POSITION ANNOUNCEMENT

Position**:** Health Navigator/Care Coordinator, Care Management Services

Function: Responsible for the development and implementation of a comprehensive care coordination plan for assigned caseload.

Reports to: Director, Care Management Services

Tasks:

- Works with client, Primary Care Provider (PCP), supervisor and other members of the care team to identify and prioritize client's health care and psychosocial goals and develop a comprehensive care plan to achieve them
- Responsible for overall management of client's care plan, including coordinating all aspects of care; monitoring and supporting adherence to care plan goals, including medications and other treatments; and documenting care plan progress toward goals
- Administer standardized health and psychosocial risk screening tools
- Uses decision support tools and supervisory support to identify appropriate interventions and health care and social service needs
- Works with client to identify barriers to self-care and self-management, and helps client to develop skill sets to address those barriers
- Supports client self-management goals and activities and intervenes on client's behalf when appropriate
- Works with family members and other collaterals of the client's choice to facilitate planning or delivery of care
- Identifies, facilitates and secures access to needed healthcare, social services benefits and community resources
- Communicates with clients, their families and caregivers to support care plan goals and integrate care delivery
- Facilitates follow-up care after hospitalization or emergency room visit
- Regularly coordinates and communicates with care team members on all care plan activities including referrals, transition care planning, and follow-up tracking
- Works in collaboration with other care team members and care providers, including behavioral health, disease care management, home care, social work and community based organizations, to help client achieve optimal health outcomes
- Provides client with necessary health education and materials
- Provides psycho-education in self-management of specific chronic illnesses occurring at high frequency among Health Home enrollees
- Reviews new information and complex cases with PCP and multidisciplinary team and incorporates additional recommendations into care plan

Qualifications: M.A. in psychology or a related field or a B.A. in psychology or a related field and significant experience in the field.

Fax/mail/email a resume, cover letter and contact information for 3 professional references to:

Kristina Garcia
Director, Care Management Services
Fax: (212)543-0418
Email: kgarcia@acmhnyc.org

ACMH, Inc., promotes the wellness and recovery of persons with mental illness living in New York City and is a leader in the provision of outreach and engagement, care management, rehabilitation, and supportive housing. For more information, visit our website: www.acmhnyc.org

Salary: $45,000 - $49,000 plus Generous Benefits Package