

# NORTHWELL HEALTH

## HUNTINGTON

### JOB DESCRIPTION

**JOB TITLE** : CASE MANAGER, RN

**DEPARTMENT** : CASE MANAGEMENT Per Diem  
8:30AM-4:30PM Including Weekend and Holidays  
Req#25833 Position#10129556

**REPORTS TO** : DIRECTOR, CASE MANAGEMENT

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

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

CASE MANAGER, RN

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**Department Head Signature**

**Date**

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**Human Resources Signature**

**Date**