Job Description

Position Title: RN Case Manager

Position Summary: The RN Case Manager is a practice-based RN who directly supports CSHC's highest risk patients. In collaboration with other members of the healthcare team, the RN Care Manager is responsible for organizing, coordinating, and providing care coordination and care management services to patients within the practice who are most at risk for health deterioration, sentinel events, and/or poor outcomes.

Primary Responsibilities:

Case Management Systems:

1. Manage CSHC high-risk patient registry
    a. Oversee systems for identifying high risk patients through EMR, referrals, registries from health insurance payers
    b. Ensure validity of registry; collaborate with Information Technology on registry functionality.
2. Develop a tracking system for patient care coordination and care management across the continuum, including care transitions, Primary and Specialty care.
3. Act as clinical liaison for Payer Based Care Management programs, including the Senior Care Options program and the One Care ("Dual Diagnosis") Program.

Direct Patient Care:

1. Conduct comprehensive assessment of patients' physical, mental, and psychosocial needs
2. Develop care plans to prevent disease exacerbation, improve outcomes, increase patient engagement in self-care, decrease risk status, and minimize hospital and ED utilization
3. Utilize behavioral strategies help patients adopt healthy behaviors and improve self-care in chronic disease management. Promote self-management goals.
4. Assist patients in navigating the health care system. Coordinate Specialty care, follow-up on test results and other care coordination needs.
5. Follow-up with patients within 24 hours on inpatient discharge & within 48 hours of ED visit notification
6. Partner with external case management programs to coordinate care
7. Ongoing evaluation and documentation of patient progress/ risk status Document in EMR; communicate with care teams
8. Document in EMR

Patient-Center Medical Home:

1. Pro-actively support PCMH initiatives related to care coordination
2. Pro-active member of care teams in team-based care initiatives
3. Partner with PCMH staff to develop integrated care management programs

Qualifications:

1. RN or greater clinical license
2. 3-5 years of experience
3. Experience in case management, disease management, home health care nursing, hospital nursing or intensive outpatient education and self-management support
4. Skills
    a. Comprehensive nursing assessment, problem identification and care plan development
    b. Disease management
    c. Screening for developmental issues, depression, other psychological conditions, and frailty.
    d. Clinical system design and development
    e. Project management
    f. Behavioral strategies including motivational interviewing and self-management support
    g. Relationship building with patients, staff, and providers
    h. Documentation in an EMR
    i. Computer skills including excel, word, and PowerPoint
5. Must possess interest in Patient Centered Medical Home transformation.
6. Organized and resourceful self-starter; strong ability to work in a team
7. Excellent written, oral and interpersonal communication skills

Working conditions: office-based with the ability to do home visits on a limited basis

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