<table>
<tr><td colspan="2" rowspan="1">STATE OF NORTH CAROLINA

OFFICE OF STATE HUMAN RESOURCES

POSITION DESCRIPTION FORM (PD-102R)</td><td colspan="3">APPROVED CLASSIFICATION:

EFFECTIVE DATE:

ANALYST:

(This Space for Personnel Department Use Only)</td></tr>
<tr><td>1.</td><td>Present Classification Title of Position:</td><td>7.</td><td>Present Position #</td><td>Proposed Position #</td></tr>
<tr><td></td><td>Social Worker II</td><td></td><td>SW2-2</td><td>SW2-2</td></tr>
<tr><td>2.</td><td>Usual Working Title of Position</td><td>8.</td><td colspan="2">Department, University, Commission, or Agency:</td></tr>
<tr><td></td><td>Case Manager</td><td></td><td colspan="2">Caswell County Government</td></tr>
<tr><td>3.</td><td>Requested Classification of Position:</td><td>9.</td><td colspan="2">Institution & Division:</td></tr>
<tr><td></td><td>Social Worker II</td><td></td><td colspan="2">Caswell County Health Department</td></tr>
<tr><td>4.</td><td>Name of Immediate Supervisor:</td><td>10.</td><td colspan="2">Section & Unit:</td></tr>
<tr><td></td><td>Bonnie Gibson</td><td></td><td colspan="2">Care Management Unit</td></tr>
<tr><td>5.</td><td>Supervisor’s Position, Title, & Position Number:</td><td>11.</td><td colspan="2">Street Address, City and County:</td></tr>
<tr><td></td><td>Social Worker Supervisor II</td><td></td><td colspan="2">2252 NC HWY 86N Yanceyville Caswell County</td></tr>
<tr><td>6.</td><td>Name of Employee:</td><td>12.</td><td colspan="2">Location of Workplace, Building, and Room #</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">Care Management Offices</td></tr>
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I. INTRODUCTION

A. Primary Purpose Of Organizational Unit:
1. The purpose of the Caswell County Health Department is to protect the health and welfare of citizens of Caswell County and to meet the county’s health needs through direct services, research and evaluations, and community partnerships.
2. The purpose of the Home Health Program is to provide skilled nursing, rehabilitative, aide, and social work services to citizens of Caswell, Rockingham, Orange, Alamance, and Guilford Counties.
3. The purpose of the CAP/DA and CAP/C Programs is to provide a variety of services to prevent placement of a client in a skilled nursing or intermediate care facility.

B. Primary Purpose Of Position:
1. Provide coordination, management, and monitoring of the Community Alternative Program for Disabled Adults (CAP-DA) and Community Alternative Program for Children (CAP-C) and provide technical supervision to RN assessing CAP clients and to Community Health Technicians providing aide services to CAP clients.
2. Provide direct services to CAP clients to enable them to live safely within the community and maintain their dignity and independence to the greatest extent possible.

C. Work Schedule:
1. Monday – Friday
2. 08:00 – 17:00
3. One hour lunch
4. After 17:00 and weekends as need arises
5. 24/7 availability in the event of a public health emergency

D. Change In Responsibilities Or Organizational Relationships:
1. There have been no changes to this position in the past year.
2. This position is subject to change as the Home Health Nursing Director and/or Health Director deems necessary or as organizational change occurs.

