



## 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:**

AA degree in social services or related field and one year of experience providing direct service OR a High School diploma/GED with four years experience in the human service field or nursing or CM/Service Coordination. Strong written and verbal communication skills.

**Salary:** \$40,223 -\$48,223 plus generous benefits

Email a resume, cover letter and contact information for 3 professional references to:

**Sharon Royer**  
**Director, Human Resources and Information Management**  
**Email: [jobs@acmhny.org](mailto:jobs@acmhny.org)**

ACMH is committed to the mental and physical wellbeing of vulnerable New Yorkers and is a leader in the provision of outreach and engagement, care management, rehabilitation, and supportive housing.

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