CASE MANAGEMENT NURSE - BILINGUAL

LOCATON:	REMOTE
STATUS:	Full-Time/Salaried/Exempt
DATE:	06/13/2022

BASIC FUNCTION

The Bilingual Case Management Nurse position is responsible for conducting case management activities in accordance with Medical Advocate Program policies and procedures. The position responsibilities include the management of assigned cases to ensure costs are contained and quality of care is maintained as the patient accesses care and services in the continuum of care.

SCOPE OF PRACTICE

Case Management, according to the Case Management Society of America, is defined as; "a collaborative process of assessment, planning, facilitation for options and services to meet an individual's health needs through communicating available resources to promote quality cost-effective outcomes." This service is recognized as an organized process designed to ensure the medical necessity and cost effectiveness of a proposed service. Case Management is designated to promote optimal recovery and rehabilitation by professional involvement throughout the continuum of care.

Case Managers work with the patient, their families, their caregivers, their providers, and the payers to ensure that the healthcare that is provided is the highest quality, most appropriate care that is available through:

- Use of information systems for ensuring adherence to quality and appropriateness standards
- Providing coaching to patient/family/caregivers
- Educating providers, patients, and families about resources available including in network acute care, post-acute care, home healthcare, transitional care, outpatient care, community resources, and self-care.
- Reinforcement of treatment plan and patient education
- Coordinating community-based social service and support needs
- Advocating for the member, providing them with emotional support, helping them understand their current health status, what they can do about it and why those treatments are important.
- Providing providers with an assistant who works within the payer system
- Managing transitions of care
- Reducing readmissions
- Avoiding poor health outcomes
- Improving a member's knowledge on their current disease state or illness as well as basic wellness

SPECIFIC DUTIES AND RESPONSIBILITIES

- Adheres to CM program goals and objectives in health care cost containment while maintaining a high quality of health care delivery system to meet the patient's individualized health care needs through adherence to program policies and procedures.
- Must become knowledgeable of URAC or other Medical Advocate Program-approved CM requirements for Case Managers for CM accreditation.
- Performs telephonic case management activities, communicating with the multidisciplinary team in the timeframes required to meet program goals and objectives.
- Collects pertinent clinical information (including specific claims data when available), documenting findings using the Medical Advocate Program's case management information system program/hard copy charting.
- Summarizes and documents pertinent verbal discussions with the patient/patient's legally appointed representative, family, practitioner, other health care provider or the health plan/payer staff, and/or any case conferences.
- Promotes alternative care and funding programs and research available options to maximize health benefits and/or replace limited or excluded benefits.
- Promotes appropriateness of resources/placement when alternative level of care is required.
- Communicates directly with the patient/patient's legally appointed representative, practitioner, other health care providers and team members when appropriate to gather all clinical information to determine the medical necessity of requested or needed health care services.
- Serves as a patient advocate when deemed applicable or as requested by the patient/patient's legally appointed representative; and,
- Initiate patient assessment.
- Assess the client's strengths, problems, prognosis, functional status, goals and need for specific services/resources, to establish short-term and long-term goals.
- Develops a plan, when indicated, through interdisciplinary collaboration which identifies options and goals.
- Identifies, procures, and coordinates services and resources necessary to implement the individual's plan.
- Provides ongoing evaluation of the individual's progress, effectiveness of the rehabilitation plan, as well as the efficacy and appropriateness of the services provided.
- Advocates on behalf of the individual to assure quality of care and attainment of appropriate goals.
- Promotes individual's self-advocacy skills to achieve maximum self-sufficiency.
- Communicates directly with the designated Medical Director/Physician Advisor or the appropriate supervisory personnel regarding all care/costs that:

    - Are questionable
    - Do not meet criteria
    - Do not appear to meet medical necessity guidelines
    - Are experimental/investigational
    - Are beyond the dollar amount or scope allowed for the individual case manager
    - Are requested/required out-of-network
    - Are required over a prolonged period of time and an extended authorization for care is deemed appropriate for meeting a patient's individualized health care needs.

- Refers cases to the appropriate supervisory personnel and/or payer/health plan's legal staff when there is a threat of litigation and/or those patient's specified by the legal department for immediate referral.
- Recommends, coordinates, or educates regarding alternate care options for patients, families, practitioners, providers, or other members of the multidisciplinary health care team.
- Identifies any teaching required by the multidisciplinary health care team before the care/alternative level of care can be implemented.
- Identifies, in collaboration with the patient/patient's legally appointed representative, practitioners, other health care providers, health purchaser, the multidisciplinary team members and/or physician advisor, the resources that will be required to meet/manage the patient's level of care/acuity of care requirements.

