Child & Youth Case Manager

Status: Full-time Position

Location: Washington County

Reports To: Washington County Program Manager

General Description:

IDENTIFICATION & ASSESSMENT

- Must coordinate & facilitate the first CFT Meeting within 30 calendar days of notification of enrollment.
- Must work with the participant and family to develop an initial crisis plan that includes response to immediate service needs.
- Must demonstrate ability in providing supportive services for participants to help them achieve goals as specified in the care plan.
- Must identify barriers that participant and family are faced with and provide assistance to overcome allowing for participant's success.
- Must complete referrals and linkages to community-based resources as established within the POC.
- Shall determine appropriate State and local child and family serving agencies to develop a network of clinical and natural supports in the community to address strengths and needs identified in participant's POC.
- Screen participants, evaluate individual situations and report any pertinent findings to the Program Manager or Administration.

DOCUMENTATION AND DATA COLLECTION

- Shall maintain participant's electronic chart and all associated documentation in accordance with COMAR 10.09.45.12 and PCMS standards.
    - Plan of Care
        - A description of the participant's strengths and needs.
        - The diagnosis or diagnoses, which enable a participant's eligibility for services and are approved by Management.
        - The goals of care coordination services to address the behavioral health, medical, social, educational, and other services needed by the participant, with expected target completion dates.
        - A crisis plan including the proposed strategies and interventions for preventing and responding to crises and the child/youth and family's definitions of what constitutes a crisis.
        - Designation of the care coordinator with primary responsibility for implementation of the POC.
        - Signatures of the care coordinator and other CFT members, if appropriate.

DOCUMENTATION AND DATA COLLECTION - Continued

- Signatures of the participant and family indicating that the participant and family have participated in the development of the POC and had choice in the selection of services, providers, and interventions, when possible, in the wraparound process of building the POC; and
- Must ensure that identified supports are incorporated as part of the POC and care coordination is supportive of ongoing engagement with identified supports.

- Outlook Calendar
  - All visits, personal car use, phone contacts made on participant's behalf.
- Ongoing Record of contacts made on the participant's behalf.
  - Encounter Nots (must be completed per COMAR 10.90.45.12(B). 1-6
  - Record Notes (documentation for all interactions completed on the participant's behalf that are not done with the participant and/or family present and according to COMAR 10.90.45.12(B).1-6)
- Encounter Ticket
  - Document face-to-face, non-face-to-face, and indirect time, diagnosis, unit#, authorization, signature with title, date.
  - Submit accurate billing for reimbursement as outlined by Management and per PCMS standards.
- Demographics
  - Participant and parent or guardian's contact information
  - Names and contact information for the participant's primary care provider (PCP), dentist, and all other health care providers identified.
- Medications
  - Updated continually to reflect participant's use with medication names, dosage, and frequency of each.
- Monthly Summary Notes
  - Reflect progress made towards the identified needs and outcome measures, if not completed in the last encounter note.
- Release of Information
  - Must be completed for all contacts related to the participant.
- Ensure that all documents are signed appropriately by the participant's parent/guardian and CC completing paperwork.

CONTINUITY OF CARE & PERFORMANCE IMPROVEMENT

- Shall safeguard the confidentiality of the participant's records in accordance with State and Federal laws and regulations governing confidentiality.
- Responsible for completing face-to-face, non-face-to-face interactions with participant and/or parent as outlined by COMAR regulations to ensure the POC is being adequately achieved.
- Coordinate and facilitate CFT meetings according to COMAR 10.90.09.11
  - Record into electronic chart, all CFT notes, CFT members present, summary of discussion, any changes to the POC, and action items for follow up, and share them with the CFT members, including those who were not in attendance.
  - Update the POC to include changes in progress, services, or other areas within 5 calendar days of the CFT meeting.

- Coordinate and facilitate CFT meetings and update the POC as clinically indicated based on the strengths and needs of the participant but not less than every 6 months for Level I, every 3 months for Level II, every 45 calendar days for Level II, and with 7 calendar days following a crisis event.
- Must review and update crisis plan, at minimum, during CFT meeting or at any time a participant and family's condition changes that may be indicative of risk.
- Ensure compliance of all PCMS policies and regulations, and state laws and regulations.
- Must work schedule according to the needs of participant and family ensuring delivery of quality services.
- Must accomplish eight (8) hours of continuing education annually.
- Actively participates in Clinical Supervision by providing accurate information for case review to ensure Level of Care is adequately meeting participant and family needs to achieve defined goals in the POC.
- Complete number of units per day to adequately provide participant and family with supportive case.

ADVOCACY & COMMUNITY ENGAGEMENT

- Empower the participant and family to secure needed services. Present options for services and assist to services that may be available and best suited to their individual needs.
- Take any necessary actions to secure services on the participant's behalf.
- Encourage and facilitate the participant, or in the case of a minor, the parent or guardian's decision making and choices leading to accomplishment of the participant and family goals as identified in the POC.
- Complete transitional care planning with participant, parent, and/or referring agency, when an inpatient or out-of-home placement has occurred but should not provide activities delivered as part of institutional discharge planning.
- Facilitate discharge planning from care coordination, when appropriate and when the family is closer to its identified vision, when family needs have been met, and when outcome measures for care coordination have been achieved.
- Act as a liaison for PCMS with community agencies and other local mental health agencies and providers, promoting positive and effective collaboration for the participant and family.

Employment Requirements:

- Bachelor's Degree in Human Services, preferred
- Minimum of 1 year experience in behavioral health working with children, youth, and/or families
- If licensed, must be in good standing with professional licensing or certification boards.
- Knowledgeable regarding community resources related to mental health and case management.
- Ability to work autonomously, manage a designated caseload and deliver quality services.
- Must complete Care Coordinator Training
- Communication skills, written and verbal.
- Valid driver's license and transportation

If you are interested, please send your resume to recruiting@pcmsinc.org

Potomac Case Management supports a diverse workforce and is an Equal Opportunity Employer that does not discriminate against individuals. We provide equal employment opportunities without regard to race, ethnicity, color, religion, sex, national origin, age, disability, marital/familial status, veteran status, sexual orientation, gender identity, gender expression, genetic information, or any other protected characteristic applicable under law.