The Alliance for Positive Change

Care Coordinator

REPORTS TO: Care Manager

SUPERVISEES: Peer Navigator

EMPLOYMENT STATUS: Full-time Regular, Non-Exempt

PRIMARY FUNCTION: Coordinating care and providing guidance to clients with complex psychiatric and/or co-morbid medical conditions. Develops effective interpersonal relationships with clients and works collaboratively with the interdisciplinary care team to improve health outcomes. Utilizes internal and community resources to educate clients and form a care plan with specific health outcomes.

DUTIES AND RESPONSIBILITIES:

- Works collaboratively with Care Manager to ensure thorough and timely monitoring of approximately 50 clients and their progress toward Care Plan goals.
- Reviews Care Plan with Care Manager and confirms intensity level of identified client to ensure service needs are met.
- Interacts with client and client caregivers to ensure continuity of care, patient adherence to care plans, and identifications of barriers preventing adherence to care plan.
- Tracks all medical, behavioral substance use and other network referrals made for clients and ensures clients follow up on referrals and attend scheduled appointments, through accompaniment when necessary.
- Provides phone and physical outreach to clients who have been non-adherent to necessary treatment appointments or have missed appointments for initial visits with new providers. Makes reminder phone calls to patients for all appointments.
- Provides outreach via phone to clients to ensure appropriate follow up regarding self-care, medication refills, Care Plan adherence, scheduled office visits, test results/lab work, and all other pertinent psycho-social issues.
- Ensures that relevant team members receive important client alerts, including ER visits, hospitalization admission/discharge information and other urgent care notifications.
- Tracks/monitors client progress through a combination of written work, agency databases, health home data system and case conferences with the Care Team. Documents and maintains case records in agency database and completes all data entry in a timely fashion.
- Becomes familiarized with service providers in the Health Home network and maintains a comprehensive list of contact information for key personnel within the network. Always represents The Alliance with the highest level of professionalism and respect.
- Monitors client entitlements, insurance, and other benefits to ensure they remain active and in place. Alerts Care Manager if benefits/entitlements lapse to assist team members with reinstatement of said benefits.
- Participates in initial and ongoing trainings as necessary to maintain a level of knowledge related to serious physical ailments as defined by Health Home regulations.
- Performs other duties as required.
- Attend a minimum of two agency events for clients and one agency fundraising event every 12 month period.

QUALIFICATIONS: Bachelor's Degree in health or human services field required and one-year working with an underserved population through employment, volunteer work, and internships; Experience with chronic disease including HIV/AIDS; Substance user; Mentally Ill; and Lesbian, Gay Bisexual and Transgender (LGBT). Fluency in a second language preferred. Excellent written and verbal communication skills required.