TITLE: Care Manager – Full-time
REPORTS TO: Director of Care Management, Suffolk Care Collaborative
FLSA: Exempt
DEPARTMENT: Population Health Management

JOB SUMMARY:
Under the general supervision of the Director of Care Management, the Care Manager serves in an expanded nursing role to collaborate with Medicaid patients as a part of the Delivery System Redesign Incentive Payment Program (DSRIP). The Care Manager will also collaborate with the patient's support systems and their Primary Care Providers to provide a model of care that ensures the delivery of quality, efficient, and cost-effective healthcare services. The Care Manager is responsible for assessing care plans and implementing, coordinating, monitoring and evaluating all options and services with the goal of optimizing the member's health status. This position will integrate evidence-based clinical guidelines, preventive guidelines, protocols, and other metrics in the development of treatment plans that are patient-centric, promoting quality and efficiency in the delivery of healthcare. The applicant will identify and enroll patients with complex and chronic health conditions and/or refer to other services/programs per policies. The applicant will support transitions of care as assigned and/or health and wellness programs for the assigned Medicaid population.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

- **45%** Fosters strong professional relationships with members of a patient's Medical Neighborhood to facilitate the coordination of referrals and ensure quality services/products are received in the most cost effective manner. Collaborates with patient clinical site to include providers and other team members in an effort identify the targeted population within his/her practice site and risk stratifies all members to prioritize needs and direct interventions. Works in partnership with primary care providers to enhance evidence-based clinical guideline adherence and promote best practice by initiating/adjusting therapies as directed by the practitioner and providing appropriate follow-up and monitoring as needed. Designs an individualized plan of care with the patient and fosters a team approach by working collaboratively with the patient, their support system, primary care provider, and other members of the health care team to ensure coordination of services.

  Note: Some Care Managers may be assigned Transitions of Care patients and will also be responsible to ensure a safe and effective transition from the inpatient setting to the community (e.g. home, rehabilitation, residential treatment services or SNF)

- **25%** Works with leadership to continuously evaluate process, identify problems, and propose process improvement strategies to enhance the assigned Primary Care Practices or Medical Home delivery of care model. Utilizes appropriate conflict resolution, negotiation, and collaboration skills in facilitating the Patient/family throughout the health care continuum.

- **20%** Continuously evaluates laboratory results, diagnostic tests, utilization patterns and other metrics to monitor quality and efficiency results for assigned population. Maintains required documentation for all care management activities. Collects required data and utilizes this data to adjust the treatment plan when indicated. Manages utilization and practice metrics to further refine the delivery of care model to

maximize clinical, quality, and fiscal outcomes.

- **5%** Implements and delivers clinical interventions based on risk stratification and evidence-based clinical guidelines utilizing various modes of delivery to include telephone communication, primary care site, or patient home visits.

- **5%** Develops and implements systems of care that facilitate close monitoring of high-risk members to prevent and/or intervene early during acute exacerbations.

NON-ESSENTIAL DUTIES AND RESPONSIBILITIES:

- Coordinates appropriate laboratory and diagnostic testing.
- Assesses the healthcare, educational and psychosocial needs of the patients and family.
- Reviews the current literature regarding effective engagement and communication strategies, care management strategies and behavior change strategies and incorporates into clinical practice.
- Adheres to SCC's administrative standards regarding member confidentiality.
- Participates in reasonable self-education efforts to understand the New York State DSRIP program
- Performs duties that may be in an embedded or remote environment.
- Performs duties as required or assigned by emergency or other operational reasons for which the employee is qualified to perform.

SKILLS AND ABILITIES:

- 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.
- Reveals ability to work autonomously and be directly accountable for results.
- Exhibits the capability to influence and negotiate individual and group decision-making.
- Incorporates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills into care management practice.
- Possess the skill to function effectively in a fluid, dynamic, and rapidly changing environment
- Displays the proven ability to positively influence behavior and outcomes.
- Protects confidentiality of data and intellectual property; insures compliance with national health information projection guidelines.
- Demonstrates flexibility and ability to adapt to evolving requirements of DSRIP program
- Serves as a role model for education and professional nursing practice
- Demonstrates proficient computer knowledge with proven keyboarding skills.

EDUCATION AND/OR EXPERIENCE:

- Requires Registered Nurse with current license. Certification in Care Management required within two years of hire and maintained throughout employment.
- BSN or comparable Bachelor's degree required.
- Minimum of three years recent experience to match responsibilities above such as acute care, home health or skilled nursing facility with a demonstrated working knowledge of Medicare/PPS/MDS guidelines required. Experience as a Care Manager PCMH preferred.
- Experience with IT solutions such as electronic health record, learning management or disease/care management systems a plus.
- Critical thinking skills and ability to analyze complex data sets required. General computer knowledge and capability to use computers required.

WORKING CONDITIONS/PHYSICAL DEMANDS:

- Work is typically performed in an office/Medical Practice with telecommuting or remote environment.
- Office/Medical Practice will occur in Suffolk County
- Requires the ability to travel as needed for training, client/company meetings, and manage fluctuating work hours.
- Valid driver's license required.

COMPENSATION:

- Salary is competitive and benefits are offered to full-time employees

The specific statements shown in each section of this description are not intended to be all-inclusive. They represent typical elements considered necessary to successfully perform the job.