

STATE OF NORTH CAROLINA OFFICE OF STATE PERSONNEL POSITION DESCRIPTION FORM (PD - 102A-92)		APPROVED CLASSIFICATION: _____ EFFECTIVE DATE: _____ ANALYST: _____ (This Space for Personnel Dept. Use Only)
1. Present Classification Title of Position: Social Worker III	7. Pres.15 Digit Pos. No. / Prop. 15 Digit 522-40-530	8. Department, University Commission, or 9. Agency: Person County Health Dept.
2. Usual Working Title of Position: BSW	9. Institution & Division: Person County Health Department	10. Section & Unit:
3. Requested Classification of Position: Social Worker III	11. Street Address, City and County: 355 A South Madison Blvd. Roxboro, NC 27573	
4. Name of Immediate Supervisor: Deanna Mangum, RN	12. Location of Workplace, Bldg. and Room No.: 355 A South Madison Blvd. Roxboro, NC 27573	
5. Supervisor's Position Title & Position Number: PHN Supervisor I		
6. Name Of Employee:		

I. A. PRIMARY PURPOSE OF ORGANIZATIONAL UNIT:

Home Health and Hospice of Person County is dedicated to providing comprehensive, compassionate, and quality home care to the residents of Person County. Our goal is to always be aware of our patient's needs and to fulfill community expectations by providing this care in a professional, cost effective and proficient manner. The purpose of Home Health and Hospice of Person County is to meet the comprehensive medical, therapeutic and supportive services needed to maintain acute, chronic and terminally ill patients in their homes. These services will be available regardless of age, sex, race, religion, creed, ethnic origin, sexual orientation, physical or mental handicaps, DNR status or ability to pay.

B. PRIMARY PURPOSE OF POSITION:

The purpose of this social work position is to provide intensive clinical social work treatment interventions to assist patients and families with complex psychosocial issues that interfere with optimal patient care, acceptance of condition and functional status of patient/family as it relates to condition or illness. The social worker conducts an in-depth diagnostic evaluation of individual patients and their families, assessing family dynamics and psychosocial needs of the patient/family as it relates to the terminal condition, limitations of illness, coping capabilities of patient/family, and reactions of patient/family to catastrophic and terminal illness. Based on the assessment, the social worker utilizes in-depth therapeutic interventions such as cognitive-behavior therapy, crisis intervention, skills teaching, problem solving, and motivational and reality therapies with patients and families to resolve crisis, fears and concerns relevant to the patient's condition or illness. The social worker conducts an in-depth assessment to screen for anticipated bereavement risk. The social worker provides bereaved families with therapeutic grief-resolving correspondence, and individual and/or family counseling to assist in the grief process. The social worker provides HIV case management. Conducting psychosocial assessments to ensure optimal patient care. Direct services are provided such as

benefit advocacy and resource referral. Other services include individual and family counseling, crisis intervention to assist the patient/family with acceptance of illness and coping with the alienation that may be experienced by the patient from family and/or community

C. WORK SCHEDULE:

Regular work hours are from 8:00 AM - 4:30 PM – Monday through Friday.

D. CHANGE IN RESPONSIBILITIES OR ORGANIZATIONAL RELATIONSHIP:

- No longer HIV Case Management as of August 2002
- No longer Bereavement Coordinator as of August 2008
- Addition of Adult Health Responsibilities November 2010

II. A. DESCRIPTION OF RESPONSIBILITIES AND DUTIES:

90% Hospice

Percentage of Time Spent Performing Services is as follows:

34% Counseling Intervention
5% Bereavement Services
24% Clinical Assessments
17% Community Resource Utilization
10% Hospice Program Development Assistance
10% IDT Collaboration

1. The social worker is responsible for interpreting the hospice benefit to the patient and family unit, ensuring the family unit clearly understands the hospice philosophy and why a hospice referral has been made. The social worker assesses the family unit's level of knowledge concerning the patient's terminal illness, prognosis and treatment options. The social worker also assesses patient/family desire for treatment (chemotherapy/radiation therapy), patient's desire for a death in the home environment, concern for the emotional stability of having small children in the home with a dying person and patient/family's desire and willingness to comply with the Hospice philosophy and level of care.
2. The social worker conducts an in depth assessment of patient/family financial, environmental, emotional, behavioral, mental, spiritual, legal and support system needs and problems. The social worker also assess the resources needed to assist patient/family with care in the home environment. This assessment will consist of patient/family financial status, as this relates to the possible loss of income and expenses associated with a terminal illness. The patient's behavioral state is assessed to determine if patient is physically/verbally abusive or cooperative with family and care providers. The patient's mental status is assessed to determine whether patient is mentally stable or not capable of patient's desire or need for assist with estate planning. The patient/family support systems are assessed to determine the level of support available within the family and community, availability of persons to relieve caregiver of care and provide them with a brief rest period, the need for additional

support and family willingness for outside support/assistance.

