Aetna Health

We are currently seeking social workers in the following geographic areas: Washington, PA; Philadelphia, PA; Spring Brook, PA; and Clearfield, PA.

There is currently a $5,000 sign-on bonus. The position is primarily work-from-home at this time, with two to three days of field work (home visits) once Covid restrictions are lifted. Anyone interested can reach out to Emily Gerlach, MSW LSW at gerlach.emilym@gmail.com for information!

Dual Special Needs Plan Social Worker-Aetna Health

Position Summary
This role will be 50-75% travel within a 50 mile radius once Covid restrictions are lifted. Help us elevate our patient care to a whole new level! Join our Aetna team as an industry leader in serving dual eligible populations by utilizing best-in-class operating and clinical models. You can have life-changing impact on our Dual Eligible Special Needs Plan (DSNP) members, who are enrolled in Medicare and Medicaid and present with a wide range of complex health and social challenges. With compassionate attention and excellent communication, we collaborate with members, providers, and community organizations to address the full continuum of our members’ health care and social determinant needs. Join us in this exciting opportunity as we grow and expand DSNP to change lives in new markets across the country.

Position Summary
The Social Worker participates in the care planning process in collaboration with the Care Manager, to include the following actions: assessment, goal setting, establishing interventions related to goals, identifying barriers and strategies to address, monitoring success of the interventions, evaluating the success of the overall care plan and reporting outcomes.

Fundamental Components
- Care Management activities are conducted through a combination of telephonic and face to face interactions which include visits to member homes, in the community, and/or provider locations.

Care management activities will focus on quality of care, compliance, outcomes and decreasing costs.
- Responsible for developing and carrying out strategies to coordinate and integrate post-acute and long-term care services to members to prevent exacerbations and/or placement of the members in custodial care.
- Performs initial and periodic assessments of the members enrolled in the Long-Term Care Program and/or care programs.
- Applies social work concepts, principles, and strategies in addressing the social determinants of health needs in members individualized care plan.
- Conducts regular discussion and updates with providers, primary care physicians, Medical Directors, pharmacists, and care management staff regarding the status of members and progress towards goals.
- Serves as a member advocate to ensure the member receives all the necessary care allowed under the member’s benefit plan and as available through Medicaid benefits and/or other community
Develops relationships with hospital social workers and community resources and utilizes available data to assure appropriate care management of catastrophic, acute, and chronically ill members with the goal of appropriate utilization, decreased length of stay, and preventable emergency room utilization.

Assists in the identification and reporting of potential quality improvement issues.

Directs social work interventions including performing psychosocial assessment of the populations, telephone follow up and in-home or facility assessments as indicated, documentation of problems, assessments, and/or interventions, and promoting ease of access to a continuum of care through appropriate information and referral.

**Required Qualifications**
Minimum of 2 years’ experience in medical social work or case management.

**Preferred Qualifications**
Complies with all state requirements in the state where job duties are performed.
Willing and able travel within a designated geographic area for in-person case management activities when Covid-19 restrictions shift.

**Education**
Master's degree must be in Social Work
License in social work required