Job Title: Case Manager
Department: Health Services
Reports To: UM Manager
FLSA Status: Exempt

Summary: Under general supervision, coordinates the care and service of selected Member populations across the continuum of illness; promotes effective utilization and monitors health care resources; and assumes a leadership role within the interdisciplinary team to achieve optimal clinical and resource outcomes. Works with the QM/UM Manager to assess, plan, implement, coordinate, monitor and evaluate services and outcomes to maximize the health of the Member. Oversees an assigned member case load and engages in activities of the health services team in order to support members with acute and chronic illness and disability to reach their optimal level of health and well-being by performing the following duties:

Essential Duties and Responsibilities: include the following. Other duties may be assigned.

- Conducts individualized clinical assessments of members care needs for all members (in case management), including the Dual SNP program and develops a personalized care plan which includes but is not limited to:
  - The member's right to opt out of the case management programs offered.
  - Documentation clinical history and medications.
  - Assessment of activities of daily living.
  - Mental health status and cognitive function assessment.
  - Assessment of life-planning activities.
  - Cultural and linguistic needs, preferences and limitations evaluation.
  - Caregiver resources.
  - Available benefits – explanation, coordination, and assisting to access dual plan benefits when applicable.
- Screens members to identify needed medical services, modifiable risk factors and educational needs and identifies or refers cases for other services.
- In conjunction with the Primary Care Provider and member develops Care Plan utilizing clinical expertise to evaluate and assess the members need for alternative services: assess short-term and long-term needs: and establish case management objectives.
- Develops a follow-up schedule for communication to the member and Provider.
- Relies on clinical support/review from Medical Director on problematic cases and has access telephonically whenever necessary.
- Demonstrate effective communication methods and skills, using lines of authority appropriately.
- Interacts continuously with member, family, physician(s) and other Providers utilizing clinical knowledge and expertise to determine medical history and

current status; assesses options for care including use of benefits and community resources to update the Care Plan.

- Act as liaison and member advocate between the member/family, physician and facilities/agencies.
- Plan team conferences and family meetings, as necessary, to discuss care options with the physician and Providers.
- Determine levels of complex case management (acuity) for all referred Members.
- Act as liaison between the PCP and contracted home health Providers to oversee medically appropriate authorization of services. Perform concurrent telephone review and/or home visits to verify the services being provided are consistent with the medical orders.
- Promote an effective working relationship with Providers. Providers may include the PCP, specialty physicians, SNF's, home care or DME vendors, infusion companies or any contracted health care agency. The Case Manager will serve as an informed resource on PUP policies and benefits to all Providers and proactively identify problems with possible solutions.
- Coordinates care for members transitioning from one setting to another and notifies the PCP of such transitions. Targets at risk members and documents findings in appropriate system. Communicates with Members post hospital/SNF discharge and tracks responses on the Post Discharge Questionnaire.
- Completes monthly review of readmits, high-utilization and high risk Members, as directed.
- Maintains accurate record of case management activities in the appropriate System or via paper; documents daily all calls and follows Case Management documentation guidelines which include but are not limited to documentation of problems, goals, interventions, barriers and outcomes and maintains accurate active caseload list. Assesses member's progress against the case management plan.
- Coordinates community resources with emphasis on the development of natural support system; coordinates benefits, regulations, laws and public entitlement programs; applies case management standards, maintains HIPAA standards and confidentiality of protected health information; reports critical incidents and information regarding quality of care issues.
- Responsible for coordinating appropriate serves, at the appropriate level of care and delivering cost-effective, quality-based health care services for health plan members.
- Identifies high-risk/high-cost members for possible case management intervention and identifies members with chronic disease process for possible disease management intervention.
- Identify and reduce member's health risk factors leading to illness and adverse health events.
- Identifies and reduces medical treatment gaps or treatment that does not meet established medical standards.
- Increases member adherence to prescribed treatment.
- Performs home visits on members with questionable needs or obtain authorization for a home health evaluation.
- Visits members at Providers' offices, as appropriate.
- Visits Providers with Medical Director and/or Sr. Director, Health Services to establish relationships.

- Evaluates each case for quality of care, documents quality issues and appropriately refers cases with questionable quality of care in accordance to established policy.
- Supports the organization's Quality Management Program; participates in ongoing clinical quality improvement activities as it relates to internal programs and processes, studies, projects or medical record review.
- Addresses the needs of internal and external customers; including co-workers, internal departments, Members, Providers and vendors.
- Ensures compliance with all state and federal regulations and guidelines in day-to-day activities.
- Attend workshops and seminar to improve knowledge.
- Participate in various task force and committee projects, as requested.

Qualifications To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and/or Experience

Appropriate education that meets the requirements for professional licensure. Continuing education requirements are met through renewal of licensure by the FL Department of Health. Case management experience a plus.

Certificates, Licenses, Registrations

RN with current unrestricted Florida License;
Complex Case Management certification preferred.

Other Skills and Abilities

Some local travel required; home and/or office visits.

Other Qualifications

At least 2 years experience in Managed Care and Medicare preferred with 2 years work experience in a direct patient care setting; prefer hospital acute care setting.

Sign-on Bonus