II. **RESPONSIBILITIES AND DUTIES**

A. Program Development and Management

1. Relative importance of this responsibility or duty
    a. Essential Service: Yes
    b. Estimated Percent of Time: 10%
2. Develop policies and program procedures for the Caswell County CAP-DA, CAP-C, and Medical Social Work program following State guidelines and assure that staff appropriately implements them
    a. Establish and/or update program goals and objectives by continually assessing needs of clients and setting priorities
    b. Establish and maintain contact and provider agreements (where necessary) with community agencies and other providers within the community to assure goals are met.
    c. Monitor the reimbursement from Medicaid to assure funds are adequate to maintain the program
    d. Assist in maintaining appropriate billing to Medicaid according to program guidelines
    e. Monitor and review the overall CAP programs
    f. Establish and maintain rapport with Department of Social Services CAP Medicaid Eligibility Specialist and reinforce CAP policies as needed
    g. Maintain continued involvement with Home Health staff and monthly meetings by advising and directing of CAP updates
    h. Provide recruitment of target population:
        1) Educate and maintain on-going contact with local physicians, hospital discharge planners, DSS, and other community-based services offering care to the elderly in order to encourage eligible Medicaid clients for CAP services
        2) Assist potential eligible patients in the process of applying for Medicaid
        3) Maintain appropriate pre-screening tool for eligible CAP clients
        4) See that FL-2 is submitted according to program guidelines
    i. Represent agency in court or in legal matters as needed or required. Prepare testimony, meet with County Manager and/or County Attorney and others involved
3. Program Supervision
    a. Essential Service: Yes
    b. Estimated Percent of Time: 15%
    c. Provide technical assistance and/or consultation to nurses and aides providing CAP services.
    d. Assist Home Health Supervisor in the orientation of all new employees to the CAP program.
    e. Educate and update staff as CAP guidelines or regulations change
    f. Review work of staff to assure quality CAP care is given according to policies and procedures
    g. Identify training needs of CAP staff and request as needed with Home Health Supervisor
    h. Work closely with Home Health Supervisor to assure CAP program goals are attained.
4. Case Management
    a. Essential Service: Yes
    b. Estimated Percent of Time: 40%

c. Assessment/Evaluation
    1) Conduct a comprehensive screening/assessment after Medicaid and patient's level of care is determined, according to program guidelines
    2) Assessment takes place in client's home
    3) Assessment tools include:
        a) Identification
        b) Approval of FL-2
        c) Coordinating Care of Physician
        d) Emergency contacts
        e) Referral information
        f) ADLs and IADLs
        g) Social Support (household composition, informal care givers outside home, family dynamics)
        h) Home Environment
        i) Economic Status
        j) Mental Health
        k) Physical assessment completed by RN
    4) Responsible for data collection and must coordinate with case nurse and client's physician to get paperwork completed in a timely fashion
    5) Evaluation must also determine need for intervention by Adult or Child Protective Services, appropriate contact and follow-through

d. Coordinate client's CAP Plan of Care
    1) Coordinate development of service plan with client, physician, case nurse, and/or client caregiver. Plan of care will be developed based on data collected during the comprehensive assessment.
    2) Develop goals for resolution will be specific with reasonable time frame. Examples of goals are:
        a) Keep client out of institution
        b) Reduce caregiver stress
        c) Maintain optimum health and safety of client
        d) Insure client awareness of available resources
    3) Be aware of treatment plans of other disciplines involved and be responsible for coordination of various plans into comprehensive care plan
    4) Implement Care Plan including cost summary with input from Medical and Nursing staff, client, and may service provider as needed
    5) Refer to any service provider for appropriate intervention
    6) Develop and implement provider agreement with each billable provider involved with the client
    7) Follow-up with client and providers through appropriate mechanisms (I.e. phone calls, home visits, mail, etc.)
    8) Update Care Plan as needs occur. Evaluate annually to determine on-going eligibility of CAP-DA services. Implement according to CAP-DA Guidelines

e. Documentation and Reporting
    1) Document all case management activities, keeping time as well as notes and dates within each chart
    2) Develop and implement time reporting system
    3) Ensure all necessary reporting and billing forms are completed in a timely manner

f. Monitoring, Reviewing, Maintenance

1) Conduct home visits to monitor quality and quantity of all services ordered
2) Instruct/counsel family regarding procedure for complaints, grievances, review in-home aides paperwork and timesheets in a timely manner
3) Instruct families on paperwork requirements and their responsibility to sign only true accounts of activities,
4) Make phone calls to clients home between visits to spot check and troubleshoot
5) Monitor condition change of client to increase or decrease level of care
6) Coordinate reassessment of client each year with client, physician and nurse

g. Consultation
1) Consult with doctors offices and DSS regarding course of treatment for client
2) Consult with service providers regarding billing procedures
3) Consult with supervisor to ensure quality service and in-services
4) Consult with in-home aides regarding service delivery, complaints, personal matters, in-service participation, disciplinary action

