Human Resources
750 S. Wolcott
Room: G-50
Chicago, IL 60612

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Job Code: 6811
Grade: 19
FLSA: Exempt

Standard Job Description

Job Title
Community Based Social Work Care Coordinator

Department
Ambulatory Care Coordination

Job Summary

The Community Based Social Work Care Coordinator (CBSWCC) supports the provision of care coordination in a manner that recognizes the Enrollee and the medical home care teams as essential partners in the Enrollee's care. These services are offered at the patient's home, physician office, and/or other health care facilities. If it is determined the Enrollees care is medically complex the CBSWCC collaborates with a nurse in the provision care coordination. Completes assessments of unmet health care needs and/or the presence of social determinants that impact the provision of care. Collaborates with Enrollee and medical home care team to develop and implement a care plan that mitigates barriers and links patients to appropriate resources. The CBSWCC works across sites of care and with multiple disciplines to achieve the desired outcomes for the Enrollees. Supervises the activities of the assigned Community Health Worker (CHW).

Typical Duties

- Uses all available information sources to support care coordination activities-this may include portals, electronic medical records, claims data, plan information, utilization management information, and Milliman Care Guidelines (MCG).
- Completes screenings, assessments and care plan in accordance with contractual requirements and Care Coordination policy and procedure.
- Integrates information from claims review, notes, screenings, assessments and Medical Home teams in care plan.
- Tracks patient progress regarding goal achievement on the care plan.
- Updates documents based on Enrollee progress, changes in priorities, changes in health status or new information.
- Supports care coordination referrals from multiple sources including Enrollee request, plan referrals, medical home referrals, grievances, data reports or changes in risk score.
- Provides relevant education, counseling and support to assist member with the achievement of goals.
- Collaborates with Nurse Care Coordinators on patients with multiple co-morbidities, frequent hospitalizations or inappropriate Emergency Department (ED) visits.
- Interfaces with Medical Home team and Enrollee at prescribed or agreed upon intervals.
- Participates in Interdisciplinary Care Teams, presents own patients, and provides guidance on others not directly managed.
- Conducts face to face visits on members with high or moderate risk stratifications on a quarterly basis.
- Conducts monthly outreach for high risk patients who are stable, more often for patients undergoing a transition or a change in treatment. Updates medical home team on status.

Typical Duties continued

- Completes all required trainings, workshops, etc. within the required timeframe.
- Collaborates with medical home assignments to identify resources and process for effective communication.
- Conducts outreach to Case Management Department at hospital when Enrollees are admitted.
- Meets established case deadlines.
- Travels to the home of the Enrollees or their sites of care.
- Performs other duties as assigned.

Reporting Relationships

Reports to the Manager of Complex Care Coordination

Minimum Qualifications

- Licensed Clinical Social Worker in the Status of Illinois
- Three (3) years of work experience as a Licensed Clinical Social Worker
- Two (2) years of work experience in culturally diverse, unserved populations
- Prior care coordination work experience in social service agency, physician group, hospital or Emergency Department setting
- Valid Illinois Driver's license and mandatory vehicle insurance as required in the State of Illinois (In accordance with the Code of Ordinances of Cook County, Illinois codified through Ordinance No. 16-0692, enacted February 10, 2016 (Supp. No. 32) § Sec. 2-673)

Preferred Qualifications

- Bilingual English/Spanish

Knowledge, Skills, Abilities and Other Characteristics

- Knowledge of Microsoft Office products
- Effectively communicates care coordination benefits to Enrollees, Medical Home Teams and hospital based staff
- Collaborates effectively with team members
- Ability to effectively prioritizes tasks
- Ability to work independently
- Ability to probe to get to underlying behaviors or Enrollee assumptions that are driving care coordination results
- Ability to communicate non-judgmental attitude

Physical and Environmental Demands

This position is functioning within a healthcare environment. The incumbent is responsible for adherence to all hospital and department specific safety requirements. This includes but is not limited to the following policies and procedures: complying with Personal Protective Equipment requirements, hand washing and sanitizing practices, complying with department specific engineering and work practice controls and any other work area safety precautions as specified by hospital wide policy and departmental procedures.

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills required of the personnel so classified.

For purposes of the American with Disabilities Act, "Typical Duties" are essential job functions.

Approval: _____ 12. 9. 2016

Mary Sajdak
Senior Director of Integrated Care

Date

Approval: _____ _____

Gladys Lopez
Chief of Human Resources

Date