IHP CASE MANAGER JOB DESCRIPTION

JOB TITLE: Case Manager **STATUS:** Exempt, Full Time

REPORTS TO: Assistant Clinical Director

This job description is intended to be a general statement about this job and is not to be considered a detailed assignment. It may be modified to meet the needs of the organization.

JOB SUMMARY

Under the direction of the Chief Medical Officer and Assistant Clinical Director, the position is responsible for facilitating and coordinating care management services to the network that include care coordination and facilitation activities that promotes the quality and cost of care. The position is responsible for developing a vision and executable plan to attain high quality performance for the clinically integrated network through partnership with the FQHC members, health plans and vendor partners and must understand case management principles, quality management and healthcare reimbursement models.

ESSENTIAL JOB FUNCTIONS

Clinical Care Management

- Identify at risk populations and provide clinical coordination necessary to improve quality of care and control cost for patients attributed to IHP's network.
- Coordinate care between health plans and health centers to ensure there is a cohesive plan to help patients achieve optimal health outcomes.
- Review payer and Arcadia quality performance reports to identify the quality metrics that are performing below performance thresholds and develop and implement clinical action plans to address gaps in care, access, and/or quality outcome issues.
- Work with clinicians and key stakeholders to develop, maintain and monitor the implementation of the care management strategies that support value-based contracts.
- Apply and teach clinical techniques for quality improvement, outcomes measurement and statistical analysis to advance quality and improve health equity of communities.

- Conducts comprehensive assessments to address the whole-person client needs.
- Create care plans for clients with short and long-term goals and the steps to achieve those goals.
- Facilitate and coordinate care needs for identified clients that promote quality and controls cost.
- Evaluate clients progress making adjustments to plan of care as needed to improve outcomes.
- Prepare case related reports that include clinical summary, barriers to goals, outcomes, and prognosis.
- Follow up on client referrals to ensure that clients can access and receive necessary services in a timely manner.
- Coordinate and provide care that is safe, timely, effective, efficient, equitable, and client centered.

Utilization Management

- Partner with the Management Services Organization (MSO), as the primary owner of UM, to perform utilization management reviews for risk-based contract performance by health center and provider.
- Work with the health centers to review utilization patterns and identify improvement plans to improve areas of concern from the UM reviews.
- Partner with payers to design UM processes to improve facility-based events (ED/IP) to ensure proper utilization and outcomes.
- Serve as a clinical resource to member health centers for care management best practices.

Coding & Documentation Integrity

- Provide clinical guidance on coding or documentation audits performed by the Coding & Documentation Integrity Team.

- Utilize CDI audit findings to educate teams on clinical performance and improvement efforts.

Other

- Develop team members and create tools to ensure strong teams and processes are in place for success.
- Meet annual goals outlined by leadership that align with the network strategic plan.
- Establish and maintain collaborative working relationships with community resources.
- Actively participate in staff meetings and training.
- Perform other duties as assigned.

QUALIFICATIONS

Education/Experience

- RN, or LCSW license required.
- CCMC, or equivalent, certification preferred.
- Must have 2-3 years clinical experience: 3+ years preferred.
- Working knowledge of regional health disparities and social determinants of health.
- Working knowledge of Medi-Cal regulations and a variety of rigorous process improvement and quality outcome measurement methodologies, such as, Rapid Cycle Testing, PDSA, FMEA, Healthy People 2010/2020, HEDIS, P4P.
- Must have strong interpersonal skills to work effectively internally and externally and across all levels in an organization.
- Working knowledge of relevant computer systems and software.
- Must have excellent written and verbal communication skills.
- Must possess valid driver's license, insurance, and own transportation for use in work, and be flexible with working some evenings and weekends within a 40-hour workweek.
- Must reside in San Diego County.
- Must be willing to travel, as needed.

Other Required Skills/Abilities

PHYSICAL REQUIREMENTS

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- Ability to sit or stand for long periods of time
- Ability to reach, bend and stoop

- Physical ability to lift and carry up to 20 lbs.
- Office setting.
- Frequent, daily use of computer, telephone, copier and FAX machines.
- Regular periods of high stress and long days
- Must be responsive to multiple deadlines.

HIPAA/COMPLIANCE

- Maintain privacy of all patient, employee and volunteer information and access such information only on as need to know basis for business purposes.
- Comply with all regulations regarding corporate integrity and security obligations. Report Unethical, fraudulent or unlawful behavior or activity.