UIC UNIVERSITY OF ILLINOIS AT CHICAGO

Division of Specialized Care for Children

3135 Old Jacksonville Road
Springfield, Illinois 62704-6488

February 12, 2016

CARE COORDINATOR/CONSULTANT
DEPARTMENT: Home Care Region 2 - Lombard
FLSA: Exempt
UNION: SEIU 73 Professional
JOB POSTING: #16-046 #16-047 (Exam Request title: Medical Social Associate)

The minimum acceptable qualifications for a Medical Social Associate are:

1. A. Bachelor's degree with a major in the social or behavioral science or related health specialty from an accredited college or university.

   or

   B. Master's degree in social or behavioral science or related health specialty area from an accredited college or university.

2. One (1) year (12 months) of progressively more responsible full-time experience in the practice of social services/agencies or medical/clinical setting maintaining acceptable standards of social work practices.

A. FUNCTION:

The DSCC Home Care-Care Coordinator/Consultant provides care coordination services to families eligible for DSCC's Home Care non-waiver services within a particular geographic area. Provides consultation to other members of the multi-disciplinary team utilizing skills and knowledge acquired from academic training and professional experience.

B. ORGANIZATIONAL RELATIONSHIPS:

The Home Care-Care Coordinator/Consultant reports to the Home Care Regional Manager (RM). The RM reports directly to the Assistant Director for Operations-Home Care.

C. WORK ACTIVITIES:

Provides services as a coordinator assistant:

- Records, prepares and transmits information, i.e., demographic and medical social data from applicants/recipients, families and Care Coordinators, including completing forms and letters in support of care coordination services.
- Assists families in collecting necessary medical and financial information to determine eligibility for non-waiver Home Care Services:
- Prepares all materials necessary so the entity or entities identified by Healthcare & Family Services (HFS) responsible for conducting the eligibility determination for the non-waiver Home Care Program can make eligibility determination.
- Develops and implements a care coordination plan that is participant/family-centered,

community-based and coordinated for assigned case load.

- Monitors the care plan activities.
- Revises the care coordination plan to address the changing and ongoing concerns and priorities of the participant/family.
- Maintains confidential applicant/recipient records, filing documents using agency guidelines, including processing transferred, volume and discontinued records.
- Receives, processes and routes incoming/outgoing written applicant/recipient correspondence, reports, etc.
- Arranges for translation or interpreter services for applicants/recipients or their family, and if applicable to their area of expertise, provides bilingual translation to staff for children and their families with Limited English Proficiency (LEP) through face-to-face, telephone and written interaction.
- Assists Care Coordinators and families with care coordination activities, including activities such as staff support for clinics, satellites, referrals to other resources, arranging medical services for applicants/recipients.
- Assists families with private/public health insurance through effective benefits management practices for participants eligible for the non-waiver Home Care Program.
- Participates in Division staff meetings and in-service training sessions.

Provides care coordination services to persons eligible for the non-waiver Home Care Program:

- Develops a care coordination plan that is participant/family-centered, community based and coordinated.
- Facilitates the implementation of the care coordination plan.
- Monitors the care plan activities.
- Revises the care coordination plan to address the changing and ongoing concerns and priorities of the participant/family.

Participates as a member of the Regional Office multi-disciplinary team:

- Complies with University, Division and Regional Office policy and procedures.
- Provides state-of-the-art discipline based expertise to the Regional Office multi-disciplinary team.
- Maintains an area of psychosocial expertise in support of the Regional Office multi-disciplinary team.

Promotes interagency collaboration and an organized network of integrated services:

- Provides community education programs regarding DSCC services.
- Participates in developing and/or implementing a networking plan for the Regional Office.

Participates in special projects impacting DSCC:

- Participates in agency committees/projects on a regional or statewide basis.
- Participates in DSCC sponsored interagency programs.

Performs other duties as assigned.

D. KNOWLEDGE REQUIRED BY THE JOB:

The Home Care-Care Coordinator/Consultant should be knowledgeable regarding:

- Medical terminology as it relates to the eligible system impairments.
- Medications as they relate to the eligible system impairments.
- Normal growth and development.
- Chronic health impairments.
- Medical equipment/supplies related to eligible system impairments.
- Laws related to children.
- Guardianship, adoption and custody.
- Therapeutic approaches in the treatment of children and families.
- Psychopathology.
- Community resources for the economic, social, psychological and medical needs of the participant/family.
- Eligibility criteria for the Core Program.

The Home Care-Care Coordinator/Consultant should have demonstrated skills in the following areas:

- Development of an appropriate participant/family centered care plan.
- Accurate interpretation of psychological/social reports, documents and reference books.
- Accurate interpretation of medical reports to confirm medical eligibility.
- Compliance with University Policy and Rules.
- Compliance with DSCC Rules, Policy and Procedures.
- Assessment of participant/family dynamics and social service needs.
- Counseling and crisis intervention.
- Effective care coordination.
- Training of staff and families.

E. POSITION RESPONSIBILITY:

The Home Care-Care Coordinator/Consultant functions independently as a professional staff person within the Regional Office. The RM directly supervises the Care Coordination/Consultant with technical assistance obtained from the Central Administrative Office. Work is periodically reviewed by the RM with feedback provided to the Home Care-Care Coordinator/Consultant. The Home Care-Care Coordinator/Consultant sets daily priorities and deadlines through routine case monitoring and contact with families, providers or other agencies.

F. GUIDELINES:

The Home Care-Care Coordinator/Consultant is required to comply with the University of Illinois Policy and Rules, DSCC Administrative Rules, and Policy and procedures.

G. SCOPE OF DUTIES AND RESPONSIBILITIES:

There is a range of complexity depending upon the specific situation on a particular case. The complexity varies because of the medical condition, multiplicity of providers, and dynamics of family system. The care coordination services also need to be in compliance with policy and procedures. This increases the decision making for the Home Care-Care Coordinator/Consultant as rules, policy and procedures need to be applied consistently to individual participant/family needs. The Home Care-Care Coordinator/Consultant needs to be timely in their response to families and service providers or services are not delivered to the child and family in an effective or timely fashion. Strict compliance with DSCC

confidentiality policy must be maintained with all child specific information.

H. PERSONAL RELATIONSHIPS:

The Home Care-Care Coordinator/Consultant interacts on a daily basis with the families and service providers. The direct interaction with their team members and consultative resources within the Division is also on a daily basis. These contacts may occur by face-to-face, E-mail, phone, or written documents.

I. ENVIRONMENTAL DEMANDS:

The Home Care-Care Coordinator/Consultant is sedentary while working in an office setting. . Requires physical ability to stand for up to 1 hour at a time, ability to walk to and from a client's home, climb stairs and carry 10-20 pounds of equipment, including but not limited to lap top computers, printers and other materials necessary to conduct home visits and patient assessments. There is a minimum/moderate amount of travel required for the position.