This tool provides a distilled list of care management staff roles that can help leaders evaluate current and future staffing composition by comparing common role functions, tasks, and titles. The framework can assist with determining a potential staffing model, based on the population health management strategy being implemented.

Due to the diversity of names associated with roles, staff are classified by role. Each role has two categories of supporting tasks:
- **Core Tasks**: responsibilities less likely to be shifted to other staff
- **Potential Tasks**: responsibilities some organizations are shifting across different staff roles
- **Asterisks** indicate tasks that organizations are centralizing to a dedicated team or system level resource

### Role Descriptions

<table>
<thead>
<tr>
<th>Role</th>
<th>Description/Function</th>
<th>Supporting Tasks</th>
<th>Common Names</th>
<th>Individual Commonly Deployed</th>
<th>Observed Caseloads</th>
</tr>
</thead>
</table>
| Inpatient Case Manager | Serves as key point of contact to coordinate care with physicians and care team; develop and document care plan, facilitate discharge planning | **Core Tasks**: Develop patient care plan, navigate patient through inpatient setting, discharge planning, identify behavioral health and social needs  
**Potential Tasks**: Quality measurement/concurrent review, utilization review*, payment review/pre-authorization*, manage patient transition to PAC setting* | Patient Care Coordinator, Unit-Based Care Manager, Hospital-based care manager | RN, LCSW | 38 beds covered; 25 patients covered¹ |
| Inpatient Social Worker | Assists patients with psychosocial needs; helps patients access benefits and community resources | **Core Tasks**: Perform patient psychosocial assessment, assist in crisis management, manage behavioral health and social needs  
**Potential Tasks**: Financial counseling, insurance enrollment* | Inpatient Counselor | LCSW, LPC | 40 beds covered; 41 patients covered¹ |
| Non-Urgent ED Navigator | Connects patients using the ED for non-acute needs with primary care, non-clinical assistance; promotes right site utilization | **Core Tasks**: Engage non-acute patients in ED, assess primary care status, address non-clinical needs, schedule appointments and consults, evaluate payment status  
**Potential Tasks**: Assist with transfer to other care sites, follow-up call* | Life Coach, Transfer Coordinator | RN, LPN, LCSW | 10-15 patients depending on ED volumes and size |
| Transitions Coach | Supports patient transitions from the hospital to home or PAC facility after discharge, provides self-management support; may offer disease-specific guidance (e.g., CHF, cancer, orthopedic care, etc.) | **Core Tasks**: Coordinate care with primary care, specialists, or PAC facility an average of 30-60 days post-discharge; expedite scheduling for patients; evaluate various treatment options with patient, navigate patient across sites of care, coordinate with staff to ensure patient comfort  
**Potential Tasks**: Schedule and/or attend medical appointments* | Nurse Navigator, Care Transitions Navigator, Transitional Health Partner | RN, LPN, nursing student, community member | 20-40 patients |

**Asterisk** – tasks organizations may be centralizing to dedicated team or system level resource

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¹ 2013 ACMA National Hospital Case Management Survey

Source: 2013 ACMA National Hospital Case Management Survey; Advisory Board Company interviews and analysis.
### Care Management Staff Audit Tool (continued)

<table>
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<th>Role</th>
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</table>
| High-Risk Outpatient Care Manager         | Navigates high-risk patients across the continuum; serves as main point of contact for patients’ providers across care settings; aims to better manage patients in ambulatory setting and reduce acute care and ED use | **Core Tasks:** Identify high-risk patients, assess clinical and psychosocial needs, make referrals to ancillary providers (disease management, pharmacy, social work, palliative care, community-organizations, non-clinical services), develop care plan in coordination with PCP, engage and activate patients  
**Potential Tasks:** Provide disease management, conduct inpatient or home visits, schedule appointments* | RN Care Manager, Outpatient Care Manager, Ambulatory Case/Care Manager | Experienced RN, LCSW | From 50-250 patients depending on care manager experience, patient acuity |
| Outpatient Health Coach                   | Manages lower-risk patients not attributed to the High-Risk Outpatient Care Manager; promotes disease management, preventative care, and wellness | **Core Tasks:** Manage disease registry, provide disease/self-management support, engage and activate patients, fill gaps in preventative and chronic care  
**Potential Tasks:** Coordinate patient appointments, fulfill non-clinical needs, support telehealth services* | Outpatient Disease Manager, Low-Risk Care Manager, Health Promoter (Promotoras) | RN, LPN, MA | From 75-200 patients depending on patient acuity, care team composition; or 1:1 staff to physician ratio |
| Non-Clinical Health Navigator            | Supports outpatient care manager or health coach in administrative or time-intensive tasks; primarily addresses psychosocial rather than clinical needs | **Core Tasks:** Schedule appointments, communicate with community resources or post-acute care providers, support staff with patient care transitions and patient follow-up  
**Potential Tasks:** Non-medical home visits, coordinate transportation, serve as point of contact for patient | Community Resource Specialist, Community Health Worker, Care Management Assistant | Community Health Worker, Non-clinical staff member, volunteer | 1 per practice (assumes average of 200 high-risk patients) |
| Telehealth Nurse                         | Uses telehealth resources (i.e., telemonitoring) to prevent chronic disease exacerbation, avoid hospital admissions | **Core Tasks:** oversee telemonitoring services*, provide disease management support and education  
**Potential Tasks:** Patient triage to appropriate site of care | IT-Based Care Coordinator | RN | Highly dependent on care model and eligibility criteria |

### Additional Care Management Support Staff

<table>
<thead>
<tr>
<th>Disease-Specific Chronic Care Coach (Cancer Navigator)</th>
<th>Pharmacist</th>
<th>Nutritionist/Dietitian</th>
<th>Social worker/Counselor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsels patients regarding disease-related symptom management, lifestyle choices</td>
<td>Consults patients on polypharmacy, may perform medication reconciliation for high risk patients</td>
<td>Consults patients on diet and eating habits; may work with patients with specific diseases</td>
<td>Assists patients with psychosocial needs; conducts behavioral health assessments and referrals</td>
</tr>
</tbody>
</table>

*Asterisk* – tasks organizations may be centralizing to dedicated team or system level resource

Source: Advisory Board Company interviews and analysis.