JOB DESCRIPTION					
TITLE: Care Manager **ONTARIO COUNTY**		DEPARTMENT: MLTC		EFFECTIVE DATE: 3/1/13 REVISED: 6/5/2013, 12/4/2013, 12/12/2013, 1/3/14, 10/20/14, 10/15/15, 8/7/17	
JOB CODE: 521	GRADE: E3	BENEFITS:	FLSA STATUS:	EEO STATUS:	PAGE:

FUNCTION: Provides advocacy, management, and coordination of health and wellness services and care for assigned members in the following county: **Ontario.** Promotes the goals of maximum independence and prevention of hospitalizations, and instructs on safety, disease processes, evidence-based health strategies, and quality of life interventions. Educates members and caregivers in covered services and benefits, and assists in the access to medical, psychosocial, and environmental resources, provisions, and services.

REPORTS TO: Care Management Manager

HOURS: 40 hours per week; M- F

RELATIONSHIPS: Interfaces with members, caregivers, internal and external Interdisciplinary Team members, referral sources, and vendors.

MANAGES/COACHES: None

Demonstrates I.C.A.R.E. Values which promote Patient and Family Centered Care Delivery Services, which are consistent with agency vision, mission, and strategic goals, as well as promote the image of the agency within the community:

INTEGRITY: Conducts oneself in a fair, trustworthy manner and upholds professional and ethical standards.

COMPASSION: Acts with empathy, understanding, and attentiveness toward all others.

ACCOUNTABILITY: Takes responsibility for own actions and joins with colleagues to deliver on the agency mission.

RESPECT: Treats patients, families, and colleagues with dignity and sensitivity, valuing their diversity.

EXCELLENCE: Leads by example, rising above the ordinary through personal efforts and those of the team.

RESPONSIBILITIES:

1. Works autonomously to provide Care Management/Coaching, health and wellness education, and coordination of healthcare services to an assigned caseload of members.
2. Develops comprehensive Plan of Care (POC), and conducts ongoing assessment to ensure appropriateness of care and services, as well as cost-effective utilization. Evaluates members' response to POC and progress towards goals, and makes modifications as necessary.

3. Conducts phone, and/or in-home/facility assessment visits in order to update the POC, according to workflows, DOH regulations, and agency policy and procedures.
4. Conducts as needed assessments when required, and makes appropriate referrals to ensure prevention of hospitalization, and that all clinical needs are met in a timely manner. Makes referrals to appropriate health and community resources as needed; providing relevant information, and assisting members with accessing. Refers skilled services, including nursing, therapies, and social work as needed to meet the safety, medical, and psychosocial needs of the members.
5. Communicates with members and their caregivers, Health Care providers, Interdisciplinary Team members, and associated vendors to ensure continuity of care.
6. Processes service authorization requests according to workflows and within expected timeframes. Approves/denies requests according to, and within the framework of covered benefits and services.
7. Makes notification to member/caregiver of outcome of approval/denial and provides rationale in writing and via phone.
8. Creates authorization requests for vendors to accompany approvals, and ensures accuracy of authorizations created. Ensures authorizations are sent to vendor in a timely manner to prevent a lapse in member services. Orders supplies, equipment, and other covered items for members according to workflows and expected timeframes, ensuring no lapse in receipt occurs.
9. Documents all communications, requests, and changes in condition along with associated interventions in appropriate data base.
10. Receives and coordinates notification of all emergent/urgent visits, acute hospital and/or SNF admissions and discharges. Follows members through any hospitalizations/admissions, and coordinates necessary discharge follow up to ensure continuum of care.
11. Educates members/caregivers on services and benefits.
12. Researches, updates, and maintains integrity and confidentiality of member charts.
13. Participates in Quality Assurance and improvement activities.
14. Participates in case conferences and service authorization/utilization conferences with Manager.
15. Other duties as assigned.

QUALIFICATIONS:

1. NY State Licensed Registered Nurse.
2. One to three years nursing experience as Care Manager/Care Coordinator/Case Manager in Managed Care environment and/or Community Health preferred.
3. Working knowledge of Community Health/Home Care and Medicare/Medicaid regulations preferred.
4. Prior experience in an interdisciplinary service delivery environment.
5. Strong assessment and comprehensive care planning/managing/coordinating skills.
6. Ability to work independently.
7. Strong organizational, interpersonal, and communication skills.
8. Strong problem solving and crisis intervention skills.
9. Ability to demonstrate strong computer knowledge/skills.

EMPLOYEE ACKNOWLEDGMENT

I have reviewed my job description and agree to perform all duties mentioned to the best of my ability. I understand my job duties may change as the needs of the company change. I further agree to notify my immediate supervisor if I am unable to complete any of my job duties in a timely manner.

_____	_____
Employee Signature	Manager Signature
_____	
Employee Print Name	
_____	_____
Date	Date

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