Program/Practice: Options Care Management or as applicable
Job and Roles Description

<table>
<thead>
<tr>
<th>POSITION LEVEL:</th>
<th>Case/Service Management</th>
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<tbody>
<tr>
<td>POSITION TITLE:</td>
<td>Options Care Manager</td>
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<tr>
<td>CM SPECIALTY:</td>
<td>Level of Care Applicable:</td>
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<tr>
<td></td>
<td>Nursing Facility Ineligible (NFI) Care Manager 672.1</td>
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<td></td>
<td>Nursing Facility Clinically Eligible (NFCE) Care Manager 672.2</td>
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<td></td>
<td>NFI/NFCE Complex Care Management (see and sign Addendum)</td>
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<tr>
<td>REPORTS TO:</td>
<td>Care Management Practices Coordinator (as assigned)</td>
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<tr>
<td>POSITION(s) SUPERVISED:</td>
<td>NONE</td>
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**Mission/Vision:** The mission of the Community Partnerships Intergenerational Practices and Programs is to promote and support the active-aging, aging-well and aging-in-place of older adults, and adults with disabilities and their informal caregivers to live with dignity and independence in settings they prefer while encouraging active engagement in community life through the coordination and oversight of in-home and community-based services and supports. The long term vision of the Center for Intergenerational Practices is that of creating a livable and all-inclusive communities across ages and abilities.

Options’ Care Management offers seniors (Participants) age 60 years and older two Levels of Care Management services: (a). Nursing Facility Ineligible (or NFI-672.1) and; (b). Nursing Facility Clinically Eligible (or NFCE-672.2). The Options’ Care Manager (OCM) Incumbent selection might be based on the Level of Care position as available and/or applicable.

**POSITION SUMMARY:** The primary functions and responsibilities of the OCM is to provide participants and their family-caregivers with high quality professional practices such as person-centered assessment and service planning, care coordination, referral, resources counseling, and on-going monitoring and evaluation of services and supports required for a safe and healthy community living which is manifested through independence and self-determination. The development of trusting, supportive relationships with those served is critical, and it is achieved through home visits and regular check-ins, reassurance calls, resource counseling, and effective engagement of both participants and family caregivers. The incumbent OCM works and adheres to all standing care management guidelines, policies, procedures and quality assurance standards. This includes but is not limited to working and conducting his/her self and business within the guidelines, policies and mission of the Family Services of Western Pennsylvania; the policies requirements of the Allegheny County Department of Human services Area Agency on Aging (ACDHS/AAA) and; other funding partners’ requirements as applicable and appropriate.

**POSITION SCOPE:** The incumbent in the OCM position is responsible for the proficient and quality delivery of a wide range of care and services coordination activities and duties to Options’ Participants and their Family-Caregivers, within community-based (homes or as otherwise applicable) settings. The incumbent must evidence a commitment to continuously promote participants’ quality of life, independent living and self-determination and the ability to foster effective promotive relationships and engagement with Participants and Family-Caregivers. This includes working collaboratively with both Participants and Family-Caregivers and ensure that their voices and choices in included in all aspects of care and service decision-making. The OCM must evidence the ability to manage and support solving for often complex situations and services delivery needs and to producing positive outcomes for the populations served. The OCM reports to the Options’ Program Coordinator as assigned.
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**ESSENTIAL QUALIFICATIONS:** The OCM must have the ability to both work independently and as an integral part of the Options’ care management team regardless to the specific CM-Team to whom the incumbent is assigned. The incumbent is accountable to support the attainment of the Options’ mission, principles, cultural and values commitments by thoughtfully and relentlessly to do their job and perform their responsibilities effectively and efficiently. The incumbent requires knowledge of, and experience with critical care management processes and practices as well as excellent analytical, interpersonal, organizational, and writing skills, and the ability to exercise extensive discretion, independent judgment and decision-making in the planning, organization, and delivery of care management services and supports. Most importantly the qualified OCM must demonstrate a commitment to continuously refine and develop their knowledge as applied to the population served. This includes conducting their work with the outmost professionalism and in accordance with standing policies and procedures and a commitment to continuous quality improvement.

In addition, the incumbent for this position is expected to work within the overarching culture that emphasizes the Sanctuary Model, Trauma Informed care and a Leadership-base HR management models that calls for committed and responsible participation in sustaining an attuning work environment to a high-impact evidence-based culture and focus on results.

The incumbent is also made aware that some of the responsibilities can involve financial and/or reporting processes, paraprofessional and/or secretarial functions, and physical facilities management responsibilities and duties.

