Appendix A

DEPARTMENT OF HUMAN RESOURCES

JOB DESCRIPTION

TITLE: Moderate Risk Care Manager

FLSA: Exempt

DEPARTMENT:

LOCATION:

JOB SUMMARY:

Provides care management and care coordination for adult and pediatric patients with mild to moderate illness, under minimal supervision. In partnership with primary care practice leadership team, the Moderate Risk Care Manager leads population management within the team through process improvement workflow redesign, providing assistance with training, and delegating to other members of the team. Collaborates with members of the health care team to empower patients to manage their chronic conditions. Assists patients, who are at risk for developing chronic conditions, to minimize these risks. Serves in an expanded health care role to collaborate with PCP and patients to ensure the delivery of quality, efficient, patient centered, and cost-effective healthcare services. Assesses, plans, implements, monitors, and evaluates delivery of individualized patient care with the goal of optimizing the patient's health status. Provides self-management support and patient education.

Works primarily with moderate risk patients to optimize control of chronic conditions and prevent/minimize long term complications. Manages a caseload of approximately 500 patients; of which 90-100 are actively supported at a time.

MAJOR DUTIES AND RESPONSIBILITIES:

1. Identifies the targeted population within practice site(s), per PCP referral and registry reports.
2. Assesses the healthcare, educational, and psychosocial needs of the patient/family.
3. Collaborates with PCP, patient, and members of the health care team, to assess patient, develop and implement an agreed upon plan.
4. Provides self-management support and empowers the patient to achieve optimal health and independence
5. Implements evidence-based care, chronic disease protocols and guidelines. Utilizes registry to identify patients with chronic conditions, and a gap in clinical care. Utilizes patient list to ensure overdue tests/labs are completed, monitors individual patient progress and population management.
6. Coordinates patient care by linking patients to resources; including community resources.

7. Provides follow up with patient/family when patient transitions from one setting to another. Completes post hospital discharge calls: Medication reconciliation, PCP or specialist follow up appointment, assesses symptoms, teaches warning signs, coordinates care, reviews discharge instructions, and problem-solves barriers.
8. Demonstrates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills.
9. Participates in continuous quality improvement to enhance care management in the office setting.
10. Maintains required documentation for all care management activities.
11. Works with practice and PO/PHO leadership to continuously evaluate processes, identify problems, and propose/develop process improvement strategies to enhance the Patient Centered Medical Home.
12. Reviews the current literature regarding effective engagement and communication strategies, care management strategies, and behavior change strategies and incorporates into clinical practice.

SKILLS AND ABILITIES:

1. Demonstrates customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, patients, and families with diverse opinions, values, and religious and cultural ideals.
2. Understands chronic disease management strategies and is able to implement appropriate protocols and guidelines.
3. Demonstrates ability to work autonomously and be directly accountable for practice.
4. Demonstrates ability to influence and negotiate individual and group decision-making.
5. Demonstrates ability to function effectively in a fluid, dynamic, and rapidly changing environment.
6. Demonstrates leadership qualities including time management, verbal and written communication skills, listening skills, problem solving and decision-making, priority setting, work delegation and work organization.

Required Qualifications:

- Current Michigan Registered Nurse, Nurse Practitioner, Physician Assistant, Licensed Practical Nurse, Master of Social Work, Registered Dietician, or Pharmacist License
- Two years of experience with adult medicine and pediatric patients in primary care/ambulatory care, home health agency, skilled nursing facility, or hospital medical-surgical, within the past five years
- Knowledge of chronic conditions, evidence-based guidelines, prevention, wellness, health risk assessment, and patient education
- Excellent assessment and triage skills
- Demonstrates excellent communication-both verbal and written

- Excellent interpersonal and facilitation skills
- Ability to affect change, work as a productive and effective team member, to be flexible, and adapt to needs/priorities
- Time management, priority setting, work delegation and work organization
- General computer knowledge and capability to use computers

Preferred Qualifications:

Bachelor's degree or higher, in clinical field
Care management experience
Experience as participant in continuous quality improvement
Completion of self-management support training