5. Counseling
a. Essential Service: Yes
b. Estimated Percent of Time: 15%
c. Perform assessment of client's mental/emotional status during comprehensive assessment using standardized tools for CAP-DA
d. Check for mental status change by questioning client and family, initiate appropriate intervention if suicide threat suspected, case management model with medical emphasis used to provide services to client
e. Conduct quarterly visits to assess mental status change and data collection to help make any necessary referrals to mental health clinic, medical doctor, minister, etc
f. Encourage client to ventilate all concerns regarding client illness or loss of independence
g. Involve client as much as possible in care plan to increase sense of independence
h. Counsel clients on importance of keeping medical appointments and following medical and nursing recommendations
i. Counsel clients as needed to Medicaid understanding and budgeting as related to CAP-DA
j. Counsel and refer client to other agencies as needed for CAP-DA non-billable services
k. Counsel client as needed for long range planning and decision making, implementing placement when CAP-DA is no longer effective.
l. Other modalities used are supportive counseling, reality therapy and crisis intervention

6. Community Liaison
a. Essential Service: Yes
b. Estimated Percent of Time: 15%
c. Social worker serves as community liaison to facilitate communication between various agencies, groups, and individuals to avoid problems of service fragmentation to better serve clients
d. Contacts agencies for CAP information
e. Contact with discharge planners at hospitals, Departments of Social Services,

doctors offices, etc for referrals, information of client need, income, etc.

f. Coordinate documentation needed by both DSS and service providers for program approval authorization of service delivery

g. Contact human service agencies to provide services and/or coordinate services, working with hospice program, home meal delivery program, to assist with upgrading of services or identifying funding for services

h. Position is responsible for being liaison person for CAP services.

7. Continuing Education and Other
   a. Essential Service: Yes
   b. Estimated Percent of Time: 5%
   c. Attend and participate in workshops and conferences as appropriate for continuing education
   d. Participate in agency in-service programs as needed
   e. Ensure all staff is aware of program goals, guidelines, and individual responsibilities
   f. Meet with community groups regarding available programs and/or topics related to case management, home management of sick person, financial resources, and/or home health in rural areas.
   g. Provide in-service opportunities for in-home aides staff to meet State requirement
   h. Coordinate activities with other programs as appropriate and perform other duties as needed
8. Team Approach
   a. The CAP Social Worker is the coordinator of a team approach to care, other members include:
      1) Client and family
      2) Physician
      3) Nurse
      4) Any service providers,
      5) In-home aides
   b. Coordinate service plan by contacting family to review their needs and client's need
   c. Contact physician to get authorization for services
   d. Develop care plan with a minimum of physician, client, nurse, and social worker team
   e. Assign physical health assessment to nurse
   f. Assign tasks that informal caregivers will be responsible for
   g. Coordinate efforts of comprehensive assessment completed b nurse/social worker team
   h. Confer with team to discuss patient, service deliver, additional need, problems, etc
   i. Evaluate service of other team members
   j. Make recommendations based on meetings, contacts, and home visits
   k. Ensure that informed supports are receptive and cooperative to formal supports of client
9. Active Caseload
   a. Maintain the allotted number of cases, as determined by Division of Medical Assistance.
10. Budget
   a. Cost effectiveness of service delivery must be insured
   b. Develop monthly costs summary

c. Monitor cost of services
d. Revise cost summary as level of need changes
e. Coordinate Medicaid deductible with DSS, and client
f. Terminate client if need exceeds cost limits
g. Coordinate other services if termination of program is required
h. Assist patient with monthly budget
i. Assist client with information and referral to community resources

11. Legal Matters
    a. Represent agency in court or legal matters as needed or required
    b. Prepare testimony, meet with County Manager, County Attorney, and others involved
    c. Inform clients of rights and responsibilities
    d. Inform families on matters related to Power of Attorney, legal guardianship, involuntary committal, refer to adult or child protective services.

