Job Code:	1862
Job Title:	Care Manager Specialist
Union Status:	Non-Union
Supervision:	No
FLSA Status:	Exempt

POSITION SUMMARY

The Care Manager Specialist (CMS) is accountable for making a positive difference in our member's lives by ensuring proactive and balanced care at the right time to improve clinical outcomes and lower costs. This position is responsible to collaborate with healthcare providers and members to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources for more complex medical issues. The CMS is responsible for supporting the management of complex medical cases and health care needs across the continuum of care using the care management process to ensure optimal care, services, and provides care coordination for members. The CMS effectively utilizes clinical criteria guidelines and accreditation standards as well as department processes and procedures to achieve utilization targets.

REQUIRED RESPONSIBILITIES

Required Responsibilities	**% of Time**
Optimal health care management for members:	80

- Identify and evaluate candidates for care coordination (discharge planning and transition of care). Assess for future needs and provide clinical support.
- Utilize clinical knowledge and critical thinking to anticipate the members needs by completing a thorough assessment of overall functioning and psychosocial needs in order to develops a plan.
- Coordinate and manage complex medical cases and services provided to care management patients resulting in appropriate care and cost-effective outcomes.
- Provide brief interventions including motivational interviewing, behavior activation, and problem-solving to actively engage members in change behaviors that support medical and behavioral health regimens impacting overall wellbeing.
- Enable shared and informed decisions working collaboratively with the member and provider.
- Ability to facilitate shared decision making in collaboration with member, and other medical professionals.
- Provide follow through on the complex care management for members identified.
- Exhibit strong understanding of a variety of complex diagnoses and chronic disease conditions including the standards of care and management of those conditions.

- Exhibit the ability to proactively engage individuals in shared decision making.

Optimal health care utilization for members: 10

- Review admissions and service requests within assigned unit for prospective, concurrent and retrospective medical necessity and/or compliance with reimbursement policy criteria.
- Exhibit strong clinical judgment to ensure that the services being requested are medically necessary and/or medically appropriate utilizing established protocols, medical policies, and purchased clinical criteria guidelines.
- Gather relevant clinical information specific to the targeted medical or behavioral health condition and assess resource utilization and cost management, diagnosis, past and present treatments, and prognosis.
- Ability to understand and analyze medical records, diagnoses and/or symptoms, and treatment plans.
- Knowledge to determine whether a diagnosis and/or symptom should respond to a specific treatment plan.
- Determination of whether requested services are considered standard of care based on clinical practice guidelines.
- Monitor the treatment plan to:
- Optimize patient outcomes to reduce costs and offer the least restrictive setting.
- Ensure appropriate and consistent care to reduce variation of care.

Research and development: 10

- Knowledge of trends/best practices in healthcare quality.
- Research and identify standards of care and contemporary medical practices.
- Assist in the development of effective internal clinical guidelines that assure appropriate and consistent coverage decisions and medical review standards, policies, and procedures.
- Assist with the evaluation of new medical management programs and emerging technology, software, and other reference sources and recommends the purchase or use of such sources as appropriate.
- Lead or participate in special projects as assigned.
- Lead or participate on committees as assigned.

Leadership Accountabilities **% of Time**

- Attract, train, develop, manage, and retain high performing staff.
- Lead or assist in leading department change and change acceptance.
- Champion, model, and coach staff to exhibit cultural beliefs.
- Lead and engage staff in continuous improvement.
- Maintain department policies and procedures.
- Serve on or lead department or enterprise project teams.

- Manage and collaborate with other department leaders on the development of the department budget, expenses and initiatives.

REQUIRED QUALIFICATIONS

- Minimum: Degree in nursing or health related professional with a certification or licensure.
- Four to six years of clinical experience in a variety of health care settings, including three to four years working in a managed care setting.
- Registered Nurse licensure or Masters-level behavioral health licensure therapist.
- Case/Care management skills, including:
- Ability to manage complex medical cases and health care needs across the continuum of care.
- Knowledge of acute and chronic diseases or disorders and treatment options available.
- Knowledge of community resources available to participants.
- Knowledge of payer resources available for various services.
- Ability to understand and analyze medical records, diagnoses and/or symptoms, and treatment plans.
- Knowledge to determine whether a diagnosis and/or symptom should respond to a specific treatment plan.
- Ability to provide telephonic care coordination.
- Determination of whether requested services are considered standard of care based on clinical practice guidelines.
- Proper interpretation of insurance policy provisions and assessment of coverage under the policy.
- Knowledge of trends/best practices in healthcare quality.
- Knowledge of Internet for research, word processing, and spreadsheet applications (Microsoft Word and Excel preferred)
- Excellent performance in present and past positions.

REQUIRED SKILLS

- Excellent verbal and written communication skills. Strong analytical and problem solving skills.
- Demonstrated ability to collaborate and communicate effectively in a team setting.
- Ability to work as an effective team member with staff.
- Ability and willingness to work with members and providers by telephone.
- Excellent organizational skills and the ability to prioritize work to manage large numbers of requests and meet required turnaround times.
- Ability to be composed and adaptive in a dynamic, fast-paced, customer-focused work environment characterized by rapid change, minimal lead times, and multiple competing priorities.

- Accountable, open, candid and transparent.
- Flexibility to work the number and schedule of hours needed to accomplish regular and ad hoc job responsibilities.
- Commitment to excellence in customer service and the employer's cultural and other values.
- Ability to professionally handle callers whom are difficult, angry or upset related to their policy limitations.
- Critical thinking, problem solving, and decision-making skills, including the ability to identify problems, research and analyze issues from different perspectives, organize information, reach sound conclusions, and work cooperatively with others to develop and implement effective solutions.
- Ability to develop and maintain effective, collaborative relationships with customers, providers, and staff at all levels of the organization

- Leadership or supervisory skills and the ability to lead others to achieve desired results, including:
- Ability to assess individual performance and communicate assessments effectively.
- Ability to identify and effectively and efficiently resolve employee performance problems or issues.
- Ability to establish goals and assist others to achieve goals and meet expectations.
- Collaboration and team building.
- Establishment and implementation of ambitious yet achievable objectives, standards, and project work plans.

WORK REQUIREMENTS

- Ability to work in typical office conditions with frequent use of computer equipment.
- Flexibility to work the number and schedule of hours needed to accomplish regular and ad hoc job responsibilities.

PREFERRED QUALIFICATIONS AND SKILLS

- A Masters-level health professional with a health certification or licensure.
- Certified Case Manager (CCM) certification.
- Familiarity with group insurance administration concepts and terminology.
- Knowledge of Interqual and/or MCG guidelines.
- Knowledge of accreditation processes: Joint Commission for Accreditation of Health Care Organizations (JCAHO), URAC, and National Clinical Quality Accreditation (NCQA).
- Case or disease management experience in a managed care environment.
- Familiarity with group insurance administration concepts and terminology.
- Experience in a clinical setting.

OTHER		
Cell Phone Stipend	**Auto Stipend**	**Commissions**