

**Job Description**

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| **Job Title** | **Health Homes Case Manager** |
| **Department/Program** | **Health Homes** |
| **Location** | **Derby / Home Visits** |
| **Supervisor** | **Kristy Gasiewicz** |
| **Classification / FLSA status** | **Non-Exempt – Full time Grade: 6** |

**Integrity • Collaboration • Quality • Compassion • Dedication**

**Job Summary**The Care Manager operates within a team of professionals who deliver services to clients of behavioral health services residing in Erie County and are identified and referred by regional health homes. The Care Manager identifies, assesses, links to and monitors the use of multiple resources benefiting individuals identified as “high risk users of health services” and who have problems accessing care.

**Note**: High risk users of services are typically identified as those individuals who experience multiple emergency room or inpatient services and/or present with behavioral health disorders coupled with chronic disease syndromes.

**Responsibilities:**

* The Care Manager addresses appropriateness, quality, adequacy, continuity, and cost effectiveness of needed resources and services. This includes intake and screening – initial contact, exploration of the client’s receptivity and eligibility for services, verification that the client is a member of the Care Management target population, identification of problem areas and potential resolutions, and case information management.
* Assessment and reassessment – securing of information through collateral sources of the nature and degree of the client’s functional behavioral impairment, identification to barriers to care and gaps in service, description of strengths, informal support system identification and environmental factors relative to the client’s care.
* Assessment of service needs – including vocational, medical, social, psychosocial, educational, financial, etc.
* Care management planning and coordination – comprehensive, detailed written care management planning and coordination including the identification of the nature, amount, frequency, and duration of care management services required by the client.
* Develop short-term and long-term goals and objectives to be achieved through the care management process.
* Monitoring and follow-up to assure that quality services identified in the care management plan are delivered to assure client satisfaction.
* Collecting data and documentation in case records and any necessary revision of the care management plan, and problem resolution following NYS Health Homes and Medicaid standards.
* Counseling and exit planning – facilitating the introduction and linkages to support groups for the client, family members and informal providers of services. Preparing the client for discharge from or admission to facilities or other programs to ensure continuity of care.
* Advocate for client’s and produce positive outcomes defined by the client.
* Other related duties as assigned by supervisor.
* Compliance and Values
* All employees are expected to obey all laws and regulations governing our Agency and to be accountable for compliance at all times.
* All employees are expected to provide the very highest level of service when working with Agency patients/clients and their work ethic should reflect Harmonia’s core values.
* Maintain a caseload of approximately 45-50.

**Skills and Abilities**

* Knowledge of behavioral health diagnoses and symptomology
* Familiarity with community resources, including entitlement programs, medical and financial, legal services, housing, and emergency food programs.
* Familiarity with the range of behavioral health treatment and rehabilitation services available.
* Must be able to engage with treatment resistant individuals
* Must have an understanding of issues related to complex diagnostic cases, such as chronic disease/behavioral health interactions.
* Must be trauma-informed.
* Must have highly developed verbal and written skills.
* Must be able to effectively broker services and resources.
* Must be able to perform duties in and efficient and independent manner.
* Must possess knowledge of and ability to provide behavioral health interventions in coordination of care.

**Education and Experience**

* A bachelor’s degree in psychology, social work, or human services with 2-3 years relevant community-based experience.
* A valid NYS Driver’s License, car and a good driving record.

GENERAL SIGN-OFF: The employee is expected to adhere to all agency policies. This job description is not designed to cover or contain a comprehensive listing of activities, duties, and responsibilities that are required of the employee.

I have read and understand this job description and recognize it may change to meet the needs of the organization.

Signature: Date:

Filename: Job Description for Health Homes Coord.