UTILIZATION MANAGEMENT MEDICAL SOCIAL WORKER

Position Status: Exempt
Reports To: Utilization Management Supervisor – Concurrent Review (RN)
Effective Date: 01/06/14
Revised Date: 04/25/24
Job Level: P2

POSITION SUMMARY

Under limited supervision, this position:

1. Participates in the Utilization Management (UM) Concurrent Review interdisciplinary team and care transitions assignments responsible for the psychosocial management of members in long term care placements and members newly discharged from an acute care or skilled care setting that are at high risk for re-admission
2. Works with, provides assistance and educates members, providers, external agencies and internal departments on UM Concurrent Review programs
3. Participates in quality improvement studies to continually evaluate program effectiveness and promotion of quality driven, cost effective and achievable goals and outcomes for members
4. Performs other duties as assigned

RESPONSIBILITIES

1. Participates in the UM Concurrent Review interdisciplinary team and care transitions assignments responsible for the psychosocial management of members in long term care placements and members newly discharged from an acute care or skilled care setting that are at high risk for re-admission, with duties including but not limited to:
   - Performing assessments of physical, emotional, psychosocial, and environmental needs of the member via methods such as review of relevant and available medical records and telephone or in-person member contact
   - Performing psychosocial assessments of members in long term care to determine social, emotional and educational needs and developing interventions to achieve successful member outcomes
   - Identifying barriers to agreed-upon plan and alterations in member's condition in a timely manner, executing appropriate interventions, evaluating outcomes and adjusting the plan as needed
   - Maintaining contact with member and/or legal representative during enrollment into programs
   - Providing support, navigation, and education to members to ensure a successful 30-day post-discharge period
   - Documenting and recommending actions to increase positive member outcomes
   - Documenting and managing the development and implementation of member-specific interventions in a timely and accurate manner with consideration of benefit coverage and regulatory program policies
   - Facilitating completion of member goals through a multidisciplinary approach and in collaboration with internal and external resources, family members and/or legal representatives

- Ensuring that members no longer requiring long-term care are transitioned to an appropriate lower level of care in accordance with the member's or legal representative's wishes and providing access to available resources in support of such transitions
- Making recommendations and authorizing services to appropriate agencies for long term care or to make appropriate transitions
- Determining member's need to be referred to complex case management upon completion of program or transition to an in-county lower level of care
- Advocating on member's behalf to ensure quality of care and attainment of appropriate goals
- Managing assigned cases in a timely and accurate manner
- Acting as a subject matter expert and resource to UM Concurrent Review Nurses
- Consulting and coordinating with the UM Concurrent Review Team, Case Management staff, County Social Services, departmental and institutional staff, attending physicians, providers, and/or vendors to identify members needing case management services and coordination of care, and referring members to appropriate agencies in an effort to reduce the risk of readmission
- Identifying and screening members eligible for transfer to another health plan or eligible for Administrative Member status change, subject to approval by the Medical Director
- Preparing and sending member correspondence as needed

2. Works with, provides assistance and educates members, providers, external agencies and internal departments on UM Concurrent Review programs, with duties including but not limited to:
    - Participating in UM Case Management multidisciplinary team meetings
    - Assisting UM Concurrent Review, Member Services, Claims, and Provider Services staff with resolution of quality of care and coordination of care issues for members within the programs
    - Representing the Alliance at community meetings and confidential multidisciplinary task forces concerning health issues or provision of health related services
    - Advocating for members during enrollment in the UM Case Management programs by reaching out to primary care providers, specialists, hospitals, Utilization Review, social workers, pharmacists, health educators, care coordinators, local mental health services, and community agencies to maximize program participation and outcomes
    - Assessing changing social needs within the community
    - Monitoring and maintaining current knowledge of legislative and regulatory changes that affect members

3. Participates in quality improvement studies to continually evaluate program effectiveness and the promotion of quality driven, cost effective and achievable goals and outcomes for members, with duties including but not limited to:
    - Participating in quality improvement studies involving re-admission, UM interventions, and re-admission rates
    - Maintaining documentation of UM Concurrent Review and care transitions interventions and data required to demonstrate the effectiveness of UM Case Management programs, re-admission rates and member health care outcomes
    - Supporting, implementing, and evaluating program processes and making recommendations for improvement
    - Auditing work for compliance with departmental workflows and procedures

4. Performs other duties as assigned

EDUCATION AND EXPERIENCE

- Bachelor's degree in Social Work and two years (or a Master's degree and one year) of Social Work experience in an acute care setting, community agency or managed care environment; or an equivalent combination of education and experience may be qualifying

KNOWLEDGE, SKILLS, AND ABILITIES

- Thorough knowledge of the principles and practices of case management, including assessment, care/treatment planning, discharge planning and documentation
- Working knowledge of the principles and practices of care transitions and coordination
- Working knowledge of governmental and non-profit resources utilized to assist members in achieving goals
- Working knowledge of the utilization of evidence-based practice guidelines, including as applied to development of a plan of care
- Working knowledge of and proficiency with Windows based PC systems and Microsoft Word, Outlook, Excel and PowerPoint
- Some knowledge of Medi-Cal, Title 22, and related policies and regulations
- Some knowledge of utilization management principles and activities
- Some knowledge of case transitions principles and activities
- Ability to exercise strong critical thinking and problem solving skills
- Ability to effectively interview members to determine their strengths, problems, prognosis, functional status, goals, and needs for specific services and resources, and to establish short- and long-term goals
- Ability to create, document, and implement intervention plans
- Ability to manage complex priorities with increasing independence, in order to meet increasing role responsibilities
- Ability to competently navigate computerized Electronic Health Records (EHRs)
- Ability to advocate on behalf of the individual to assure quality of care and attainment of appropriate goals
- Ability to manage persons who are non-compliant and or have a history of behavioral health issues
- Ability to understand and apply concepts pertaining to managed health care
- Ability to evaluate medical records and other health care data
- Ability to use pro-active customer service skills in handling complex and demanding situations
- Ability to exercise good judgment and tact in relating to members and health care providers

DESIRABLE QUALIFICATIONS

- Bilingual English/Spanish or Hmong, depending upon location of assignment
- Master's degree in Social Work
- Current and unrestricted California licensure as a Licensed Clinical Social Worker (LCSW)
- Work experience as a medical social worker
- Working knowledge of MCG guidelines and other tools utilized in the level of care determination process

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 20 pounds
- 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

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The job duties, elements, responsibilities, skills, functions, experience, educational factors and the requirements and conditions listed in this job description are representative only and not exhaustive of the tasks that an employee may be required to perform. The Alliance reserves the right to revise this job description at any time.