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
- Communicates with Providers to facilitate care delivery by expediting appointments, obtaining information, and arranging for transport to critical healthcare appointments
- Build relationships with clients utilizing motivational interviewing to encourage clients to work towards permanent housing, sobriety, if appropriate, etc.
- Provides time-limited, motivational approaches to promote treatment adherence for chronic conditions and/or behavioral change to reduce risk factors.
- As necessary, assesses domiciled client's living conditions by conducting home visits

- Liaise with Health Home care team staff and other service providers to identify client housing needs
- Delivers housing placement services to clients by completing psychosocial assessments, the HRA 2010e and other appropriate housing applications, as well as securing safe haven if possible, stabilization bed, and ultimately permanent housing
- Documents all client-related contacts and activities, supports Health Home Quality Assurance and SDOH required reporting processes
- Administers CSD funds (Client Service Dollars) and submits required documentation according to agency procedures
- Regularly participates in care team meeting and rounds as needed to review client cases and progress
- Attends in-service training as requested
- Provides coverage as needed for other staff on the program team
- Duties as assigned by supervisor

Qualifications: A Bachelor's degree in any of the following (Master's degree preferred): child & family studies, community mental health, counseling, education, nursing, occupational therapy, physical therapy, psychology, recreation, recreation therapy, rehabilitation, social work, sociology, or speech and hearing; OR A Credentialed Alcoholism and Substance Abuse Counselor (CASAC); OR A Bachelor's level education or higher in any field plus two years of experience in at least one of the following:

- Providing direct services to individuals with serious mental illness OR
- Linking persons who have been diagnosed with serious mental illness to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services.)

Additional requirements per Health Home lead may apply. Spanish speaking a plus.

Salary: $46,350 plus Generous Benefits Package

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

Sharon Royer
Director of Human Resources and Information ManagementCare Management Services
Fax: (212)925-7958
Email: jobs@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