Arroyo Vista Family Health Center

JOB DESCRIPTION

Position Title: Lead Care Manager (LCM), Enhanced Care Management (ECM) Program

Salary Range: $22.00 To $26.00 Hourly

Summary:

Under the direct supervision of the ECM Director, the ECM LCM is responsible for providing intensive case management services to medically and socially complex high-risk members in a person-centered and compassionate manner. The ECM Lead Care Manager is responsible for the development and implementation of an individualized care plan with each assigned ECM member and/or caregiver (referred as "member"). The ECM LCM works with a multidisciplinary team for timely identification and intervention of care plan goals and objectives that meet the self-identified strengths, health care and psychosocial needs of the member. The ECM LCM acts as member advocate providing timely interventions and support to assigned members.

DUTIES AND RESPONSIBILITIES:

- Responsible for regularly engaging eligible ECM members in accordance with Department of Health Care Services (DHCS) and contracted Managed Care Plans (MCP) intensive care guidelines, to meet Arroyo Vista ECM policy and procedures for LCM performance and productivity expectations.
- Responsible for maintaining a member schedule in the Practice Management and Electronic Health Record (PM/EHR) system, including scheduling recurrent member appointments, processing encounters, documenting, coding and billing following organization policy and each MCP program guidelines.
- Responsible for providing person-centered services where the ECM member lives, seeks care, or finds most easily accessible, within ECM program care provision and safety guidelines.
- Responsible for ensuring timely provision of ECM services and implementation of ECM Initial Health Assessment, monthly ECM Care Plan development and interventions as well as, timely reassessments, transition of care and program completion questionnaires, as per MCP guidelines.
- Responsible for connecting with ECM member in-person or by phone or other telehealth modalities to facilitate engagement, assessment, follow-up, and education/training visits in order to develop and address the member's care plan goals and barriers.
- Responsible for collaborating with ECM member and multidisciplinary team to regularly identify, update and achieve Care Plan goals and objectives.
- Responsible for following motivational interviewing, trauma- informed care, and harm-reduction approaches and implementation of Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) goals documentation.
- Responsible for proactively monitoring member services utilization and coordinating timely transition of care with member, hospital staff and PCP following member-centered discharge plan, including monitoring treatment adherence, medication reconciliation and in-home support.

- Responsible for providing adequate health promotion and self- management coaching to members in a culturally and linguistically appropriate manner to address members' health literacy needs.
- Responsible to advocate on behalf of members with health care and social services professionals, and for researching, facilitating and coordinating community, social services and/or resources that aligns with ECM member's care plan goals and population of focus priorities. ECM LCM is responsible for leveraging resources to ensure timely access, through contracted primary care, specialist and hospital network, MCP contracted Community Support (CS) services contractors, and/or other member accessible social services to ensure a seamless experience for the Member and non-duplication of services.
- Responsible for arranging transportation, accompanying ECM member to appointments, as appropriate and in accordance with MCP and organization guidelines.
- Responsible to convene care conference meetings with clinical consultants and multidisciplinary team members to inform and ensure optimal care coordination.
- Responsible for coordinating with community partners, MCP and multidisciplinary team to ensure accurate care plan data and updates.
- Responsible for utilizing AVFHC's PM, EHR, Population Management and HIEs and other communication systems to schedule, document and coordinate services, and to track, input data and generate accurate and timely ECM program activity and progress reports.
- Responsible for attending required ECM trainings and active participation and reporting at monthly internal and MCP meetings.
- Under the direction and supervision of the ECM Director, responsible for facilitating internal ECM trainings/updates to AVFHC clinical and interdepartmental staff members to optimize ECM referral, enrollment and integration across organization.
- Under the direction and supervision of the ECM Director, responsible for collaborating with AVFHC IT department to ensure ECM templates are appropriate and effective at capturing needed data/information and reporting, as well as with the Billing department to ensure appropriate and timely claims and encounter data submission.
- Responsible for following ECM guidelines in alignment with AVFHC policy and procedures, including but not limited to HIPAA, member consent and data confidentiality, and to provide timely feedback for continuous quality improvement of ECM protocols, policies, and workflows.
- Responsible for maintaining accurate member EHR and master database documentation, for completing required ECM data entry in MCP portals and submit monthly reports and other internal reports in a timely manner and as assigned.
- Responsible for providing support with ECM outreach and enrollment activities as assigned.
- Performs other related duties as assigned.

KNOWLEDGE, SKILLS AND ABILITIES

- Ability to provide compassionate, person-centered care, utilizing motivational interviewing, trauma-informed care, and harm-reduction approaches to engage vulnerable populations.
- Strong documentation, attention to detail, and follow-through skills.
- Ability to multi-task and prioritize when needed.
- Ability to independently seek out resources and work collaboratively.
- Ability to develop and maintain good working relationships with staff.
- Ability to use computer and learn new software programs.
- Excellent interpersonal skills reflecting clarity, diplomacy, and the ability to communicate accurately and effectively with all levels of staff and management.
- Demonstrates ability to work in a regulatory climate that includes oversight of state and federal entities, payer contracts etc.
- Possesses ability to communicate effectively, both verbally and in writing.
- Proficient knowledge of Microsoft Outlook, MS Word and Excel.

- Able to travel to meet with members, attend professional meetings, conferences, as assigned.

REQUIREMENTS:

- Registered Nurse (RN), Licensed Vocational Nurse (LVN) or paraprofessional with bachelor's degree in behavioral health, social work, sociology, human services or related fields with at least 2 years of case management or related experience in the field preferred.
- Medical Assistants certification with related case management experience will be considered in lieu of license or bachelor's degree.
- Two or more years of experience providing home health, medical and/or social services case management to low income populations with one or more of the following: complex chronic conditions, high utilizer of emergency room and tertiary health care services, severe mental illness, and/or homelessness, preferred.
- Bilingual in English/Spanish (oral and written).