3. The social worker must conduct an intensive and on-going assessment of the patient/family ability to cope with complex personal, emotional, spiritual, and environmental difficulties which impact on the care provided and interfere with patient/family obtaining the maximum benefit of Hospice care. The social worker must assist patient/family in resolving these difficulties through individual counseling, group counseling or through referrals to the local mental health center. The social worker may encounter families that feel that Hospice care is giving up. Families may also feel that patient needs to be in hospital to get round the clock care. This assessment is critical in focusing on the patient's wishes and needs.
4. The social worker must also assess the patient/family pre-bereavement needs. This assessment focuses on the changes in roles among family members, financial stability of primary caregiver/family funeral preparations and estate planning.
5. The social worker participates with the Interdisciplinary Team in developing, implementing and updating a plan of care. The social work component of the care plan addresses patient's needs, clinical counseling interventions/need for community resources, goals, and if needs are resolved. The social worker and patient/family use the care plan as a working tool to focus on needs, intervention strategies and resolution of needs. The social worker also had the responsibility of interpreting patient/family problems, needs, and coping capacities relative to the functional limitations of the terminal condition and its impact on the family dynamics to members of the Interdisciplinary Team.
6. The social worker must assist patient/family with understanding, accepting, and following medical recommendations of physician/medical doctor through intensive counseling. This counseling intervention must be provided to ensure optimal and beneficial patient care.
7. The social worker must provide psychological and emotional support and counseling to patient/family relevant to patient's terminal condition. Therapeutic counseling must be provided to assist patient/family with the complex family dynamics, role changes, strengthening of coping mechanisms and to assist with their acceptance of the terminal condition. This support and counseling is provided on an on-going basis due to the complexity of the issues surrounding the terminal condition and to also assist caregiver/family with developing new financial management and consumer skills. This assistance is needed to help caregivers plan their financial future without presence of spouse and income. Counseling must be provided on an on-going basis to also assist patient/family with recognizing and working through the stages of the dying process.
8. The social worker must assist the patient and family with accessing community resources relative to the identified problems and needs. Community resources are utilized to assist family with patient's physical care, assist patient/family with transportation to medical facilities, and also to enable patient to remain in the home environment.
9. The social worker is responsible the annual memorial service to assist families in the healing process by the remembering of their loved ones. The social worker must also

provide anticipatory grief counseling before the patient's death to assist family members with preparing for patient's death. This may involve assisting family members with taking over financial and physical responsibilities of the patient, and teaching family members budgeting skills, consumer skills and household management techniques.

10. The social worker may assist in the organization of the Hospice Volunteer Training. The social worker is responsible for interpreting psychosocial issues relative to the terminal condition, family dynamics and grief counseling.
11. The social worker may assist with interpreting the Hospice program to community, church groups, and local civic groups. The social worker maintains a liaison relationship with other agencies for professional/community education and public relations. This relationship will be maintained to assist the social worker in advocating for needed resources, and for providing follow-up to ensure that appropriate patient services are being provided.

5% Home Health

Percentage of Time Spent Performing Services is as follows:

- 29% Counseling Intervention
- 26% Clinical Assessments
- 28% Community Resource Utilization
- 10% Service Evaluation and Monitoring
- 7% Home Health Team

1. The social work performs an intensive assessment of the patient's psychosocial, environmental, financial and support system needs as it relates to patient's medical condition. The psychosocial assessment is completed to determine patient/family level of understanding of condition, willingness to participate in medical care, willingness to assist in resolving problems/needs and ability of patient/family to resolve needs. Environmental needs are assessed to determine safety, atmosphere and comfort of the patient in the home environment. Financial needs are assessed to determine if budget counseling is appropriate or if a lack of financial resources interfere with patient's care. Support systems are assessed to determine amount of care being provided by family and outside providers. It is also assessed to determine if relief of caregiver is being provided.
2. The social worker also assesses the patient/family's strengths level of encouragement, functional level of coping and willingness to comply with medical regime.
3. The social worker assesses the impact of complex mental, social, environmental, legal, emotional, behavioral problems on the patient's medical condition and treatment. Patient may be depressed about medical condition and have no motivation to resolve needs which may interfere with patient obtaining proper medical treatment.
4. The social worker is responsible for developing a plan of care which includes goals agreed upon with patient/family, services to be provided or obtained, and resolution of needs. The social worker must complete detailed progress notes that detail service provided, appropriateness and effectiveness of service and progression of care relative to client needs.

