

**Lane Council of Governments
Job Classification**

Job Classification Title: Case Manager Diversion and Transition

Job Title: Transition Coordinator

Range: 15

FLSA Status: Non-Exempt

Division: Senior & Disabled Services

Reports To: Program Supervisor

Created: April 2008

General Statement of Duties

The purpose of this position is to provide two types of services, Diversion and Transition.

Diversion services are provided to prevent a person from becoming a long term resident of a Nursing Facility, prior to Medicaid funding covering the cost of care. Diversion can begin prior to Nursing Facility placement of while a person is receiving skilled Nursing Facility care.

A person residing in a Nursing Facility, with Medicaid funding covering the cost of care is eligible for Transition services. These services may be provided to enable a client to move from the Nursing Facility.

Supervision Received

Work is performed under general supervision and work performance is evaluated through periodic checks and through the adequacy and timeliness of products and services provided and results observed.

Supervision Exercised

None.

Resource Responsibility

Minimal responsibility for monetary or human resources. Makes final decisions or recommendations regarding correct use of resources with only general checks for reasonableness of actions.

Distinguishing Features

Positions assigned to the Range 15, Diversion and Transition classification are distinguished from Range 13, Case Manger by duties which include reviewing current or performing PAS CA/PS initial assessment.

Essential Job Functions

Assist participant in choice of community housing; assist and coordinate all arrangements needed to prevent the participant from entering the nursing facility.

Essential Job Functions (Continued)

- Develop individual housing option (s) for participant.
- Assist participant with arrangements necessary to allow participant to move.
- Locate a qualified provider or in-home caregiver who can meet the person's needs.
- Arrange visits allowing the person to participate in the selection of their new home.
- If the person has an existing provider/caregiver, identify additional supports needed to maintain the placement.

Assist potential Diversion/Transition participants in making the decision to participate in the Diversion/Transition Program.

- Meet with potential Diversion/Transition participants and their families to explain program and concepts.
- Complete all needed assessments and service plans.
- Verify that participant is eligible for Diversion/Transition Services.
- Work with local eligibility staff to establish Medicaid financial eligibility.
- Work with local case management staff to establish/update Medicaid functional eligibility.
- Set up process for communication with participant, family, and/or guardian, significant others, and nursing facility that develops on-going timeline to transition period.

Facilitate relocation using the following three types of approaches:

- Full Case Management and transition services to very complex Nursing Facility resident until the person has been moved to their new placement, with 30-60 days monitoring, and the case can be transferred to an on going Case Manager.
- Co-Case Management for an existing Nursing Facility resident or a person at risk of becoming a Nursing Facility resident. In these situations, the TC and the existing Case Managers will share duties with the TC providing the time consuming work of placement identification and discharge planning.
- Consultation to existing case managers who need ideas or time limited, task specific assistance to either support a Nursing Facility discharge or prevent a Nursing Facility placement.

Client Assessment for Diversion/Transition:

- Review current or perform PAS CA/PS initial assessment, review hospital, current provider or nursing facility charts.

Essential Job Functions (Continued)

- Update CA/PS as necessary to reflect transition-planning activity.
- Meet with client and staff to determine medical, mental and physical level of functioning for possible diversion/transition to less restrictive, less costly care setting.
- Facilitate care conference with client and/or representative or guardian, nurses, social workers, therapists, doctors and current Case Manager to determine appropriate community placement plan. Enter all documentation and progress notes in ORACESS narration

Work with other project staff, policy teams and/or resource developers to recommend and implement strategies to minimize barriers to participant relocation.

Other Job Functions

Work with other project staff, policy teams and/or resource developers to recommend and implement strategies to minimize barriers to participant relocation.

Working Conditions

This position will usually work a standard workweek. Some irregular hours may be encountered as a result of participant needs. Day travel will be regularly required within the service area; some overnight travel may be required for training. The position will require the ability to work on tasks simultaneously, sometimes with short time frames and will also require regular contact with a variety of people, including families and self-advocates; state employees; employees of local governments; stakeholders and consumer advocates; long-term services and health care providers, and employees of other state governments and of the federal government.

Knowledge, Skills, and Abilities

Knowledge of client assessment techniques, and the skills and ability to apply this knowledge in the completion of a comprehensive assessment of a client's functioning, resources and needs;

Considerable knowledge of community resources and services for the elderly and disabled;

Knowledge of service plan development, and the skills and ability to apply this knowledge in the development of a comprehensive and safe plan to meet a client's needs;

Knowledge of issues, problems, and concerns of senior citizens and people with disabilities;

Knowledge, Skills, and Abilities (Continued)

Knowledge of legal requirements, standards, regulations, policies and procedures related to programs administered on behalf of clients;

Knowledge of medical terminology, anatomy and physiology, disease processes, and associated care needs.

Knowledge of legal requirements regarding guardianships, conservatorships, powers of attorney, advance directives and related matters.

Skilled in interpersonal communication and problem solving;

Skill and ability to respond and work effectively with angry and hostile clients, client representatives and service providers;

Ability to communicate effectively with other employees, clients, representatives of clients, representatives of other agencies, physicians, nurses, other medical providers and the general public, using tact, courtesy and good judgment;

Ability to establish and maintain effective working relationships with other employees, clients, representatives of clients, representatives of other agencies, physicians, nurses, other medical providers and the general public.

Ability to educate clients, clients' representatives and/or family members, medical providers and others regarding care options and the importance of client choice;

Ability to resolve conflict effectively;

Ability to obtain photographic evidence as necessary per Statute guidelines;

Ability to prepare reports and maintain accurate, up-to-date records;

Ability to work with accuracy and attention to detail;

Ability to understand and execute oral and written instructions, policies and procedures;

Ability to work in a fast-paced environment, to manage a high volume of work, and set priorities in order to meet deadlines;

Ability to operate a networked personal computer and other standard office equipment, such as a calculator, fax machine and photocopier;

Ability to physically perform assigned duties.

Education and Experience

Bachelors' degree in social work and three years of progressively responsible experience working in human service programs, preferably with the elderly or disabled, or any combination of education and experience that provide the applicant with the desired knowledge, skills and ability required to perform the job. Medical knowledge, certification such as an RN degree, and previous adult protective service experience desirable.

Licenses, Certificates, and Other Requirements

Valid Oregon State drivers' license or the ability to obtain reliable transportation to various sites within Lane County; ability to pass a criminal history check.