

NORTHWELL HEALTH

HUNTINGTON

JOB DESCRIPTION

JOB TITLE : CASE MANAGER, RN
DEPARTMENT : CASE MANAGEMENT 1.0FTE
Requisition#0035P5 Position# 10113424
Including Every Other Saturday
REPORTS TO : DIRECTOR, CASE MANAGEMENT

POSITION SUMMARY	Serves as liaison between the patient and facility/physician. Ensures a continuum of quality patient care throughout hospitalization and oversees provisions for patient's discharge. Assesses, plans, oversees and evaluates the appropriateness of care throughout admission and hospitalization of the patient.
RESPONSIBILITIES	<ul style="list-style-type: none">* 1. Facilitates patient management throughout hospitalization.<ul style="list-style-type: none">• Participates in patient management rounds and patient centered meetings.• Identifies potential delays and resolves issues with appropriate departments.• Identifies appropriate utilization of Social Work Services and makes referrals when appropriate.• Confers with physician regarding referrals for Physical Therapy, nutrition, speech and swallow.* 2. Serves as an in-patient liaison - planning, assessing, implementing and evaluating patient in collaboration with the health care team.<ul style="list-style-type: none">• Serves as a resource to the health care team regarding quality, utilization of clinical resources, payer, and reimbursement issues.• Works with on-site screeners in transitioning patients to appropriate post discharge settings.• Collaborates with payers, providing all necessary clinical documentation for the maximization of benefits.• Serves as a liaison to patient, family, admitting, primary care physician, health care team, and hospital departments.• Collaborates with and provides feedback to the primary care physician and multidisciplinary team regarding patient's status with regard to length of stay, utilization of resources and discharge status.* 3. Provides support to the in-patient health care team as well as to patient and family regarding all aspects of admission, hospitalization and discharge plan.<ul style="list-style-type: none">• Involves patient and/or family in discussion and planning for anticipated need for care following discharge.• Ensures patient and/or family are given information regarding their choices regarding transferring the patient to another level of care according to regulatory standards.* 4. Performs concurrent utilization management using Interqual criteria.<ul style="list-style-type: none">• Conducts chart review for appropriateness of admission and continued length of stay.• Contacts and interacts with third party payers to obtain approval of hospital days, pre-certification and post-discharge eligibility in relation to clinical course.• Ensures compliance with current state, federal, and third party payer

	<p>regulations.</p> <ul style="list-style-type: none"> • Identifies patients for Alternate Level Care (ALC) care list and notifies appropriate health team members. • Communicates with insurance companies and physicians regarding utilization issues. • Utilizes important message from Medicare (IMM) when appropriate. • Ensures managed care reviews are up to date and accurately reflect patient’s clinical progress and acute needs. <p>* 5. Participates in the quality management of patient care outcomes.</p> <ul style="list-style-type: none"> • Submits data to management regarding case management and/or quality initiatives. • Participates in data collection regarding patient’s length of stay, utilization of clinical resources, IPRO citations including appropriate recommendations and re-admission within 30 days. <p>* 6. Initiates appropriate discharge planning as supported by initial assessment at time of admission.</p> <ul style="list-style-type: none"> • Reviews patient's chart. • Assesses each patient physically, psychosocially and financially. • Assesses patient's support system to facilitate appropriate discharge to community. • Substantiates, with the physician, the need for home care services. • Coordinates procurement of any supplies, equipment or home lab work needed by patient to evaluate discharge. • Arranges for post-hospital transportation, when indicated. • Interacts and coordinates with community agencies, families, vendors facilities and institutions to facilitate patient discharge. <p>* 7. Documents the case management process in the medical record.</p> <ul style="list-style-type: none"> • Completes and documents a psychosocial assessment on the patient. • Documents on-going processes of patients’ hospitalization. • Documents finalized discharge plan and disposition. • Completes applicable areas of the Patients Discharge Instruction Sheet and the Patient Transfer Sheet. • Ensures Patient Review Instrument (PRI) is completed and reflects clinical profile of the patient. • Ensures case management sheet is current and accurate. <p>8. Performs related duties, as required.</p> <p>*ADA Essential Functions</p>
<p>REQUIRED EXPERIENCE AND QUALIFICATIONS</p>	<ul style="list-style-type: none"> • Bachelor’s Degree in Nursing, required. • Current license to practice as a Registered Professional Nurse in New York State. • Case Management Certification, preferred. • Minimum of one (1) year related experience, required. Experience in case management and clinical pathways, variance analysis and trending, quality management/utilization review and home care/discharge planning, preferred. • Keeps abreast of developments in the field and serves as a resource to other staff.

Department Head Signature

Date

CASE MANAGER, RN

Human Resources Signature

Date