RN Care Manager, Bridges Health Partners
Job Description

Job Summary

The Registered Nurse ("RN") Care Manager is a key member of the Bridges Health Partners ("Bridges") clinically integrated network ("CIN"), Medicare accountable care organization ("ACO"), and population health services organization ('PHSO") care management team and reports to the Bridges Health Partners Director of Care Management or designee. The RN Care Manager ("CM") is responsible for coordinating and managing care throughout the care continuum. As a part of the care management team, the CM will provide direct support to physician practices and identified complex patients or patients with targeted conditions who need additional care management, coaching, education, supervision, and/or support. The CM focuses on prevention and wellness services and treatment of chronic and acute episodes of care for the high-risk patient populations. The CM supports providers through identification of gaps in overall care delivery. The CM is a crucial member of the healthcare team, and is accountable for improving patient care through effective utilization and monitoring of healthcare resources. To that end, the CM operates in an outcomes-driven environment, utilizing appropriate resources and tools to monitor clinical, financial, and operational outcomes. The CM contributes to the development and revision of the care delivery model in response to internal and external factors, and participates in continuous improvement activities in all aspects of patient care.

Job Responsibilities

Across the care continuum, the CM is responsible for caring for and managing high-risk patients who are identified through various means. The CM's responsibilities include biopsychosocial management of chronic disease; supporting physician care plans for complex medical conditions. The CM is responsible for the following across the care continuum:

- **PATIENT CARE**: Provide excellent patient care.
  - Conducts an in-depth assessment of patients to determine what needs to be done to help the patient optimize his or her healthcare status. This includes monitoring medication compliance and adherence, teaching self-management skills, coaching, and determining the needed assistance with activities of daily living or socialization.
  - Develops a care plan with the patient as a partner.
  - Implements the plan and develops the tools that help the patient follow it. Implementation strategies will vary from patient to patient.

- Provides timely follow-up to the care plan, including communicating with the patient and when necessary the healthcare team, regarding their compliance, recommended interventions, referrals, and disease management activities. Follow-up can include face-to-face appointments and phone calls. All follow-up activities and results must be documented using appropriate tools.
- Monitors patient's outcomes related to adherence to their plan of care and their overall healthcare status.

- **COLLABORATION**: Works collaboratively with physicians, patients, families, nurses, social workers, other practitioners, caregivers, and community resources and agencies.
  - Conducts initial and period assessments of the care managed population. Prioritizes patients according to intensity, need, and required follow-up.
  - Contributes to the development of a goal-oriented, plan of care through an interdisciplinary team process that is prioritized and based on determined medical diagnosis, patient needs, and expected patient outcomes.
  - Interacts with patients and physicians to explore the most appropriate setting to meet patient needs.
  - Collaborates with physicians and care team members to support the assessment of the need for acute care hospitalization or other provider services.
  - Participates in the development, implementation, evaluation, and ongoing revision of initiatives to improve quality, continuity, and cost-effectiveness.
  - Works collaboratively with other providers and services to define and study areas of inefficiency and participates in process improvement projects.
  - Fosters positive internal and external customer relations.
  - Promotes patient engagement and self-management, and empowers patients, families, and caregivers to achieve maximum levels of wellness and independence.
  - Assists patients in identifying and/or developing their support systems, and encourages its utilization.

- **COMMUNICATION**: Communicates timely, relevant, and accurate information to all parties involved in a patient's care.
  - Communicates patient needs related to advancing the medical treatment plan and/or discharge plan to appropriate professionals and follows up.

- Communicates continually with patients and families, physicians, and caregivers, to facilitate coordination of clinical activities and to enhance the effect of a seamless transition from one level of care to another across the continuum, including facilitating and participating in patient care conferences.
- Communicates with patients and families to ensure understanding of clinical guidelines and to arrange referrals, as needed.
- Communicates with and educates patients and families on disease processes.
- Provides clear and thorough documentation of patient and provider activities based on established standards.
- Has a working knowledge of care management support systems, other databases and platforms used across various care settings, and the overarching health information technology ("HIT") infrastructure used to support information exchange.
- Utilizes available HIT tools to effectively input, manage, and report patient, quality, and clinical data.

