Clinical Care Manager, Rhody Health Options- Custodial

CareLink Mission: The CareLink mission is to lead its members in the development of a high quality, responsive, and relevant aging services network that cares for adults with complex health issues.

CareLink Vision: CareLink and its members will create and implement innovative solutions within the health care system that make a positive impact on the lives of adults living with complex health issues.

Position Overview:

This program that provides case management services to a portion of the nursing home population. The Clinical Care Manager conducts patient chart reviews, completes assessments for appropriateness of relocation back to the community. The Clinical Care Manager completes assessments at the nursing home/nursing center and/or by telephone working as part of the Interdisciplinary Care Team (ICT) with the residents and nursing home staff.

Duties/Responsibilities:

1. Abide by laws governing confidentiality of client identifiable health information, and adherence to organization policies and procedures.
2. Perform complete and accurate in-person assessments of members in nursing facilities or in the community in a timely fashion; timely data entry of assessments, case activity, and maintenance of care plan records in care management system.
3. Interpret the appropriate information needed and compare assessment data to baseline assessment to monitor a member's progress, recognize alterations in function, including life-threatening situations. Intervene and document appropriately.
4. Maintain ongoing responsibility for assigned caseload, and schedule work load for maximum efficiency.
5. Conduct comprehensive, culturally and linguistically appropriate assessments, re-assessments, and care planning.
6. Reviews assessments and presents client findings at periodic case review.
7. Seeks and provides peer consultation about cases that are problematic and/or present significant deviations from the plan of care.
8. Coordinate and confirm that long-term social supports are in place; assist member in accessing community-based support services, including, but not limited to, assisting with scheduling appointments, transportation, and vendor services when needed.
9. Responsible for providing continuous support and regular communication with members and families, vendors, primary care practitioners (PCPs), and other involved providers; including coordination of assessments and transitional discharge plan, implementation of the care plan, follow up, and reevaluation as needed.
10. In addition to telephonic contact with members, duties require travel throughout RI to maintain face-to-face contact with members throughout the care management process, including but not limited to home visits, hospital visits, or nursing home visits; provide supervision to paraprofessionals performing home visits.
11. Participate in ICT meetings as often as required, and as needed, to develop and update member care plans.

12. Describe and provide proposed care plan to member for approval. Review and make revisions in collaboration with member, and/or their representative, and the ICT as appropriate.
13. Ensure prompt implementation of care plan upon approval by the member.
14. Support member compliance by promoting effective and ongoing health education and disease prevention activities for the member, facilitating informed choice and promoting self-management of members.
15. Assist in transitional discharge planning of members to the community while helping to ensure continuity of care/services, taking steps to avoid interruptions of care/services in an effort to minimize transitions for the member.
16. Assist member with documentation of advance directive in coordination with medical professionals regularly and as needed.
17. Attend assigned trainings and continue regular ongoing education to increase skills, knowledge, and expertise to effectively deliver care management assistance.
18. Provide some on-call member support after hours including weeknights, weekends, and holidays on a rotating basis.

Requirements:

- Licensed RN, MSW, LCSW, or LICSW, State of Rhode Island.
- 3 to 5 years' experience in community health setting, public health, chronic disease management, community nursing, and/or case management preferred.
- Experience working with primary care providers and patients to coordinate care and disease management.
- Ability to work in an interdisciplinary setting.
- Strong organizational and documentation skills.
- Excellent customer service orientation.
- Experience with risk-scoring tools and level assessment.
- Bi-lingual (English/Spanish) a plus.
- Ability to work independently and maintain good judgment and accountability.
- Ability to multi-task and prioritize tasks to meet deadlines.
- Ability to problem solve and work effectively in a fast-paced growing environment.
- Ability to work cooperatively as a team member.