Appendix B

DEPARTMENT OF HUMAN RESOURCES

JOB DESCRIPTION

TITLE: Complex Care Manager

FLSA: Exempt

DEPARTMENT:

LOCATION:

JOB SUMMARY:

Provides care management and care coordination for adult and pediatric patients with complex illness, in the primary care setting, under minimal supervision. In partnership with the primary care practice leadership team, the Complex Care Manager leads care management within the team through process improvement, workflow redesign, providing assistance with training, and delegating to other members of the team. Serves in an expanded health care role to collaborate with specialists, members of the health care team, and patients/families to ensure the delivery of quality, efficient, and cost-effective health care services. Assesses plans, implements, coordinates, monitors and evaluates all options and services with the goal of optimizing the patient's health status. Integrates evidence-based clinical guidelines, preventive guidelines, and protocols, in the development of individualized care plans that are patient-centric, promoting quality and efficiency in the delivery of health care.

Manages a caseload of approximately 150 complex patients; of which 30 to 50 patients are actively followed by complex care manager. Provides targeted interventions to avoid hospitalization and emergency room visits. Coordinates care across settings and helps patient/families understand health care options. Infrequent, but possibility of home visits.

MAJOR DUTIES AND RESPONSIBILITIES:

1. Identifies the targeted high risk population within practice site(s) per PCP referral, risk stratification, and patient lists. Includes patients with repeated social and/or health crises.
2. Assesses over time the health care, educational, and psychosocial needs of the patient/family. Uses standardized assessment tools such as depression screening, functionality, and health risk assessment.
3. Collaborates with PCP, patient, and members of the health care team, including continuum of care settings and community. Responsible for developing a comprehensive individualized plan of care and targeted interventions. Continually monitors patient/family response to plan of care, and revises the care plan as indicated.
4. Provides patient self-management support with a focus on empowering the patient/family to build capacity for self- care.
5. Implements systems of care that facilitate close monitoring of high-risk patients to prevent and/or intervene early during acute exacerbations.

6. Implements clinical interventions and protocols based on risk stratification and evidence-based clinical guidelines.
7. Coordinates patient care through ongoing collaboration with PCP, patient/family, community, and other members of the health care team. Fosters a team approach and includes patient/family as active members of the team. Takes the lead in ensuring the continuity of care which extends beyond the practice boundaries. Serves as liaison to acute care hospitals, specialists, and post-acute care services.
8. Provides follow-up with patient/family when patient transitions from one setting to another. Completes timely post-hospital follow-up: Medication reconciliation, PCP or specialist follow-up appointment, assess symptoms, teach warning signs, review discharge instructions, coordination of care, and problem solve barriers.
9. Demonstrates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills.
10. Maintains required documentation for all care management activities.
11. Works with practice and PO/PHO leadership to continuously evaluate process, identify problems, and propose/develop process improvement strategies to enhance care management and Patient Centered Medical Home delivery of care model.
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. Demonstrates ability to work autonomously and be directly accountable for practice.
3. Demonstrates ability to influence and negotiate individual and group decision-making.
4. Demonstrates ability to function effectively in a fluid, dynamic, and rapidly changing environment.
5. Demonstrates leadership qualities including time management, verbal and written communication skills, listening skills, problem solving, critical thinking, analysis skills and decision-making, priority setting, work delegation, and work organization.
6. Demonstrates ability to develop positive, longitudinal relationships and set appropriate boundaries with patients/families.

Required Qualifications:

- Current Michigan Registered Nurse, Nurse Practitioner, Physician Assistant or Master of Social Work License

- Three years of experience with adult medicine and pediatric patients in primary care/ambulatory care, home health agency, skilled nursing facility, or hospital medical-surgical setting, within the past five years
- Knowledge of chronic conditions, evidence based guidelines, prevention, wellness, health risk assessment, and patient education
- Critical thinking skills and ability to analyze complex data sets. Ability to manage complex clinical issues utilizing assessment skills and protocols
- Excellent assessment and triage skills. Ability to implement evidence base interventions and protocols for chronic conditions
- Demonstrates excellent communication--both verbal and written
- Excellent interpersonal and facilitation skills
- Ability to affect change, work as a productive and effective team member, and adapt to changing needs/priorities
- Time management, priority setting, work delegation and work organization.
- General computer knowledge and capability to use computer

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