Licensed Master Social Worker Job Description

Job title:	**LMSW Care Manager**
Reporting to:	**Practice Manager, Care Management Services**
Department:	**Care Management**
Hours:	**Full-time 40 hours per week**
Performance Review period:	**Annual**
Revision Date:	**01/30/2020**

PURPOSE OF THE POSITION

The MSW Care Manager supports the primary care physician network by providing service to patients with complex chronic conditions and psychosocial problems. In collaboration with the physician and interdisciplinary team, the MSW Care Manager develops and implements an individualized plan designed to promote maximum functioning, self-management, quality of life, and improved clinical outcomes. This position provides service in primary care practices, telephonic outreach, telemedicine, and individual patient homes.

Responsibilities & duties

- Conduct comprehensive assessment (in-home, in primary care office, or telephonically) to identify areas of risk that may impact the patient's independence, functional status, and adherence to the treatment plan. This assessment includes screening for cognitive impairment, depression, social support, caregiver burden, financial status, environment, home safety and social determinants of health.
- In collaboration with the patient, PCP, and interdisciplinary team, develop an individualized care plan and intervention strategies to meet the patients' needs and personal goals focused on reducing potential risks and barriers to care. The MSW will monitor the care plan for effectiveness, update and modify as appropriate to optimize the patient's progress and well-being.
- Advocate for patients and caregivers and facilitate access to community resources, alternative placement, support groups, transportation, prescription assistance, etc.
- Facilitate discussions with the patient and caregiver regarding advance directives and palliative care.
- Collaborate with the care team members on patient goals/needs and appropriately refer patient for additional support services.
- Provide basic supportive counselling to assist patients and caregivers in coping with issues related to the impact of living with chronic conditions, end-of-life care, and catastrophic illness.
- Assess and intervene in crisis and develop management plans to minimize risk.
- Maintain timely and complete documentation and billing of all care management encounters.
- Actively participate in Care Management Department monthly meetings and multi-disciplinary care team conferences, huddles and discipline specific team

meetings.Work with the practice and physician organization to continuously evaluate processes and develop improvements to advance the care management program.
- Serve as a positive ambassador for United Physicians in the practices, and support initiatives leading to practice transformation.
- Adhere to the scope of practice for Social Work per state regulatory guidelines.
- Respect confidentiality of all persons and follows state, federal and organization policies and procedures.
- Effectively participate in various internal committees and performs other duties as requested by management.
- Evaluate patients for needed health services (HEDIS metrics) assist in closing "gaps" for screening and other quality measures (preventative and condition specific).
- Miscellaneous duties and projects as assigned.
- Maintain continuing education requirements for Complex Care Management as required for role.
- Maintain continuing education required for MSW licensure.
- Maintain Healthcare Basic Life Support as required for role.

Qualifications

- Valid unrestricted State of MI Social Work License (or equivalent) required
- Master's Degree from an Accredited Social Work Program
- Valid unrestricted State of MI Driver's License and ability to drive to multiple locations
- Minimum two years of case management, home health care, hospice, or related experience
- Case management certification preferred
- Basic Healthcare BLS certification
- United Physician's health screening and vaccination requirements

Performance Skills

- Ability to work independently and rapidly develop productive and collaborative relationships with representatives from other healthcare providers
- Knowledge of principles and case management guidelines in the assigned program arena
- Recognize and address the unique culture, language, health literacy and age appropriate care of diverse patients and caregivers.
- Advanced patient interviewing and assessment skills
- Exceptional interpersonal and communication skills
- Excellent problem solving, analytical, and decision-making skills.
- Current knowledge of standards of care and clinical guidelines for patients with chronic illness.
- Effective collaboration within a multi-disciplinary team
- Ability to work autonomously, maintain work schedule at multiple sites, prioritize, and maintain productivity through proactive case finding and referrals.
- Working knowledge of insurance and regulatory guidelines for practice

- Knowledge of HEDIS or NCQA quality measures
- Proficient in computer applications related to work including Microsoft Office Suite (MS Word and Excel), electronic medical records and patient registries