Detailed Job Description

Job title: Nurse Practitioner
Reporting to: Manager, Care Management Clinical Operations
Department: Care Management
Hours: Full time 40 hours per week
Performance Review period: Annual
Revision Date: 11/9/2015

Purpose of the position

The Nurse Practitioner (NP) supports the high intensity care management model by supporting the primary care physician network in the delivery of healthcare services to vulnerable older adults who are at risk for geriatric complications and functional decline. In collaboration with the physician, MSW, and interdisciplinary team, the NP develops and implements an individualized care plan designed to promote maximum functioning, quality of life, and improved clinical outcomes. This position provides service in primary care practices and individual patient homes.

Responsibilities & duties

- Perform in-home geriatric comprehensive assessment partnered with the care team's MSW. The NP is responsible to obtain medical history, geriatric review of systems, perform physical exam, functional assessment, and conduct preventative screening procedures to identify potential health risks.
- Perform annual wellness and health history and diagnosis capture appropriate for age and history when clinically indicated.
- Integrate assessment findings into a individualized care plan supporting evidenced based protocols in collaboration with the primary care physician, patient, and interdisciplinary care team.
- Implement, monitor for effectiveness, and modify the care plan according to the patient's goals and medical condition. The NP will order and prescribe pharmacologic therapies, diagnostics tests and services, and make referrals to physicians, other healthcare professionals and agencies within the scope of the primary care physician – NP collaborative agreement.
- Provide patient/caregiver education on management of chronic conditions. Enhance the patient's self-efficacy to prevent progression or exacerbation of chronic illness and support the patient's goals of care.
- Establish and support the patient's self- management goals
- Monitor high risk patients following hospital and sub-acute discharges to ensure timely follow-up with primary care and prevent readmissions.
- Facilitate discussions with the patient and caregiver regarding advance directives and end of life care.
- Align resources with the patient including referrals to other disciplines of the care management team, home care, community resources, and other healthcare providers.
- Maintain timely and complete documentation and billing of all care management encounters.
- Work with the practice and physician organization to continuously evaluate processes and develop improvements to advance the care management program.
- Serve as a positive ambassador for United Physicians in the practices, and support initiatives leading to practice transformation.

- Adhere to the scope of practice for Advanced Practice Registered Nurses per state regulatory guidelines.
- Evaluate patients for needed health services (HEDIS metrics) assist in closing “gaps” for screening and other quality measures (preventative and condition specific)
- Respect confidentiality of all persons and follows state, federal and organization policies and procedures.
- Effectively participate in various internal committees and performs other duties as requested by management.
- Miscellaneous duties and projects as assigned.

Qualifications

- Graduate from a program accredited by the National League for Nursing Accrediting Commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE)
- Master’s or doctoral education concentrating in geriatric/gerontology area of advanced nursing practice
- Current unrestricted registered nurse and nurse practitioner license
- Certified by American Nurses Credentialing Center (ANCC) or American Academy of Nurse Practitioners (AANP)
- Basic CPR Certification
- 1-2 years’ experience with geriatric population preferred
- Current unrestricted state of MI driver’s license and ability to drive to multiple locations
- United Physician’s health screening and vaccination requirements

Performance Skills

- Ability to work independently and rapidly develop productive and collaborative relationships with representatives from other healthcare providers
- Knowledge of principles and case management guidelines in the assigned program arena.
- Recognize and address the unique culture, language, health literacy and age appropriate care of diverse patients and caregivers.
- Advanced patient interviewing and assessment skills
- Exceptional interpersonal and communication skills
- Excellent problem solving, analytical, and decision making skills.
- Current knowledge of standards of care and clinical guidelines for patients with chronic illness.
- Effective collaboration within a multi-disciplinary team
- Ability to work autonomously, maintain work schedule at multiple sites, prioritize, and maintain productivity through proactive case finding and referrals.
- Working knowledge of insurance and regulatory guidelines for practice
- Knowledge of HEDIS or NCQA quality measures
- Proficient in computer applications related to work including Microsoft Office Suite (MS Word and Excel), electronic medical records and patient registries

Disclaimer

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not construed as an exhaustive list of all responsibilities, duties and skills required of personnel so classified. All personnel may be required to perform duties outside of their normal responsibilities from time to time, as needed. All personnel may be required to perform duties outside of their normal responsibilities from time to time, as needed.