UW HEALTH JOB DESCRIPTION

RN Transitional Care Case Manager

Job Code: 800056	**FLSA Status: Exempt**	**Mgt. Approval: S. Kroenke**	**Date: February 2024**
Department: Nursing – Transitional Care		**HR Approval: K. Fleming**	**Date: February 2024**

JOB SUMMARY

The RN Transitional Care Case Manager is responsible for managing a patient's successful transition from hospital to home and is accountable for developing, implementing, and evaluating comprehensive transitional care interventions for high risk medical, surgical, and/or trauma patients at UW Health. They are responsible for managing the post-acute care of high-risk patients that are at risk for poor health outcomes, frequent emergency room visits, and hospital readmissions and working with complex and varied patients and situations.

The RN Transitional Care Case Manager identifies hospitalized high-risk, complex patients for program enrollment and communicates with all entities involved in the care of the patient to promote and maximize care coordination. Key aspects of the Transitional Care Program protocols are based upon inpatient and post-discharge workflows. Inpatient workflow includes participation in hospital multidisciplinary daily rounds, patient and family education regarding disease states and self-care, identification of patient-level concerns regarding discharge, social risk factor assessment, and anticipation of potential gaps in care. The inpatient encounters are designed to educate patients/caregivers surrounding their post discharge health care needs and to empower them to play an active and informed role in managing their care post-discharge.

Upon patient hospital discharge, the post-discharge workflow is telephonic follow-up for 30 to 180 days, facilitating clinical care, patients access to appropriate services, and service referrals and appointments. This includes a focus on medication reconciliation and adherence, management of patient's quality of life and functionality, management of both acute and chronic disease states, identification and rectifying gaps in care, assessment and support of patient's ability to perform self-cares, coordination of post-discharge appointments and services (durable medical equipment, home health), and coordination of care across the care continuum. The practice of this position has a direct impact on patient outcomes and UW Health performance measures for Medicare compliance.

The RN Transitional Care Case Manager utilizes research findings in practice and participates in Transitional Care Program design, implementation, and evaluation and participates in ongoing quality improvement activities. They collect clinical path variance data that indicates potential areas for system-wide improvement of cares and services and provides identifying errors and discrepancies in care that negatively impact the patient. The RN Transitional Care Case Manager then seeks to rectify errors and discrepancies through a broader systems approach. This approach includes contacting individual discharging providers, including attending and resident physicians, to provide feedback on gaps in care. This feedback is a critical component of resident medical education and serves to meet Accreditation Council for Graduate Medical Education (ACGME) requirements for transitional care education.

MAJOR RESPONSIBILITIES

CLINICAL CASE MANAGEMENT

A. Assessment

1. Identifies patient/family education needs and ensures that patient/family members have adequate information to participate in transition planning.
2. Critically evaluates and analyzes physical and psychosocial assessment data.
3. Conducts health literacy assessment.
4. Interprets screening and selective laboratory/diagnostic tests.
5. Initiates and maintains communication and collaboration with physicians, social workers, care team leaders, staff nurses, other care giving disciplines, and patients/families to develop, implement, and evaluate a transition plan of care for each patient.
6. Conducts a comprehensive patient/family assessment and transition/home care planning evaluation upon program enrollment to initiate and maintain the patient's transitional plan of care.
7. Utilizes financial and insurance resources as well as UW Health assistance programs (i.e. Medical Assistance Program) to maximize the health care benefit to the patient.
8. Monitors the achievement of clinical outcomes and communicates with inpatient teams, primary and specialty physicians and staff, regional providers, and community resources (Home Health) regarding unanticipated variances.
9. Assesses complexity of care needs and potential/actual issues or gaps in care.
10. Arranges post-discharge medical and community referrals for patients with health problems requiring further evaluation and/or additional services.
11. Advocates for patients and families within the health care system with community providers and across the continuum

of care.
12. Identifies, tracks, and conducts root cause analyses on readmissions to address programmatic and system-wide improvements.
13. Works with physicians, providers, researchers, and Transitional Care leadership to identify broader system issues affecting patient care.

B. LEADERSHIP
1. Coordinates and facilitates patient progression throughout the continuum. Collaborates with all members of the healthcare team and external customers.
2. Participates in clinical performance improvement activities to achieve set goals.
3. Applies advanced critical thinking and conflict resolution skills using creative approaches.
4. Supports Transitional Care leadership with system-level quality improvement.

