BETHESDA HOUSE OF SCHENECTADY, INC.

Job Description: Care Coordinator
Responsible to: Director of Social Work
Status: Full-time, Exempt

Function:

Bethesda House's Care Coordinator exercises compassion and dedication to serving the vulnerable members of our community. The Care Coordinator will develop a professional and trusting relationship with clients and community providers to ensure coordination and collaboration of services supporting positive outcomes. The Care Coordinator is responsible to provide a full range of services to clients and their families, to include: care coordination and collaboration, advocacy, information/education, referral to community resources and providers, as well as visits to the client's home. Upon enrollment, a Care Coordinator collects information via a comprehensive assessment that will support developing a comprehensive plan of care with the client. The assessment will include their medical and behavioral health needs, substance use history, activities of daily living, their socio-economic and housing status, and provides an opportunity to understand their social determinants of health. Additional responsibilities include conducting and developing a person centered care plan that coordinates and integrates a comprehensive array of a client's needs and services in collaboration with an interdisciplinary care team. The aim is to assist the client in reaching optimal wellness and recovery.

Duties/Responsibilities:

- Conduct an assessment for the establishment of a person centered care plan that coordinates and integrates a comprehensive array of a client's needs and services in collaboration with an interdisciplinary care team.
- Respect all client's right to self-determination and assist in creating a person-centered plan of care.
- Assist clients through the healthcare system by acting as a patient advocate and navigator.
- Maintain regular and consistent contact with clients, care team participants, etc., to support continuity of care and the needs as identified in the Plan of Care. Contact frequency should match the needs of the client as well as provide the core services identified in the plan of care.
- Promotes clear communication amongst care team and treating clinicians by ensuring awareness regarding member care plans.
- Understand the Core Services and how they are delivered to support care coordination.
- Track due dates to ensure quality assurance and compliance with CRHC policy and NYSDOH standards & requirements.
- Complete all documentation within required timeframes (as defined in CRHC Policies). It is the expectation that all interactions with or on behalf of a Health Home client be documented in the electronic health record, and be unique and detailed.
- Be an engaged team member who supports colleagues and department needs. This includes participation in team and department meetings; as well as supervision.

Qualifications:

- Licensed Master Social Work degree with two – three year's experience ***or*** Bachelor's Degree in Human Services or related field with two to five years experience providing services to individuals with chronic medical conditions and behavioral health issues.
- Interest and/or experience working with the homeless population; people who have mental illness and/or substance abuse history.
- Interest and/or experience in working with clients who are difficult to engage and maintain in traditional mental health programs and other service programs.
- Strong written and verbal communication skills.
- Computer literacy.
- Knowledge of agencies, programs, and services in the community.
- Knowledge of eligibility criteria and application process for mainstream/entitlement programs.
- Demonstrated resourcefulness, work independently, take initiative
- Valid, clean NYS Driver's License.
- Own a reliable insured vehicle.

Essential Functions:

- Extensive planning, organizational skills.
- Ability to interview clients to assess decision making, coping skills, and barriers to managing their healthcare needs.
- Must be able to work closely with others and work with members in both routine and stressful situations related to their medical conditions and social determinants of health.
- Ability to work with computers including the ability to work with automated output and the ability to enter and analyze data in automated systems.
- Ability to work with statistical data.
- Ability to work independently, setting priorities to coordinate care plan efficiently. As well as the ability to work in a team environment
- Effective behavioral and educational strategies, including but not limited to, motivational interviewing, teach-back method and self-management support.
- A working knowledge of entitlement programs (SSI, SSDI, Medicare, Medicaid, and Public Assistance) and community resources strongly preferred.
- Knowledge of area agencies and programs serving the homeless and low-income population.
- Ability to work during normal business hours on a regular basis.
- Ability to efficiently and effectively work in a fast paced environment.
- Ability to effectively handle conflict and/or confrontation in order to reach a resolution satisfactory to all parties.
- Ability to work with diverse and challenging clientele.
- Ability to work under deadline pressure to meet established work goals. May also include ability to work hours above normally scheduled hours to accomplish same.
- Ability to effectively communicate (both orally and in written form) with guests, peers, and superiors.
- Ability to represent the agency in a professional manner to all parties with which she/he comes into contact.