B. <u>Other Position Characteristics</u>

1. Nature And Degree Of Accuracy Required In Work:
    a. This position must ensure program follows guidelines regarding CAP Budget, maximum hours of service per client per month, coordinate billing dates, dates of services and dates of deductible met
    b. Ensure matching funds, meet deadlines for agency paperwork and reports to state, insure in-home aides receive 12 hours of in-service per year
    c. This position must perform assessment accurately in order to develop an client care plan.
2. Consequence Of Error Or Greatest Potential Effect On The Organization:
    a. Errors by the CAP Social Worker can result in problems affecting the social, psychological, and emotional health of clients and their families.
    b. Errors or lack of knowledge regarding regulations could result in reimbursement denials.
    c. Significant errors can effect Caswell County Health Department's reputation, effectiveness, and endanger the funding it receives.
    d. Significant errors can result in possible litigation against the employee and/or the agency.
3. Type Of Instructions Provided To Employee:
    a. Position is supervised by the Home Health Nursing Director
    b. Most of the work performed by this position is performed independently.
    c. When necessary, direction is provided by CAP manual and program guidelines, program policies, Medicaid policies, and yearly meetings.
    d. In the event of a public health emergency, the employee will receive "Just-in-time" training once he/she arrives on the site.
4. Guidelines, Regulations, Policies And References Used By Employee:
    a. Caswell County government employee handbook
    b. Caswell County Health Department Policies and Procedures
    c. North Carolina Pandemic Flu Plan
    d. National Response Plan
    e. OSHA Regulations
    f. Caswell County Emergency Response Plan
    g. Public Health Law
    h. Nurse Practice Act
    i. Service definitions from Medicare/Medicaid
    j. CAP Manual from DMA
5. Supervision And Observation Of Work Received By Employee:

a. CAP-C Plans of care are sent to Division of Medical Assistance for approval within 60 days after the FL-2 approval date.
b. After local case manager receives local approval from RN-Supervisor, the case manager is responsible for accuracy of plan of care..
c. Daily time sheets and chart notes are reviewed periodically.
d. Any information publicly distributed (ex. Newspaper articles, HH program brochures) must be approved by the agency's Public Information Officer (PIO), the Health Director. If the Health Director is unavailable the Health Educator serves as the back-up PIO.

6. Variety And Purpose Of Personal Contacts With Examples Of Issues Or Problem Resolution:
   a. This position has frequent contact with clients through home assessments, review assessments and monthly follow-up calls
   b. Nurses, Physicians, and Family members are also contacted regarding assessments, care plans, and follow-up
   c. Obtain referrals from other social workers at other agencies and also for follow-up of clients.
7. Physical Effort:
   a. Requires frequent travel to client's homes
   b. Requires the ability to move around health department on a daily basis and
   c. Occasionally enters public or private facilities that may not be handicap accessible.
   d. It also requires the ability to:
      1) use a computer and telephone on a daily basis;
      2) travel to meetings locally and occasionally statewide—sometimes requiring overnight stay.
   e. Lifting and carrying equipment and supplies from the storage room to the car and from the car to the client's home is frequent. This may require climbing steps.
8. Work Environment And Condition:
   a. The Caswell County Health Department is a two-story, climate controlled building that is not completely handicap accessible with stairs (no elevator) to reach the other floor.
   b. This position requires home visits, that are often made in inclement weather and requires driving on both primary and secondary roads.
   c. Home visits are sometimes unsafe and animals may present a hazard.
   d. This position requires frequent contact with the public which may lead to exposure to tobacco smoke, perfumes, or other irritants. Likewise, interaction with the public has the potential for infectious disease concerns.
   e. During a public health emergency, being exposed to the elements or various hazards may be necessary.
9. Machines, Tools, Instruments, Equipment And Materials Used:
   a. Computer
   b. Office Equipment (Copier, Fax Machine, etc)
   c. Telephone with voice mail system and Cell phone
   d. Automobile
   e. Audio-visual equipment (TV, DVD Player, etc)
10. Visual Attention, Mental Concentration And Manipulative Skills:
    a. Charting, writing assessments, letters and forms.
    b. Close visual attention required for interviewing families observing body language, feelings, and behavior.
    c. Preparing budgets, computing matching funds, billing coordination requires

