



JOB DESCRIPTION – CARE MANAGER CARES - ENHANCED CARE MANAGEMENT (ECM)

Title: Care Manger CARES – ECM

Responsible to: Program Supervisor CARES - ECM

Employment Status: Non-Exempt – Full-Time

Job Summary:

Under the direction of the Program Supervisor, the Care Manager provides direct service, as well as coordinates care management and functions as a part of a "Care Team" for the Enhanced Care Management Program (ECM). The CARE Manager oversees specific cases, coordinates health care benefits, provides education and facilitates client access to care in a timely and cost-effective manner. The CARE Manager collaborates and communicates with clients, caregivers/family support persons, and other providers to promote wellness, recovery, independence, resilience, and empowerment, while ensuring access to appropriate services and maximizing client benefit. The CARE Manager also serves as an advocate for clients, an active client of the interdisciplinary team, a liaison with other programs and external health and social service providers in the community.

Competencies (Essential Functions):

- **Assesses Strengths and Needs:**
 - Assesses client needs in the areas of physical health; mental health; SUD; oral health; trauma- informed care; social supports; housing; vocational/employment; wellness; and referral and linkage to community-based services and supports.
 - Oversees the development and implementation of the Individual Care Plan/Health Action Plan.
 - Offers services where the participant lives, seeks care, or finds most easily accessible, including office-based, telehealth, or field-based services.
 - Connects participants to other social services and other support that is needed (e.g., community support group).
 - Coordinates/advocates, with permission, on behalf of participant with health care professionals (e.g., PCP)
 - Utilizes evidence-based practices, such as Motivational Interviewing, Harm Reduction Techniques, and Trauma- Informed Care principles.
 - Gathers, organizes, summarizes and interprets behavioral health and biopsychosocial
- **Provides Services:**
 - Works collaboratively with primary care and/or hospital staff regarding Transitional Care Planning
 - Conducts outreach and engagement activities to facilitate linkage to the ECM program. Outreach and Engagement consists of phone calls, mailed information, and field visits.

- Accompanies clients on office visits, as needed and appropriate.
 - Evaluates progress and update goals.
 - Provides mental health promotion.
 - Arranges transportation for clients.
 - Establishes trust, builds rapport, and is empathetic and compassionate to participants and families.
 - Engages and activates participants in their treatment planning and care.
 - Plans and implements treatment and discharge plans.
 - Educates participants/families about services, support, resources and treatment options that are available and appropriate for their situation.
 - Works collaboratively with collateral resources such as residence or housing staff, therapeutic behavioral service providers, medical providers, educators, and/or psychiatric providers.
 - Applies assessment and evaluation tools to measure progress and outcomes; communicates progress and outcomes to participants/families.
- **Individualizes Care in accordance with FF Values:**
 - Delivers services in a manner consistent with FF core values of participant/family centered, culturally responsive, strength-based, complexity capable, trauma-informed, and needs-driven practice.
 - Assesses the influence of key individual, family, and community characteristics; tailors services to individual/family/community characteristics; modifies plans and services based on participant/family experience.
 - Delivers services to participants with an awareness and integration of the developmental milestones of children, youth, or young adults, including those impacted by trauma.
 - Demonstrates Cultural Responsiveness: works with the “whole person;” is welcoming, inclusive and respectful; embodies cultural humility; appreciates diversity. Embodies trauma-informed principles: Manages stress, maintains health; is self-aware and regulates emotions in order to be present for and responsive to others; is reflective and thoughtful when faced with complex, uncertain or ambiguous situations; maintains openness and approaches situations with an appreciation for multiple perspectives and a spirit of inquiry; promotes participant/family “voice and choice” about services.
- **Case Management/Care Coordination:**
 - Coordinates care collaboratively with treatment team and collateral contacts throughout the assessment, reassessment, treatment planning, service delivery, and discharge planning process.
 - Links participants to resources by identifying recommended resources; supporting individual’s and family’s decision-making in selecting resources; and connecting individuals and families to community resources.
 - Assesses participants’ health and behavioral health service delivery systems and community resources for strengths, limitations, cultural relevance and impact, and modifies referral process accordingly.
 - Advocates on behalf of participants and families by supporting and coaching participants in self-advocacy.

