TRILLIUM COMMUNITY HEALTH PLANS

POSITION DESCRIPTION

POSITION TITLE: Nurse Level III, Trillium Care Coordinator

POSITION SUMMARY: Responsible for coordination of Plan medical care management services which promote quality, cost-effective care outcomes while ensuring the appropriate implementation of quality assurance and Medical Management policies and procedures, Health Plan and other regulatory requirements. Responsible for advocating and facilitating for Trillium members with special health or social needs, challenging behaviors, mental and physical disabilities, substance abuse needs, or who may be vulnerable, fragile, or at-risk.

PRIMARY RESPONSIBILITIES & DUTIES

1. Prepare, negotiate and implement care coordination interventions appropriate for the member's medical status and contract benefits, and which are coordinated with the care activities of the PCP and other providers:
   - Identify needs from multiple areas, including providers, patients or member's support system, outside agencies, or from prospective, concurrent, or retrospective review of authorization or claims data. Establish contact with patients requesting Care Coordination services within one business day.
   - Gather and assess all available data, beginning with the results of the Health and Lifestyle Assessment, to identify individual needs, and develop a comprehensive case management plan. Interview patients, review medical records, and research medical texts and guidelines. Assess health literacy, home environment, physical, financial and psychological factors affecting recovery or functional abilities. Include support systems and communication, transportation and other service needs.
   - Use motivational interviewing tools to facilitate active member goal development. Document strategies and outcomes designed to meet the member's needs as identified through both the assessment and coordination process.
   - Coordinate care activities, including utilization of available resources across a continuum of care (e.g. treating physicians, ancillary, home health and medical equipment providers, pharmaceuticals, wellness programs, hospital and rehab teams, behavioral health and chemical dependency providers, social service agencies, safety net clinics, and the member's family.)
   - Provide ongoing condition specific health coaching at a level that best meets the members needs and empowers them to be actively engaged in the care coordination process.
   - Provide nutrition and depression evaluation and support. Maintain communication regarding these needs with the appropriate provider.
   - Perform ongoing assessment/evaluation and timely revisions of individual care plan in order to determine current level of medical necessity and to assure appropriate utilization and cost-effective care. Utilize care coordination tools and software, hospital reports, delivery data, pharmacy profiles, and input from caregivers, hospital discharge planners and social workers.
   - Evaluate outcomes by comparing treatments (length and cost) and medical improvement feedback. Determine care coordination plans effectiveness in reaching outcomes and goals.
   - Maintain documentation of all member related activities, communications and special services provided.
   - Encourage and empower member to actively participate in their care with their Provider to achieve optimum outcomes.

2. For members with both Medicare and Medicaid plans (dual eligible members) work collaboratively internally with the Medicaid Exceptional Needs Care Coordinators and Medical/Surgical Case Managers and DME Benefit RNs to maximize navigation between Plans:
    - Review potential decisions regarding denials of requests for authorization of services. Communicate with member or Providers as needed to identify or facilitate use of alternative resources when indicated. Provide feedback on potential denial decisions if additional information may impact the decision.
    - Evaluate appropriate utilization of funds, including monitoring of patient's insurance benefits (limitations and exclusions).

3. Interact with, report to and maintain compliance with insurers, third party administrators, and regulatory bodies such as Medicare, OMAP, CMS and other certification bodies.

4. Attend and participate in internal and external meetings for coordination of service delivery to Trillium members.

5. Participate in the ongoing development of the Care Coordination program.

6. Perform other duties as assigned.

Reports To: Direct of Medical Management

JOB REQUIREMENTS

Education:
Graduate of accredited school of nursing (RN) and hold current Oregon State Board of Nursing License.

Experience:

- Five years nursing experience with varied medical exposure.
- Prior experience with managed care contracts preferred.
- Knowledge of diagnosis and appropriate care modalities. ICD9 & CPT codes, health insurance benefits and exclusions and state and federal mandates.
- Experience with word processing, healthcare guidelines, technology assessment tools and online information search techniques.
- Must be able to evaluate a situation and make appropriate care management decisions and work to control costs through monitoring all aspects of the patient's plan of care and disposition.
- Excellent oral and written communication skills are required.
- Must have cooperative working skills, leadership skills, and interpersonal skills.
- Must be able to demonstrate a courteous, caring and understanding attitude toward patients, families, co-workers, physicians and staff of other facilities and agencies.