Required Screening: All potential new employees will undergo a background and Office of Inspector General exclusion report and periodically thereafter.

Post-Employment Requirements:

1. All new employees must complete all mandatory trainings, communication training, Health literacy and patient safety, within the first week of employment.

2. All new employees must complete training in coordination of care for patients and maybe assigned to a care team to support patients and families in self-management, self-efficiency, and behavior change within the first 2 weeks of employment as administered by leadership.
3. All new employees must complete training in population management within the first month of employment as administered by leadership.
4. All clinical employees must complete at least basic motivational interviewing training within 3 months of employment.

SCRFHC is an Equal Opportunity Employer, M/F/D/V are encouraged to apply