Suffolk Care Collaborative (SCC)
JOB DESCRIPTION

TITLE:	Social Worker (MSW)	**FLSA:**	Exempt
DEPARTMENT:	Population Health Management	**LOCATION:**	Suffolk County

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JOB SUMMARY:

The Social Worker will work under the general supervision of the Director of Care Management, Suffolk Care Collaborative (SCC) and work directly with the Suffolk County Medicaid population as a part of the Delivery System Redesign Incentive Payment Program (DSRIP).

This position will function as part of SCC's regionally based health care team and be a resource to the embedded and office based care managers, health managers, community-based organizations, and other provider partners to address complex patient needs.

The social worker will collaborate with patients, Primary Care Providers, community agencies, behavioral health, dental and other SCC network partners to provide a model of care that ensures the delivery of quality, efficient, and cost-effective healthcare services. This position is responsible for assessing the biopsychosocial needs of assigned patients, creating individualized care plans, implementing, coordinating, monitoring and evaluating all options and services with the goal of optimizing the patient's physical and psychosocial health status.

The Social Worker works collaboratively with the care manager and multi-disciplinary care team to ensure patient needs are met and care delivery is coordinated across the continuum. The expertise of the Social Worker is sought to resolve psychosocial patient care issues and to develop and implement a complex patient care plan. This professional ensures that patients are assisted in order to achieve their highest level of function.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

- 15% Work with Care Management leadership in the design, implementation, and evaluation of the Care Management model for the assigned Medicaid population.

- 15% Assist with state required functions for Medicaid members with a specific emphasis on meeting requirements of the New York DSRIP initiative

- 15% Assist care managers to develop coordinated care plans for patients with complex behavioral health and/or psychosocial needs. Fosters a team approach by working collaboratively with the patient, family, behavioral health provider, primary care provider, and other patients/members of the health care team to ensure coordination of services. Assesses the psychosocial needs of referred patients and designs appropriate plans of care.

- 15% Help to identify outreach, community resources and education planning needs of the patient/membership and communicate findings to the care manager and health care team.

- 10% Coordinates referrals between and among physical, behavioral and/or dental health providers and other community resources to improve overall patient/member outcomes. Ensures appropriate clinical

management information is shared timely with peers, providers and outside agencies while securing system privacy standards.

- 10% Provide outreach, including telephonic, meetings or oral presentations, to community based and county transportation (or designated subcontractors) to assist patients/members to access Medicaid compensable services.

- 10% Works closely with Medical Management to appropriately apply patient/member benefits and serve as a resource to the patient/member and healthcare team. Supports creation of social work related policies and procedures.

- 10% Adheres to Suffolk Care Collaborative administrative standards regarding patient/member confidentiality.

NON-ESSENTIAL DUTIES AND RESPONSIBILITIES:

- Maintains required documentation for all care management activities. Collects required data and utilizes this data to adjust the treatment plan when indicated.

- Works with leadership to continuously evaluate process, identify problems, and propose process improvement strategies to enhance the Medical Home delivery of care model.

- Works with Medical Management team as needed to appropriately apply patient/member benefits and serve as a resource to patient/member and health care team.

- Incorporates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills into care management practice.

- Conducts in-home patient assessments for referred patients with complex psychosocial needs in collaboration with Care Manager, contracted home health agency or physician.

- Develops collaborative relationships with community based agencies to improve care, services and access for Health Plan patients/patient/membership.

- Utilizes appropriate conflict resolution, assertiveness, negotiation, and collaboration skills in facilitating patient/member throughout the health care continuum.

- Performs duties as required or assigned by emergency or other operational reasons for which the employee is qualified to perform.

SKILLS AND ABILITIES:

- Demonstrates customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, patients, and families with diverse opinions, values, and religious and cultural ideals.
- Demonstrates ability to work autonomously and be directly accountable for practice.
- Demonstrates ability to influence and negotiate individual and group decision-making.
- Demonstrates leadership qualities including time management, verbal and written communication skills, listening skills, problem solving and decision-making, priority setting, work delegation and work organization.
- Demonstrates organization and delegation, negotiation and conflict resolution, and possesses the ability to be self-directed, flexible, and committed to the team concept.

- Demonstrates teamwork, initiative and willingness to learn, accepts and respects diversity without judgment, and demonstrates strong customer service values.

EDUCATION AND/OR EXPERIENCE:

- Master's Degree in Social Work (MSW) from accredited university required.
- Care Manager Certification preferred, required within three years of position acceptance.
- A minimum of two (2) years of clinical experience as Social Worker required.
- Knowledge of Social Work theories, therapies and techniques as used in individual family and group treatment.
- Master Prepared and Licensed Social Worker in the state where work is performed required.
- Positions may require Medicaid specific experience.
- Knowledge of the basic concepts and principles of Care Management and NY Medicaid required.
- Critical thinking skills required. General computer knowledge and capability to use Microsoft software and computers required.

WORKING CONDITIONS/PHYSICAL DEMANDS:

Work is typically performed in an office environment or at the provider's office. Some home visits may be required.
Must have a driver's license and be able to travel locally.

The specific statements shown in each section of this description are not intended to be all-inclusive. They represent typical elements considered necessary to successfully perform the job.