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**Options’ Care Manager Duties and Responsibilities**

Care Management is the practice of supporting the aging-in-place, and thereby preventing early and often unnecessary institutionalization, of older adults 60 years of age and older (participants). This goal is accomplished through person-centered assessment and service planning, safety checks, resource counseling, and through coordinating access to and delivery of in-home services and care as fitted to support and promote participants to live independently in their homes or a community residence of their choice. The care management practice also includes regular home visiting, reassurance calls, and monthly contacts with both participants and family-caregivers. The qualified incumbent in this position thoughtfully places every participants and their family-caregiver at the center of decision-making and helps them to feel valued, knowledgeable and to become informed user of community-based resources and supports. The requirements listed in this job description are representative of the minimum expected responsibilities, knowledge, skills, and abilities that the incumbent in this position must be able to demonstrate in the performance of their role.

**Delivery of High Quality Accountable Care Management Practices**

1. **ENGAGEMENT/DEVELOPING ENDURING AND INCLUSIVE RELATIONSHIPS.** Develops relationships with the participant, his/her family-caregivers and/or other important people in his/her life as identified and within the self-determination and choices of the participants. This engagement process is ongoing and persistent throughout the permanence of the participant in the Options’ Care. The persistence must be evident through frequent outreach and demonstrate by a genuine concern for the participants’ and family-caregivers’ situations and needs.

2. **PERSON-CENTERED STRENGTHS-BASED ASSESSMENT.** Assures that required assessment are completed in accordance with expected time-frames and according to the established practice’s standards. This includes using and applying collaborative approaches; conducting informed observation, gathering extant social, clinical and functional information, and eliciting direct input through interviews of and consultations with participants and family-caregivers, in an effort to provide the most comprehensive functional assessment of the participants’ needs and strengths.

3. **PERSON-CENTERED SERVICE PLAN.** Works in close collaboration with the participant, family-caregivers and other formal and informal caregivers as applicable or required, in developing, documenting and implementing a comprehensive service/care plan. A person-centered plans is informed and driven by the data gathered through the assessment and includes the choices and preference as asserted by participants. The service/care plan is a living document (i.e., continuously changing and adapted according to the needs, circumstance, and other health and functional factors).
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4. Resource Counseling and Informed Decision-Making. Actively supports and assists participants and family-caregivers in researching, identifying, accessing and navigating services and resources to meet the strengths and needs identified in the service plan. This includes enabling informed decision-making by communicating with prospective resources and functioning as a liaison on behalf of the individuals being served; maintaining an up-to-date catalog of available community resources and in-home services, including location, service area, cost, eligibility requirements and alternatives. The OCM also specifically works with family caregivers and provides assistance in gathering information and increasing their knowledge of available resources and services. Resource Counseling and enabling informed decision-making also includes the performance of the following activities:

a. Linkages to Natural Supports. Whenever possible the OCM maximizes the use and involvement of the natural support system in addressing and meeting the participants’ needs. Assists individual and family to identify, link, access and coordinate such resources. The involvement of families is highly desirable and will vary based on the participant’s wishes, the age of the participant and other unique factors.

b. Cultural Competency. Demonstrating the professional understanding and compassion of the population served, their conditions, culture, preferences and life contexts and ensures that all services and care are delivered and accessed in a culturally competent manner and with due consideration for the individual’s race, religion, sex, sexual orientation, age and ethnic background/identification and/or other personal choices and situations.

c. Representation and Advocacy. Functioning as an advocate to the participants and family caregivers. This includes ensuring the equity and responsiveness of and from the natural, community, and specialized services/supports delivery systems. Advocacy includes providing information, removing barriers to access, creating options and resolving problems, as well as calling case-reviews at the county level as situations or cases demands.

Accountability for Results

The OCM continuously monitors and evaluates the service/care plan and ensures with the input of participants and their family caregivers that is all of the identified and targeted objectives, goals and outcomes are being accomplished by:

5. Assuring that at a minimum, the Services/Care Plans are formally reviewed every three months, and/or as needed and/or according to accreditation, contract and applicable state and county’s regulations.

6. Consistently evaluating and assuring authorization of all services received/delivered to participants. This includes but is not limited to:

a. Consistently reviewing the service-orders and compliance with the scheduled and delivery of all services;

b. Meeting with participants’ families, to review satisfaction with services and in-home service providers;

c. Assuring contractual compliance of service providers;

d. Facilitating problem solving; and other quality assurance and evaluation activities as applicable or required.

e. Convening and facilitating meetings or other related procedures to ensure the appropriateness and responsiveness of services in relation to individual and/or family needs, and targeted outcomes.

