



POSITION:	LEAD CARE MANAGER
REPORTS TO:	DIRECTOR OF PATIENT SERVICES
POSITIONS SUPERVISED:	NONE
CLASS:	REGULAR
CAT:	FULL-TIME
	NON-EXEMPT

BASIC FUNCTIONS

The Enhance Care Management (ECM) Lead Care Manager (CM) will provide a wide range of case management services for the California Advancing and Innovating Medi-Cal (CalAIM) initiative. This position reports to the Director of Health Education. Duties include the development of collaborative care management plans with clients which support clients' needs in the areas of physical health, mental health, substance use disorders, community-based long-term services support, oral health, palliative care, social supports, and social determinants of health. Core ECM activities include but are not limited to, outreach, comprehensive assessment and care management, care coordination, health promotion, comprehensive transitional care, identifying client support needs, and coordination of and referral to community and social services support.

DUTIES AND RESPONSIBILITIES

1. Client outreach and engagement, including direct communication with client such as in person meetings, mail, email, texts and telephone; community and street-level outreach
2. Maintains compliance with all applicable county, state and federal laws and regulations, funder and program requirements
3. Maintains compliance with all Medi-Cal requirements
4. Complete client assigned service bundles within the MCP and CalAIMs allocated time frame and maintain up to date documentation for services provided to respective clients compliant with Knox-Keene, HIPAA, and DMHC standards
5. Carries a caseload of 30-50 active cases. Typical client engagement/contact requirement is 1x/month based on level of acuity for a period of 6-12 months
6. Complete/update inbound reporting file and outreach log within 24hrs of service rendered
7. Complete a Comprehensive Intake assessment on each patient
8. Develop a Care Management Plan (CMP) that incorporates member's needs in the areas of physical health, mental health, SUD, community-based Long Term Services Support, oral health, palliative care, social supports, and Social Determinants of Health
9. Care coordination and organizing patient care activities per the CMP and case conferences for care coordination
10. Sharing and maintaining information with client's multidisciplinary team and implementing activities per CMP, including Community Supports
11. Support client engagement in treatment including coordination or medication review and or reconciliation, scheduling appointments, appointment reminders, coordinating transportation, accompany client to critical appointments, identify and address other barriers to client's engagement in treatment
12. Ensuring regular contact with the member and their family member(s), guardian, caregiver, and/or authorized support person(s) as part of care coordination
13. Engage and help client participate in and manage their care
14. Coaching members to make lifestyle choices based on healthy behavior - goal is for members to successfully monitor and manage their health
15. Supporting members in strengthening their skills to identify and access resources to assist them in managing and prevention of chronic condition

16. Linkage to resources based on member's needs such as smoking cessation, self-help recovery, etc.
17. Provide transitional care for clients during discharge from hospital or institutional setting including developing a transition care plan, and coordination of care to provide adherence support and referrals to appropriate resources and community supports, as needed
18. Identify supports needed for client
19. Collaboration with Community Supports provider to coordinate services
20. Provide appropriate education of the member and/or their family support/authorized support about care instructions for the member
21. Assist members in accessing additional benefits and related documentation such as, Social Security Insurance (SSI), CalFresh, cash aid, and obtaining required documentation to apply (ID, birth certificate, immigration status, financial records, marriage/divorce records, proof of medical conditions, etc.)
22. Develop, establish, and maintain professional and collaborative working relationships with internal and external care team
23. Network with community and stakeholders to remain current on issues and activities as they impact coordination of care for clients.
24. Coordination of care with health plans
25. Attend required training to maintain provider certification and current industry knowledge
26. Performs administrative tasks including timely record keeping and data entry
27. Maintains up to date, within 24 hours of service delivery, adequate records and other documentation necessary for the collection of data and statistics pertaining to program outcomes demographics, and information as required by funders
28. Collaborate as an active member of a team
29. Actively models and communicates the mission and vision and supports a corporate culture of empowerment, team building, and open communication
30. Assist other departments as needed, maintaining confidentiality of VHT's business.
31. Observe and practice all VHT Patient Experience Service Standards as outlined in "World Class Practices: My Commitment to Care (which I have read and signed).
32. Practice CICARE techniques, including phone etiquette guidelines when interacting with patients, their families, visitors, or internal customers.
33. Respect privacy and dignity of our patients, family members, visitors and co-workers.
34. Maintain professionalism in the presence of patients, their families, visitors and co-workers.
35. Act as a role model, verbally and behaviorally demonstrating skill, enthusiasm, positive problem solving, commitment and loyalty to the profession and the organization.
36. Follow applicable regulations and standards: Joint Commission, OSHA, HIPAA, and CLIA.
37. Perform other duties as assigned by supervisor.

