JOB DESCRIPTION

Position Title: **RN Transitional Care Navigator**
Reporting to: **Director, Clinical Services**
Department: **Care Management**
Performance Review period: **Annual**

Position Summary:

The RN Transitional Care Manager is responsible for managing the high-risk complex Senior Care population successful transitions from an inpatient admission or emergency department event to home with coordination of care, necessary interventions, and ensure timely post discharge Primary Care Physician (PCP) follow up. They are responsible for managing the post discharge care of high-risk senior Medicare Advantage patients who are at risk of readmissions, frequent inpatient admissions, emergency department visits, and poor health outcomes. The RN Transitional Care Manager monitors daily ADT report to identify patients in need of post discharge follow up and facilitates care with the assigned care team, Mobile Medic for post discharge visit, or the Primary Care office for an office appointment.

Responsibilities & duties

- Identifies inpatient, skilled nursing facility, and emergency department discharged patients on the daily ADT report.
- Validates program eligibility, insurance, physician, and practice.
- Conducts outreach to patient/family and assesses patient needs, understanding of medication and discharge instructions, support.
- Facilitates a post discharge visit from United Physicians mobile medic partner, Medstar, to be completed within 24-48hrs of discharge.
- Communicates information to care management staff and the patient's primary care physician. Facilitates a follow up office appointment with the PCP within appropriate timeframe based on acuity post discharge.
- Analyzes and tracks inpatient admissions, readmissions, emergency visits, and patient outcomes to address process improvement.
- Works collaboratively with physicians, care management team, Senior Care Program Manager, and care management leadership to identify any barriers affecting timely patient care.
- 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.
- Advocates for patients and families across the care continuum.
- Provide regular feedback and education to the Care Management and Physician leadership.
- 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.
- 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, or an advanced practice RN program
- 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.