Health Home Care Manager

Job ID: 223254

Position Summary:

The Health Home Care Manager will perform professional, consultative, investigative, advisory and education activities for patients and families, site staff, and collaborative community agencies. Consistent with New York State regulations and policies for the provision of Health Home services the Health Home Care Manager conducts patient level data analyses to track patient adherence with treatment protocols and performs non-clinical interventions to assist patients in developing service plans to overcome barriers to access and care. The Care Manager communicates and collaborates regularly with patients, physicians, community agencies and office staff to adapt and refine and address support mobilization as needed.

Clinical Responsibilities & Duties:

With significant independence and latitude for action, serves as liaison, and patient advocate between the practice team, specialists, community agencies, and the patients to assist and educate patients in overcoming barriers to care. Health Home Care Manager is to:

- Complete initial and annual comprehensive assessment of medical, behavioral health and social service needs for all assigned health home enrollees
- Provide disease specific education and information regarding community resources
- Collaborate with a variety of community providers and resources to obtain needed services and supports, utilizing community and family resources to create sustainable support system
- Request and coordinate team and patient meetings as needed or requested by patient/family and/or team
- Escalate care management when medical assessment is needed
- Ensure diagnostic, post-hospitalization and specialty referrals have been executed and results received and acted upon as needed
- Document plan of care, patient utilization, activities and other required information in State and EMR.
- Monitor assigned enrollees' utilization of services, ensuring care is accessible, attended and effective
- Provide regular data to team on patient compliance and strategies to improve patient compliance
- Participate in HH care management discipline training-sponsored by UR Medicine Home Care
- Participate in on-call activities as directed/scheduled-by Program Coordinator
- Participate in regularly scheduled team meetings as prescribed by the practice's policy
- Participate in cultural competency events and training appropriate to job duties
- Assisting patient and family in developing service plan goals
- Frequent non-medical management coaching, education, follow-up visits and phone calls to patients to monitor progress and identify new barriers or concerns
- Assisting with financial or other social issues that may provide barriers to patient compliance
- Providing education/guidance to patient and family on tools to manage chronic illnesses, develops individual and web-based tools and resources to improve compliance
- Identifying and connecting patient with community resources to assist with improving compliance with treatment protocols and social issues (e.g. legal aid)

- For patients referred for health home activities, provides outreach focused on finding, connecting and retaining patients in health home care management services. Outreach activities include:
- Patient finding and health home enrollment

In compliance with UR Medicine policy, New York State Health Home regulations and Patient Centered Medical Home regulations, accurately and timely documents all interventions into prescribed electronic medical record systems to ensure timely reimbursement.

Participates in patient/outpatient care conference utilizing dashboard and quality metrics to develop care management strategies for difficult to manage patients, educates office staff on patient or office system issues, including communicated patient care inconsistencies between the primary care physician and referring specialists.

Qualifications

- The Health Home Care Manager must have a BSW or a BA with relevant experience from an accredited social work and/or Bachelor's program.
- Optimally 5 years' experience in a clinical setting (some ambulatory care experience preferred).
- Excellent communication and team skills including ability to form strong collaborative interdisciplinary partnerships across care settings.
- Sound computer knowledge and skills including an aptitude for using health information technology to guide activities.
- Ability to work independently and meet deadlines. Creativity and strong organizational skills.
- Valid NYS driver's license including access to reliable transportation that enables fulfillment of position's travel requirements.

To Apply:

Current University of Rochester employees: apply through HRMS.

Non-University of Rochester employees:

1. Go to the UR Careers Page.
2. Under Job Search, select All Other Openings.
3. In the Search Jobs box, enter the Job ID at the top of this posting.
4. Select the posting.
5. Select Apply for Job.

Both: Please include a cover letter that tells us how you would contribute to our Purpose and Values.

Please note to avoid confusion: The title of this position in our application system is Social Work Assist and the department is Social Work.