

## **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

### Added Practice Supports through Nurse Case/Care Manager

The Nurse Case Manager (NCM) will:

- Be provided to practice or practice to be reimbursed\*
- Be integrated into the practice team
- Provide patient needs assessments, transportation, care management and coordination
- Provide nursing interventions as part of practice team
- Manage a case load of 50-100 moderate to high risk patients
- Provide and promote disease education and self-management supports
- Refer and encourage Medicaid beneficiaries to complete the Stanford Chronic Disease Self-Management 6-week workshop to promote self-management of chronic conditions
- Provide patient outcome measures to DHS
- Recruit and encourage patients in the practice to enroll in the Connect Care Choice Program

\* Reimbursement:

- Beneficiaries who are determined by DHS to be at moderate and or high risk will be provided with a Nurse Case Manager (NCM)
- NCM will have a case load of 50 to 100 patients who are at moderate or high risk
- DHS will reimburse practices at \$30 pmpm for members requiring a NCM or DHS will provide a dedicated NCM to practices from an outside entity



#### For more information

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