Registered Nurse Care Manager Job Description

Job title: **Adult RN Care Manager**
Reporting to: **Manager, Clinical Staff Operations**
Department: **Care Management**
Performance Review period: **Annual**

PURPOSE OF THE POSITION

The Adult RN Care Manager supports the Primary Care Physician network by providing service to patients with chronic conditions who are at risk for disease progression, complications, cognitive and functional decline. In collaboration with the physician and interdisciplinary team, the RN Care Manager develops and implements an individualized care plan designed to promote the patient, family/caregiver's understanding, and management of their condition, optimize quality of life, and improve clinical outcomes. This position provides service in the primary care practices, telephonic outreach, telemedicine, and individual patient homes.

Responsibilities & duties

- Actively seeks to engage moderate and high-risk patients in the care management program through proactive telephonic outreach, telemedicine, practice, and home-based encounters.
- Conduct comprehensive assessments (in-home, in primary care practice, telemedicine or telephonic encounter) to identify the patient's needs and goals, health behaviors, functional and/or cognitive impairment, psychosocial issues, environment, and areas of risk that may impact the patient's adherence to the treatment plan.
- In collaboration with the interdisciplinary care team, develop an individualized care plan and intervention strategies to meet the patients' needs and focused on improved clinical outcomes and patient satisfaction. The RN Care Manager will monitor the care plan for effectiveness, review with the primary care physician, and modify as needed to optimize the patient's progress and well-being.
- Establish and support the patient's self-management goals.
- Provides education on management of chronic conditions and enhances the patient's self-efficacy to prevent progression or exacerbation of chronic illness and promote healthy behavior change.
- Coordinate care transitions and monitoring of 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 palliative care.
- Align resources with the patient including referrals to other disciplines of the care management team, home care, community resources, and other healthcare providers.
- Actively participate in Care Management Department monthly meetings and multi-disciplinary care team conferences, huddles, and discipline specific team meetings.
- Maintain timely and complete medical record 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 Registered Nurses per state regulatory guidelines.
- Respect confidentiality of all persons and follow state, federal and organization policies, and procedures.
- Effectively participate in various internal committees and performs other duties as requested by management.
- Evaluate patients for needed services (HEDIS metrics) assist in closing “gaps” for needed health services (preventative and condition specific)
- Miscellaneous duties and projects as assigned.
- Maintain continuing education requirements for Complex Care Management as required for role.
- Maintain Healthcare Basic Life Support as required for role.

Qualifications

- Graduate of accredited school of nursing, BSN
- Valid unrestricted State of MI Nursing License required.
- Valid unrestricted State of MI Driver’s License and ability to drive to multiple locations.
- Certification in Case Management and /or Chronic Care Professional preferred
- Minimum two years of case management, home health care, hospice, or related experience in adult and pediatric populations
- Basic Healthcare BLS certification
- 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 skill
- 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.