

Core
Resource
Set for
PACE

CRSP

SAMPLE JOB DESCRIPTIONS

PACE SOCIAL WORKER



National
PACE
Association

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SAMPLE A

11/02

I. IDENTIFICATION

Position Title: Clinical Social Worker

Cost Center(s) #:

Job Code:

Area Dir. Title: Director, Senior Services

Date Completed:

Work Location(s):

II. PRINCIPAL ACCOUNTABILITIES (SUMMARY)

The Clinical Social Worker at (*PACE Program*) contributes the profession's unique psychosocial perspective to the interdisciplinary evaluation, assessment, plan of care, ongoing services, and disenrollment processes that occur once (*PACE Program*) participants begin the intake process and continue with ongoing services. The Social Work interventions could include individual participant contacts; appropriate collateral contacts; participant and family education, assessment, and counseling; mobilizing resources, addressing mental health needs as they arise; ongoing case management; advocacy to ensure patient needs are addressed; and disenrollment procedures. The Social Worker collaborates with the interdisciplinary team to ensure effective, efficient and appropriate care in order to optimize the health status and quality of life of (*PACE Program*) participants. The Social Worker is knowledgeable regarding social systems and institutions, and individual behavior, and can skillfully apply appropriate interventions to meet the needs of the participant and family.

III. POSITION REQUIREMENTS

	Minimum	Desired
Education, credentials, licenses:	MSW, LSW	MSW, LISW
Specialized knowledge:	Geriatric experience Community resources	Geriatric experience Community resources Medical Terminology Crisis Intervention Ongoing Case Management
Kind & length of experience:	1 year experience in a hospital, nursing home or community-based	2+ years experience post-Masters Mental Health knowledge

Working Conditions/Physical Demands Required: Must be able to handle stress and a fast-paced work environment. Must be able to organize and prioritize caseload to meet the needs of participants. Must be willing to make home visits.

Activity	Rarely	Occasionally	Frequently	Consistently	Activity	Rarely	Occasionally	Frequently	Consistently
Walking			X		Manual Dexterity		X		
Sitting			X		Use of Hands				X
Pushing		X			Talking				X
Pulling		X			Hearing				
Climbing	X				· Normal Conversation				X
Stooping		X			· Other Sounds				X
Kneeling		X			Vision				
Reaching		X			· Acuity, Near				X
Lifting					· Acuity, Far				X
· Over 50 lbs	X				· Color		X		
· Under 50 lbs		X			Standing			X	

Patient Care Providers Only: Incumbent must be trained to provide assessment, treatment or care for patients of all ages with additional education focused on treatment and care of adult and elderly patients.

IV. PERFORMANCE MEASURES & STANDARDS

MAJOR RESULTS/STANDARDS THIS POSITION IS EXPECTED TO ACHIEVE.	% WEIGHT
1. Actively participates in interdisciplinary evaluation, assessment, and plan of care for all participants enrolled in <i>(PACE Program)</i> . Contributes professional Social Work perspective to these processes. Begins work for enrollment immediately after the initial psychosocial assessment; involves participant and family members in the planning process and ongoing care. Responds to identified needs of participants and their families in a clinically sound, therapeutic manner on an ongoing basis.	20%
2. The Social Worker develops appropriate plans of care, based upon assessment information, for the psychosocial needs of the participant. The Social Worker utilizes information obtained by other caregivers, including appropriate data from the medical record, participant and interdisciplinary team. The Social Worker provides counseling and crisis intervention, and addresses mental health needs as they arise. The Social Worker provides linkages to community services, demonstrating a keen awareness of resources available and appropriateness to the needs of the participant and family. Maintains current information related to community resources, and federal and state guidelines. Facilitates participant and family adjustment to lifestyle changes.	20%
3. The Social Worker effectively communicates and collaborates with all customers at all times. The Social Worker responds to customer complaints and actively works to resolve issues/concerns. The Social Worker maintains a positive working relationship with all customers. Consistently collaborates with and respects <i>(PACE Program)</i> team members, referral sources and outside agencies. The Social Worker projects a professional image in appearance and action. The Social Worker maintains self-control in difficult situations and listens to all concerns, and gathers information for problem resolution as necessary.	20%
4. Medical chart documentation is completed according to established documentation standards and in a timely manner.	10%
5. Statistics and paperwork requested by community agencies or the supervisor are turned in by deadline. Actively involved and participates in departmental committees as assigned.	10%

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|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| 6. | The Social Worker consistently follows the Social Work Code of Ethics, treats all people with respect, maintains confidentiality and strives toward service excellence. | 10% |
| 7. | The Social Worker continues professional development through attendance at staff meetings and engaging in educational opportunities to maintain professional competence and licensure. | 10% |

100%

V. PROBLEM SOLVING

BELOW ARE TWO TYPICAL PROBLEMS THIS POSITION MUST RESOLVE TO ACHIEVE THE STANDARDS LISTED IN SECTION IV.

1. A participant with impaired cognition begins to have increased difficulty managing his/her finances. He/she has become more forgetful and has forgotten to pay his/her rent, which could result in eviction. In addition, the nephew is taking money without the participant's permission.

(Solution: Social Worker and participant meet together to consider all available options. Social Worker makes contact with appropriate agencies to assist. As required by law and the Code of Ethics, the Social Worker contacts Adult Protective Services for investigation of possible exploitation. The Social Worker also recommends to the participant that a representative payee be established to ensure that bills are paid and prevent eviction.)

2. The Social Worker receives information that a participant is refusing to attend the Day Health Center. The Social Worker talks with the participant and/or family over the phone as well as appropriate staff to determine what is causing the participant to refuse attendance.

