**Nursing Care Manager – Pediatrics Full Time (40 hours)**

**POSITION SUMMARY**

Under general supervision of medical home physician champion, and working within primary care practice setting, provides comprehensive care coordination services to patients with high risk or complex medical and/or behavioral health needs. Provides screenings, assessment, care coordination services, disease education and self-management support to patients and families. Participates as a member of multidisciplinary healthcare team within the Patient-Centered Medical Home environment for patient-centered care. Works collaboratively with medical and behavioral health providers, other clinical, support and managerial staff to achieve desired quality and cost outcomes. Serves as medical home advocate and mentor to ensure effective and supportive patient/family-centered environment. Participates in efforts required to maintain NCQA (National Committee for Quality Assurance) Medical Home recognition.

**PRINCIPAL DUTIES AND RESPONSIBILITIES**

As a member of the physician office practice, utilizes multidisciplinary team approach to identify opportunities to plan and coordinate care. Establishes relationships with children, youth and families through introductory visits dedicated to setting expectations for care coordination.

Promotes communication with families and among professional partners and defines minimal intervals between communications.

Provides condition specific and related medical, behavioral health, financial, educational, and social supportive resource information, while coaching patients and families to develop and maintain self-management skills.

Completes a child/youth and family assessment that includes family status, home environment growth and development assessment.

Working with the patient and family (as appropriate), establishes written care management plans, interventions, treatment, and self-management goals, and as appropriate, an emergency plan that reflects mutual goals. Promotes compliance with and evaluates effectiveness of established care plan.

Utilizing established practice staff & system resources, ensures the coordination of all medical, developmental, behavioral health and social referrals and tracking of referrals, testing and other order results. Coordinates care with and referral to state-designated community health teams as appropriate.

Ensures health care team integrates multiple sources of health care information; communicates this summary to the patient/caregiver, thereby building caregiver skills and fostering relationships between the health care team and families.

Coordinates family-centered team meetings (across organizations as needed).

Supports and facilitates all transitions of care between practices and/or facilities and from pediatric to adult systems of care. Functions as Patient-Centered Medical Home liaison to hospitals, long-term care institutions, specialists, and home health representatives to coordinate administrative and clinical issues related to patient care. Interacts and coordinates activities with third party insurance case and disease management representatives regarding patient care issues within the Patient-Centered Medical Home.

Maximizes usage of electronic medical record/chronic disease and behavioral health registry reporting to effectively deliver and continually monitor care coordination and effectiveness of service delivery.

Initiates and maintains effective relationships within community as required by patient population. Demonstrates flexibility and creativity in recommending resources to meet patient/family needs, such as identifying and utilizing appropriate cultural and community resources to support needs of diverse patient population.

Prepares and maintains quarterly reports on service volume, distribution of patients by plan and types of services provided.

Ensures open communication regarding patient status with providers and office staff.

Provides orientation, training, and consultation to other practice staff (including physicians and non-professional staff) regarding Patient-Centered Medical Home and Integrated Behavioral Health objectives.

Participates in quality improvement and evaluation processes related to Care Management.

Provides clinical triage of patient/family calls to the practice within established protocols, documents advice provided and sends to provider for review.

Manages requests for prescription refills, approves refills as provider delegate according to established protocols. Manages prior authorization process required by insurers.

May perform procedures or tests such as, but not limited to: Intramuscular injections, administration of immunizations, wound care/dressing.

**Qualifications & Experience**

Current licensure to practice as Registered Nurse in Rhode Island, or in another state that participates in Nurse Licensure Compact.

Demonstrated knowledge & skills necessary to provide care to patients with consideration of aging processes, human development stages & cultural patterns in each step of the care process.

At least three years professional nursing experience in community health setting, public health, or community nursing, including experience with chronic disease and/or behavioral health management. Experience should demonstrate thorough knowledge of chronic disease and/or behavioral health management, with demonstrated effectiveness in coordinating patient care with primary care and/or behavioral health providers. Case management experience with patient care coordination and disease management/education preferred. Experience utilizing EHR/disease registry reporting to prioritize patient outreach and follow up preferred. Experience in pediatrics or family care setting strongly preferred.

**Interested applicants should submit their resume and apply for Job ID: 19776 at** [**https://jobs.lifespan.org/**](https://nam02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fjobs.lifespan.org%2F&data=04%7C01%7Cccarr1%40lifespan.org%7C6ae20ca7c49f4b327de208d93d7db3f5%7C3764e7d08fff4c8cbd1306c688fed784%7C0%7C0%7C637608432369957346%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=1k2K2Wv%2BfeqrnEoGR69t%2BVHYcr3H9PY5uVLOB7LR3KE%3D&reserved=0)