Nurse Care Manager

1. Perform initial nursing assessment and needs assessment on new referrals to the care coordination program. Collect key information from chart review prior to initial assessment.

2. After initial nursing assessment and needs assessment is completed, develop plan of care. Determine priorities for interventions, delegating to the care coordinator, as appropriate, to facilitate implementation of plan of care.

3. Provide ongoing monitoring and assessment with patients with higher level of medical complexity at regular intervals. Examples of patients: transitioning out of inpatient setting to home, chronic disease patients, chronic disease patients with mental health issues.

4. Medication management:

   - perform medication reconciliations
   - evaluate medication adherence, effectiveness, and toxicity
   - recommend or make guideline-directed changes in regimen

5. Provide emotional support and monitor patient's psychosocial state, recommending appropriate mental health or supportive interventions when necessary.

6. Provide guidance and leadership in the development of St. Lukes - EOMA Care Coordination (CC) Program through participation in the care coordination committee and providing staff education regarding the care coordination program.

7. Provide community education and outreach related to Patient Centered Medical Home and Care Coordination.

8. Performing and/or overseeing all care coordination duties necessary to successfully implement the plan of care.

9. Act in a supervisory/leadership role with the care coordinators when needing guidance regarding patient care and/or issues.