Registered Nurse (Care Coordinator)
We are looking for Care Coordinator (RN) for our Family Medicine practice in Buffalo.

THE OPPORTUNITY

The Care Coordinator is member of the nursing team that influences and achieves optimal clinical and resource outcomes. This is achieved by identifying and
stratifying the patient population in accordance with our practice population care management program and providing proactive care management services
to high-risk patients with chronic health conditions in order to: reduce the burden of illness, improve compliance with evidence based clinical guidelines,
encourage patient self-management, increase coordination of care, increase the utilization of resources and services across the continuum and improve patient
experience of care while reducing the total cost of care. The Care Coordinator serves as a change agent for clinical performance and process improvement
and provides operational and clinical support to the site Office Manager.

Responsibilities:
• Identifies which patients in the specialty care practice have ongoing care coordination needs for their specialty condition.
• Outlines the nature and duration of involvement needed by the specialty care team and specialty care coordinator then identifies the primary care team involved.
• Utilizes assessment skills and risk assessment tools to identify patients with actual or potential care needs that would require care coordination.
• Conducts targeted outreach to a defined panel of high-risk patients (chronic illness, lack of social support, readmissions, ED visits, surgical episodes, etc.) to ensure timely and efficient care delivery across the continuum of care.
• Utilizes technological tools (registries, patient lists, care team tab, etc.) to manage populations.
• Conducts comprehensive clinical assessments that include disease-specific, age-specific, medical, behavioral pharmacy, social and end of life needs of each patient.
• Informs the patient and family regarding coordination of their care and shares this information with the healthcare team.
• Works collaboratively with interdisciplinary team to develop goals and plan interventions to maximize patient outcomes.
• Monitors patient compliance with plan of care.
• Performs reassessments regarding patient progress toward goals and updates plan of care as appropriate.
• Ensures care gaps are closed around specialty disease/chronic disease/surgical episodes.
• Serves as primary patient contact for team related to condition/surgical episode and facilitates access to services.
• Coordinates members of the patient care team.
• Serves as the liaison between patients, families, and physicians, clinical staff by advocating for patient and families then responding to and facilitates resolution of patient/family questions and concerns.
• Assists in managing transitions of care across care setting, ensuring optimal communication and planning. Identifies barriers to receiving care and facilitates solutions.

• Partners with other care coordinator teams such as primary and transitional care social work, rehabilitation, pharmacy, palliative care and others.
• Defines and ensures compliance with disease-specific care paths for specialty care or chronic disease.
• Works with the patient and family to assess current knowledge, health literacy, and readiness to change, utilizing teach back to assess level of knowledge.
• Coaches patient and family on self-management support; including setting long and short-term goals.
• Educates about managing a specialty or surgical condition (inclusive of preoperative, perioperative, postoperative and recovery) inclusive of prevention and health maintenance tasks. Educates and connects to other care providers and community resources to enhance care.
• Works with practices on quality and process improvement initiatives.
• Other duties as assigned.

EDUCATION & SKILL REQUIREMENTS

- Graduate of an accredited school of professional nursing
- Associate's or bachelor's degree in nursing
- 1 year nursing experience required
- Previous case, disease, or utilization management experience preferred
- Previous experience in a physician office or ambulatory care setting preferred
- Current New York State Professional Nurse Registration required

Pay:DOE

Benefits: 401(k), 401(k) matching, Dental insurance, Disability insurance, Flexible schedule, Flexible spending account, Health insurance, Health savings account, Paid time off, Parental leave, Vision insurance

Please send resume and cover letter to bbinner@apwny.com