7. Ensuring at all times the highest level of professional and timely documentation, this includes but is not limited to:

a. Maintaining an accurate and timely record of all Care Management activities in SAMS or as otherwise instructed.

b. Maintaining and updating records of all individuals being served and collateral contacts.

c. Updating forms and other documentation as needed.

d. Reviewing and assuring charts/files/documents for compliance with regulations.

e. Preparing for internal and external charts audits.

f. Assuring that documentation is culturally competent, adheres to standing regulations and professional standards; that is written in appropriate language and that is inclusive of the participants’ perspective.

g. Completing all Service Documentation forms, Care Management Outcomes and other program performance and quality assurance requirements and within the designated time frames.

h. Assures and complies with the processes associated with FCSP financial documentation and any other relevant documentation regarding family caregivers.

8. Identifying and confirming participant’s natural supports’ dynamics, including the family’s perception of the situation, and their capacity and willingness to provide assistance and/or render sustained care; intervene as necessary while respecting participant choice.

9. Facilitating the safe and guided transition across the continuum of care and/or services.
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10. Helping and acting to reduce/buffer participants and family-caregivers’ stress and strains by providing guidance, support, and assistance in navigating, negotiating and mediating access to resources and services.
11. Annually, or as otherwise applicable, completes a self-assessment of competencies and performance and works with direct supervision to develop work-plans using the appropriate personnel evaluation forms and/or other appropriate performance assessment tools.

Risk Management Responsibilities

12. Creating and sustaining a workplace culture and value that is based on reciprocal respect, promotes a safe and healthy work environment.
13. Assuring the provision of highly ethical practice, promoting honesty, transparency, performing work in safe and competent manner, ensuring a work-place free of fraud, and discrimination by assuring a professional conduct in accordance with the seven Sanctuary principles.
14. Making timely, informed decisions that take into account the facts, goals, constraints, and risks, and proactively report any incidents, injuries, hazards, waste-abuse or unsafe work practices.
15. Ongoing compliance with the DHS/AAA and FSWP Practice Requirements and Expectations.
16. Perform back-up office duties as needed including answering Care Manager of the Day calls, mail, filing, etc.
17. Provides back-up support for coordinating the assignment of triages and assuring that these are completed within the required standard timelines.
18. Participate in mobilizing a response to help older adults during community emergencies and disasters.

Essential Practice-Informed Abilities

- Ability to work under limited supervision and use high level professional skills, informed decision-making.
- Ability to effectively represent FSWP and Division’s interests.
- Ability to anticipate and apply measures to alleviate potential problems, address complex issues and overcome obstacles to effective servicing participants and family-caregivers.
- Ability to utilize/access professional networks, relevant research and established best practice in order to continuously improve the quality of services delivered.
- Ability to provide leadership, including mentoring, gain cooperation, motivate and develop positive relationships.
- Ability to manage complex and competing priorities within strict timelines.
- Ability to manage change and be innovative.
- Ability to engage and provide advices and guide to staff and other relevant individuals in working with a wide range of community service providers and to mobilize resources and services as needed or applicable.
- Ability to transform the work-settings, home-visits and/or any places in social learning environments that promotes empowerment and enhances a leadership climate and culture.
- Ability to plan for and to thoughtfully work to ensure excellence in care management practices.

Continued Professional Development

The qualified incumbent for this position demonstrates a commitment to continue learning and strengthening of the skills and competencies involved in the provisions and delivery of high-quality care management services by:

- Taking the responsibility to initiate the development of a set of professional goals to work on and accomplish during or by the end of the fiscal year; including indicating the steps they will be taking and the schedule by which each of the identified professional goals will be completed and attained.
- Maintaining up-to-date professional knowledge, resources and skills through reading research literature, attending appropriate conferences, or in-service education, attendance at multi-disciplinary meetings and/or by seeking other appropriate professional development training and continued education venues.
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- Maintaining qualifications essential for the role including attending to the Training responsibilities to complement the existing Team Coach Training Protocols.
- Researching new innovative and effective ways to address care management practices improvements and effectiveness.
- Maintaining self-up-to-date with changing policies and procedures as necessary to assure ongoing adherence to best-practice standards as relevant for and applicable to care management practices.

