POSITION ANNOUNCEMENT

Position: Health Navigator/Care Coordinator, Care Management Services
Function: Responsible for the assessment and engagement of clients around health and wellness and the development of a comprehensive care plan.
Reports to: Director, Care Management Services
Location: Manhattan/Bronx or Queens/Manhattan
Tasks:

- Develops rapport with clients in order to engage them in improving their health and wellness.
- Administers standardized health and psychosocial risk screenings according to Health Home protocols and timeframes.
- Utilizes health screenings to identify interventions and develop a comprehensive care plan
- Collaborates with members of the care team to identify needs and develop a plan to help client achieve optimal health outcomes.
- Implements tasks outlined on the care plan and ensures follow up and continuity of care between client interactions.
- Regularly reviews and updates the care plan to correspond with services being provided.
- Documents all interventions and attempted contacts in the EHR in accordance with program standards.
- Works in collaboration with care providers to address Gaps in Care
- Assesses domiciled client's living conditions by conducting home visits
- Works with family members and other collaterals of the client's choice to facilitate planning and delivery of care
- Provides comprehensive transitional care following hospitalization events in accordance with ACMH Critical Time Intervention (CTI) Protocols.
- Reviews new information and complex cases with PCP and multidisciplinary team and incorporates recommendations into the care plan.
- Facilitates care delivery by scheduling appointments, obtaining necessary information, and arranging transportation.
- Utilizes evidenced based practices, such as motivational interviewing, to empower clients to grow and attain goals.
- Embraces the team model by collaborating with members of the team and providing support as needed
- Identifies community resources and makes referrals as needed.
- Supports client goals and serves as an advocate on client's behalf
- Administers CSD funds (Client Service Dollars) and submits required documentation
- Regularly participates in team meetings and weekly clinical conference
- Attends in-service training as requested
- Duties as assigned by supervisor

Health Navigator/Care Coordinator Qualifications: **B.A. or M.A.** degree in social services or related field and two years of experience providing direct service in the human service field or nursing or CM/Service Coordination. Strong written and verbal communication skills. Bilingual English/Spanish preferred.

Salary: $56,623 plus generous benefits.

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

Kelsey O'Donnell
Senior Director for Care Management Services
Email: KODonnell@acmhnyc.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, crisis support, and supportive housing. ACMH is committed to becoming an anti-racist organization and seeks to promote actionable change to create an intentional culture of equity at individual, interpersonal and institutional levels.

For more information, visit our website: www.acmhnyc.org