SENIOR CARE INTEGRATION NURSE (RN)

Position Status: Exempt
Reports To: Care Integration Manager
Effective Date: 11/04/21
Revised Date: 10/28/25
Job Level: P3

POSITION SUMMARY

Under direction, this position:

1. Provides direct Enhanced Care Management (ECM), Community Supports (CS), and transitions of care (TOC) support and care coordination for Alliance members to ensure timely connection to appropriate care and optimize utilization
2. Monitors and audits ECM, CS, and TOC provider performance to ensure delivery of high-quality, non-duplicative services
3. Coordinates with internal and external teams and members to support seamless transitions across the care management continuum
4. Acts as a liaison between the ECM/CS Program and external providers, community agencies, and Alliance departments
5. Assists in ECM/CS program implementation, oversight, reporting, and provider training to support compliance with regulatory requirements
6. Performs other duties as assigned

RESPONSIBILITIES

1. Provides direct Enhanced Care Management (ECM), Community Supports (CS), and transitions of care (TOC) support and care coordination for Alliance members to ensure timely connection to appropriate care and optimize utilization, with duties including but not limited to:
    - Ensuring that members not yet enrolled or engaged in ECM/CS receive timely connection to needed services to reduce gaps in care
    - Coordinating with hospitals, providers, and community partners to support members through critical transitions, such as from hospital to home
    - Supporting transitions of care activities and discharge planning for Dual Eligible Special Needs Plan (D-SNP) members in alignment with Centers for Medicare & Medicaid Services (CMS) Model of Care (MOC) requirements.
    - Engaging and educating eligible members on ECM/CS services and assisting with linkage to ECM/CS providers
    - Addressing medical, behavioral, and social needs during transitions to prevent avoidable readmissions
    - Documenting interventions and outcomes to support effective member tracking and service planning
    - Educating members and families about ECM/CS services, promoting engagement in care coordination activities, and facilitating connections to community resources
    - Conducting post-discharge outreach for D-SNP members within CMS-mandated timeframes to assess needs and coordinate follow-up care
    - Collaborating with D-SNP case managers and providers to ensure the development and implementation of individualized, member-centered care plans during transitions

- Educating members and families about ECM/CS services, promoting engagement in care coordination activities, and facilitating connections to community resources
- Tracking D-SNP-specific TOC metrics, including time-to-outreach post-discharge, medication reconciliation, and follow-up appointment completion
- Reviewing care transitions for D-SNP members to ensure compliance with CMS audit protocols and MOC expectations

2. Monitors and audits ECM, CS, and TOC provider performance to ensure delivery of high-quality, non-duplicative services, with duties including but not limited to:
   - Auditing ECM/CS provider assessments and care plans to ensure alignment with ECM/CS core service requirements and member needs
   - Monitoring D-SNP TOC providers to ensure adherence to CMS-required timeliness standards for outreach and care coordination post-discharge.
   - Reviewing documentation to confirm that members are not receiving duplicative ECM services from other 1915(c) waiver programs
   - Monitoring closed loop referrals and collaborating with providers and members to address any gaps in care
   - Identifying gaps or inconsistencies in ECM/CS documentation and collaborating with providers to address issues
   - Monitoring provider performance and supporting performance improvement through ongoing feedback and collaboration

3. Coordinates with internal and external teams and members to promote seamless transitions across the care management continuum, with duties including but not limited to:
   - Participating in and leading multidisciplinary case discussions, including Interdisciplinary Care Team (ICT) meetings, to align care planning, reduce duplication, and optimize resource utilization and transitional care support
   - Maintaining compliance with D-SNP Interdisciplinary Care Team (ICT) processes for members undergoing transitions of care
   - Working with Case Management (CM) teams to receive and send referrals for members requiring ECM, CS, or Complex Case Management (CCM) services
   - Working directly with members to address ECM, CS and transitional care needs
   - Supporting step-down transitions from ECM to CM when clinically appropriate, recognizing complex case management as part of the broader care management continuum
   - Collaborating with Provider Services to develop and implement education of TOC/ECM/CS providers on core services, reporting, and quality improvement areas
   - Ensuring accurate documentation and handoffs when transitioning members between internal programs
   - Acting as a liaison between D-SNP case management teams, discharge planners, and providers to support timely transitions and care continuity for dual-eligible members
   - Coordinating with D-SNP pharmacy, behavioral health, and primary care partners to ensure medication reconciliation and safe transitions post-discharge
   - Coordinating with Medicare Advantage partners and external entities to ensure timely data exchange, continuity of care, and compliance with D-SNP transitional care protocols
   - Assisting other Alliance department staff with resolution of quality and coordination of care issues for members within the programs
   - Collaborating with Provider Services to develop and implement education of TOC/ECM/CS providers on core services, reporting, and quality improvement areas

- Collaborating with internal stakeholders to ensure providers are aware of ECM/CS core service components and delivery strategies, and that TOC/ECM/CS benefits and services are implemented according to contractual requirements
- Making presentations, supporting and training end users, and developing related materials

4. Acts as a liaison between the ECM/CS Program and external providers, community agencies, and Alliance departments, with duties including but not limited to:
    - Collaborating with internal stakeholders to ensure providers are aware of ECM/CS core service components and delivery strategies, and that TOC/ECM/CS benefits and services are implemented according to contractual requirements
    - Representing the Alliance at community events and external stakeholder meetings
    - Serving as point of contact for D-SNP hospital discharge planners to resolve barriers to safe discharge and timely follow-up care
    - Collaborating with health plans and CMS-regulated D-SNP partners to align TOC workflows and improve outcomes for dual-eligible members

