APLA Health's mission is to achieve health care equity and promote well-being for the LGBT and other underserved communities and people living with and affected by HIV. We are a nonprofit, federally qualified health center serving more than 14,000 people annually. We provide 20 different services from 15 locations throughout Los Angeles County, including: medical, dental, and behavioral health care; PrEP counseling and management; health education and HIV prevention; and STD screening and treatment. For people living with HIV, we offer housing support; benefits counseling; home health care; and the Vance North Necessities of Life Program food pantries; among several other critically needed services. Additionally, we are leaders in advocating for policy and legislation that positively impacts the LGBT and HIV communities, provide capacity-building assistance to health departments across the country, and conduct community-based research on issues affecting the communities we serve. For more information, please visit us at aplahealth.org.

We offer great benefits, competitive pay, and great working environment!

We offer:

- *Medical Insurance*
- *Dental Insurance (no cost for employee)*
- *Vision Insurance (no cost for employee)*
- *Long Term Disability*
- *Group Term Life and AD&D Insurance*
- *Employee Assistance Program*
- *Flexible Spending Accounts*
- *12 Paid Holidays*
- *3 Personal Days*
- *10 Vacation Days*
- *12 Sick Days*
- *Metro reimbursement or free parking*
- *Employer Matched 403b Retirement Plan*

This is a great opportunity to make a difference!

This position will pay $80,683.20 - $104,116.36. Salary is commensurate with experience.

POSITION SUMMARY:

This position is responsible for the management of the daily operations of Utilization Management (UM) at APLA Health and Wellness (APLAHW). This position will ensure that all processes, programs and operations of utilization management are fully implemented for APLAHW.

The Utilization Manager will be proactive in establishing collaborative working relationships with each member of the Care Delivery team to assure a sound Utilization Management Program.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

- Develops and Implements a standardized Utilization Management Program to ensure that all functions meet internal, Government, Health Plan/IPA and medical group requirements.
- Ensures staff competency utilizing inter-rater reliability tools and evidence-based criteria for utilization review.
- Develop, implement and maintain compliance, policies and procedures regarding medical utilization management functions.
- Establishes excellent working relationships with all internal/external constituents and staff, including the Chief Medical Officer, clinic directors and site medical directors. Promotes collaborative relationships. Works cooperatively with other managers in the Quality Department, including the quality manager and risk/compliance manager.
- Participates in the collection, analysis and reporting of data relevant to utilization management.
- Collaborates with the Quality Director to identify opportunities for process improvements in Utilization management that are consistent with the organization's vision and strategic long term goals.
- Develop, implement, and maintain utilization management programs to facilitate the use of appropriate medical resources and decrease the business unit's financial exposure.
- Compile and review multiple reports on work function activities for statistical and financial tracking purposes to identify utilization trends and make recommendations to management.
- Communicates with the staff both verbally and in writing to convey health plan, contract or operations information to ensure all staff members have a consistent and appropriate knowledge base to perform their duties.
- Promotes staff growth and development by identifying educational opportunities to increase efficiency and maintain compliance with industry standards.
- Participates in staff meetings, assuring policy and procedures are adhered to and, when necessary, modified to address changing strategic objectives.
- Supervise a staff of referral coordinators, currently consisting of one supervisor and 5 other referral coordinators; Supervise at least 2 patient engagement and retention specialists; Supervise at least 2 medical records coordinator.
- Optimize processes and workflows for the UM staff.
- Ensure the referrals staff are meeting key quality and risk management goals and referrals are being properly tracked.
- Hire and train new UM staff as needed.
- Manage the medical group's referral filter tool, flagging questionable referrals for further evaluation by the site medical director.
- Supervise staff who are monitoring patients in emergency departments and hospitals in real time and ensuring that such patient receive appropriate follow up

by clinical staff. If necessary, this may require directly contacting patients to coordinate care to minimize risk of hospital readmission.
- Ensure that high utilizing patients are appropriately engaged in case management programs
- Report key UM metrics at monthly agency quality meetings
- Lead monthly UM committee meetings
- Other duties may be assigned to meet business needs

REQUIREMENTS:

Training and Experience:
- Five (5) years' utilization/care management experience in a clinical or managed care setting preferred.
- Four (4) years management/supervisory experience (in a formal or informal role) preferred.
- Requires either a Bachelor's degree in Nursing (RN with active California certification) or other Healthcare related field like MPH, MHA, MBA/MS in healthcare related filed
- Basic computer skills in a Windows operating environment including Microsoft Word, Excel, and an e-mail system.
- Must be a dynamic leader, able to navigate a complex environment, with excellent verbal and written communication skills, as well as strong operations experience.
- Effective influencing, negotiation, relationship-building and communication skills are essential.
- Effective employee management skills.
- Possess strong leadership, critical-thinking and motivational skills/abilities.
- Excellent problem-solving and organizational skills required.

Knowledge of:
- Knowledge of InterQual and/or Milliman software preferred.
- Knowledge of electronic health records systems (eclinicalworks preferred).
- Knowledge of ambulatory healthcare delivery and management.
- Knowledge of NCQA, DMHC, CMS and other regulatory agency requirements pertaining to delivery of health care in the managed care setting.

Ability to:
- Ability and willingness to travel among APLAHW locations.
- Manage people through change.
- Demonstrate flexibility through change.
- Lead and form a collaborative team.
- Work effectively under pressure due to changing priorities.
- Independently and self-direct activities.
- Work effectively, establish, and promote positive relationships.
- Adapt quickly to changing conditions while managing multiple priorities.

WORKING CONDITIONS/PHYSICAL REQUIREMENTS:

This is primarily an office position that requires only occasional bending, reaching, stooping, lifting and moving of office materials weighing 25 pounds or less. The position requires daily use of a personal computer and requires entering, viewing, and revising text and graphics on the computer terminal and on paper.

SPECIAL REQUIREMENTS:
Must possess a valid California driver's license; proof of auto liability insurance; and have the use of a personal vehicle for work related purposes. COVID Vaccination and Booster require or Medical/Religious Exemption.

Equal Opportunity Employer: minority/female/transgender/disability/veteran.

To Apply:

Visit our website at www.aplahealth.org to apply or click the link below: https://www.paycomonline.net/v4/ats/web.php/jobs/ViewJobDetails?job=121088&clientkey=A5559163F67395E0A2585D2135F98806