UNIVERSITY of HOUSTON
GRADUATE COLLEGE of SOCIAL WORK

Date Posted: 8/2025

Job Title	**Social Worker II PRN - Palliative Care**
Employer/ Agency	Houston Methodist Clear Lake Hospital
Job Description	At Houston Methodist, the Social Worker II PRN (SW II PRN) position comprehensively provides compassionate, clinical social work, psychosocial assessments, diagnosis and treatments, and complex discharge planning to patients and their families of a targeted patient population on a designated unit(s). In collaboration with physicians and the interprofessional health care team, this position sensitizes other health care providers to the social and emotional aspects of a patient's illness to collaboratively facilitate efficient quality care and achievement of desired treatment outcomes and affect positive patient and family outcomes. This position uses case management skills to help patients and their families address and resolve the social, financial and psychological problems related to their health condition. The SW II PRN position holds joint accountability with case manager, assuring that psychosocial and continuing care issues are addressed and treated as needed across the continuum of care and has responsibility for unit or departmental social work program development. This position serves as a hospital-wide, service-line leader for psychosocial related issues, complex discharge planning activities, and population disease management. **Requirements:** **PEOPLE ESSENTIAL FUNCTIONS** • Role models communication in an active, positive and effective manner to all health care team members and reports pertinent patient care and family data in a comprehensive and unbiased manner, listens and responds to the ideas of others. Uses therapeutic communication to establish a relationship with patients and families and communicates the discharge plan, facilitating transitions and hand-offs. Supports patients and families in clinical or ethical issues. • Provides staff education specific to patient populations and departmental processes. Functions as a preceptor and mentor to new employees. Identifies opportunities for professional growth of self and peers. **SERVICE ESSENTIAL FUNCTIONS** • Serves as a hospital/post acute-based leader for comprehensive case management activities including assessing high-risk patients and leading team to identify at-risk patients, participating in daily Care Coordination rounds, and identifying and leading resolution to barriers of efficient patient throughput. Completes a full assessment based on the social work assessment, leading and addressing solutions of social determinants which is accomplished by patient/family interview, review of the medical record including previous episodes of care, H&P, lab and other test results/findings, plan of care, physician orders, nursing and progress

notes. Uses advanced knowledge and clinical expertise and screening tools to identify need for case management and/or social work intervention.

- Addresses and manages conflict associated with a comprehensive psychosocial treatment plan utilizing appropriate clinical social work diagnoses, treatments and interventions, including crisis intervention, brief individual, marital and family therapies, and patient, family and caregiver groups. Maintains ownership of the psychosocial component, assessments, diagnosis and treatment, of the discharge planning process on assigned units. Assists with screening, identification, diagnosis, management and treatment of victims of abuse, neglect, and domestic violence and of mental health and/or substance abuse problems in patients and family members.
- Establishes mutual educational goals with patient and family, providing appropriate resources, incorporating planning for care after discharge. Provides education to physicians and other interprofessional health care team members on mutually identified goals of care and uses knowledge of levels of care, working with patient and family, to ensure discharge disposition is the appropriate level and facilitates transfers.
- Uses knowledge for different levels of care, working with patient and family, to ensure discharge disposition is to the appropriate level and facilitates transfers, Provides brief, goal-directed counseling services to assist patients/families to cope more effectively with the transition.

QUALITY/SAFETY ESSENTIAL FUNCTIONS

- Consistently documents to reflect completed patient screening/assessment and reassessment upon admission and concurrently as needed. Modifies care based on continuous evaluation of the patient's condition, demonstrates problem-solving and critical thinking, and makes decisions using evidence-based analytical approach. Considers variables that impact treatment plans including diagnosis of emotional, social, and environmental strengths and problems related to their illness, treatment and/or life situation.
- Consistently reviews the total picture of the patient for opportunities for care facilitation and needs for discharge planning. Works with case manager for routine discharge and anticipates/prevents and manages/elevates emergent situations with specific focus given to discharge plan and elimination of psychosocial barriers.
- Collaborates with staff from the interprofessional health care team concerning safety data to improve outcomes and the safe transition of care through effective patient handoffs.

FINANCE ESSENTIAL FUNCTIONS

- community resources required for effective transition by demonstrating an effective community resource knowledge base and judgment/ability to effectively select and coordinate available resources, including referrals to regulatory agencies, i.e. CPS/APS.
- Identifies, obtains and utilizes alternative resources to fill gaps in

	established community resources. • Guides discharge planning activities for assigned patients and collaborates with the case managers and other members of the interprofessional health care team, as well as patient and family by intervening and coordinating cost-effective, complex discharge planning outcomes and decreased length of stay. **GROWTH/INNOVATION ESSENTIAL FUNCTIONS** • Provides education to hospital physicians, nurses, and other healthcare providers on community resources and psychosocial impact on care needs. • Identifies areas for improvement based on understanding of evidence-based practice literature. Completes and updates the individual development plan (IDP) on an on-going basis. • Identifies, initiates and leads evidence-based practice/performance improvement projects based on observations by offering solutions and participating in unit projects and activities.
Qualifications	**EDUCATION** • Master Degree in Social Work from accredited University (MSW) **WORK EXPERIENCE** • Three (3) years social services experience in a healthcare setting **LICENSES AND CERTIFICATIONS - REQUIRED** • LCSW- License Clinical Social Worker - State Licensure -- No additional credential needed if LCSW OR • LMSW - Licensed Medical Social Worker - State Licensure -- If LMSW, need one additional credential AND • ACM-SW - Accredited Case Manager-Social Worker (ACMA) OR • CCM - Certified Case Manager OR • ACM - Accredited Case Manager (ACMA) OR • ACM - Accredited Case Manager (NBCM) OR • C-SWHC - Certified Social Worker in Health Care (NASW) **KNOWLEDGE, SKILLS, AND ABILITIES** • Demonstrates the skills and competencies necessary to safely perform the assigned job, determined through on-going skills, competency assessments, and performance evaluations • Sufficient proficiency in speaking, reading, and writing the English language necessary to perform the essential functions of this job, especially with regard to activities impacting patient or employee safety or security

	• Ability to effectively communicate with patients, physicians, family members and co-workers in a manner consistent with a customer service focus and application of positive language principles • Knowledge of community resources and health care financial and payer issues, and eligibility for state, local and federal programs • Maintains individual competencies around critical Social Work functions including; payor rules and regulations, psycho-social assessments and discharge planning methods • Ability to work independently and exercise sound judgment in interactions with physicians, payors, and patients and their families • Well versed in computer skills of the entire Microsoft Office Suite (Access, Excel, Outlook, PowerPoint and Word) • Critical thinking, collaboration, negotiation, and mediation skills • Time management and prioritization skills • Adherence to the clinical practice standards set forth by NASW practice standards for healthcare settings and more specifically in hospitals and medical centers • Maintains level of professional contributions as defined in Career Path program
Salary/Hours	Full-time
Address	18300 St John Dr, Nassau Bay, TX 77058
Application Method	https://www.houstonmethodistcareers.org/job/109066/social-worker-ii-transition-in-care-sunday-wednesday-case-management-social-work-corporate/
Opening Date	Immediately

To post a job opportunity or if your response to this job posting results in successful employment, please email the GCSW Office of Alumni and Career Services at mswjobs@central.uh.edu with the hiring details of your new job opportunity. Thank you.

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