5. Assists with ECM/CS program implementation, oversight, and reporting, and provider training to support compliance with regulatory requirements, with duties including but not limited to:
    - Supporting the Care Integration Manager in the development and implementation of program partnerships, care delivery models, and community health practices designed to achieve TOC/ECM/CS strategic and tactical objectives
    - Providing oversight of TOC/ECM/CS service delivery through review of ECM/CS member assessments, care plans, case notes, and related documentation obtained via the care coordination software platform
    - Supporting implementation and ongoing operational oversight of D-SNP MOC transition of care elements, including staff training and documentation standards
    - Providing oversight of TOC/ECM/CS reporting, identifying any needed process improvements, developing solutions, and making recommendations for improvement
    - Ensuring that reporting metrics are accurate and submitted timely, complete and reflective of member experience
    - Participating in program development and implementation activities, performance monitoring, and the development of policies, procedures, and other Care Integration Program documents
    - Assisting with the development of policies, procedures, and other program documents
    - Monitoring D-SNP MOC compliance related to TOC activities and participating in audits, readiness reviews, and corrective action planning as needed
    - Training internal staff and D-SNP partners on transition of care documentation, reporting requirements, and CMS care coordination expectations
    - Identifying process improvement opportunities and assisting with implementation of best practices in care integration and across ECM/CS provider networks
    - Maintaining a thorough and up to date knowledge of regulatory guidance on transitions of care, ECM/CS, and other Alliance benefits
    - Collaborating with Provider Services and other internal departments to deliver training and technical assistance to providers
    - Educating providers on ECM/CS service expectations, documentation standards, transitions of care, and care coordination principles
    - Supporting efforts to improve provider reporting and performance through training, feedback, and resource sharing
    - Assisting with the development of policies, procedures, and other program documents

6. Performs other duties as assigned

EDUCATION AND EXPERIENCE

- Current unrestricted license as a Registered Nurse issued by the State of California
- Associate's degree in nursing and a minimum of seven years of experience in outpatient medical, care management, community health service delivery, behavioral health practice management, or related healthcare experience (a Bachelor's degree may substitute for two years of the required experience); or an equivalent combination of education and experience may be qualifying

KNOWLEDGE, SKILLS, AND ABILITIES

- Thorough knowledge of the principles and practices of community-based nursing
- Working knowledge of the principles and practices of community-based service delivery to at risk populations, including motivational interviewing, trauma informed care, and other best practices
- Working knowledge of community-based organization and/or public health practices and processes
- Working knowledge of the principles and practices of case management
- Working knowledge of care management and coordination
- Working knowledge of evidence-based practice guidelines in the development of care plans
- Working knowledge of the principles and practices of customer service
- Working knowledge of and proficiency in the use of Windows-based PC systems and Microsoft Word, Outlook, PowerPoint and Excel, and database software
- Some knowledge of research, analysis and reporting methods
- Some knowledge of the principles and practices of program and project management
- Some knowledge of the concepts and guidelines related to Medi-Cal Managed Care
- Some knowledge of electronic medical record systems
- Some knowledge of utilization management principles and activities
- Ability to analyze, interpret and apply legal, regulatory and contractual language, policies, procedures and guidelines, and legislative and regulatory directives
- Ability to evaluate medical records and other health care data
- Ability to act as a technical resource and explain regulations, processes, and programs related to area of assignment
- Ability to manage multiple projects simultaneously, organize work, and achieve goals and timelines
- Ability to assist with the development and implementation of policies, procedures, projects, systems, and programs
- Ability to prepare narrative and statistical written reports, oral reports, correspondence, and other program documents
- Ability to maintain organized and accurate records
- Ability to present information, data and results in a clear and understandable manner utilizing methods appropriate to various forums
- Ability to develop training materials, in conjunction with Training and Development staff, and conduct training
- Ability to facilitate meetings and make presentations
- Ability to attend in-person meetings with community partners, providers, hospitals, and within Alliance offices

- Ability to communicate effectively and build collaborative working relationships with internal and external stakeholders
- Ability to demonstrate cultural awareness while acting as a liaison to providers serving the Alliance's diverse population of members
- Ability to exercise good judgment and tact when relating to health care providers
- Ability to work independently and as a member of a team

DESIRABLE QUALIFICATIONS

- Bilingual (English/Spanish or English/Hmong)
- Bachelor of Science in Nursing (BSN)
- Certification by a nationally recognized case/care management organization
- Experience in community health, public health, home health, or population health focused nursing
- Some knowledge of the state and federal regulatory processes
- Some knowledge of community care resources with the Alliance service area counties

WORK ENVIRONMENT

- Ability to sit in front of and operate a video display terminal for extended periods of time
- Ability to bend, lift, and carry objects of varying size weighing up to 10 pounds
- Ability to work effectively in a remote work environment
- Ability to travel to different locations in the course of work
- Possession and ongoing maintenance of a valid Driver's License, transportation, and automobile liability insurance in limits acceptable to the Alliance

This position description, and all content, is representative only and not exhaustive of the tasks that an employee may be required to perform. Employees are additionally held responsible to the Employee Handbook, the Alliance Standard Knowledge, Skills and Abilities and the Alliance Code of Conduct. The Alliance reserves the right to revise this position description at any time.