- **FACILITATION**: Facilitates the progression of care by advancing the care plan to achieve desired outcomes.
  - Ensures that all activities to facilitate and coordinate the plan are being implemented and that the plan is continuously modified based on the patient's changing needs.
- **COORDINATION**: Integrates the work of the healthcare team by coordinating resources and services necessary to accomplish agreed-upon goals.
  - Comprehensively assesses patients' goals as well as their biophysical, psychosocial, environmental, economic/financial, and transitional care needs.
  - Procures services and resources for identified patients and families, serving as an advocate to promote achievement of agreed-upon goals.
- **ADVOCACY**: Advocates on behalf of patients and caregivers for service access or creation, and for the protection of the patient's health, safety, and rights.
- **RESOURCE MANAGEMENT**: Assures prudent utilization of all resources (fiscal, human, environmental, equipment, and services) by evaluating the options available and balancing cost and quality to assure the optimal clinical and financial outcomes.
  - Assesses the appropriateness and timeliness of level of care, diagnostic testing and clinical procedures, quality and clinical risk issues, and documentation completeness.

- **ACCOUNTABILITY**: Accepts responsibility and accountability for achievement of optimal outcomes within scope of practice.
  - Seeks out information and resources and uses creative problem solving for complex transition planning, quality of care, and utilization issues. Explores new resources when the opportunities for the patient are absent or in short supply.
  - Continually evaluates case management services and client outcomes.
- **PROFESSIONALISM**: Acquires and maintains knowledge and competence related to the expectations of the position and practices within scope.
  - Studies information available to remain informed of reimbursement modalities, community resources, review systems, and clinical and legal issues that affect patients and providers of care
  - Serves as a resource and provides education to patients, physicians, and professional staff on levels of care, quality of care issues, and regulatory concerns.
  - Provides orientation and mentoring to new staff.
  - Works in accordance with applicable state and federal laws and within the unique requirements of reimbursement systems.
  - Is knowledgeable about, and acts in accordance with laws and procedures regarding patient confidentiality and release of information, Americans with Disabilities Act ("ADA"), other laws protecting rights, and worker's compensation laws when applicable to the CM's practice.

Essential Skills

- Excellent critical thinking skills; ability to work in fast pace team environment; ability to prioritize and multi-task; ability to effectively communicate and collaborate with physicians and ancillary staff.
- Exceptional communication skills to enable communication and collaboration with physician, patients, families, and ancillary staff.
- Must be able to effectively communicate with elderly and chronically ill patients and families.
- Good working knowledge of benefit plans; Commercial, Employee, Medicare, Medicare Advantage, Medicaid, etc.
- Experience with and knowledge about PQRS, HEDIS, Meaningful Use, Patient-Centered Medical Home, or other quality metrics and tracking.

- Knowledgeable about population health management and clinical integration principles and processes.
- Experience with relevant systems (e.g., electronic medical records, disease registries). Strong technical skills preferred.

Basic Qualifications and Experience

- Qualified candidates will have a Bachelor's degree from a four-year college and/or a professional certification requiring formal education beyond a two-year college, graduation from an accredited School of Nursing.
- Licensed Registered Nurse in the State of Pennsylvania.
- Certified Case Manager (CCM) certificate preferred.
- Minimum 3-5 years of acute nursing experience in critical care and case management background. 3-5 years of direct ambulatory care experience (primary care preferred, but other specialties acceptable) preferred.
- Experience with managed care organizations, integrated delivery systems, physician-hospital organizations, or physician organizations preferred.
- Bi-lingual or multi-lingual preferred.
- Basic Cardiac Life Support certification.

Organizational Relationships

Reports to: Bridges Health Partners Director of Care Management or designee

Supervises: NA

Supports/Coordinates with: Bridges Health Partners CIN/Medicare ACO provider network and Bridges Health Partners PHSO care management team