CARE COORDINATION SOCIAL WORKER – D-SNP (LCSW)

Position Status: Exempt
Reports To: Medicare Care Management Manager (RN)
Effective Date: 09/02/25
Revised Date:
Job Level: P2

POSITION SUMMARY

Under limited supervision, this position:

1. Develops and manages an individualized intervention plan for Medicare Dual Eligible Special Needs Plan (D-SNP) members referred into the Care Coordination program with the goal of promoting optimal, achievable outcomes in the most cost effective and appropriate manner
2. Works in conjunction with the interdisciplinary Care Coordination team to facilitate quality outcomes across the continuum by educating members, caregivers, providers, external agencies, and internal teams and providing assistance in navigating the managed care system
3. Participates in program evaluation and quality improvement efforts to ensure D-SNP program effectiveness and compliance with regulatory requirements
4. Performs other duties as assigned

RESPONSIBILITIES

1. Develops and manages an individualized intervention plan for Medicare Dual Eligible Special Needs Plan (D-SNP) members referred into the Care Coordination program with the goal of promoting optimal, achievable outcomes in the most cost effective and appropriate manner, with duties including but not limited to:
    - Performing comprehensive assessment of physical, emotional, psychosocial, and environmental needs of the member by reviewing relevant and available medical records and communicating by telephone and in person
    - Performing psychosocial and environmental assessments to identify barriers, risks, and member goals
    - Working collaboratively with Nursing and Care Coordination staff to develop member-centered goals
    - Developing individualized, strength-based care plans that align with D-SNP Model of Care (MOC) requirements
    - Supporting members with complex psychosocial needs, addressing barriers to care, long-term services and supports (LTSS), and social determinants of health
    - Recognizing members' barriers to compliance and changes in psychosocial condition and adjusting the intervention plan of care as needed
    - Maintaining regular member contact with assigned members and updating care plans based on member's evolving needs and progress
    - Assisting members in understanding and utilizing D-SNP and Medi-Cal benefits and community resources
    - Providing culturally responsive support, education, and coaching to empower members in navigating complex care systems
    - Documenting and recommending case management actions in accordance with established processes and procedures

- Documenting all care coordination activities in accordance with regulatory and programmatic standards
- Facilitating completion of member goals through a multidisciplinary approach of collaboration with internal and external resources and member or authorized representatives
- Making recommendations and referrals to appropriate agencies
- Advocating appropriately, based on the scope of the health plan, on members' behalf to ensure quality of care and attainment of appropriate goals
- Preparing and sending member correspondence that meets contractual requirements
- Managing assigned cases and interventions in a timely and accurate manner

2. Works in conjunction with the interdisciplinary Care Coordination team to facilitate quality outcomes across the continuum by educating members, caregivers, providers, external agencies, and internal teams and providing assistance in navigating the managed care system, with duties including but not limited to:
   - Providing consultative social work expertise to the D-SNP team and external partners
   - Collaborating with members, caregivers, providers, community agencies and internal teams to support continuity of care, engagement, and member satisfaction
   - Coordinating with providers, LTSS vendors, behavioral health resources, and internal departments to support integrated care
   - Collaborating with internal staff and external providers to address care transitions and service delivery gaps
   - Participating in interdisciplinary case conferences and team rounds
   - Assisting other department staff with resolution of quality and coordination of care issues for members within the programs
   - Representing the Alliance at community meetings and confidential multidisciplinary task forces concerning health issues or provision of health-related services

3. Participates in program evaluation and quality improvement efforts to ensure D-SNP program effectiveness and compliance with regulatory requirements, with duties including but not limited to:
   - Supporting continuous program improvement through participation in quality assurance initiatives, audits, and reporting
   - Participating in quality improvement efforts involving access to care, member education, and behavioral changes of members who require on-going care coordination
   - Maintaining documentation of case management plans and interventions required to demonstrate the cost effectiveness of care coordination and the impact on members' health care outcomes
   - Supporting, implementing, and evaluating program processes on a timely basis to make recommendations for improvement
   - Identifying opportunities to improve member outcomes and experiences
   - Participating in the development of D-SNP policies, workflows, and training materials for new staff
   - Auditing work for compliance with departmental workflows and procedures
   - Assisting with preparation for Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) audits and implementation of corrective action plans

4. Performs other duties as assigned

EDUCATION AND EXPERIENCE

- Possession and continued maintenance, in good standing, of a Licensed Clinical Social Worker (LCSW) license issued by the State of California.
- Master's Degree in Social Work or related field and two years of social service experience in an acute care, community-based, or managed care environment which included developing and managing member-centered care plans; or an equivalent combination of education and work experience may be qualifying.

KNOWLEDGE, SKILLS, AND ABILITIES

- Thorough knowledge of the principles and practices of case management and coordination, including assessment, care/treatment planning, discharge planning. and documentation
- Thorough knowledge of the availability and means of utilizing community resources for special services
- Working knowledge of reporting methods for cases of abuse or neglect
- Working knowledge of community resources and behavioral health systems
- Working knowledge of the needs of older adults, individuals with disabilities, and/or those with complex medical or psychosocial needs
- Working knowledge of and proficiency in the use of Windows-based PC systems and Microsoft Word, Outlook, and Excel, and care management platforms
- Some knowledge of the principles and practices of health care and health care systems, including managed health care
- Ability to effectively interview members to determine their strengths, problems prognosis, functional status, goals, and need for specific services and resources, and to establish short-term and long-term goals
- Ability to assess psychosocial needs and conduct culturally competent interviews
- Ability to use proactive customer services skills in responding to complex and demanding situations
- Ability to advocate on behalf of the individual member to assure quality of care and attainment of appropriate goals
- Ability to develop, document, and implement intervention plans
- Ability to prepare reports, correspondence, and other program documents
- Ability to perform public speaking in a variety of forums
- Ability to exercise strong critical thinking and problem-solving skills
- Ability to understand and interpret medical records and other health care data
- Ability to support members who are non-compliant and/or have behavioral health issues
- Ability to work effectively with people of ethnically and culturally diverse backgrounds
- Ability to work independently and as a member of an interdisciplinary team

DESIRABLE QUALIFICATIONS

- Bilingual (English/Spanish or English/Hmong, depending upon work location)
- Certification by a nationally recognized case/care management organization
- Experience working with D-SNP and/or older adult populations
- Experience working as a Medical Social Worker
- Working knowledge of Medi-Cal and Medicare benefits and related policies and regulations

- Working knowledge of the needs of D-SNP populations, MOC requirements, and LTSS programs

WORK ENVIRONMENT

- Ability to sit in front of and operate a video display terminal for extended periods of time
- Ability to bend, lift and carry objects of varying size weighing up to 10 pounds
- Ability to work effectively in a remote work environment
- Ability to travel to different locations in the course of work
- Possession and ongoing maintenance of a valid Driver's License, transportation, and automobile liability insurance in limits acceptable to the Alliance

This position description, and all content, is representative only and not exhaustive of the tasks that an employee may be required to perform. Employees are additionally held responsible to the Employee Handbook, the Alliance Standard Knowledge, Skills and Abilities and the Alliance Code of Conduct. The Alliance reserves the right to revise this position description at any time.