Nurse Case Manager

SUMMARY

The lead facilitator of referrals and care coordination for referrals outside the center for high risk/cost patients. The NCM will utilize quality reports to focus the resources of care team on providing additional support to achieve triple aim goals. This position coordinates the clinical and care management for targeted patient assignments. Performs overall utilization management, resource management, care facilitation, and referral to other levels of care. Works with care teams and other resources including integrated and contracted behavioral health to facilitate achievement of desire quality and financial outcomes.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following:

- Incorporate Care Manager role into health care team to team base care-patients referred to CSM based upon identified need, risk scores/risk factors, or sharp increase in annual cost of care.
- Complete a comprehensive physical, medical, and psychological assessment on high risk high cost patients.
- Identify and monitor disease specific individual goals and program measures (such as smoking cessation) and individual self-management goals with PCP and practice team to reach and maintain targets.
- Oversees referrals to community organizations and CAP partners for additional enabling services and social work, or to behavioral services either through integrated onsite programs or Gateway for assessment, treatment, or peer mentoring program.
- Conduct a face-to-face interview (home visit optional) in order to: assess baseline knowledge of conditions; determine patient strengths/skills; identify patient’s support system and current community supports/agencies and providers; include patient’s identified needs and barriers.
- Establish care plan, goals, interventions and contact schedule based on risk category, and patients/family members identified medical and social needs.
- Promote compliance with disease specific clinical outcomes by providing each individual with self-management supports including:
  - Disease specific educational materials at a 5th grade level or below
  - Medication charts and side effects
  - Signs and symptoms to watch for and report to MD
  - Nutritional recommendations
  - Exercise and activity
  - Community supports, services and resources including current provider information such as Pharmacy, DME, and Home Care providers
  - How to communicate with your doctor
  - Care plan and treatment goals including self-management goals
- Incorporate RN Care/Case Manager role into office based health care team to promote patient centered care, frequent contact with Primary Care Providers and medical home team members and actively participate in multidisciplinary patient centered team meetings.
- Promote, arrange, and participate in optimal planned Primary Care MD visit scheduling and arrange transportation and visit reminders.
- Coordinate care and communication between multiple providers, medical, nursing, social, and behavioral health.
- Identify and monitor disease specific individual goals and program measures (such as smoking cessation) and individual self-management goals with PCP and practice team to reach and maintain targets.
- Provide liaison roll to practice for members hospitalized at unaffiliated facilities in order to communicate admission information provided by DHS to PCP to facilitate discharge planning and
- Develop/maintain registry or electronic tracking system and obtain quality indicators
  - Identify population of patients
  - Set alerts/reminders to identify patients overdue for recommended care/services
  - Document self-management goals and patient specific care plan
  - Obtain quality indicators for reporting
Review quality outcomes data with health care team
○ Implement strategies to improve care
  ▪ Occasional off-site community and/or home visits may be required
  ▪ Other duties may be assigned

SUPERVISORY RESPONSIBILITIES
None

QUALIFICATIONS
To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION, EXPERIENCE, & SKILLS
RN with BSN
3-5 years of experience in community health setting, public health, chronic disease management, community nursing, case management preferred
Experience in care coordination and disease management/education
Experience working with primary care providers in practice setting to coordinate care and disease management
Strong communication skills, both verbal and written
Knowledge of case management, disease management, and chronic care principles

LANGUAGE SKILLS
Excellent written and verbal communication skills in English
Bilingual ability required, preferably in Portuguese or Creole (Portuguese-based Creole)
Cultural sensitivity necessary to work with a diverse patient and staff population

PHYSICAL DEMANDS
The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is frequently required to stand; walk; sit; climb stairs; use hands to finger, handle, or feel; reach with hands and arms; talk or hear and taste or smell. Specific vision abilities required by this job include color vision and ability to adjust focus.

Must have own transportation
Must be able to manage a fluctuating workload

WORK ENVIRONMENT
The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Ability to work independently and manage a large volume of work
Ability to build trust with multiple complex patients

CONTACT
Interested candidates please send a CV or resume to mwhite@bvchc.org or fax to the Human Resources Department at 401-729-9901.