Position: Health Home Care Manager
Reports to: Sr. Manager, Direct Care Management

The Greater Rochester Health Home Network (GRHHN), a subsidiary of FLPPS, is a Health Home (HH) serving the most vulnerable people in our community, especially those struggling with multiple medical and behavioral health conditions. GRHHN works closely with Care Management Agencies (CMA) under the care management service model to ensure communication among all an individual's caregivers with the goal of addressing all the patient's needs in a comprehensive manner.

The Finger Lakes Performing Provider System assists clinical and community-based organizations across a 13-county region to close gaps in care and support high-risk individuals and populations to remain well. Building on DSRIP Promising Practices, FLPPS and our affiliated health home, the Greater Rochester Health Home Network, continue to advance system transformation and population health throughout the Finger Lakes region.

POSITION SUMMARY

Provide care management services working with clients in the community and in collaboration with providers and clients' care team. Proactively manage the needs of clients with high risk or complex medical, behavioral health and/or psychosocial needs through community and home-based visits and telephonic support. Develop and implement a care management plan based on client assessment, goals, preferences and disease states to promote improved health care outcomes and quality of life.

Link clients to appropriate community resources, facilitate referral to appropriate care services, support client self-management, and communicate with providers to reduce barriers to improved health care outcomes. Maintain written documentation meeting NYSDOH, Managed Care Organizations (MCOs), GRHHN, and other applicable requirements for appropriate billing and clinical interventions.

RESPONSIBILITIES

Care Management

- **Contact potential and referred clients within appropriate time frame, addressing any urgent /emergent issues and scheduling in-person assessment.**
- **Engage clients to enable intervention and support; obtain appropriate consent to share information signed by the client or caregiver/ authorized representative.**
- **Conduct an assessment of client condition, needs, preferences and clinical and psychosocial barriers, collecting information from clients and their families and caregivers with client consent.**
    - **Identify risk of adverse health outcomes (e.g. death, disability, inpatient admission, SNF admission or ED visit).**
- **Develop a care management plan based on the client's goals, strengths and barriers that promote improved health care outcomes and quality of life.**
- **Implement the client approved plan of care in collaboration with the care team and client:**

- **Provide culturally sensitive self-management support, health promotion, connection/referral to appropriate providers and community-based organizations to decrease barriers to following the plan of care**
  - **Utilize Self-Management Support interventions to promote self-advocacy. Monitor the client's level of engagement relative to their health goals over time.**
  - **Advocate for clients to assure access and timely service delivery across the continuum of care and community resources.**
  - **Provide education/ information to clients/caregivers in support of care plan goals.**
  - **Optimize insurance and other benefits to support client access to needed services.**
- **Provide care coordination with Primary/Specialty Medical care, acute and outpatient medical, mental health and substance abuse services, and other care managers involved in supporting the individual**
- **Provide comprehensive transitional care to coordinate care and services post critical events (i.e. emergency department use, hospital inpatient admission and discharge, residential facility or skilled nursing facility admission and discharge)**
- **Provide crisis intervention planning to address events such as emergency department visits, inpatient admissions or other crisis events to ensure planned crisis interventions are effective. Make necessary modifications to the Plan of Care**
- **Conduct medication reconciliation as appropriate and communicate needs for adjustments to care team/provider**
- **Work with family regarding the client's needs; assess caregiver's burdens; provide family and caregiver support; ensure language access/translation services**

- **Maintain contact with the client at appropriate frequency to meet the acuity and/or complexity of the client's current needs, condition or situation.**
- **Address the unique needs and provide required services to clients who are members of special populations (e.g. Health and Recovery Plan (HARP) members, children, those qualifying for Health Home Plus, etc.)**
- **Provide feedback to providers regarding client progress and barriers encountered**
- **Review client plan of care progress no less frequently than semi-annually**
- **Modify goals and care management interventions as appropriate to the needs/progress of the individual**
- **Share information (e.g. progress, barriers, new conditions, etc.) between Team members and other care providers;**

Documentation

- **Document care management activities in a clear, concise and timely manner to ensure documentation is thorough and reflective of client's plan of care.**
- **Complete and update assessments, plans of care, and level of service determination requests within required time frames, in collaboration with the client, providers, and MCOs.**

- **On a monthly and as needed basis, review charts for regulatory compliance and address errors/omissions.**
- **Collect and provide reports of activities as required to meet regulatory requirements and for reporting to internal/external entities.**

Case Review and Collaboration

- **Facilitate Care Team meetings: schedule, prepare and participate in care team meetings to share discoveries, concerns and collaborate in the development of plans of care.**
- **Ensure Care Team meeting output is communicated to the client and all consented care team members.**
- **Contribute to the GRHHN Care Management team to foster positive work relationships and support team members for cross coverage as workload dictates.**
- **Collaborate with other staff related to client needs, barriers to care and outcome enhancement strategies.**

QUALIFICATIONS

- **Bachelor's degree in Social Work, Counseling, or related field**
- **3 years' experience in a community health or equivalent position providing direct services to one or more of the following populations: people with serious mental illness/serious emotional disturbance, developmental disabilities, alcoholism or substance abuse or serious medical conditions or an equivalent combination of education and experience**
- **3 years' experience linking individuals to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing, and financial services) or an equivalent combination of education and experience**
- **Experience with individuals of diverse cultural and religious backgrounds, demonstrating respect for individual/family diversity and a high level of cultural competency**
- **Demonstrated history of compliance with all HIPAA Privacy and Security Standards**
- **Knowledge and experience working with community-based organizations and resources**
- **Knowledge of and ability to work collaboratively with providers and county/community health and human services**
- **Proficiency with Microsoft Office Suite (Word, Excel, Outlook). Ability to learn new software; Knowledge of data analytics tools and dashboards to support analysis and reporting**
- **Must have and maintain an unrestricted NYS driver's license and insured vehicle for frequent/daily travel in the community travel**
- **Bilingual skills, preferred**

COMPETENCIES

- **Outstanding client and partner focus: service mind-set, build rapport, prompt follow through.**
- **Excellent communication skills, demonstrating the ability to adapt, actively listen and engage to build relationships and influence outcomes in sensitive situations**

- **Strong organizational skills, proven ability to work independently and to manage time appropriately to achieve metrics and deliverables**
- **Ability to interact with external partners, members and staff in a fast-paced environment, sometimes under pressure, remaining positive, flexible, proactive, resourceful and efficient, with a high level of professionalism**
- **Initiative and the ability to effectively participate in an environment in which collaboration is highly valued and reporting relationships are not direct; possess a flexible, "can-do" attitude.**
- **Sound reasoning and problem-solving skills; using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems**
- **Exercise discretion and judgment regarding highly confidential internal and external communications and within generally defined practices and policies**
- **Appropriate handling of Protected Health Information and Medicaid Data as documented in the policies and procedures**
- **Flexibility and positive attitude to accept duties as assigned to support changing activities.**
- **Consistent demonstration of FLPPS Personality traits: Collaborative, Trusted, Result-Oriented, Strategic and Adaptive**

This job description is only a summary of the typical functions of the job, not an exhaustive or comprehensive list of all possible job responsibilities, tasks and duties. Additional responsibilities, tasks and duties may be assigned as necessary.