Title: Care Manager
Program/s: Care Management (RN or Behavioral Health) – Float Position
Reports to: Manager of Care Management
Classification: Individual Contributor
Job description revision number and date: V2.0; 11.7.2022

Organization Summary:
Community Care Cooperative (C3) is a 501(c)(3) non-profit, Accountable Care Organization (ACO) governed by Federally Qualified Health Centers (FQHCs). Our mission is to leverage the collective strengths of FQHCs to improve the health and wellness of the people we serve. We are a fast-growing organization founded in 2016 with 9 health centers and now serving hundreds of thousands of beneficiaries who receive primary care at health centers and independent practices across Massachusetts. We are an innovative organization developing new partnerships and programs to improve the health of members and communities, and to strengthen our health center partners.

Job Summary:
As an integral member of the care management team the RN and/or Behavioral Health (BH) Care Manager (CM) will have the opportunity to make a profound impact on the lives of people living with complex and/ or chronic conditions, many of whom also face multiple barriers in their lives which makes it difficult for them to achieve the self-care required to improve their health and well-being. This position requires flexibility and may vary from day-to-day to meet members where they are.

The Float Pool Position is hybrid though primarily remote and will cover care management vacancies at C3 affiliated FQHC's and affiliated provider groups.

Job Responsibilities:

- Conducts Comprehensive Clinical Assessments
- Assures that medication reconciliation is complete depending on MA state licensure. The RN CM will complete the medication reconciliation and may include a pharmacist and/or primary care Team. BH CM will facilitate medication reconciliation with pharmacist and/or primary care team
- Engages members and care givers in active care planning with a focus on, medical, behavioral, social, member-centered care needs. Coaches and guides member/representative to meet bio/psycho/social care goals.
- Provide care coordination, which may include but is not limited to facilitating care transitions, supporting the completion of referrals, and/or providing or confirming appropriate follow-up
- May be required to meet members while they are inpatient to provide education and support about the discharge process and transition the member into care management
- Assesses the member's knowledge of their medical, behavioral health and/or social conditions and provides education and self-management support based on the member's needs and preferences.
- Connects members with primary care, behavioral health, flexible services, Community Partner, respite, and other community based social services as indicated and appropriate.
- In collaboration with Community Health Workers creates and maintains a comprehensive inventory of local community resources through a web-based application, improving accessibility for members and providers, and linking members with the appropriate support services.

- Participates in the integrated care team meetings and rounds as required
- Maintain accurate, timely documentation in electronic systems including health center EHRs
- Provides coverage for team members who are out of office
- Other duties as assigned

Required Skills:

- 3-5 years of nursing experience, preferably in-home health, ambulatory care, community public health, case/care management, coordinating care across multiple settings and with multiple providers or 2-3 years of Inpatient or Community Social Work experience providing patient-centered outreach, behavioral health services, needs assessment and support
- Demonstrated success in working as part of a multi-disciplinary team including communicating and working with Providers, Pharmacists, Nurses, Community Health Workers, and other health care teams
- Ability to flexibly utilize clinical expertise to solve complex problems
- Experience working with patients with chronic and behavioral health needs
- Must be flexible and adaptable to change
- Demonstrate the ability to work independently
- Must demonstrate excellent interpersonal communication skills

Desired Other Skills:

- Bi-lingual preferred
- Additional qualities that would be a good fit for our team include; Enthusiasm and passion for helping patients, genuine spirit, kind, and empathetic nature, and one who embraces a 'go with the flow' mentality
- Experience using appropriate technology, such as computers, for work-based communication
- Experience and proficiency with Microsoft Office and online record keeping
- Experience within the ACOs member population preferred including Medicare/Medicaid
- Experience working with Federally Qualified Health Centers is strongly preferred
- Experience with anti-racism activities, and/or lived experience with racism is highly preferred

Qualifications:

- Current, active MA Registered Nurse license or Licensed Clinical Social Worker (LCSW or LICSW), or Licensed Mental Health Counselor (LMHC)
- Associate degree in Nursing; Bachelor's Degree in Nursing preferred or master's degree in Psychology, Social Work, or related field
- Case Management Certification (CCM, ANCC RN-BC) preferred though not required

***** In compliance with Covid-19 Infection Control practices per Mass.gov recommendations, we require all employees to be vaccinated consistent with applicable law. *****