C. EDUCATION
1. Participates in the orientation of new department staff. Provides learning opportunities for students in various health care disciplines as requested.
2. Develops, implements, and evaluates comprehensive patient education programs that assure quality and appropriateness of care across settings (i.e. inpatient, post-discharge, and home).
3. Supports the UW Health outreach mission through consultation and/or education of community.
4. Supports agencies as requested through the Department of Coordinated Care.

D. RESEARCH
1. Participates in research surrounding transitional care. Identifies recurring clinical practice issues and contributes to the development of specific plans to address identified issues.
2. Demonstrates knowledge of research findings related to clinical specialty.
3. Participates in activities that support the advancement of care transitions, case management, and discharge planning through literature review, professional organizations, research, committee participations, etc. Consistently uses new knowledge, technology, and research in practice.

E. PROFESSIONAL DEVELOPMENT
1. Provide educational offerings in area of expertise at UW Health and its affiliates, the Coordinated Care Department, and in the community.
2. Monitor and improve quality of services provided to patients/families through ongoing participation in team and departmental quality improvement activities.

ALL DUTIES AND REQUIREMENTS MUST BE PERFORMED CONSISTENT WITH THE UW HEALTH PERFORMANCE STANDARDS.

JOB REQUIREMENTS

Education	Minimum	Bachelor's degree in Nursing (BSN)
	Preferred	Master’s degree in Nursing or Health Care related field
Work Experience	Minimum	Three (3) years of relevant clinical nursing experience. Equivalent combination of education and experience will be considered.
	Preferred	Surgical, medical, trauma, and intensive care experience
Licenses & Certifications	Minimum	• Licensed as a Registered Nurse (RN) in the State of WI or holds a license issued by a jurisdiction that has adopted the nurse licensure compact • RN licensure to practice in the State of Illinois within six (6) months of hire • Current CPR/BLS Certification
	Preferred	ACMA certification as a case manager
Required Skills, Knowledge, and Abilities		• Excellent interpersonal communication, problem-solving, and conflict resolution skills • Computer skills in word processing, database management, and spreadsheets

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AGE SPECIFIC COMPETENCY (Clinical jobs only)

Identify age-specific competencies for direct and indirect patient care providers who regularly assess, manage and treat patients.

Instructions: Indicate the age groups of patients served either by direct or indirect patient care by checking the appropriate boxes below. Next,

	Infants (Birth – 11 months)		Adolescent (13 – 19 years)
	Toddlers (1 – 3 years)	**X**	Young Adult (20 – 40 years)
	Preschool (4 – 5 years)	**X**	Middle Adult (41 – 65 years)
	School Age (6 – 12 years)	**X**	Older Adult (Over 65 years)

JOB FUNCTIONS

Review the employee's job description and identify each essential function that is performed differently based on the age group of the patient.

PHYSICAL REQUIREMENTS

Indicate the appropriate physical requirements of this job in the course of a shift. *Note: reasonable accommodations may be made available for individuals with disabilities to perform the essential functions of this position.*

	Physical Demand Level	**Occasional** Up to 33% of the time	**Frequent** 34%-66% of the time	**Constant** 67%-100% of the time
X	**Sedentary:** Ability to lift up to 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. Although a sedentary job is defined as one, which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.	**Up to 10#**	**Negligible**	**Negligible**
	Light: Ability to lift up to 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may only be a negligible amount, a job is in this category when it requires walking or standing to a significant degree.	**Up to 20#**	**Up to 10#** or requires significant walking or standing, or requires pushing/pulling of arm/leg controls	**Negligible** or constant push/pull of items of negligible weight
	Medium: Ability to lift up to 50 pounds maximum with frequent lifting/and or carrying objects weighing up to 25 pounds.	**20-50#**	**10-25#**	**Negligible-10#**
	Heavy: Ability to lift up to 100 pounds maximum with frequent lifting and/or carrying objects weighing up to 50 pounds.	**50-100#**	**25-50#**	**10-20#**
	Very Heavy: Ability to lift over 100 pounds with frequent lifting and/or carrying objects weighing over 50 pounds.	**Over 100#**	**Over 50#**	**Over 20#**
List any other physical requirements or bona fide occupational qualifications:				

Note: The purpose of this document is to describe the general nature and level of work performed by personnel so classified; it is not intended to serve as an inclusive list of all responsibilities associated with this position.