Job Title:	**REGISTERED NURSE/CARE COORDINATOR**
Department(s):	Nursing
Position Summary:	The RN/Care Coordinator works in collaboration and continuous partnership with patients and their family/caregiver(s), hospitals, specialty providers and staff, and community resources in a team approach. The RN also provides supportive functions to NHS providers

Supervision Received: Director of Clinical Operations

Supervision Exercised: None

Hours/Week ☒ Full-Time or ☒ Part-Time

FLSA Definition:

ESSENTIAL FUNCTIONS & RESPONSIBILITIES:

General Nursing

- Serves as the contact point, advocate, and informational resource for patients, care team, family/caregiver(s), payers, and community resources
- Handles incoming triage calls:
  - Provides appropriate patient education regarding medical condition
  - Provides medication instructions
  - Supports providers by following up with patients regarding their lab/imaging results as guided by the provider
  - Documents telephone discussions in the patient's electronic medical record (EMR)
- Handles incoming Nursing Home Orders
- Handles incoming pharmacy questions, clarifications and prior authorizations
- Calls patients with medication changes, directions and education, as ordered by providers
- Provides nursing support, when needed, to the Nurse Midwives and NHS providers
- Utilizes the Patient Portal to communicate with patients
- Sees patients on daily nurse schedule:
  - Responds to the needs of walk-in patients
  - Assists providers as needed
  - Provides education on medical condition, e.g., asthma, diabetes, family planning
  - Reads and documents PPD results
- Provides refill requests that come through the EMR, phone or fax
- Reconciles medications

- Maintains a log book of all dispensed medication at the direction of the medical provider
- Maintains an emergency box of medications
- Oversees the application/enrollment and tracking process for patients in indigent medication programs
- Prescribes medications per standing order protocols, e.g., STI treatment, Vitamin D deficiency
- Provides community-based nursing care as established by the organization, as requested

Care Coordination/Case Management Support

- Maintains Health Care Home (HCH) and FUHN registries for patient follow-up:
  - Assists with the identification of "high risk" patients (those with chronic illness and/or special health care needs)
  - Contacts patients to enroll them into HCH and documents patient's acceptance or declination, to populate the registry
  - Contacts patients that are on the FUHN ID/ Stratification tool to get them in for follow-up care and educates patients on when to utilize the ER
  - Reviews FUHN/ID Stratification patient's EMR to see what patients may need; refers to specialty providers and to helps with medication reconciliation
- Works with patients to plan and monitor care:
  - Assesses patient's unmet health and social needs
  - Develops a care plan with the patient, family/caregiver(s) and providers (emergency plan, health management plan, medical summary, and ongoing action plan, as appropriate)
  - Monitors adherence to care plans, evaluates effectiveness, monitors patient progress in a timely manner, and facilitates changes as needed
  - Creates ongoing processes for patient and family/caregiver(s) to determine and request the level of care coordination support they desire
- Facilitates patient access to appropriate medical and specialty providers
- Educates patient and family/caregiver(s) about relevant community resources
- Cultivates and supports primary care and specialty provider co-management with timely communication, inquiry, follow-up, and integration of information into the care plan regarding transitions in care and referrals
- Facilitates and attends HCH meetings between patient, family/caregiver(s) and provider
- In collaboration with the primary care provider, assigns the appropriate tiering level based on required criteria for HCH patients
- Advocates for the participant in understanding needs surrounding transportation, shelter, child care and safety. Refers participant to behavioral health services if warranted
- Keeps EMR care plans updated for easy access by HCH Team
- Interacts, communicates and collaborates with HCH Team daily in-person, by phone, inbox messaging and/or team huddles to update and advance care coordination within the Team
- Utilizes all available tools to deliver education, instruction, care coordination and training,

including: computer; patient registry; HCH brochure; HCH care plan; other HCH policies & procedures (tiering process, pre-visit planning, screening process); after-visit summaries; disease management brochures; disease management participant tracking records (Diabetes glucose records, nutritional records, wellness/exercise plan, blood pressure record); disease-specific educational handouts; services offered by NHS

CORE REQUIREMENTS:

- Works collaboratively and respectfully with staff and others—individually and as part of a team—to achieve optimal efficiency, outcomes and morale
- Interacts in a culturally competent manner with individuals and groups from diverse backgrounds, including but not limited to: socio-economics, race and ethnicity, nationality and religion, both in-clinic and in the community
- Maintains excellent and punctual attendance
- Attends and actively participates in staff and departmental meetings
- Attends agency functions and meetings as relevant or required
- Works at any or all NHS clinics, as needed
- Uses computer daily including e-mail, word documents, spreadsheets, patient management system, electronic health record, and patient portal, as needed to carry out essential job functions
- Maintains any required licensure/certification
- Demonstrates commitment to agency mission and goals
- Abides by corporate compliance program, HIPAA regulations and other agency policies and procedures
- Participates daily in pre-visit planning and huddles (RN, Provider, Medical Assistant, Front Desk)
- Plans, organizes, and multitasks
- Speaks, understands, reads and writes English sufficiently to carry out all essential duties
- Performs other duties as assigned

QUALIFICATIONS

- Graduation from an accredited nursing program
- Current Minnesota RN license
- Minimum one year experience in a primary care setting preferred
- Patient education experience
- Family planning experience highly desired
- Motivated to improve the health of the community
- Excellent interpersonal communication

Attachments

- Physical and Mental Requirements
- Work Environment

Employee Signature: _____ **Date:** ____/____/____