5. The social worker must counsel patient and family about long range planning and decision making relative to patients care in the home environment. Intensive therapeutic counseling must be provided to assist patient and family with the adjustment to the illness/condition, management of illness at a healthy functional capacity and assisting patient with complying with medical regime. The social worker provides assistance related to social and emotional issues adversely affecting the patient's recovery or condition of illness, such as real or imagined alienation from family, friends and community. The emotional issues may involve patient and/or family feeling hopeless/helpless about patients condition and its affects on the functional status of the family unit.
6. The social worker must identify, educate and assist patient/family with obtaining needed community resources. Community resources are utilized to assist patient and family with managing long and short term care of the patient in the home environment. Community resources obtained are based on the client needs identified in the assessment. The patient and family needs may include homemaker services, financial assistance, transportation, medical equipment and services, emergency response system services, entitlement programs and assistance with insurance providers and service. The social worker must provide follow-up with service providers and family members to assure their effectiveness, appropriateness and continued need for resource/service.
7. The social worker must assist the patient/family with placement (nursing home, rest home and group home) based on the determination of patient and family, interdisciplinary team and social worker that home environment is not appropriate for patient's level of care. The social worker must consult with the patient's doctor to inform him/her of recommendation and need for assistance. The social worker must assist patient/family with obtaining insurance/assistance needed for placement. The social worker must assist patient and family with obtaining most appropriate placement facility based on patient/family's needs and wishes.
8. The social worker must provide crisis intervention when the home environment is unsafe and it places patient at risk, endangers or interferes with patient care. Assessment of mental illness, alcohol/substance abuse, unsafe home environment are conducted at intake to ensure optimum patient care and staff safety. Findings are reported to the interdisciplinary team, as well as the referring physician.

5% Adult Health

Percentage of time Spent Performing Services is as follows:

20% Guardianship Committee

10% Court Hearings

70% Direct Care of Ward

1. The social worker will participate in monthly Guardianship Committee meetings as a representative of the Person County Health Department. Other departments represented on the committee are Person County Department of Social Services and OPC Mental Health.

2. The social worker, under direct supervision of the Health Director, will determine appropriateness of Wards to be under the care of the Person County Health Department.
3. The social worker will act as the Health Director's Designee and attend court hearings to where competency is determined by the court.
4. After appointment the social worker will be responsible for coordinating care of the Ward as the Health Director's Designee as North Carolina court statutes allow, i.e., medical appointments, transportation to and from appointments, personal needs, housing, etc.
5. After appointment the social worker will be responsible for appropriate documentation for care if the Ward, i.e., DHHS Blanket Bond, follow up with Ward, health care providers and family members, etc.

II. B. OTHER POSITION CHARACTERISTICS:

1. Accuracy Required in Work:
Psychosocial Assessments must be timely, accurate and informative. All visits, phone calls must be documented within 48 hours.
2. Consequence of Error:
Errors in negotiations with 3rd party insurance providers could be very costly to our program. The health department's hospice program is paid on a per diem basis and costs incurred in excess of the daily reimbursement rate could be considerable. The MSW must have a good working knowledge of our program as well as that of the 3rd party insurance providers.
3. Instructions Provided to Employee:
Orientation to health department, especially home health and hospice. Supervisor and Health Director directs verbally or by written memo. Agency policies and procedures. Information relevant to care also obtained from staff meetings, IDT meetings, and case management meetings, in-services, trainings and workshops, and ongoing education. Information also obtained through hospice journals and publications.
4. Guides, Regulations, Policies, and References Used by Employee:
Policy and Procedure Manuals for Home Health and Hospice Medicare Reimbursement rules and regulations
Manuals, tests and references relating to Home Health and Hospice
Technical advice from supervisor.
5. Supervision Received by Employee:
Social Worker is directly supervised by the Home Health and Hospice Nursing Supervisor. Documentation is checked daily. Performance evaluation is conducted yearly. Additional supervisory hours are provided by a LCSW if required by the MSW to obtain or maintain licensure as a clinical social Worker.

