Who We Are

Led by highly successful physician executives with a mission to improve health care quality for underserved populations. Rendr is a primary care-driven, multi-specialty medical group serving approximately 200,000 patients through its 90+ locations in Staten Island, Brooklyn, Manhattan, and Queens. Rendr is a growing physician practice dedicated to serving the Chinese American population throughout the New York metropolitan area. We bring together a group of world-class physicians with a proven executive leadership team and a robust care management platform to deliver the best care possible to this underserved population.

Department: Health Home

Location: New York, NY

Position: Care Coordinator

Rendr is seeking for a Care Coordinator who will be responsible for guiding chronically ill patients through the health care system by assisting with access issues, developing relationships with service providers, and tracking interventions and outcomes. The Care Coordinator will act as the team leader, will provide direct services to patients including the completion of needs assessments, development of patient focused care plans, periodic reassessments, and overall comprehensive service coordination. The Care Coordinator is ultimately responsible for the overall provision and coordination of services to assigned patients caseload.

Essential Functions

- Provides direct service to a caseload of approximately 65+ patients, any collateral person, and their children
- Screens for functional scale eligibility, conducts initial assessments, and periodic reassessments of patients’ needs including medical, mental health, substance use, financial, housing and support needs
- Provides crisis intervention and health education services as needed
- Develops patient focused care plans with documented input and approval from other providers and the patient in compliance with Health Home standards
- Work with the medical staff to develop, implement, and coordinate the care plan for patients with chronic diseases, such as diabetes, asthma, congestive heart failure, hypertension, mental health condition, and substance abuse etc, based on the Health Home chronic disease care coordination model standards
- Conducts home/field visits and maintains patient contact in accordance with program standards
- Coordinates patient services with internal and external service providers through regular case conferencing
- Ensures appropriate record documentation from all members of the case management team
- Assist in coordinating care with pharmacies, insurance companies, hospital discharge planning and other providers in the Network
- Facilitates related services for health center patients as appropriate with respect to their confidentiality and privacy
- Ability to handle protected health information (PHI) in a manner consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Perform other duties as assigned by Manager
Qualifications

• BA/BS Degree is required
• 2 years of care coordination is preferred
• Bilingual in English and Chinese required
• High level of professionalism and strong sense of responsibility
• Good communication skills: kind, compassionate, patient interaction with patients and team
• Multitasking ability

Benefits

• Competitive pay
• A friendly and fast-paced environment working with passionate people
• Medical, vision, dental and life insurance
• Short and Long-Term Disability
• PTO and Paid Holidays
• A Comprehensive Benefits Package
• 401k Plan with Match