**TRAINING AND CERTIFICATIONS RESPONSIBILITIES.** OCM incumbent attends training programs as provided through the State, County and Family Services of Western Pennsylvania and is to successfully complete and obtain any certification as required and/or applicable to the position. It is the OCM professional responsibility to maintain his/herself up to date on new approaches, best practices standards, strength-based assessments, and other required evidence-based practices.

### Additional Requirements

**The incumbent in this position has strong foundational skills in the following areas:**

- Administer and/or complete assessments and other required forms and documentations
- Good writing and communication skills
- Critical and analytical skills
- Interpret and explain presented instructions
- Use and perform basic computer functions/tools such as word processing, excel spreadsheets, searching/using the internet and other technologies as applicable
- Maintaining and keeping records/files organized and in accordance to HIPAA requirements
- Working knowledge and understanding the use of SAMS database.
- Supporting data collection activities of the program, including fidelity observation and satisfaction’s surveys as assigned and applicable.
- Discuss end of life issues with participants and their natural supports and do so in a thoughtful, informed, and realistic manner
- Establish trust in relationships with participants and natural supports
- Use and apply motivational interviewing and anticipatory guidance
- Apply cultural understanding to practice situations that reflects a broad perspective on cultural diversity, including LGBT issues

### Caseload Management

**672.1 - NFI Level of Care:** On average maintains a caseload ranging between 68 and 78 participants not including family caregivers. During period of staff shortage or vacancy the NFI OCM might be required to take on additional cases as needed.

**672.2 - NCCE Level of Care:** Focuses on participants with higher level of care intensity and presenting more complex conditions or situations. On average maintains a slightly lower caseload ranging between 42 and 62 participants, not including family caregivers. In addition, the NCCE OCM is also responsible to assure continuity of care and to take on additional cases of both NFI and NCCE participants as applicable and required and to facilitate and coordinate the completion of transition/waiver planning and assessments.

### Minimum Qualifications and Additional Information

**Education and Training:** Bachelor of Social Work, or other related social sciences degree. Gerontology and/or disabilities specialization preferred. Licensing and other appropriate certifications a plus. [Degrees beyond the range listed above require approval of the Chief Executive Officer and may require additional experience from what is described below. All degrees must come from an accredited college or university].

**Minimum Required Experience:** One (1) to two (2) years of human service experience; working knowledge of the provision of health care in various settings; knowledge of...
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community resources and care delivery systems; proficiency in use of a laptop computer with MS Office Suite software, relational databases including expert user of SAMS database, ability to use the Internet, and smart phone technology; case management experience and experience working with older adults.

Child Abuse History and Criminal Clearance (ACT 33/34) - FBI Clearance for all staff required before accepting this position. Valid PA Driver’s License and reliable transportation with willingness to travel extensively

SALARY RANGE & BENEFITS: Salary is contingent upon available funding, and is commensurate with experience and qualifications.

Physical Demands: The incumbent in this position must be able to work in environments where numerous conversation and activities might be taking place at the same time. He/she might be frequently required to stand, bend, kneel, scooch, lifting objects and/or carry materials to and from different locations and loading/unloading materials for use with participants and/or family-caregivers.

Work Conditions: This position is primarily mobile requiring to work outside the office (e.g., participants’ homes); this will involve traveling in various weather conditions and the ability to be available and/or work according to the assigned schedule. All of these environmental conditions may present strains, challenges and frustration that the incumbent in this position must be able to effectively cope with while working.

PRIVACY: Security Level Eight: All individually identifiable health information, or a broad definition, including mental health, drug and alcohol, and mental retardation, is accessible to the incumbent. This security level allows for:

A. Access to entire care management records and SAMS. Entire record-quality related to record and services billing and will have access to the caseload of program overseen by this position and the program for which this position provides a backup support function.

B. With the ability to disclose private health information including: Participants/clinical information with authorization of participants.

The intent of this job description is to provide a representative summary of the major duties and responsibilities performed by incumbents in this position. Incumbents may be requested to perform job-related tasks other than those specifically presented in this description.

APPROVED: ___________________________     DATE: ________________

Direct Supervisor

APPROVED: ___________________________     DATE: ________________

Associate Director

APPROVED: ___________________________     DATE: ________________

Chief Executive Officer

The Employee [First and Last Name: ___________________________] signature below, indicates that he/she has reviewed the contents of this job description and accepts to perform and fulfill the position’s role/work and responsibilities according to the outlined quality standards, principle, cultural and values commitments.

EMPLOYEE: ___________________________     DATE: ________________
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File Pathname: Care Service Management/ Specialist 671.1 and 671.2
Revised: 10/30/2016