



CONNECT CARE CHOICE PROGRAM

NURSE CASE MANAGER ROLE AND RESPONSIBILITIES

Job Summary:

The Connect Care Choice Nurse Case Managers provide comprehensive screening, assessment, care coordination services, disease education and self management support to a caseload of 50–100 moderate to high risk Medicaid only adults with complex chronic health conditions, in a community primary care practice setting.

Essential Responsibilities:

- Manage a caseload of 50 to 100 moderate to high risk Medicaid only adults age 21 and older with chronic medical conditions and co-occurring behavioral health
- Complete comprehensive physical, medical, and psychosocial assessment (currently using MDS for home care) on all new program enrollees including the SF-36 Health Status Survey, PHQ-9 Depression Screen and the “Katz” functional assessment
- Conduct a face-to-face interview (home visit optional) in order to: assess baseline knowledge of conditions; determine patient strengths / skills; identify patient’s support system and current community supports / agencies and providers; include patient’s identified needs and barriers.
- Establish care plan, goals, interventions and contact schedule based on risk category, and patients / family members identified medical and social needs.
- Promote compliance with disease specific clinical outcomes by providing each individual with self management supports including:
 - Disease specific educational materials (Krames)
 - Medication charts and side effects
 - Signs and symptoms to watch for and report to MD
 - Nutritional recommendations
 - Exercise and activity
 - Community supports, services and resources including current provider information such as Pharmacy, DME, and Home Care providers.
 - How to communicate with your doctor
 - Care plan and treatment goals including self-management goals
- Incorporate RN Care / Case Manager role into office based health care team to promote patient centered care, frequent contact with Primary Care Providers and medical home team members and actively participate in multidisciplinary patient centered team meetings.



Nurse Case Manager Role and Responsibilities

Essential Responsibilities (cont)

- Promote, arrange and participate in optimal planned Primary Care MD visit scheduling and arrange transportation and visit reminders.
- Coordinate care and communication between multiple providers, medical, nursing, social and behavioral health.
- Identify and monitor disease specific individual goals and program measures (such as smoking cessation) and individual self-management goals with PCP and practice team to reach and maintain targets.
- Refer and encourage individuals to complete the Stanford Chronic Disease Self Management 6 week program to promote and achieve self-management goals.
- Provide liaison roll to practice for members hospitalized at unaffiliated facilities in order to communicate admission information provided by DHS to PCP to facilitate discharge planning and follow up.
- Develop / maintain registry or electronic tracking system and obtain quality indicators
 - Identify population of patients
 - Set alerts / reminders to identify patients overdue for recommended care / services
 - Document self-management goals and patient specific care plan
 - Obtain quality indicators for reporting
 - Review quality outcomes data with health care team
 - Implement strategies to improve care