RN CARE MANAGER

RECRUITMENT INSTRUCTION

REQUIREMENTS

- A current New York State License to practice as a Registered Nurse
- The Care Manager's RN license need to be endorsed for the state she/he is working for
- Associate Degree in Nursing required, Bachelor's or Master's degree in Health, Human or Education services preferred
- Experience in managed care and/or care management preferred
- Experience with geriatric population preferred
- Excellent communication skills, both written and verbal
- Proficient in Microsoft Office (Word, Excel, Outlook)
- Ability to build relationships with patients, co-workers, and providers

+ <For International RNs>

- English Speaking/Writing Skills (Bilingual preferred)
- English Proficiency Test Score for VSC(Visa Screening Certificate)

CONTACT

+1-718-461-9602 ext.329
cm@completecaremanagement.com
http://completecaremanagement.com
212-12 Northern Blvd 3rd FL. Bayside, NY 11361

ABOUT CCMI

We provide top of the line care management services for New York Managed Long Term Care Plans (MLTCs).

JOB DESCRIPTION

Overview

- The Care Manager coordinates care management services and assures the quality of care for MLTC (Managed Long Term Care) plan members.
- The Care Manager collaborates with other professionals (typically a Social Worker and Care Management Coordinator) to develop a thorough plan of care that addresses the specific needs of each individual member.
- All members of the care management team interact with the member, thereby assuring continuity for the member in the delivery and coordination of services.

Working Condition

- Works from home
- Training in office - Each MLTC insurance plan have own internal protocols that need to be followed and each employee needs some training in those protocols (1-2 weeks to get started)

COMPLETE CARE MANAGEMENT NEW YORK

RN CARE MANAGER

RESPONSIBILITIES

- Develops and updates the individualized care plan based on a comprehensive assessment of members in consultation with the member and family/caregiver and the assessment nurse
- Implements the care plan and authorizes/arranges for delivery of covered services consistent with the care plan
- Conducts ongoing communication and collaboration with a member, family caregiver, or member's designated representative, as well as with member's PCP and other significant health care providers
- Monitors provision of services by Integra' s network providers to ensure they are appropriate and in accordance with the member's care plan
- Conducts ongoing monitoring of member's health, safety, and functional status, and progress towards established goals
- Provides coordination of care transitions, including discharge and transition planning from the hospital or nursing homes
- Determines member eligibility for Integra's program and quality initiatives; Facilitates the establishment of Advance Care Planning and assuring appropriate administration of the member's Health Care Proxy
- Reviews member's medical status and issues, identifying follow up issues
- Serves as primary contact with member's PCP or specialist physicians as well as member's long term care service providers
- Monitors member's medication adherence in conjunction with the RN, Care Management Supervisor
- Provides education/coaching in self-management of disease processes
- Conducts monthly outreach to the member to check on member's status
- Updates member case records
- Participate in Quality Assurance and Improvement activities as directed by the Director of Care Management
- Other duties as assigned by the Care Management Supervisor and/or the Director of Care Management

COMMUNITY HEALTH NURSE

RECRUITMENT INSTRUCTION

COMPLETE CARE MANAGEMENT NEW YORK

ABOUT CCMI

We provide top of the line care management services for New York Managed Long Term Care Plans (MLTCs)

REQUIREMENTS

- A current New York State License to practice as a Registered Nurse
- Associate Degree in Nursing required, BSN preferred
- Minimum of one (1) year general clinical nursing experience required
- Current Driver's License, required insurance and car available for work as required
- Computer/laptop proficiency required

+ <For International RNs>

- English Speaking/Writing Skills (Bilingual preferred)
- English Proficiency Test Score for VSC(Visa Screening Certificate)

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JOB DESCRIPTION

Over View

Under the direction of a Nurse Manager, the PACE Community Health Nurse (PCHN) provides skilled care and routine clinical nursing assessment visits to PACE members and families utilizing all elements of the nursing process and in compliance with applicable laws, regulations and agency policies. The PACE CHN primarily provides nursing visits in the member's home in the community but can routinely visit members in the PACE center, hospitals, nursing homes, and other alternate setting as deemed necessary for care coordination consistent with the PACE model of care. The PACE CHN is a core interdisciplinary team (IDT) member who assigned to a PACE member in compliance with CMS PACE regulatory requirement.

Working Conditions

- Works outside in varied weather conditions in all areas of the community, using private or public means of transportation
- Walks to and from patients' homes
- Works inside in well lighted, heated or air conditioned office

COMPLETE CARE MANAGEMENT NEW YORK

COMMUNITY HEALTH NURSE

RESPONSIBILITIES

- Carries out the agency's mission, philosophy, goals and objectives within guidelines of Agency policy and position function.
- Interprets and implements the Agency's philosophy to staff and members of the community.
- Assumes responsibility for assignments given, seeks supervision appropriately, and is accountable for his/her actions by performing within the limits of his/her education and experience.
- Knows and conforms to the law governing the practice of professional nursing and provides professional nursing care using all elements of the nursing process.
- Assesses and evaluates the health care needs of patients and families with consideration regarding physiological, psychological, social and environmental factors.
- Identifies complete, accurate and logical Uniform Assessment System (UAS) for NY and appropriate sequencing of diagnoses in collaboration with the PCP to maintain compliance with state and federal regulations.
- Participates in mandatory PACE comprehensive care planning meetings routinely as required by PACE regulations. Collaborates with all members of the IDT in developing a comprehensive care plan based on member-specific needs, physician orders, UAS-NY CAPS, other IDT assessments, members' specific parameters and identified goals that are respectful of member, family, community and agency resources.
- Implements the nursing care plan and revises it whenever necessary by regularly assessing, observing, and evaluating the patient's condition, needs and response to care and makes appropriate nursing judgments and decisions for care plan revision.
- Initiates and applies appropriate preventative, therapeutic and rehabilitative nursing procedures and techniques.
- Administers medications and treatments as prescribed by the PCP. Ability to independently perform skilled nursing procedures and techniques based on the changing nursing needs that the member requires.
- Teaches the patient and family/caregivers self-techniques whenever appropriate and provides instruction regarding medication, diet, safety and treatment modalities in accordance with the plan of care.
- Recognizes and utilizes additional opportunities for health counseling/education with patients, families and other caregivers and provides them with information that will facilitate decisions regarding the promotion, maintenance and restoration of health.
- Delegates responsibility appropriately, and supervises ancillary personnel in a manner that will assure quality care and compliance with the care plan.
- Evaluates for and promotes a safe environment for the patient and complies with National Patient Safety Goals.
- Completes, maintains and submits all required documentation that is timely (in compliance with agency policy) accurate, and relevant.
- Meet all requirements for UAS-NY assessor function: timely completion within regulatory standards, follow-up assessments, and significant change assessments as needed.
- Reviews and confirms eligibility of member in the PACE program based on Nursing Facility Level of Care (NFLOC) score obtained from the UAS-NY assessment. Confirms eligibility of members with the members of the IDT.
- Performs care coordination as part of their nursing visits to PACE members across all settings of care. Collaborative care coordination to include internal (e.g., other IDT members) and/or external health care professional (e.g., MD specialists, SNF staff, hospital staff) in a manner that assures care plan coordination as well as continuity of care.