(Solution: Social Worker talks with participant and addresses participants' concerns or issues. Encourages attendance, if appropriate. Informs team, especially medical staff, to determine need for participant attendance (i.e., doctor's appointment, specialist appointment, ongoing therapy, medical procedures, etc.). Refers participant to medical staff if appropriate. Social Worker informs manager, if appropriate, for follow-up. Social Worker also may visit with participant upon arrival to DHC or consider a home visit to discuss attendance issues. Informs team of outcome.)

VI. POSITION STRUCTURE

Incumbent(s) report to what position? (PACE Program) Operations Manager

What other positions report to the same position? Day Health Center Supervisor
Marketing and Intake Coordinator
Recreational Therapist

Therapists (OT & PT)

What team/committee(s) is incumbent(s) a member of? Quality Assurance Committee
Growth Management Committee
Ethics Committee

What departments/cost centers report directly to this position? None

What titles report directly to this position? none

How many FTEs report to this position? ___0___ Directly ___0___ Indirectly

Annual operating budget? _____Revenues _____Expenses

Management Approval _____

SAMPLE B

Job Title: Care Coordinator – Social Work

Reports To: Center Director

Revised: (Date)

JOB OBJECTIVES:

Within an Interdisciplinary Care Team setting, incumbent promotes and maintains the mental and social health of enrolled participants through assessment, treatment, teaching and counseling. Provides basic casework and consultation for (*PACE Program*) participants. Facilitates communication between participants, their family and the Care Team. Facilitates the participant council to create a dialogue among participants, caregivers and the staff. Responsible for the implementation of social work care plan and coordination of social work with other services.

JOB RESPONSIBILITIES:

- I. Using all information sources available, assesses participants' psychosocial health status and social work needs**
 - A. Completes assessments at admission and for quarterly care planning according to regulatory requirements and as condition change indicates.
 - B. Determines participant and family needs related to social support, financial support, counseling and housing.
 - C. Confers with participant and family to identify participant goals and expectations.
 - D. Coordinates with the interdisciplinary team to develop a comprehensive care plan for each participant.
- II. In cooperation with the Care Team, plans and performs psychosocial interventions designed to keep the participant in the community and enhance quality of life to the greatest extent possible.**
 - A. Provides individual and group counseling to participants and their families as needed or prescribed in the care plan.
 - B. Coordinates the completion of participants' health care wishes and advance directives in cooperation with their primary care physician, the participant and their family.
 - C. Provides discharge planning in the event of disenrollment.
- III. Acts as participant advocate and liaison between participant and various governmental and private agencies in order to maximize the participant's support network and obtain needed services.**
 - A. Facilitates communication between participant and various government programs such as Medicaid, SSI, Medicare and Social Security.
 - B. Reviews Medicaid eligibility, monitors time frame for recertification and facilitates Medicaid applications for certification and recertification.
 - C. May participate in inter-agency meetings as needed.
 - D. Assists participants in obtaining housing and eligibility for low income housing options.
 - E. Evaluates need for and assists with the set up of money management systems for participants who require assistance.
 - F. Keeps up-to-date on changing rules and regulations regarding Medicaid and Medicare eligibility and other entitlement programs and services.

IV. Acts as participant advocate and liaison between participant, family and Care Team

- A. Facilitates communication between participant, family and Care Team to maximize or maintain participant support systems.
- B. Facilitates or participates in family meetings as required.
- C. Facilitates the Participant Council to create a vehicle for dialogue between participants and the Care Team and empower participant responsibility.
- D. Conducts family support groups, education or training sessions and routine Family Caregiver meetings for education, support and dialogue.

V. Provides leadership within the Care Team to ensure continuity and coordination of care and for staff development.

- A. Ensures that the Service Coordinator is informed of care plan changes and requirements and logistics are appropriately arranged to include transportation, escorts, meals and appointments.
- B. Works with Center Director to provide orientation and in-service programs for Care Team to enhance staff understanding of psychosocial issues and meet regulatory requirements and support performance improvement.
- C. Coordinates with mental health-related providers including drug and alcohol treatment to arrange appointments and share pertinent information.

VI. In cooperation with the Coordinator of Quality Management participates in the Quality Management Program to support continued performance improvement

- A. Completes and ensures completion of documentation of clinical services reviewing medical record to continuity and completeness.
- B. Participates in quality studies according to the quality plan.
- C. Recommends studies for the annual quality plan.
- D. Participates in committees that support performance improvement.

PREPARATION AND TRAINING

Requires Masters in Social Work; (State) Certification preferred.

CONSEQUENCE OF ERROR

Poor judgment could lead to escalation of participant or family crises or impede social well-being. Involves attention to detail and high levels of responsibility.

LEVEL OF SUPERVISION

A high level of autonomy is required for clinical and management decisions. Reports to Center Director.

DIRECTS WORK OF OTHERS /# OF EMPLOYEES SUPERVISED

Manages a caseload of up to (number) participants.

EXPERIENCE

Thorough working knowledge of current community health practice for the frail elderly from direct service experience. Working knowledge of the interdisciplinary model of care management. Experience working with cognitively impaired seniors is important. Must be able to relate well with seniors and their families to deal with sensitive issues and facilitate problem solving. Must be flexible and able to change easily. Multi-cultural experience.

CONFIDENTIAL DATA

Has full and complete access to participant medical records and reports, requiring utmost integrity to protect participants and the program.

MENTAL/VISUAL DEMAND AND PHYSICAL EFFORT

The mental demands of this position can be high, with varied care needs of participants in the management of frail seniors in a community setting. Frequently required to manage many details within a distracting environment. Must be able to handle crisis situations.

ENVIRONMENT

While most of the work will be in the day center, the work environment will include a variety of clinical settings from day center to hospitals to nursing homes. Some exposure to odors, fumes, infections, dirt and other undesirable conditions may occur in the center.