



CARE MANAGER POSITION DESCRIPTION

The Care Manager role is both a leadership and managerial role with clinical/assessment duties as well as administrative, and operational duties. The Care Manager is responsible for recruiting, supervising, empowering and providing support to the field staff in carrying out the Care Plan for each client. Additionally, they are responsible for the entire Care Plan formulation and execution including, conducting initial client assessments, reviewing progress and providing updates to stakeholders. The Care Plan itself must also be continuously re-assessed and revisions made where necessary. The Care Manager must have a BSN, LCSW, MSW, or a Master's degree in Social Work or Clinical Psychology, as well as at least ten years of experience in the mental health or nursing field.

CARE MANAGER TASKS/RESPONSIBILITIES

Intake/Assessment

- Complete consultation call, explain fees, assessment process, and set date for assessment.
- Transmit service agreement to person handling financial responsibilities. Arrange for completion and signature of all forms.
- Complete assessment, complete service agreement forms and collect assessment and security deposit via check or credit card.
- Establish guidelines and expectations for all parties involved with care. Provide a written description and timeline for meeting responsibilities.
- Write initial Care Plan and Home Book. Include responsibilities on initial care Plan as seen on template.
- Provide Care Plan to any/all parties involved with client care and have them sign and date.

Staffing:

- Hire, train and provide ongoing supervision for care coaches and/or caregivers in each client household.
- Collaborate with Staffing Coordinator to review and recruit field staff specific to client requirements, as needed.
- Meet all incoming staff for the third interview (once cleared by Staffing Coordinator).
- Orient staff to case/client in detail (i.e. diagnosis, relationships, specific needs, dietary issues, etc).
- Provide staff with Care Plan, and all contact numbers and necessary information as included in Home Book.
- Create/discuss/approve schedule with client/family/responsible party.

Procedural/Operational

- Introduce client to Care Coach/Caregiver (done for all new staff providing care).
- Monitor client progress emails sent by care coaches and caregivers after every shift.
- Provide updates as needed to family/responsible parties.
- Review progress weekly and address changes as necessary with client and staff.
- Serve as health care or psychiatric advocate for clients and provide crisis prevention interventions if necessary.
- Alter Care Plan once goals are met or new goals/risks/needs are identified, and update Home Book as needed, every six weeks at a minimum.
- Meet with client weekly, bi-weekly, or monthly depending on need.
- Review financial, legal or medical issues and coordinate all resulting treatment needs.
- Offer referrals/recommendations to specialized service providers, if necessary.
- Provide support for placement in a retirement complex, assisted living facility, or nursing facility if at-home care is no longer feasible or desired.

Administrative

- Place outreach and marketing calls.
- Meet with professionals in community to establish and maintain mutual referral relationships.
- Develop internal system for providing support and supervision to staff.
- Meet with CEO weekly or as needed to coordinate goals and action plan.
- Meet with Human Resources Manager weekly or as needed to discuss staffing needs.
- Meet and review cases weekly or as needed with Junior Care Managers.
- Oversee all cases and provide direction/ feedback to field staff.
- Identify needs of clients/staff and establish guidelines, interventions, and suggestions.

QUALIFICATIONS

- RN (BSN minimum) or LCSW, MSW, Master's degree in Social Work or Clinical Psychology
 - Care Manager certification desired
- Minimum 10 years of experience in the mental health or nursing field with experience in geriatric health.
 - Managerial experience desired.