

Job Description

TITLE: Care Manager

REPORTS TO: [Medical Director] [Lead Provider] [other]

SUMMARY OF POSITION:

The Care Manager leads disease management and disease prevention activities. Disease management activities include case management, referral coordination, and hospital/emergency department follow-up for high risk/complex patients. Disease prevention activities include integration of evidence-based clinical and prevention guidelines into care. This position will lead health center efforts in development of individualized care plans that are patient-centric, promoting quality and efficiency in the delivery of health care. The Care Manager will also develop strategies to assess for social determinants of health and measure patient and staff experiences. This position will contribute to the integrated care team's activities around process improvement, workflow redesign, and training, allowing staff to work at the top of their licensure and skill set.

DUTIES AND RESPONSIBILITIES:

DISEASE MANAGEMENT ACTIVITIES

- Identifies patients meeting criteria for case management (e.g., multiple chronic conditions, repeated health crises, high social risk) through registries, risk stratification, and provider referral.
- Engages patients in care management, including obtaining patient consent.
- Assesses patient/family health, education and psychosocial needs using standardized assessment tools such as depression screening, functionality, and health risk assessment.
- Implements clinical interventions and protocols based on risk stratification and evidence-based clinical guidelines, including age-appropriate wellness screenings (e.g., cancer).
- Develops a comprehensive individualized plan of care and targeted interventions that involve patient/family in the decision-making process; include patient's preferences and goals as well as the care team's treatment goals.
- Continually monitors patient/family response to plan of care, and revises the care plan as indicated.
- Provides patient self-management support with a focus on empowering the patient/family to build capacity for self-care; providing resources and education as necessary.
- Assists in pre-visit preparations and post-visit follow-up.
- Implements systems of care that facilitate close monitoring of high-risk patients to prevent and/or intervene early during acute exacerbations.
- Coordinates patient care through ongoing collaboration with provider, patient/family, community, and other members of the health care team. Fosters a team approach and includes patient/family as active members of the team. Takes the lead in ensuring the continuity of care which extends beyond the practice boundaries. Serves as liaison to acute care hospitals, specialists, and post-acute care services.
- Provides follow-up with patient/family when patient transitions from one setting to another. Completes timely post-hospital follow-up, including medication reconciliation, PCP or specialist follow-up, teaching, and problem solving barriers.
- Performs medication management, including reconciling discharge medications with ongoing medication regimens and develops a patient-directed self-management strategy for compliance.
- Refers patients to a variety of other specialty medical, mental health, substance abuse and community services; track and manages patient referral and follow-up.
- Maintains an updated list of community resources to refer patients to.
- Maintains required documentation for all care management activities in electronic health record; ensures chart is up to date with information on specialist consults, hospitalizations, and ER visits.

- Conducts follow-up phone calls to patients to find out if they are meeting their goals and how they are managing their health issues; celebrates successes and provide suggestions about how to overcome barriers.
- Prepares/assists with ongoing quality improvement activities and facilitates development and ongoing activities for consumer involvement.
- May make home visits as needed and approved by supervisor.
- Other duties as assigned

DISEASE PREVENTION ACTIVITIES

- Oversees efforts and staff (e.g., medical assistants or other staff) responsible for coordination of prevention activities and completion of age-appropriate health screenings.
- Executes a strategy for planned visits, including incorporation of appropriate health prevention and screening activities.
- Using data systems, monitors gaps in care and oversees scheduling of patient appointments for needed tests and services.
- Establishes processes for documenting preventive care and services performed elsewhere (e.g., colonoscopy, mammogram).

EDUCATION/TRAINING

Registered Nurse. Bachelor of Science in Nursing or Masters-level training a plus.
Licensure as a Registered Nurse in the State.

SKILLS AND ABILITIES

- Demonstrates customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, patients, and families with diverse opinions, values, and religious and cultural ideals.
- Demonstrates ability to work autonomously and be directly accountable for practice.
- Demonstrates ability to function effectively in a fluid, dynamic, and rapidly changing environment.
- Demonstrates leadership qualities including time management, verbal and written communication skills, listening skills, problem solving, critical thinking, analysis skills and decision-making, priority setting, work delegation, and work organization.
- Demonstrates ability to develop positive, longitudinal relationships and set appropriate boundaries with patients/families.
- Demonstrates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills.
- Proficient in Microsoft Office.
- Previous work with electronic health records (ER); knowledge of current ER a plus
- Demonstrates respect and maintains confidentiality
- Knowledge of chronic conditions, evidence based guidelines, prevention, wellness, health risk assessment, and patient education and ability to manage complex clinical issues utilizing assessment skills and protocols.

PREFERRED QUALIFICATIONS:

- Experience in a community health center or community health program.
- Care management experience and knowledge of the Chronic Care Model.
- Experience in continuous quality improvement.
- Completion of self-management support training, including motivational interviewing.
- Bilingual.