COOK COUNTY HEALTH

Standard Job Description

Job Code: 7809
Grade: 24
HCWR: N

Job Title	**Department**
CountyCare Director of Utilization Management and Care Transitions	CountyCare

This position is exempt from Career Service under the CCH Personnel Rules.

Job Summary

The Director of Utilization Management (UM) and Care Transitions serves as a part of Health Plan Service's clinical leadership team. This position is responsible for developing and implementing each health plan's strategies to ensure members receive cost-effective, evidence-based health services to achieve high quality outcomes. This position ensures that each health plan, its delegated vendors and its providers meet accreditation and regulatory performance standards and requirements for UM and Care Transitions. The Director of UM and Care Transitions oversees the UM Program for medical, behavioral, Long Term Services and Supports (LTSS), dental, vision, and pharmacy, as well as each health plan's Transition of Care (TOC) Model which includes delegated vendor oversight, supervision of staff and close collaboration with medical leaders and other key stakeholders.

General Administrative Responsibilities

Collective Bargaining

- Review applicable Collective Bargaining Agreements and consult with Labor Relations to generate management proposals
- Participate in collective bargaining negotiations, caucus discussions and working meetings

Discipline

- Document, recommend and effectuate discipline at all levels
- Work closely with labor relations and/or labor counsel to effectuate and enforce applicable Collective Bargaining Agreements
- Initiate, authorize and complete disciplinary action pursuant to CCH system rules, policies, procedures and provision of applicable collective bargaining agreements

Supervision

- Direct and effectuate CCH management policies and practices
- Access and proficiently navigate CCH records system to obtain and review information necessary to execute provisions of applicable collective bargaining agreements

General Administrative Responsibilities

Management

- Contribute to the management of CCH staff and CCH' systemic development and success
- Discuss and develop CCH system policies and procedures
- Consistently use independent judgment to identify operational staffing issues and needs and perform the following functions as necessary; hire, transfer, suspend, layoff, recall, promote, discharge, assign, direct or discipline employees pursuant to applicable Collective Bargaining Agreements
- Work with Labor Relations to discern past practice when necessary

Typical Duties

- Oversees director staff or vendors that perform prior authorizations and employ inpatient certification review staff for initial, concurrent, and retrospective review. Ensures that review staff consist of Registered Nurses (RN), Physician Assistants (PA), and/or Licensed Practical Nurses who are experienced in inpatient reviews and who operate under the direct supervision of an RN, Physician, or PA
- Develops innovative, patient-centered and provider-friendly approaches to UM and TOC using evidence-based guidelines and industry best practices
- Ensures effective and efficient authorization and review processes, in accordance with contract, accreditation and regulatory requirements set by the Centers for Medicare and Medicaid Services (CMS), the National Committee on Quality Assurance (NCQA), the Illinois Department of Family and Healthcare Services (HFS)
- Builds effective relationships with providers, vendors and oversight agencies and represents the health plan on external committees and workgroups
- Interprets benefit coverage and scope of clinical authorization for all medical, behavioral services, and LTSS, dental, vision, pharmacy, and new technology and facilitates clinical leadership involvement in decision making concerning policies, authorizations, denials, and appeals
- Develops and revises UM and TOC criteria, policies and procedures, program description, program evaluation and work plan
- Designs and/or approves reports, metrics, and analyses to measure health care utilization and outcomes, contract and regulatory compliance, member and provider satisfaction, and quality improvement
- Analyzes health plan outcome data to analyze trends, over and under-utilization and outlier performance against established benchmarks
- Develops and implements business plans to reduce cost, improve quality and efficiently, and enhance member and provider satisfaction
- Leads UM committees, workgroups, and forums including preparation of agendas, minutes, reports and presentation materials
- Leads TOC program for all service types and coordinate utilization activities with Care Management, Population Health and Behavioral Health
- Develops or leverages secure information transfer between vendors and provider through electronic interfaces when possible

Typical Duties

- Applies utilization and health outcome data to ongoing network analysis and development
- Participates in Delegated Oversight Committee and ensure vendor performance of UM and TOC contractual requirements and initiate corrective action, as necessary
- Oversees the member appeals process and provide leadership to the Grievance and Appeals Committee
- Assists in quality improvement activities, including annual Healthcare Effectiveness and Data and Information Set (HEDIS) studies
- Hires, trains, coaches and mentors staff; Conducts performance management and evaluations
- Contributes to departmental annual budgetary process and monitor performance and initiate corrective action as necessary to prevent budget variance
- Travels to work sites throughout Cook County including community agencies, network providers, government and other agency offices. May require travel to Springfield, Illinois for meetings
- Performs other duties as assigned

Minimum Qualifications

- Bachelor's degree from an accredited college or university
- Licensed in the State of Illinois as one of the following: Registered Professional Nursing, Social Worker (LSW), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Clinical Professional Counselor (LCPC)
- Five (5) years of utilization management experience with two (2) years of full-time utilization management experience with Medicaid and Medicare at a supervisor and/or manager level for a health plan
- Two (2) years of experience working within health care delivery systems including work in a direct clinical capacity
- Experience and direct involvement with Utilization Review Accreditation Commission (URAC) and/or National Committee for Quality Assurance (NCQA) accreditation
- Must be able to travels to work sites throughout Cook County including community agencies, network providers, government and other agency offices; may require travel to Springfield, Illinois for meetings with Illinois Healthcare & Family Services

Preferred Qualifications

- Licensed as a Registered Professional Nurse in the State of Illinois
- Master of Business (MBA), Master of Health Administration (MHA), or Master of Nursing (MSN) from an accredited college or university
- Experience in a Medicaid or Medicare Managed Care Organization
- Case management, disease management, and/or quality improvement experience in a Medicaid (MCO)
- Experience working with integrated behavioral and physical health care
- Certified Professional Utilization Management (CPUM) or Certified Professional Utilization Review (CPUR)

Knowledge, Skills, Abilities and Other Characteristics

- Comprehensive knowledge of Medicaid, Medicare and LTSS programs, services and regulations
- Knowledge of the social determinants of health and interventions to provide effective health care to persons with low-income
- Proficiency knowledge of Microsoft Office products (Word, Excel, PowerPoint, Outlook)
- Mission-focused and committed to underserved populations
- Strong interpersonal skills; ability to establish strong working relationships and to communicate effectively with leaders, patients/members, physicians and clinicians, regulatory professionals, data analysts, network and finance teams
- Strong leadership capability, problem-solving and organizational skills
- Excellent written and verbal communications skills
- Demonstrated ability to drive improvement
- Ability to communicate in a confidential and HIPAA compliant manner
- Ability to demonstrate respect and sensitivity for cultural diversity patients and coworkers
- Ability to work in multiple operating systems simultaneously
- Ability to travel throughout Cook County for program oversight

Physical and Environmental Demands

This position is functioning within a healthcare environment. The incumbent is responsible for adherence to all hospital and department specific safety requirements. This includes but is not limited to the following policies and procedures: complying with Personal Protective Equipment requirements, hand washing and sanitizing practices, complying with department specific engineering and work practice controls and any other work area safety precautions as specified by hospital wide policy and departmental procedures.

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills required of the personnel so classified.

For purposes of the American with Disabilities Act, "Typical Duties" are essential job functions.