Case Manager The Texas Medical Center

The purpose of the Case Manager position is to support the physician, primary medical homes, and interdisciplinary teams. Facilitates patient care, with the underlying objective of enhancing the quality of clinical outcomes and patient satisfaction while managing the cost of care and providing timely and accurate information to payors. The role integrates and coordinates resource utilization management, care facilitation and discharge planning functions. In addition, the Case Manager helps drive change by identifying areas where performance improvement is needed (e.g., day-to-day workflow, education, process improvements, patient satisfaction). The position is responsible for coordinating a wide range of self-management support and provides information to update and maintain relevant disease registry activity. Accountable for a designated patient caseload and plans effectively to meet patient needs across the continuum, provide family support, manage the length of stay, and promote efficient utilization of resources.

Principal Accountabilities

- Coordinates/facilitates patient care progression throughout the continuum.
- Works collaboratively and maintains active communication with physicians, nurses and other members of the multi-disciplinary care team to effect timely, appropriate patient care.
- Addresses/resolves system problems impeding diagnostic or treatment progress.
- Proactively identifies and resolves delays and obstacles to discharge.
- Seeks consultation from appropriate disciplines/departments as required to expedite care and facilitate discharge.
- Utilizes advanced conflict resolution skills as necessary to ensure timely resolution of issues.
- Collaborates with the physician and all members of the multidisciplinary team to facilitate care for designated caseload. Monitors the patient's progress, intervening as necessary and appropriate to ensure that the plan of care and services provided are patient focused, high quality, efficient, and cost-effective.
- Facilitates the following on a timely basis: completes and reports diagnostic testing, completes treatment plan and discharge plan, modifies plan of care as necessary, to meet the ongoing needs of the patient, communicates to third-party payors, and other relevant information to the care team.
- Assigns appropriate levels of care.
- Completes all required documentation in TQ screens and patient records.
- Collaborates with medical staff, nursing staff, and ancillary staff to eliminate barriers to efficient delivery of care in the appropriate setting.
- Completes Utilization Management and Quality Screening for assigned patients.
- Applies approved clinical appropriateness criteria to monitor appropriateness of admissions and continued stays, and documents findings based on department standards.
- Identifies at-risk populations using approved screening tool and follows established reporting procedures. Monitors LOS and ancillary resource use on an ongoing basis.
- Takes actions to achieve continuous improvement in both areas.

- Refers cases and issues to the Care Management Medical Director in compliance with department procedures and follows up as indicated.
- Communicates with the Resource Center to facilitate covered day reimbursement certification for assigned patients.
- Discusses payor criteria and issues on a case-by-case basis with clinical staff and follows up to resolve problems with payors as needed.
- Uses quality screens to identify potential issues and forwards information to Clinical Quality Review Department.
- Ensures that all elements critical to the plan of care have been communicated to the patient/family and members of the healthcare team and are documented as necessary to assure continuity of care.
- Manages all aspects of discharge planning for assigned patients.
- Meets directly with patient/family to assess needs and develop an individualized continuing care plan in collaboration with the physician.
- Collaborates and communicates with multidisciplinary team in all phases of the discharge planning process, including initial patient assessment, planning, implementation, interdisciplinary collaboration, teaching and ongoing evaluation.
- Ensures/maintains plan consensus from patient/family, physician and payor.
- Refers to appropriate cases for social work intervention based on department criteria.
- Collaborates/communicates with external case managers.
- Initiates and facilitates referrals through the Resource Center for home health care, hospice, medical equipment, and supplies.
- Documents relevant discharge planning information in the medical record according to department standards.
- Facilitates transfer to other facilities as appropriate.
- Actively participates in clinical performance improvement activities.
- Assists in the collection and reporting of financial indicators including case mix, LOS, cost per case, excess days, resource utilization, readmission rates, denials and appeals.
- Uses data to drive decisions and plan/implement performance improvement strategies related to case management for assigned patients, including fiscal, clinical, and patient satisfaction data.
- Collects, analyzes, and addresses variances from the plan of care/care path with physician and/or other members of the healthcare team.
- Uses concurrent variance data to drive practice changes and positively impact outcomes.
- Collects delay and other data for specific performance and/or outcome indicators as determined by Director of Outcomes Management. Documents key clinical path variances and outcomes that relates to areas of direct responsibility (e.g., discharge planning).
- Uses pathway data in collaboration with other disciplines to ensure effective patient management concurrently.
- Leads the development, implementation, evaluation and revision of clinical pathways and other case management tools as a member of the clinical resource/team.
- Assists in the compilation of physician profile data regarding LOS, resource utilization, denied days, costs, case mix index, patient satisfaction, and quality indicators (e.g., readmission rates, unplanned return to OR, etc.).
- Acts as preceptor/mentor to new hires.

- Assists in development of orientation schedule and helps identify individual learning needs.
- Ensures safe care to patients, staff and visitors; adheres to all Memorial Hermann policies, procedures, and standards within budgetary specifications including time management, supply management, productivity, and quality of service.
- Promotes individual professional growth and development by meeting requirements for mandatory/continuing education and skills competency; supports department-based goals that contribute to the success of the organization; serves as preceptor, mentor and resource to less experienced staff.
- Demonstrates commitment to caring for every member of our community by creating compassionate and personalized experiences. Models Memorial Hermann's service standards by providing safe, caring, personalized and efficient experiences to patients and colleagues.
- Other duties as assigned.

Minimum Qualifications

Education: Graduate of an accredited school of professional nursing required; Bachelor of Nursing preferred, or graduate of an accredited Master of Social Work program.

Licenses/Certifications:

- Current and valid license to practice as a Registered Nurse in the state of Texas or
- Current and valid license as a Master Social Worker (LMSW) in the state of Texas required, LCSW preferred.
- Certification in Case Management required within two (2) years of hire into the Case Manager position.

Experience / Knowledge / Skills:

- Three (3) years of nursing or social work experience acute hospital-based preferred, or three (3) years of experience comparable clinical setting (i.e., ambulatory surgery center, infusion/dialysis clinic, Federally Qualified Health Clinic (FQHC), skilled nursing facility, or wound clinic).
- Experience in utilization management, case management, discharge planning or other cost/quality management programs preferred.
- Excellent interpersonal communication and negotiation skills.
- Demonstrated leadership skills.
- Strong analytical, data management and PC skills.
- Current working knowledge of discharge planning, utilization management, case management, performance improvement, disease or population management, and managed care reimbursement.
- Understanding of pre-acute and post-acute venues of care and post-acute community resources, physician office routines, and transitional procedures for pre and post-acute care. Demonstrated understanding of motivational interviewing and change management.

- Strong organizational and time management skills, as evidenced by the capacity to prioritize multiple tasks and role components.
- Ability to work independently and exercise sound judgment in interactions with physicians, payors, and patients and their families.
- Effective oral and written communication skills.

Must-Haves

1. Education: Graduate of an accredited school of professional nursing required; Bachelor of Nursing preferred, or graduate of an accredited Master of Social Work program.

2. Current and valid license to practice as a Registered Nurse in the state of Texas or

3. A Current and valid license as a Master Social Worker (LMSW) in the state of Texas is **required, LCSW is preferred.**

4. Certification in Case Management is required within two (2) years of hire into the Case Manager position.

5. Must have recent acute care case manager hospital experience. Three (3) years of nursing or social work experience acute hospital-based preferred, or three (3) years of experience comparable clinical setting