

## **Case Manager/Care Guide Job Description**

The Cornerstone Case Manager/Care Guide is responsible for working with clients enrolled in Cornerstone Solutions to help them access, navigate and coordinate medical, mental health, oral health, chemical health and social service related systems and services. The position will have the primary responsibility of providing care coordination to consumers who have a diagnosis of a mental health, physical health or developmental disability. This position will work as an advocate for the consumer across a variety of county agencies and will be responsible for developing and maintaining relationships with providers and community partners.

- **Program Expectations:**

- Assist all enrollees on case load in accessing preventative health, mental health and oral health care (at least annual appointments for each which include a holistic diagnostic assessment). (Have at least annual communication with the enrollees medical, mental health, oral health and chemical health providers).
- Assist all enrollees on case load in coordinating all physical, mental health, chemical health and oral health services- including specialty services.
- Ensure that all enrollees on case load maintain enrollment in their health plan.
- Ensure that all enrollees have access to evidence based practices.
- Ensure that all enrollees have access to appropriate disease management practices.
- Assist all enrollees in the coordination and accessing of appropriate school, vocational, housing, culturally specific services, community based services (example, after school programming for a child, community support programming for adults) and county social services (respite care, housing support).
- Comply with all state and federal rules.

- **Care Guide Expectations:**

- Provide direct clinical support when appropriate to maintain stable mental health & community tenure for clients.
- Provide the standardized Health Risk Screening (HRS)/ Functional Assessment and crisis within 30 days for all enrollees in person.
- Update the comprehensive face-to-face Health Risk Screening/functional assessment and crisis plan as needed and at the very least, 180 days.
- Develop the standardized comprehensive care plan with enrollees on case load and their identified natural supports within 14 days of completing the functional assessment.
- Update the comprehensive care plan as needed and at the very least, every 180 days.
- Keep a record of all care coordination activities for each enrollee in standardized documentation notes.
- Timeline for documentation, ie. Document within 5 business days from date of service.
- Ensure that all adults ages 18-21 have a transition plan.
- Meet with all enrollees face to face at least once every three months (quarterly). For members who refuse to meet every three months (quarterly), the reason for the lack of a face to face contact must be documented within the case note. \*If performing Mental Health Targeted Case Management duties, meet with enrollees face to face at least once a month (monthly). For members who refuse to meet monthly, contact by telephone and document the reason for the lack of face to face contact within the case note.

- Ensure that all enrollees receiving medication treatments have an annual comprehensive medication evaluation to check for counter indications for prescribed medications and that medications are being filled as scheduled.
- Ensure that all barriers to medication compliance are addressed via communication with and/or referral to appropriate providers. Barriers may include complaints of side effects, complications and/or access to medications, such as unaffordable copays or formulary.
- Collect required outcome measures for all enrollees at entrance into the program, every six months after entering the program and when exiting the program.
- Attend all required trainings including at least quarterly case consultation meetings/trainings with the Care Coordination Management Team.
- Obtain appropriate supervision for levels of care guides/case managers including documentation of clinical supervision through the monthly review of care guide/case manager notes for all mental health practitioners.
- Obtain signed releases for communications with all medical, mental health and social services providers, as well as natural supports annually. In cases where members refuse to sign releases, document the refusal in the case notes.
- Provide all required documentation, as indicated in the contract with MHP.

**Qualifications:**

- Master's Degree in Psychology, Social Work or related field or licensed as a Practical Nurse. Licensure as a mental health professional is preferred.
- Must have two years of experience working with adults with a certified disability.
- Must have experience and knowledge about mental health, physical health, cognitive and medical disabilities and conditions.
- Must have experience and knowledge of services typically accessed by adults with disabilities.
- Must have experience working with culturally and economically diverse populations and communities.
- Experience as a case manager is required.
- Experience in and knowledge of common computer applications such as Word, Excel etc.
- Experience with complex data bases. Experience with county/state reporting data bases preferred (HSIS, MAXIS)
- Experience and knowledge of working with a variety of community organizations and systems.
- Preference is given to applicants with bi-lingual oral and written skills in Spanish, Hmong, Somali and/or Russian.