6. **Variety and Purpose of Personal Contacts:**
Patient and family for direct services. Staff and team members for collaborations, planning and implementing the care plans. Community contacts to promote programs and provide education.
7. **Physical Effort:**
Moderate physical activity is required in this position, frequently supplies and equipment is taken to the patient's home.
8. **Work Environment and Conditions:**
Occasionally required to work in poor home environments with difficult clients. Exposure to second hand smoke in the home environment. Inclement weather may pose travel problems.
9. **Machines, Tools, Instruments, Equipment, and Materials Used:**
Agency vehicle, computer, phone, calculator, cell phone, fax machine, copier, and VCR.

II. B. OTHER POSITION CHARACTERISTICS: (continued)

10. **Visual Attention, Mental Concentration, and Manipulative Skills:**
Focused attention required to conduct thorough psychosocial assessment, must be able to quickly establish a therapeutic relationship with the clients and families.
11. **Safety for Others:**
Infection control policies, OHA blood borne pathogen standards, safety of staff in unfamiliar areas of county. Need to be aware of hazardous weather conditions and high crime area.
12. **Dynamics of Work:**
The dynamics of the work done in this position are complex and varied. The MSW must maintain 3 separate positions, Bereavement Coordination and Home Health/Hospice Social Worker simultaneously. Understanding that psychosocial services must be delivered according to accepted standards of practice, the social worker, guided by the patient/family's needs and wants, coordinated the resources of the family, the agency, and the community into an integrated program of support.

III. KNOWLEDGES, SKILLS, AND ABILITIES AND TRAINING AND EXPERIENCE REQUIREMENTS:
INTERPERSONAL COMMUNICATIONS:

A. Scope of Contacts:

Includes clients and families, a variety of professional disciplines, Community agency groups, court officials, students, interns or residents.

B. Nature and Purpose:

To determine extent of neglect, abuse, and facilitate move to appropriate setting to assess strengths and risk factors related to physical and mental health; and provide counseling to alleviate family crises. Employees also

communicate to facilitate adaptive coping responses to illness and surgery, provide expert opinions to legal officials or medial staff, and provide didactic experiences for students, residents and interns.

IV. OTHER WORK DEMANDS:

A. Work Conditions:

Employees work in settings, which range from human services agencies, clinics, hospitals, or offices, but often involve visits to client's home or contacts in institutions or correctional facilities.

B. Hazards:

Includes contacts with clients and/or family members who may be hostile, resistant, and violent.

V. RECRUITMENT STANDARDS:

A. Knowledge, Skills and Abilities:

Through knowledge of social work principles, techniques, and practices, and their application to complex casework, group work, and community problems. Considerable knowledge of a wide range of medical, behavioral, and/or psychosocial problems and their treatment theory. Considerable knowledge of family and group dynamics and a arrange of intervention techniques, governmental and private organizations, and resources in the community, laws, regulations, and policies which govern the program. General knowledge of the methods and principles of casework supervision and training. In certain settings, considerable knowledge of medical terminology, disease processes and their treatment as they relate to decisions regarding clinical interventions and appropriate therapies based on medical or psychological diagnosis. Skill in establishing rapport with a client and in applying techniques or assessing psychosocial, behavioral, and psychological aspects of client's problems. Ability to supervise, trains, or instructs lower-level social workers,, students, or interns in the program. Ability to establish and maintain effective working relationships with members of caseload and their families, as well as civic, legal, medical, social, and religious organizations. Ability to express ideas clearly and concisely and to plan and execute work effectively.

B. Required Minimum Training:

Masters of Social Work from a accredited school of social work and one year social work or counseling experience; or a Bachelor's degree from an accredited school of social work and two years of social work or counseling experience; or a Master's degree in a counseling field and two years of social work or counseling; or four year degree in a human service field or related curriculum including a t least 15 semester hours in courses related to social work or counseling and three years of social work or counseling experience; or graduation from a four year college or university and four years of experience in techniques of casework, group work, or community

organization; or an equivalent combination of training and experience. **For Medicare certified Home Health, must have MSW from a School of Social Work accredited by the Council on Social Work Education.**

Additional Training / Experience:

Knowledge of and ability to apply psychosocial skills and counseling techniques in a wide variety of hospice and home health situations.

Ability to conduct educational seminars and trainings for civic, church, volunteer and professional groups.

Equivalent Training and Experience:

N/A

License or Certification Required by Statute or Regulation:

N/A