Key roles of Care Manager and Care Coordinator

Care Managers and Care Coordinators function as key members of the Care Team, fulfilling a number of roles as outlined below:

Care Manager

☐Identify the targeted population within practice site(s) per PCP referral, risk stratification, patient lists and other strategies. (Including patients with repeated social and/or health crises.)

☐Target interventions to avoid hospitalizations and emergency department visits, ensures standards of care, and coordinates care across settings. Focuses on patients with mild to moderate chronic disease and patients with high complexity, high cost, and/or high utilizers of the health care system.

☐Ensure patients have timely and coordinated access to medically appropriate levels of health and support services and continuity of care.

☐Complete comprehensive assessment of patient's health conditions, treatments, behaviors, risks, supports resources, values, preferences and overall service needs. This can be done in coordination with other members of the care team.

☐Develop comprehensive, individualized care plans; coordinate services required to implement the plan; provide continuous patient monitoring to assess the efficacy of the plan; periodically re-evaluate and adapt the plan, as necessary.

☐Provide a range of client-centered services that link patients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services); coordination and follow-up of medical treatments; patient-specific advocacy and/or review of utilization of services.

☐Conduct medication reconciliation

☐Promote patient's and family caregiver's active engagement in self-care.

☐Coordinate and communicates with all professionals engaged in a patient's care, especially during transitions from the hospital

☐Assist with advance directives, palliative care, hospice and other end-of-life care coordination

Care Coordinator

☐Determine with the care team, the patient's needs for coordination, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations and need for support services.
☐Demonstrate knowledge about community resources by providing information on the availability of and, if necessary, coordinate these services that may help support patients' health and wellness or meet their care goals.

☐Jointly create and manage the individualized plan of care with the patient/family, care team and community based organizations, that outlines the patient's current and longstanding needs and goals for care and addresses coordination needs and gaps in care.

☐Contribute to ongoing maintenance, which includes monitoring, following up and responding to changes in the patient's individualized plan of care.

☐Facilitate transitions of care with the practice team members to ensure timely and complete transmission of information and/or accountability

☐Support self-management goals to promote patient health

☐Align resources with patient and population needs

☐Contact patients with identified gaps in care and communicate recommended tests/services to the patient. Provide additional resources to under insured patients.

☐Demonstrate administrative skills to organize, evaluate, and present information clearly both verbally and in written communication; maintain documentation according to practice specifications.

Care Manager and Coordinator Hiring

"Care Coordinator" means an individual member of the Care Team, who is not required to be licensed, who provides patients assistance with self-management support, accessing medical services, making linkages to community services, and other related patient supports as appropriate. *The following types of professionals are eligible to serve as a Care Coordinator: Bachelor's Social Worker, Social Services Technician, Certified Community Health Worker, Certified or Registered Medical Assistant, or other similar types of health professionals determined by MDHHS.*

"Care Manager" means a licensed individual assigned to provide care management services, including targeted interventions to avoid hospitalizations and emergency department visits, ensure standards of care, coordinate care across settings, and help patients understand options. The following types of professionals are eligible to serve as a Care Manager: *Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Licensed Master Social Worker, Licensed Professional Counselor, Licensed Pharmacist, Registered Dietician, Physician's Assistant, or other similar types of licensed health professionals determined by MDHHS.*