



## Cayuga County Department of Human Resources and Civil Service Commission

### JOB SPECIFICATION

Civil Service Title: **Care Manager** (formerly Health Home Care Manager)  
Jurisdictional Class: Competitive  
Civil Division: County  
Adoption: CSM 3/9/16  
Revised: CSM 6/21/18; 10/17/18; 1/21/2020 (from Health Home Care Manager to Care Manager)

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#### **DISTINGUISHING FEATURES OF THE CLASS:**

The Care Manager is responsible for working with adults who are diagnosed with mental illness and/or chronic health conditions. In conjunction with the client, the incumbent completes a comprehensive assessment to identify needs followed by a plan of care that outlines goals and objectives to be achieved through care management. The incumbent acts as a service coordinator making necessary referrals to connect an individual with community resources and also collaborates with an individual's care team to achieve goals identified in the plan of care. The work is performed under the direct supervision of the Deputy Director. The work requires adherence to the New York State Department of Health guidelines for Health Home Care Management and requires training provided through the state and the agency. Does related work as necessary.

#### **TYPICAL WORK ACTIVITIES: (Illustrative Only)**

- Provides quality-driven, cost-effective, culturally appropriate, and person and family centered care management services;
- Coordinates and provides access to high quality health care services informed by evidence based clinical practice guidelines, to preventive and health promotion services, including prevention of mental illness and substance use disorders, to mental health and substance abuse services, to comprehensive care management, care coordination, and transitional care across settings, such as participation in discharge planning, to chronic disease management, including self-management support to individuals and their families, to individual and family supports, including referral to community, social support, and recovery services, to long term care supports and services;
- Develops a person centered plan of care for each individual that coordinates and integrates identified medical and social needs which requires referrals to medical, community, social support, and recovery services;
- Demonstrates a capacity to use health information technology to link services, facilitates communication among team members and between the health team and individual and family caregivers, and provides feedback to practices, as feasible and appropriate;
- Participates in a continuous quality improvement program and collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience in care outcomes, and quality of care outcomes at the population level;
- Is responsible to complete an assessment with each individual to identify areas of need, personal resources and supports, strengths, goals, and objectives;
- Will assist the individual through linkages and referrals, to achieve maximum functional independence;

**TYPICAL WORK ACTIVITIES: (Illustrative Only) Continued**

Maintains contact with individuals on a scheduled basis that is appropriate to their status and needs and that is in accordance with Department of Health regulations;

Maintains information on community and health resources including, but not limited to: transitional housing, financial entitlements, medical and mental health care, vocation and psychosocial rehabilitation, and transportation;

Monitors progress of interventions and objectives outlined in the plan or care and ensures continuity of service in order to achieve goals;

Intercedes on behalf of the individual to assure access to services required in the individual's service plan;

Provides services which are expeditious and coordinative in nature rather than primary treatment services;

Assists with crisis response and intervention as needed;

Maintains accurate client documentation and other pertinent paperwork and reports utilizing health information technologies;

Accurately completes job assignments, forms, and written documents within assigned deadlines;

Effectively communicates, both orally and in writing, with clients, families, members of the care team, coworkers, supervisors, other service agencies, and the community;

Convenes and/or attends meeting and conference to discuss client needs and progress toward treatment goal plans;

Provides monitoring services to individuals receiving Assisted Outpatient Treatment;

Participates in trainings related to practice as assigned.

**FULL PERFORMANCE KNOWLEDGES, SKILLS, ABILITIES, PERSONAL CHARACTERISTICS:**

Good knowledge of the social factors affecting psychiatric illnesses; working knowledge of community resources including mental health, health, medical, social, vocation, education, recreational, housing, transportation, spiritual, rehabilitation, legal and financial services; ability to make assessments of the needs of individuals being served; ability to negotiate and advocate on the individual's behalf; ability to show respect for the individual's or family's choices; ability to establish trust and induce patient cooperation; ability to work independently in a variety of community based settings; ability to maintain confidentiality; ability to prepare records and reports; ability to communicate both orally and in writing; physical condition commensurate with the demands of the position; ability to demonstrate the capacity to meet the transportation needs involved in carrying out work responsibilities which will include travel to areas not served by public transportation.

**MINIMUM QUALIFICATIONS:**

- (A) Graduation from a regionally accredited or New York State registered college or university with a Master's Degree in a qualifying field including social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology or speech and hearing; **AND** either:
1. One (1) year of experience in providing direct services to individuals diagnosed with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with Serious Emotional Disturbance; **OR**
  2. One (1) year of experience in linking individuals diagnosed with Serious Mental Illness, developmental disabilities, and/ or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services); **OR**

- (B) Graduation from a regionally accredited or New York State registered college or university with a Bachelor's Degree in a qualifying field listed in (A) above; **AND** either:
1. Two (2) years of experience in providing direct services to individuals diagnosed with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with serious emotional disturbance; **OR**
  2. Two (2) years of experience in linking individuals diagnosed with Serious Mental Illness, developmental disabilities, or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services); **OR**
- (C) Graduation from a regionally accredited or New York State registered college or university with a Bachelor's Degree or higher in ANY field **AND** either:
1. Two (2) years of experience as a Health Home Care Manager serving people diagnosed with Serious Mental Illness or Serious Emotional Disturbance; **OR**
  2. Three (3) years of experience in providing direct services to individuals diagnosed with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with serious emotional disturbance; **OR**
  3. Three (3) years of experience in linking individuals diagnosed with Serious Mental Illness, developmental disabilities, or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

**SPECIAL REQUIREMENT(S):**

Certain assignments made to employees in this class will require reasonable access to transportation to meet field work requirements made in the ordinary course of business in a timely and efficient manner. Operation of county-owned vehicles requires employees to possess a current valid New York State Motor Vehicle operator's license.