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DIVISION SCOPE OF SERVICE

Division: CONTINENTAL
Classification: CARE MANAGER
Applicant Name:

Care Manager:
The Care Manager must have equivalent qualifications, competence and function in the same role as employed individuals performing the same or similar services at the facility, as defined by facility job description.

Definition of Care or Service:
The Care Manager role is to help the patients of the primary care residency practices receive the appropriate care in the appropriate setting, and to help them become active in the management of their health so that they avoid unnecessary illness and improve their health. The Care Manager must support the continuity of medical care by becoming an expert on the medical neighborhood, i.e., the resources available to patients and how to assist patients in accessing those resources.
The Care Manager must at all times work collaboratively with all members of the primary care residency faculty and staff, including those employed by HealthONE, and assist in the implementation of the decision of the care team.
The Scope of Service may include:

- Must effectively communicate with primary care providers, referral providers, community organizations, the patient, the patient's caregivers, and family to assist with the receipt of needed services, ensure communication across the care team, reinforce adherence with the care plan and facilitate self-management skills
- Able to track the status of patients with respect to important clinical variables and report changes in health status of groups of patients with similar diagnoses in order to discover best practice and advance the objectives of population health management (PHM) and incorporate these best practices into the curriculum for residents
- Works collaboratively in pre-visit preparation, working with the care team during and after the patient visit
- Develop relationships with specialist providers in the medical neighborhood and community payor sources, and act as practice liaison to coordinate care, information, etc., with payors.
- Assist with processing prior authorizations of medications (in collaboration with the practice pharmacist), home health care, imaging, etc., as needed.
- Act as liaison for our practice to community agencies that co-manage high-risk patients.
- Assist and guide patients in navigating the medical neighborhood (payor sources and specialists) to ensure high quality care and positive outcomes.
- Provide referral tracking, coordination, and follow-up, and coordinate with facilities and managed care programs for medical transitions.
- Participate with Program and Clinic leadership in designing and developing the processes and procedures for working with managed care plans and insurance plans on collection and dissemination of quality and outcome data.
- Facilitate complex case management, chronic disease management, medication compliance, treatment plan, and follow-up visits in collaboration with other team members:
- Manage patient educational information;

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- Assist with patient transition from inpatient to outpatient care settings in collaboration with hospital staff, pharmacist, and/or social worker;
- Assist with management of chronic disease patients and their care plans;
- As patient needs are identified, reach out to patients and/or their families to follow up on issues such as needed visits, completion of tests and referrals, progress in meeting self-management goals, connection to community resources, and help with transition of care; and
- Participate in patient visits as requested by providers.
- Complete and document home or community-based visits, in coordination with other team members, as needed.
- Implement patient registries and reporting relevant to referrals and care transitions.
- Document interventions in clinical record.
- Participate in the residency practice's quality improvement projects.
- Assist faculty and staff in the development of plans to reduce preventable hospital admissions, re-admissions, emergency department visits, executive therapies, unneeded DME, etc.
- Educate residents on topics relevant to skill set that may include nutrition, diabetes wellness, smoking cessation, and basic health behavior change.
- Project management for NCQA PCMH Elements to Referral Process and Care Transitions.
- Ownership and oversight of PCMH Elements 5B and 5C: Referral tracking/coordination and follow-up and coordination with facilities and managed care transitions.
- Attend practice meetings, webinars, and learning collaboratives as required.
- Design an evaluation framework for assessing impact of Care Manager's work on patient population health improvement and other program objectives.
- Comply with all HealthONE policies and develop and nurture a strong working relationship with the HealthONE Clinic leadership and staff to promote collaboration, alignment of objectives, priorities, and work plan between education and clinical enterprises.
- Demonstrates Clinical and Service excellence behaviors to include code of HCA Healthcare conduct core fundamentals in daily interactions with patients, families, co-workers and physicians.

Setting(s):

- Healthcare facilities including but not limited to hospitals
- Patient care areas, all settings

Supervision: Residency Program and Medical Directors

Evaluator: Residency Program and Medical Directors

Tier Level: 2

eSAF Access Required: YES

Qualifications:

- **One** of the below is needed:
  - Bachelor Degree or higher
  - Experience which includes a background in nursing, social work, nutrition, psychology, or exercise physiology

NOTE: Where education may not be defined in qualifications area of the Scope, HCA Healthcare requires the highest level of education completed (not training or courses) confirmed on your background check.

State Requirements:

- N/A

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Experience:

- A minimum of two years of experience in a healthcare setting is required.
- Experience working with Home Care, Medicaid populations, and related social/economic issues.

Preferred Experience:

- Experience working with an electronic medical record system.
- Training in motivational interviewing and behavior change is a plus.

Competencies:

The Care Manager demonstrates:

- Accurate patient information review and evaluation
  - Uses at least two ways to identify patients before meeting with the patient and family unit
  - Accesses the patient medical record appropriately
  - Documents in the medical record according to the facility standard / policy
- Appropriate case management activities
  - Engages community resources in accordance with current laws, regulations and policies surrounding medical and behavioral healthcare
  - Engages patient and family to gather, evaluate, analyze and integrate pertinent information to complete assessment and form conclusions
  - Gathers and reviews information with attention to individual, family, and community resources
  - Respects patient and family preferences
  - Implements interventions appropriate for identified patient needs
- Knowledge of HIPAA rules and regulations
- Excellent written and verbal communication skills
- Excellent interpersonal and organizational skills with the ability to prioritize multitask and follow up.
- Intermediate skills in using Microsoft Office products, such as Excel, Word, and Access.
- Skill sets that are useful in helping patients optimize their ability to make healthy lifestyle choices and otherwise engage in the management of their health within a Patient Centered Medical Home (PCMH) practice setting.
- Infection Prevention
  - Practices consistent hand hygiene
  - Uses personal protective equipment (PPE)
  - Required immunizations per Division requirements
  - Complies with Isolation precautions
  - Maintains sterile field

References:

Case Management Society of America (CMSA). (2008-2011). Retrieved from http://www.cmsa.org/

Job Description for a Care Manager/eHow.com. (1999-2011). Demand Media, Inc. Retrieved from http://www.ehow.com/about_5208008_job-description-case-manager.html

Ocean to Ocean Healthcare (2008-2011) Care Manager Description. Retrieved from http://www.oceantoocean.net/pdfs/A_Website_-_JOB_Case_Manager.pdf

NCQA PCMH elements http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

Commission for Case Manager Certification

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https://ccmcertification.org/get-certified/certification/ccmr-eligibility-glance
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Your signature confirms you will be able to comply with the Qualifications and Competencies listed within this Scope of Service and that you will confirm education via your background check.

Applicant Printed Name: _____

Signature: _____

Date: _____