- **Working with Others/Teamwork:**
 - Communicates collaboratively and regularly with essential team members to keep them informed and to facilitate continuous open lines of communication and to integrate care across systems.
 - Considers the mode, timing, frequency, method, context, and amount of information to offer to others. ○ Communicates clearly and effectively, both verbally and in writing, with co- workers, supervisors, participants, and other providers.
 - Comprehends, follows, and clearly conveys instructions to others.
 - Builds positive relationships; maintains appropriate boundaries.
 - Collaborates as part of an integrated team that may include peer specialists, psychiatric providers, and/or paraprofessional staff. Understands, values, and adapts to the diverse professional cultures of an integrated care team.
 - Participates in agency Continuous Quality Improvement Committees, if assigned.
- **Documentation:**
 - Completes all documentation within the timeframes established by the individual action plans.
 - Writes concise, clear, and cohesive progress notes and reports in a timely manner. ○ Utilizes the Electronic Health Record system(s) or other technology effectively to complete documentation.
 - Demonstrates knowledge of and capacity to meet documentation standards in accordance with agency deadlines.
 - Participates in quality assurance activities as assigned.
 - Verifies all aspects of documentation meet or exceed county, state and federal guidelines.
 - Meets all HIPAA standards including but not limited to exchanging information, keeping Protected Health Information (PHI) secure, and following procedures to protect electronic transmission/access to PHI at the agency and in the community.
- **Behaving Professionally and Ethically:**
 - Attends weekly staff/team meetings and supervision.
 - Attends training as assigned (e.g., ACEs Certification).
 - Fulfills responsibilities and commitments.
 - Maintains clear and healthy interpersonal boundaries, complies with laws and regulations, and adheres to all professional ethical standards including abuse reporting and maintenance of participant confidentiality.
 - Adheres to all agency and program policies including Boundary Code of Ethics, Code of Conduct, Employee Handbook and state and federal regulations.
 - Participates in supervision and training.
 - Manages work relationships and workload and adapts to organizational change.
 - Seeks opportunities to improve knowledge, skills, and abilities.
 - Strives for excellence, has positive attitude, accepts changes flexibly, is collaborative, is relationship-oriented, shows initiative, attends to detail, is accurate, and is responsible.
 - Represents FF with integrity in every community situation, including participation in community committees and presentations as assigned.

- Additional Duties:
 - Other related duties as assigned by Supervisor.
 - Required to drive on agency business, as needed.

Qualifications

Required

1. A minimum of three (3) years of relevant work experience.
2. High school graduate or GED.
3. Long-time resident of the community with good knowledge of the resources of this community
4. Ability to complete the training program and ongoing educational requirements as assigned.
5. Ability to work flexible hours, including occasional night/weekend work.
6. Interpersonal savvy, demonstrated by the ability to interact with and influence people to establish trust and build strong relationships.
7. Ability to do home visits and outreach.
8. Experience with usage of EMR/EHRs/Care Management software
9. Strong organizational skills and ability to manage and maintain a personal schedule.
10. Ability to establish priorities and meet deadlines.
11. Ability to work independently within a virtual operating environment and as part of a team.
12. Excellent oral and written communication skills
13. Ability to exercise judgment in the application of professional services.
14. Active listening skills and genuine compassion for others
15. Enjoys collaboration within a team environment and working with people of different skills and experience.
16. Knowledge of community resources in the local market
17. Able to maintain clear professional boundaries with patients and coworkers.
18. Commitment to represent the company with professionalism.
19. Demonstrates cultural competency and ability to work with diverse groups of community clients.
20. Comfortable using computer for documentation, communication, and organizing work.
21. Demonstrated cultural responsiveness in working with diverse families and communities.
22. Must be able to respond quickly to emergencies, and to learn and implement Pro-ACT (or other agency approved crisis de-escalation training).
23. Clean driving record: current CA Driver's License or ability to obtain within 10 days after hired.
24. Must have access to dependable transportation; personal car insurance meeting minimum liability coverage required if position requires driving for work or transporting participants.
25. Basic computer and keyboarding competence with the ability to use Microsoft Office Suite and/or competency with electronic clinical documentation systems.

Preferred

1. Multilingual capabilities.

2. Prior experience as a Community Health Worker, Peer Support Specialist, Medical Assistant or similar role.
3. Fluency in threshold languages

Physical Demands:

The physical demands and work environment described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodation may be made to enable individuals to perform the essential functions. The position is sedentary 60% of the time. The noise level in the work environment is usually quiet and, at all times, maintained within safe California Division of Occupational Safety and Health (CAL/OSHA) standards.

Communication

1. Must be able to express or exchange ideas by means of the spoken word to impart oral information or detailed spoken instructions accurately, loudly, or quickly.
2. Must be able to hear, understand and distinguish speech and/or other sounds (i.e., alarms, etc.).

Physical Activities

1. Must have visual acuity to view a computer terminal; to perform activities such as preparing reports, analyzing data; and to determine accuracy, neatness and thoroughness of work assigned.
2. Must be able to work on a computer for up to 20 hours per week.
3. Must be able to move in and out of offices, participant's homes or other community settings, and on the Coolidge Campus if based in Northern CA.
4. Possesses the ability to actively participate in and supervise participants' recreational activities, including noncompetitive sports.
5. Must be able to bend, lift as much as 25 lbs., and walk up to a mile at one time.
6. Must be able to operate office equipment requiring repetitive hand movement and fine coordination including use of a computer keyboard.
7. Must be licensed and have the ability and skill to drive cars, vans, or other vehicles.
8. Must be able to drive locally 30% of the workday.
9. Must be able to physically monitor youths to ensure they do not hurt themselves or others.
10. The job has potential for injury or harm, and the ability to assess and avoid threats posed by participants and the community is necessary to maintain safety.

I have read and understand the duties and responsibilities of my position as ECM – Lead Case Manager-. I understand that this job description should in no way be construed as a contract for employment, but rather is intended to indicate the general nature and level of work to be performed. Nothing in this job description restricts management's right to assign or reassign duties and responsibilities to or from this job at any time. It is not designed to contain nor be

interpreted as a comprehensive account of all the responsibilities and/or qualifications required of an employee assigned to this job. These job duties may be subject to change at any time due to reasonable accommodation or other reasons. Further, I understand that if I have any physical limitations or require any accommodation to perform the essential functions of my job, I must immediately inform my manager and/or Human Resources.

Signed: _____ Date: _____

Printed Name: _____