

PeaceHealth Oregon Region Job Summary - STAFF

Job Code/Title: 324M - Social Work Care Coordinator

Department: PeaceHealth Medical Group

Job Purpose and Responsibilities:

Provides care management services across the continuum of care for PHMG patients. PeaceHealth Care Coordination is available to all patients of Family Practice and Internal Medicine providers for the purpose of addressing the patient's short-term and long-term medical, functional, socioeconomic, psychosocial, financial and cognitive concerns. The role of the Care Manager is to *collaborate* with individuals and their families using the care management process including: *assessing* a person's functional level, their physical, cognitive, social, emotional status and their support system – family, friends, financial and environmental; developing a *plan of care* that addresses the needs and problems identified and incorporating the services that are needed to enhance the current support system; identifying and arranging for *coordinated delivery* of those services; *monitoring* changes in the person's condition, the person's circumstances and the provision of services; and *reassessing* the person's needs on a regular basis. The Social Work Care Coordinator works collaboratively with the care team. The Care Coordinator identifies cost-effective protocols and care paths and participates in developing guidelines for care. The Care Manager facilitates the coordinated utilization of resources for maximization of health outcomes and patient/family satisfaction.

Major responsibilities included but not limited to:

ASSESSMENT

1. Screens and identifies individuals who need care coordination services.
2. Collaborates with the multi-disciplinary team, identifying problems or needs that require special planning, intervention, teaching or follow-up.
3. Assesses the health care needs, status and goals of the patient. Conducts a comprehensive assessment by interviewing the individual and/or family to identify the patient's needs and goals.
4. Identifies key problems, strengths and resources to be addressed in the patient's plan of care
5. Actively supports measures that prioritize the patient's needs and promotes the effective use of resources.

PLANNING

1. Facilitates the patient's involvement in the direction of care.

2. Assumes responsibility for assessment, care plan development, documentation of the care plan, patient and family education, facilitation of patient involvement and choice, resource coordination and care conferencing.
3. Identifies, plans and arranges for appropriate services by applying a knowledge of local regional and federal services and regulations.

IMPLEMENTATION

1. Intervenes by arranging for services, and by providing psychosocial support to the individual and their family.
2. Assesses the patient's readiness to learn and the patient's preferred learning modality. Engages the patient in actively learning about their medical and/or psychological conditions, available resources and appropriate treatments.

COORDINATION

1. Collaborates with the individual, family, physician, interdisciplinary care team and community services.
2. Coordinates implementation of the care plan with all involved parties.
3. Provides patient/family advocacy.
4. Strives to maximize continuity of care.

MONITORING

1. Monitors the individual's condition and responsiveness to the care plan interventions.
2. Communicates with providers who are delivering care and services for the purpose of maintaining the quality of care.
3. Maintains and revises the care plan as the patient's needs change.

EVALUATION

1. Documents assessments, plans, interventions, the individual's goals and their response to care management.
2. Evaluates the individual's response to the plan of care and the appropriateness of services.
3. Collaborates with team members to identify the patient status and need for care plan adaptation.

QUALITY/PROCESS IMPROVEMENT

1. Participates in process improvement groups.
2. Utilizes benchmarking and other sources to identify best practice.
3. Participates in setting performance targets to improve quality.
4. Promotes and assists with development of education materials.
5. Will be involved with the interdisciplinary team to improve quality, reduce costs and improve patient

PROFESSIONAL ACCOUNTIBILITIES

1. Promotes and facilitates effective communication through the continuum of care.
2. Builds autonomy, responsiveness and decision making skills in coworkers.
3. Creates a positive attitude towards change and redesign to eliminate unproductive activities.
4. Maintains, updates and actively improves care management skills, including case finding high risk individuals, care coordination, transition planning and implementation, documentation and evaluation of effectiveness, chronic disease interventions and issues, teamwork, physician communication, process improvement, and knowledge of community resources.
5. works collaboratively with other Care managers including scheduling and vacation coverage to assure patient's care management needs are covered.

The job may have additional responsibilities as assigned. All job duties must be performed in a manner that demonstrates the PHOR Basics of continuous improvement, respectful communications, customer service and support of the Mission & Values of PeaceHealth Oregon Region.

Education:

Masters degree in social work (MSW). In lieu of an MSW, the following qualifications and experience may be accepted:

- 1) Masters degree in counseling or a related field with a minimum of two years work experience in a medical or health care setting, or social service agency or community organization focusing on health and/or welfare issues.
- 2) BSW degree plus four years employment in a medical or health care setting, or social service agency or community organization focusing on health and/or welfare issues .

Licensure/Certification:

Certification in Case Management highly desired. LCSW preferred.

Experience:

A minimum of two years employment in a medical, health care, or community agency dealing with health and/or welfare issues. Demonstrated knowledge of community health, welfare and social agencies is required. Demonstrated knowledge of and ability to apply age specific principles of growth and development and life stages to meet each patient's needs.

Special Skills Required:

- Excellent verbal and written communication skills including sensitivity to other cultures and ethnicities.

- Must possess excellent ability for conceptual thinking, good listening, problem resolution, and planning skills.
 - o Interpretation of data and follow through for interventions.
- Must demonstrate management and leadership skills.
- Must possess excellent organizational skills.
- Must demonstrate computer skills in e-mail, Crossroads, word processing and Community Health Record.
- Must be knowledgeable about issues related to chronic illness, developmental disabilities and special needs, mental illness, grief and transition, substance abuse, domestic violence, child abuse and senior abuse.
- Demonstrates proficiency in social work and care coordination practice.
- Must have good understanding of and adherence to core social work and care coordination values and ethics.

Interpersonal Behavior:

Demonstrates a caring, respectful and compassionate attitude towards all people.

- Takes responsibility for personal growth.
- Takes initiative to meet the challenges within the environment.
- Oriented toward solutions through collaboration.

Physical Abilities:

Walking, sitting, standing, or other means of mobility within the acute care setting – 70% time is walking/standing.

Link to Standard Competencies:

[PHOR Basics: Our Personal Accountabilities Professional/Technical](#)

CLINICAL ROLES FOR CARE COORDINATOR/SOCIAL WORKER AT SHWC - November 2001

The Care Coordinator works as part of the SHWC clinical team to help maintain continuity of patient care between all involved providers, family members, and other community caregivers.

Referrals

The referral process is an open system whereby anyone may refer a patient to the Care Coordinator. It is helpful to specifically identify the referral problem and the urgency of the necessary response.

Patients Served

Any SHWC patient experiencing the following:

- Multiple or unstable chronic illnesses
- Life-threatening illness
- Self-care and/or health knowledge deficits
- Problems with accessing appropriate health care and community resources
- Psychosocial, behavioral or environmental health risks
- Communication difficulties between patient and their care providers

Referral problem areas

- Coordination for medical management of chronic diseases
- Mental/emotional health
- Financial needs
- Long term care planning including resources for in home care, residential care, and information on legal aspects of care.
- Psychosocial support including assist with family conflict, abuse, and living situation safety issues.

Care Coordination/Patient Focused Activities

- Psychosocial and care needs assessments in a variety of settings.
- Home visits for the purpose of assessment.
- Coordination of healthcare services.
- Facilitate communication between patients, health care providers, and caregivers.
- Patient education regarding the health care system and self-management.
- Information and referral to community resources.
- Participate in community based care plan meetings as requested.
- Ongoing case management of all clients to include appropriate, timely documentation.

Clinic Based Activities

- Attend all staff business meetings.
- Attend all Care Plan meetings
- Attend all Care Coordination staff meetings (weekly)
- Participate in various additional projects and grants as requested.