- Identifies and communicates to supervisor, all hospital ancillary providers, physician providers and physician offices, any concerns related to patient safety.
- Develops, monitors, and updates an individualized patient specific CM Plan in collaboration with the patient/patient's legally appointed representative, practitioners, and the multidisciplinary team members.
- Sets realistic goals for the patient as the CM Plan is developed and/or revised.
- Monitors the CM Plan at regular time intervals and/or at the time frequency dictated by the patient's level of acuity, making recommendations for change when opportunities are identified and/or as the patient's illness/health care needs improve or deteriorate.
- Attempts to negotiate discounts or reduced charges when an out-of-network provider is required to manage the level of care/acuity of the case at hand and/or in accordance with payer/health plan's contractual requirements.
- Maintains an active role in assuring continuity of care for patients through early identification and appropriate discharge planning by close and frequent collaboration with the hospital discharge planning/social worker staff.
- Closes stabilized cases after collaboration with the appropriate supervisory personnel.
- Readily available to non-clinical staff to answer questions and ensure that non-clinical staff is performing within the scope of the non-clinical role.
- Customer Services – Internal:
    - Creates and supports a positive and supportive working environment.
    - Identifies and resolves potential personnel/peer problems and issues proactively.
    - Communicates to the appropriate supervisory staff all problems, issues and/or concerns as they arise.
    - Maintains a courteous and professional attitude when working with all Medical Advocate Program staff members and the management team.
    - Actively participates in any CM team meetings.
    - Actively participates in any Medical Advocate Program committee meetings as assigned; and,
    - Serves as a positive role model for peers.
- Customer Services – External:
    - Works, communicates, and collaborates in harmony and in a courteous and professional manner with patients, practitioners/providers, health plan clients and their staff, and the Medical Advocate Program multidisciplinary team.
    - Timely processes and communicates, identifies, and resolves all issues and concerns related to the day-to-day case management activities as assigned/designated.
    - Communicates appropriately and according to Medical Advocate Program policy, and/or regulatory requirements with the practitioners, providers, patients, or their legally appointed representatives, and/or the health plan's UM/Member/Customer Services or claims staff, regarding CM issues or UM coverage Determinations.
    - Serves as liaison and patient advocate when deemed applicable for quality of care and cost outcomes; and,
    - Maintains a working knowledge of the health plan contracts and relevant regulatory requirements.

STANDARDS OF PERFORMANCE

A. Maintenance of company information in a confidential manner.
B. Detailed oriented.
C. Professional appearance, warm demeanor, positive attitude.
D. Motivated self-starter with ability to learn new information quickly.
E. Ability to work independently and be accurate, efficient, and organized.
F. Ability to work as a team member.
G. Ability to manage multiple tasks simultaneously.
H. Ability to work under pressure with time constraints in a changing environment.
I. Ability to communicate effectively with all levels of the organization, customers, and the public.

WORKING ENVIRONMENT

A. This position requires working remotely.
B. The position may require interacting with team members and clients in person, virtually and telephonically.

EDUCATION, EXPERIENCE AND TRAINING

- Registered Nurse
- A Bachelors (or higher) degree in a health-related field preferred.
- **CCM or equivalent preferred**
- **Current, Unrestricted RN licensure required**
- Five (5) years full-time direct clinical or critical care to patients in an acute care hospital medical/surgical or behavioral health setting.
- Three years of experience in applying healthcare criteria or a behavioral health set of criteria or
- Five years clinical experience in case management or acute hospital discharge planning preferred.
- Bilingual in Spanish and English, both verbal and written communication
- Strong communication, documentation, clinical and critical thinking skills, and problem-solving skills are essential.
- Working knowledge of community resources and alternate funding resources.
- Working knowledge of details/resources that are required to individualize a case, contain costs, and maintain quality of care for persons with a complex, chronic, catastrophic, or high-cost illness or injury.
- Strong problem-solving, decision-making, and negotiating skills are essential.
- Strong skills in dealing with difficult and challenging personalities and situations are essential.
- Excellent typing and computer skills, and ability to collect data as assigned for reporting purposes.
- Ability to communicate and work with a multidisciplinary team (internal and external) to facilitate day-to-day workflow; and,
- Ability to recognize and communicate any concerns or issues to appropriate supervisory personnel in a professional and timely manner.

EQUIPMENT AND TOOLS

A. Computer and peripherals
B. Office equipment