mental concentration.

11. Safety For Others:
    a. Safe use of a motor vehicle
    b. Employee should use universal precautions when necessary
    c. Employee should participate in annual respiratory training program and be fit tested for masks.
    d. Employee will ensure the confidentiality of patient information.
    e. Must ensure that all service provision can be provided to client safely
    f. Determine inappropriateness of client for program due to promotion of unsafe environment
    g. Check/verify references of employees and supervision of subordinates to ensure quality service
    h. Recognize signs of neglect/abuse and mental status change to determine need for intervention.
12. Dynamics Of Work Or Changes That Impact Work – i.e. Technology, Policies, Seasonal Changes, Etc:
    a. Must be an effective team player, flexible, and have the ability to change at a moment's notice if public health emergencies occur.
    b. In the event of a public health emergency the employees role may change.
13. First Responder Duties
    a. Public Health is a first responder agency for natural disasters (e.g. hurricanes, tornadoes, floods, winter storms), naturally occurring infectious disease outbreaks (e.g. influenza, SARS), technological hazards (hazardous materials releases, critical infrastructure disruptions), and terrorist incidents. This position, like all other positions within the Caswell County Health Department may be required to participate in emergency response activities as deemed necessary by the Caswell County Health Director or his/her designee. Availability during emergencies and exercises is required.

III. KNOWLEDGE, SKILLS, & ABILITIES AND TRAINING & EXPERIENCE REQUIREMENTS

A. <u>Knowledge, Skills And Abilities:</u>
   1. General knowledge of budgeting principles
   2. Considerable knowledge regarding the aging process and death and dying
   3. Considerable knowledge in the techniques of counseling
   4. Ability to assess home safety
   5. Excellent written and verbal communication skills
   6. Decision making and problem solving abilities
   7. Ability to communicate effectively with all populations
   8. Ability to listen effectively
   9. Ability to document concisely and factually
   10. Ability to prioritize needs and assign tasks

B. <u>Training and Experience Requirements</u>
   1. Required Minimum Training:
      a. BS Degree in Social Work from an accredited school of social work, or
      b. BS Degree in Human Services field from an accredited college or university and one year directly related experience, or
      c. BS Degree from an accredited college or university, and two years of directly related experience
         1) Case management
         2) Assessment and referral
         3) Supportive counseling

4) Intervention
5) Psychosocial therapy
6) Treatment planning

C. License Or Certification Required By Statute Or Regulation:

1. Employees who are required to drive in the performance of their job duties must show proof of a valid driver's license.

I. Signatures indicate agreement with all information provided, including designation of essential functions.
Supervisor's Certification: I certify that (a) I am the immediate Supervisor of this position, that (b) I have provided a complete and accurate description of responsibilities and duties, and (c) I have verified (and reconciled as needed) its accuracy and completeness with the employee.

Signature: ______________________________________ Title: ____________________________ Date: __________

Employee's Certification: I certify that I have reviewed this position description, completed by the above named immediate supervisor, is complete and accurate.

Signature: ______________________________________ Title: ____________________________ Date: __________

Section or Division Manager's Certification: I certify that this position description, completed by the above named immediate supervisor, is complete and accurate.

Signature: ______________________________________ Title: ____________________________ Date: __________

HR Director's Certification: I certify that this is an authorized, official position description of the subject position.

Signature: ______________________________________ Title: ____________________________ Date: __________