South Central Human Relations Center
Position Description

Title: Registered Nurse/Care Coordinator	**Division/Department:** Adult Mental Health Case Management
Department: Adult Mental Health Targeted Case Management	**FLSA Status:** Non-Exempt
Reports To: Clinical Nurse Specialist & Adult Mental Health Program Manager	**Supervises:** This position has no supervision duties

SUMMARY

This program is designed for working collectively as a team with Adult Mental Health Case Managers, Case Aides, CRMT's, and others, to provide a holistic approach to health care for members of South Country Health Alliance's Ability Care product. The purpose of the nurse is to provide medical care coordination to the team for dealing with serious and persistent mentally ill adults, who reside in Dodge, Steele, or Waseca Counties. It is to assist this population to become independent and better functioning members of the community.

PRIMARY RESPONSIBILITIES

1. Accepts referrals from CRMT and/or Adult Mental Health Case Managers for serious and persistent mentally ill adults.
    a) Gathers medical information about member referrals from the referral source, available documents, etc.
    b) Makes initial contact with the member through different means such as telephone, home visiting, community outreach, etc.
    c) Provides members with information about the types of medical services, responses, care coordination, and availability of them.

2. Provides medical assessment services to members in Dodge, Steele and Waseca Counties.
    a) Completes an Ability Care Comprehensive Health Assessment within 10 days of request, if one has not already been completed.
    b) Reviews the Health Screening form for the purposes of determining the medical healthcare needs of the member.
    c) Makes initial decisions about medical necessity and if intervention and on-going medical care coordination is essential for the member.
    d) Obtains client agreement to pursue medical care coordination on-going if needed.
    e) Assesses the member's chronic health conditions.
    f) Reviews all medications taken, i.e., prescription, over the counter, vitamins, etc.
    g) Reviews immunizations and arranges for an update of immunizations as appropriate.

3. Provides medical care coordination as defined by Minnesota Rules and by South Country Health Alliance policy and procedures.

a) Develop a medical support plan to coordinate cares given by other team members.
b) Evaluates and monitors the services identified in the plan.
c) Provides at least quarterly contact with members.
d) Assists in monitoring and managing chronic health conditions.
e) Refers as appropriate to other agencies or services for necessary medical care.

4. Provides medical care coordination with the Primary Care Physicians or other primary medical providers.
   a) Develops communication with the member's primary care provider and encourages at least annual visits and assist with scheduling and attending appointments.
   b) Assists the member with accessing the correct level of care, thus reducing inappropriate use of emergency care.
   c) Works with Hospital Social Worker on high utilization clients.
   d) Facilitates communication of medication list to PCP's.
   e) Assists the member in providing a complete medical history to the PCP's.
   f) Accompanies the member to PCP visits and writes notations about any medical care needs, etc.

5. Connects with the members face-to-face or by telephone as part of outreach.
   a) Provides minimum face-to-face contact with members annually.
   b) Demonstrates support, validation, and positive interactions with members.
   c) Provides education on management of medical conditions to members and family care-givers.

6. Possible day-to-day supervision of Care Coordinators in the future.
   a) Provide guidance and feedback to Care Coordinators.
   b) Provide communication with South Country Health Alliance and disseminate information and changes to Care Coordinators.
   c) Train new Care Coordinators.

7. Maintains records, files, and bills for services through the CCM system.
   a) Documents in electronic health record, daily contacts with members, whether in person or other contacts means.
   b) Completes the necessary screening documents and service agreements to comply with state and federal requirements and assures they are entered in the appropriate data system.
   c) Provides an annual review of the service plan.

8. Consults and collaborates with colleagues and community providers on a consistent and as needed basis.
   a) Attends regularly scheduled consultation meetings with colleagues and care management team.
   b) Provides information and consultation to care-givers who also are assisting the client, assuming there is a proper release of information.
   c) Informs/consults with the Supervisor regarding emergency situations.

SECONDARY RESPONSIBILITIES

1. Performs miscellaneous projects and completes various tasks as requested by management.

2. Encourages family members to be part of the programming for each member.
3. Assists in pre-commitment screenings when possible, if asked.

JOB SPECIFICATIONS

Education, Experience and Credentials

- Minimum of Associate's Degree in Nursing.
- Current licensure by the State of Minnesota as a Registered Nurse.
- Two years experience working with individuals with a Severe and Persistent Mental Illness.

Level of Access for Electronic Protected Health Information

- Nurses

Knowledge, Skills and Abilities

1. The Care Coordinator must have people and problem-solving to assist and support clients with severe and persistent mental illnesses and their families.
2. The Care Coordinator must have a sound knowledge of medical, mental health and chemical health issues and how they interact and manifest individually and together within individuals.
3. The position requires solid organizational skills and the ability to make contacts and establish relationships to get information necessary for optimum client care.
4. Knowledge of computers and software.
5. Medical Records management.
6. Strong commitment to the right and ability for each person with a severe and persistent mental illness to live in normal community residences, work in market jobs and have access to helpful, adequate, competent, and continuous supports and services.
7. Skills and competence to establish supportive, trusting relationships with persons with severe and persistent mental illnesses.
8. Respect for client rights and personal preferences in treatment is essential.
9. Must have a valid Minnesota Driver's License.

PHYSICAL REQUIREMENTS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to stand; sit; use hands to finger, handle, or feel; reach with hands and arms; and talk or hear. The employee is occasionally required to walk; climb or balance; and stoop, kneel, crouch, or crawl. The employee must frequently lift and/or move up to 10 pounds and occasionally lift and/or move up to 25 pounds. Specific vision abilities required by this job include close vision, and ability to adjust focus.

Work Schedule:

Regular office hours are 8:00am to 5pm, Monday through Friday. Must have flexibility to adjust the schedule occasionally in response to work demands.

______________________________________ ____________

Employee Signature Date

______________________________________ ____________

Supervisor Signature Date