MINIMUM QUALIFICATIONS

1. Bachelor's Degree from an accredited college or university; 1-2 years related experience and/or training or equivalent combination of education and experience
2. Minimum 1-2 years of work experience, preferably providing enhanced/intensive case management services with Medi-Cal physical, behavioral health, and high-risk populations
3. Familiarity and experience documenting medical necessity meeting Medicare/Medi-Cal standards
4. Equivalent combination of education, training, and work experience to demonstrate ability to perform the above tasks
5. Certificate of Health Education Specialist (CHES) preferred
6. Bi-lingual English and Spanish, fluent both in written and oral communication
7. Current Basic Life Support Card

MINIMUM KNOWLEDGE AND ABILITY

1. Ability to communicate effectively and work with an interdisciplinary team
2. Highly motivated and creative individual with lots of energy
3. Strong customer service skills (preferably within the service industry) and maintain an effective and positive working relationship with staff and patients

4. Strong clinical skills in bio-psychosocial assessment, comprehensive case management and supportive services
5. Excellent oral and written communication skills – be able to provide information in a clear and concise manner; good interpersonal skills and show professionalism at all times
6. Knowledge of substance use, mental health, assessments, intervention, and coordinated care strategies
7. Be self-motivated, independent and have the ability to prioritize work and meet deadlines
8. Must be computer literate and have working knowledge of MS Office Suite (e.g. Word, Excel, etc.)
9. Modern office practices and procedures (including email)
10. Must have excellent attention to detail
11. Must have own reliable transportation available for daily use, valid California Driver's License and current proof of automobile insurance coverage as required by the State of California
12. Demonstrated ability to provide world-class patient experience using CICARE principles and practices. Ability to be proactive and to go above and beyond the call of duty; take initiative to provide a world class patient experience in all encounters via email, phone or in person

TYPICAL WORKING CONDITIONS: The office setting is a normal work environment. Occasionally work during early morning, evening or weekend. May be subjected to temperature variances in the office and out in the field. Local travel required,

TYPICAL PHYSICAL DEMANDS: Requires sitting, standing, or walking for up to eight hours a day. Some bending, stretching, or reaching may be necessary. Lifting up to 60 pounds may be required on occasion. Vision must be correctable to 20/20 and hearing must be in the normal range for telephone contact.

WORK ENVIRONMENT: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee may come in contact with hazardous equipment such as liquid nitrogen, cleaning agents, and sharps. The noise level in the work environment is usually moderate but may become excessively loud with the increased patient flow during a busy clinic day.

I, the employee, understand the responsibilities and standards of my position as listed above, and I agree to fulfill them to the best of my ability. I understand I am an at-will employee and can be terminated at any time with or without cause. I also understand the Valley Health Team Inc. will not be responsible in any manner for termination's which are due to defunding of Federal or State Contracts. I also agree that the VHT Board of Directors have the right to modify the Personnel Policies which govern my employment at any time.

This organization is an Equal Opportunity Employer. It is our policy to comply with all applicable state and federal laws prohibiting discrimination in employment based on race, age, color, sex, religion, national origin, or other protected classification.

Employee's Signature

Date