Cordova Community Medical Center
Job Description
Nurse Case Manager

Job Title:	Hospital Case Manager	Status:	Full -Time
Supervisor:	LTC Director of Nurses	Pay Grade:	DOE
Department/Division:	Nursing Department	Classification:	Non-Exempt

POSITION SUMMARY

Works with residents, patients, their families, guardians, physicians, health care professionals and community resources, to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident or patient. Protect and advocate for the rights of residents and patients and ensure that the quality of care they receive meets all state and federal requirements. Provide admission and discharge planning services focused on continuity of care, resident/patient and family preferences and available resources.

ESSENTIAL RESPONSIBILITIES:

1. Record interventions, observations, assessments, and other important data, in the medical record.

2. Maintain an organized, current case file system that reflects the needs of the residents and patients and the efforts made to meet those needs.

3. Assist residents, patients and/or representatives with Medicaid applications and qualifications.

4. MDS REQUIREMENTS: Participates in MDS/RAI process for long term care and skilled nursing residents. Provides Minimum Data Set information and Care Area Assessment summaries for designated MDS sections. Honors established MDS/RAI timelines to meet regulatory requirements.

5. Completes social histories for each resident at admission. Ensures that the residents comprehensive care plan and resident daily care plan include interventions that address social services needs.

6. Assist new residents and their families in adjusting to life in the long term care setting,

7. Assess and identify the medically related psychosocial needs of residents and develop a plan of care to meet those needs.

8. Develop at the time of admission and maintain an active discharge plan for each resident at the time of admission if applicable.

9. Participate in multi-disciplinary care conferences and intra-agency meetings to facilitate treatment, needs assessment, and discharge planning,

10. Arrange for and coordinate the discharge or transfer of appropriate residents or patients to their homes or other community placements, and appointments to assure continuity of care.

11. Meet the psychosocial needs of residents and acute patients by providing short-term individual and/or family counseling, crisis intervention services, referral to outside resources and pertinent information as needed or directed.

12. Network with other facilities and social workers throughout the State of Alaska to facilitate admissions to our LTC and Swing Beds.

13. Implement care/services that recognize age/diversity specific needs/issues of customers served.

14. Is expected to respond to the hospital, if requested, to assist in the event of an emergency or if the hospital activates its emergency management plan.

15. Outreach and serves as a liaison between community members and needed services. The focus of this work is to connect community members with resources and services to assist with accessing primary care, behavioral health and core services including food, housing, clothing and other necessities.

16. Core task focus will be on improving individual social determinants of health through:

    A. Develop plans of care to meet the needs of the client utilizing person-centered, strengths-based methods.
    B. Provide information about and linkage with available resources.
    C. Assist with Public Assistance, Unemployment, Social Security paperwork, and other application materials.
    D. Provide education and relevant printed materials on relevant health topics including Covid-19, vaccinations, preventative care, accessing health care.
    E. Work in collaboration with other team members and community providers to remove barriers to services: e.g., acquisition of identification, legal aid, benefits assistance, scheduling appointments, arranging transportation to appointments, enrollment with service providers.

17. Actively participate in community meetings and consortiums relative to the provider network, collaborating effectively with coordinating service delivery.

The above is not intended to be an all-inclusive list of essential functions for the job described, but rather a general description of some of the responsibilities necessary to carry out the duties of this position.

QUALIFICATIONS

EDUCATION: Must possess GED and advancing education consistent with Licensed Practical Nurse (LPN), must have case management and social services support experience.

EXPERIENCE: Preferred, as a minimum, one (1) year social services experience in a long term care setting or hospital.

REQUIREMENTS: At must possess a State of Alaska LPN license. The responsibilities for this position generally require a 20 to 24 hour work week. However, additional time may be necessary due to special events, crisis situations and/or unexpected demands of the caseload. esAbility to effectively communicate in English, both orally and in writing. Ability to assess psychosocial behavior and medically related resident needs, and develop a meaningful plan of care, appropriate interventions, and effective discharge plans. Ability to effectively communicate with residents, families, other professionals, and the community, in a positive, professional manner. Ability to articulately express in writing, resident assessments, plans of care, and place these in the record in a timely manner as required by facility policy.

ADDITIONAL REQUIREMENTS

Upon date of Hire: Current Negative TB Test
Ability to Pass a DHSS Criminal History Check and Drug Test
Must be current in all immunizations

EQUAL EMPLOYMENT OPPORTUNITY

CCMC shall seek to insure and provide equal opportunity for all persons seeking employment without regard to race, age, color, religion, gender, marital status, sexual orientation, military status, national origin, disability, or any other characteristic as established by law.

ACKNOWLEDGEMENT OF RECEIPT OF JOB DESCRIPTION

Position: Hospital Case Manager

I acknowledge I have received a copy of this job description. I understand the duties, and am fully able to meet the requirements, and perform the essential functions of this position, with or without reasonable accommodations. I further acknowledge, and understand, this job description does not create an employment contract, and nothing contained herein alters my at-will employment status.

_____ _____

Employee Signature Date

_____

Print Name

_____ _____

Manager Signature Date

_____

Print Name