MA CARE MANAGER/COORDINATOR JOB DESCRIPTION*

Title: MA Care Manager – Care Coordinator
Status: Exempt, benefits-eligible
Hours: 30/40 per week
Salary:
Reports to: Practice Manager

OVERVIEW
The MA Care Manager - Care Coordinator’s primary responsibility is to administer care management and coordination activities for the patients of the primary care practice. This will include developing and monitoring care management and care coordination processes and support primary clinical teams with these efforts. It will also include identifying the high acuity patient population and working more directly to ensure care management, as well as care coordination for this patient population. The position may involve some patient triage. The MA care Manager – Care Coordinator behaves in a professional manner, and consistently demonstrates and promotes the values (core values of organization listed). The Care Manager – Care Coordinator will work with the Practice Manager and Medical Director (lead physician) of the practice to develop this position to best serve the needs of the patient panel and the primary care teams.

RESPONSIBILITIES:
CARE MANAGEMENT
• Work with all clinical teams as a resource on care management of all patients of the practice, this would include the following:
  ➢ Pre-visit planning workflow to ensure care completion prior to visit whenever possible
  ➢ After visit summary review with patients whenever appropriate
  ➢ Involving the patients in activities to improve their health (patient engagement);
  ➢ Educating the patient about self-management tasks they can undertake to gain greater control of their health status;
  ➢ Works with IT resources to facilitate registry reporting at the site & documentation of EBC in searchable fields
  ➢ Works with physician leadership to define quality measure/outcome reporting process
  ➢ Works with physician leadership to develop protocols and point of care reminders using nationally recognized EBC measure/outcomes
  ➢ Serves as a resource to clinical staff and providers to establish quality goals using reports
  ➢ Maintains strict confidentiality; follow HIPPA regulations
  ➢ Treats staff, physicians, NPs/PAs, visitors, patients and families with dignity and respect
  ➢ Participates in professional development activities
  ➢ Performs other related work as required
• Actively manages assigned panel of chronic care patients (high acuity):
  ➢ Develop relationship with patient as an integral member of team
  ➢ Provide follow-up contact with patient as indicated to ensure compliance with recommendations – medications, lab/x-ray, specialist visits, PCP visits, dieticians, CDE, etc.
  ➢ Manage many aspects of the patient’s care: referrals to specialists, hospitalizations, ER visits, ancillary testing, and other enabling services;
- Responsible for being available to provide telephone advice per protocol, handle urgent calls and emergent calls
- Anticipate the needs of this patient population, seeing that necessary documentation and pre-visit planning is completed or requested before patient visit;
- Responsible for working with patient and patient’s care team to coordinate change readiness, needs assessment and develop an individualized treatment care plan
- Assist patients in setting SMART goals for self-management, teaching them how to do self-management tasks and report abnormal findings to their physician team;
- Collaborates with the patient, physician, and other care team members in assessing the patient’s progress toward individual health care goals;
- Assess barriers when patient has not met treatments goals, is not following treatment plan of care, or has not kept important appointments;
- Oversees the development, procurement, and adoption of patient self-management educational resources used by the primary clinical teams;
- Collaborate with payer Case Managers for additional services when appropriate
- Develops a list of medical supply and community resources available to patients and maintains collegial relationships with the entities used most frequently;
- Work with IT staff member or department to coordinate the following:
  - Efficient consult request communication
  - Consistent documentation of patient self-management measures, mutually agreed upon care plan that is efficiently available to all and reporting of progress towards goals

**CARE COORDINATION**

- Ensure safe and effective care while the patient transitions in the care continuum. To serve as the bridge between consulting physicians, hospitals, ER and other frequently used healthcare resources and the patient and/or family.
  - Facilitate physician leadership to develop written agreements with consulting physicians, key facilities and community resources to define the roles and method of communication
  - Collaborate with physician, NP/PAs, clinical and non-clinical staff to identify appropriate patients for care transition services
  - Prioritize referrals and activities according to protocols
  - Coordinate consult/referral, hospital/ER, community resource follow-up/tracking process for the practice
  - Develop workflows and protocols within the PCP that ensure ER, hospital, community resource follow-up
  - Provide clinical follow-up with patients per protocol when indicated
  - Provide information and guidance to patients and/or family regarding effective care transitions and enhanced patient-care team communication
  - Maintain accurate and timely documentation
  - Participates in measuring clinical outcomes, analysis activities, and performance improvement. Represents care coordination program on performance improvement teams.

**Skills:**

- Knowledge of medical practice and care of patients
- Knowledge of examinations, diagnostic and treatment procedures,
- Knowledge of medical equipment and instruments
- Knowledge of common safety hazards
- Skills in developing and maintaining clinical quality assurance
- Ability to use good judgment and critical thinking skills; ability to identify and resolve problems
- Ability to interpret, adapt, and apply guidelines and protocols
• Ability to maintain medical records
• Ability to establish and maintain effective working relationships with patients, families, medical staff, and co-workers
• Ability to work independently, while collaborating with other team members
• Ability to self-motivate, prioritize, and be willing to invest in a change process to improve efficiencies
• Excellent written, verbal and listening communications skills
• Proficient computer skills – data entry, retrieval and report generation
• Ability to work with a diverse patients/family population

**QUALIFICATIONS:**
• Active Medical Assistant certification
• Current Basic Life Support certificate
• Minimum of one (1) year medical experience in physician’s office
• Advance knowledge of medical terminology
• Experience in Primary Care with this population is highly desirable
• Supports practice mission and goals
• Bilingual Spanish may be preferred

The MA Care Manager - Care Coordinator reports to the Practice Manager.

*This is a sample job description that models PCMH principles that can be used to help develop your own description. Workflow and actual roles/responsibilities within the practice should be considered as job descriptions are developed. The sample description does not take into consideration regulatory bodies or corporate policies that should always be incorporated into descriptions.*