Care Transitions Coach

Care Transitions Coach will use an evidence-based care coordinator process to assure continuity of care and smooth transitions across multiple care settings and practitioners. Coordinator/Nurse will work directly with patients, families, and caregivers providing them with the tools and support that promote knowledge and self-management. Additional responsibilities will include:

* Refining and further developing the project work plan within the first month of project start and maintain as a living document to meet project outcomes and deliverables.
* Functioning as liaison and educator for Care Transition program across multiple care settings and practitioners.
* Monitoring work plan progress relative to timeline and budget and report variances.
* Consulting with hospital discharge planner, physicians, and multidisciplinary team to identify patients who would benefit from the Transitional Care Program.
* Conducting informational sessions with potential Care Transitions participants engaging caregivers when possible and completing enrollment into the program when selected.
* Implementing Care Transitions Intervention (CTI) with high-fidelity to the evidence-based model.
* Conducting assessments of need for community-based service and support and facilitates early linkages when opted.
* Actively consulting and collaborating with hospital multidisciplinary team in planning and executing patient’s care transition.
* Completing a comprehensive patient assessment using valid and reliable instruments that includes evaluation of patients’ physical, cognitive and emotional health status, patients’ and caregivers’ goals and availability and adequacy of family and social support.
* Actively engaging patients and caregivers in the discharge planning process using valid and reliable instruments.
* Directing engagement with patients and caregivers to complete the discharge preparation checklist, personal health record, medication reconciliation, as well as identification of educational needs in chronic disease process and self-management skills.
* Visiting patient 24 hours prior to hospital discharge to ensure that patient and family are fully engaged and prepared for care transition process; visiting patient within 48 hours of transition to home or other care setting to review care transition process.
* Establishing an ongoing plan for home visits and phone contacts specific to patient needs.
* Tracking program and individual performance objectives and routinely reporting on progress and outcomes.

Bachelor’s degree in related field from an accredited college/university, plus a minimum of 3 years of related experience working with the adult population experiencing chronic diseases. Knowledge of geriatrics, home and community-based services and social services preferred, along with a working knowledge of chronic disease self-management and experience working with chronically ill patients to identify patient goals and outcomes and provide education necessary for patient self-management. A valid driver’s license and access to a reliable vehicle are required.

There are two positions available—one in New Kensington and one in Monroeville. Position will work primarily out of one of these two locations; however, travel to Downtown Pittsburgh for meetings will be required.

Interested candidates should submit resume and cover letter stating position title and referral source to:

Diversified Care Management
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