Title: RN Care Manager
Program/s: Care Management
Reports to: Manager of Care Management
Classification: Individual Contributor
Job description revision number and date: 1/12/22

Summary:

Community Care Cooperative (C3) is a 501(c)(3) not-for-profit, Accountable Care Organization (ACO) governed by FQHCs. Our mission is to leverage the collective strengths of Federally Qualified Health Centers (FQHC) to improve the health and wellness of the people we serve.

As an integral member of the care management team the Registered Nurse (RN) 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. Outreach methods may vary based on the needs of the organization and may include telephonic or in person in a variety of potential settings such as but not limited to, the *health center, community, home, or an inpatient facility. * This role is currently remote in accordance with Mass DOH Covid prevention guidelines. Upon lifted Covid restriction, it may require health center, medical/BH hospital facility, community, or home-based work.

Responsibilities:

- Conducts Comprehensive Assessments
- Assures that medication reconciliation is complete. The RN CM will complete the medication reconciliation and may include a pharmacist and/or primary care team.
- Engages members and care givers in active care planning with focus on medical, behavioral, social, member-centered care needs. Coaches and guides member/representative to meet bio/psycho/social goals.
- Provide care coordination, which may include but 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 members into care management.
- *Travel throughout assigned area to engage members at their homes or other locations where the member may be located.
- Assesses the member's knowledge of their medical, behavioral health and/or social conditions and provides education and self-management support including symptom response plans 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

Desired Skills:

- Demonstrated success in working as part of a multi-disciplinary team including communicating and working with Providers, Pharmacists, Social Workers, Community Health Workers, and other health care teams.
- Ability to flexibly utilize clinical expertise to solve complex problems
- Bi-lingual preferred
- 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
- 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

Qualifications:

- Experience within the ACOs member population preferred including Medicare/Medicaid
- Experience working with Federally Qualified Health Centers is strongly preferred
- Associate degree in Nursing; Bachelor's Degree in Nursing preferred
- Current, active MA Registered Nurse license
- Case Management Certification (CCM, ANCC RN-BC) preferred
- 3-5 years of nursing experience, preferably in-home health, ambulatory care, community public health, case management, coordinating care across multiple settings and with multiple providers
- A valid driver's license and provision of a working vehicle
- Experience with anti-racism activities, and/or lived experience with racism is highly preferred

* *In compliance with Covid-19 Infection Control practices* per Mass.gov recommendations