# NORTHWELL HEALTH

# HUNTINGTON

## JOB DESCRIPTION

**JOB TITLE** : CASE MANAGER, RN

**DEPARTMENT** : CASE MANAGEMENT
1.0FTE 8:30AM-4:30PM
Includes Weekends and Holidays
**Req# TBD Position#10062458**

**REPORTS TO** : DIRECTOR, CASE MANAGEMENT

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| **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** | * 1. Facilitates patient management throughout hospitalization.<br>• Participates in patient management rounds and patient centered meetings.<br>• Identifies potential delays and resolves issues with appropriate departments.<br>• Identifies appropriate utilization of Social Work Services and makes referrals when appropriate.<br>• Confers with physician regarding referrals for Physical Therapy, nutrition, speech and swallow.<br>* 2. Serves as an in-patient liaison - planning, assessing, implementing and evaluating patient in collaboration with the health care team.<br>• Serves as a resource to the health care team regarding quality, utilization of clinical resources, payer, and reimbursement issues.<br>• Works with on-site screeners in transitioning patients to appropriate post discharge settings.<br>• Collaborates with payers, providing all necessary clinical documentation for the maximization of benefits.<br>• Serves as a liaison to patient, family, admitting, primary care physician, health care team, and hospital departments.<br>• 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.<br>* 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.<br>• Involves patient and/or family in discussion and planning for anticipated need for care following discharge.<br>• Ensures patient and/or family are given information regarding their choices regarding transferring the patient to another level of care according to regulatory standards.<br>* 4. Performs concurrent utilization management using Interqual criteria.<br>• Conducts chart review for appropriateness of admission and continued length of stay.<br>• Contacts and interacts with third party payers to obtain approval of hospital days, pre-certification and post-discharge eligibility in relation to clinical course.<br>• Ensures compliance with current state, federal, and third-party payer |



RD: 08/00, 09/00, 04/01; CV/RD: 07/08 (CB); JDP09
131/88

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| | regulations.<br>• Identifies patients for Alternate Level Care (ALC) care list and notifies appropriate health team members.<br>• Communicates with insurance companies and physicians regarding utilization issues.<br>• Utilizes important message from Medicare (IMM) when appropriate.<br>• Ensures managed care reviews are up to date and accurately reflect patient's clinical progress and acute needs.<br>* 5. Participates in the quality management of patient care outcomes.<br>• Submits data to management regarding case management and/or quality initiatives.<br>• 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.<br>* 6. Initiates appropriate discharge planning as supported by initial assessment at time of admission.<br>• Reviews patient's chart.<br>• Assesses each patient physically, psychosocially and financially.<br>• Assesses patient's support system to facilitate appropriate discharge to community.<br>• Substantiates, with the physician, the need for home care services.<br>• Coordinates procurement of any supplies, equipment or home lab work needed by patient to evaluate discharge.<br>• Arranges for post-hospital transportation, when indicated.<br>• Interacts and coordinates with community agencies, families, vendors facilities and institutions to facilitate patient discharge.<br>* 7. Documents the case management process in the medical record.<br>• Completes and documents a psychosocial assessment on the patient.<br>• Documents on-going processes of patients' hospitalization.<br>• Documents finalized discharge plan and disposition.<br>• Completes applicable areas of the Patients Discharge Instruction Sheet and the Patient Transfer Sheet.<br>• Ensures Patient Review Instrument (PRI) is completed and reflects clinical profile of the patient.<br>• Ensures case management sheet is current and accurate.<br>8. Performs related duties, as required.<br><br>***ADA Essential Functions** |
| **REQUIRED EXPERIENCE AND QUALIFICATIONS** | • Bachelor's Degree in Nursing, required.<br>• Current license to practice as a Registered Professional Nurse in New York State.<br>• Case Management Certification, preferred.<br>• 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.<br>• Keeps abreast of developments in the field and serves as a resource to other staff. |

*Alma Aspiras/pd* *11/24/2022*

**Department Head Signature** **Date**

**Human Resources Signature** **Date**