



We are seeking a Community Health Coordinator to provide thirty-day interventions to targeted patients who have been recently hospitalized. The main function of this role will be to identify eligible clients, provide specialized intervention with the goal of preventing avoidable hospitalizations and to empower patients to be the leaders in their healthcare. To accomplish this, the Community Health Coordinator will act as an information and referral source, provide a thirty-day intervention to patients and work with hospitals and health plans to prevent re-admissions. The Community Health Coordinator will also work as a member of the multidisciplinary health care team to assure that discharge planning critical paths are followed, providing for successful care transitions. Additional responsibilities will include:

- Interacting with designated AAA staff, hospital staff and participants when active patients are admitted into the hospital.
- Consulting with hospital discharge planner, physicians and multidisciplinary teams to identify patients who would benefit from the Program.
- Conducting assessments of need for community based service and support and providing referrals.
- Actively consulting and collaborating with hospital multidisciplinary team in planning and executing patient transitions.
- Actively engaging patients and caregivers in the discharge planning process using valid and reliable instruments; including a discharge preparation checklist, personal health record, medication reconciliation process and plan for medical follow-up.
- 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 daily at hospital to ensure that patient and family are fully engaged and prepared for care transition process, including necessary tools and competency in self-management skills.
- Providing additional coaching and education as necessary to assure transition is executed consistent with patient and caregiver goals.
- Visiting patient within 48 hours of transition to home or other care setting to review care transition process including adhering with discharge preparation checklist, evaluating self-management skills, medication reconciliation, caregiver knowledge and self-management skills. Recognizing and addressing red flags and planning for medical contact and follow-up.
- Establishing an ongoing plan for home visits and phone contacts specific to patient's needs.
- Tracking program and individual performance objectives and routinely reporting on progress and outcomes.

- Actively participating in readmission reviews with hospital staff and health plans.

Education/Experience Requirements:

Bachelor's degree from an accredited college/university in human services, plus a minimum of 2 years experience working in the human services field.

OR

Any equivalent combination of education and experience that meets the required knowledge, skills and abilities.

The ideal candidate will be knowledgeable in geriatrics, with respect to home and community-based services and social services and have experience working with chronically ill patients to identify patient goals and outcomes and provide education necessary for patient self-management. A candidate with a strong understanding of a coaching model with the ability to train others in this discipline and apply various coaching methodology to cases is also preferred. Strong communication skills, both oral and written are essential, as the Community Health Coordinator will be expected to interact and engage with participants/family members/caregivers/direct care workers in addition to working collaboratively with other health care professionals to assure coordination and continuity of patient care. To be successful in this role, the desired candidate should be highly organized, possess strong time management skills, be proficient in Microsoft Office products, including Word, Excel and PowerPoint and be able to work as part of a team as well as independently with minimal supervision. At times, this position will require work to be done during non-traditional hours on an as needed basis. Valid driver's license and access to a reliable vehicle are required for local travel.

Salary: \$35,000 per year

Interested candidates can complete an application and submit a resume at
https://glbridcm.ourhcm.com/System/Start_public/pub_index.aspx

****If hired for a position, candidates would work for Allegheny County, Department of Human Services and be employed by Diversified Care Management.***

About Allegheny County Department of Human Services (DHS)

In Allegheny County, we appreciate people who think big, act boldly, and care about making a difference. You don't have to be from here to feel at home, or to make your mark. With only 1.3 million people in the County, it's small enough for motivated people to get things done. Allegheny County's Department of Human Services (DHS) is a perfect place to get things done that directly affect people in need in a positive and lasting way. We help children grow up safer and healthier, older adults remain

able to live independently, and neighborhoods to thrive. Our mission is to improve the health and well-being of people in Allegheny County.

DHS is the largest agency in Allegheny County government, with a budget of nearly \$1 billion. DHS serves over 200,000 people a year through services that include: Protecting children and youth from abuse and neglect and preventing future occurrences of maltreatment; improving child wellness through family support, home visiting, early intervention and in-home services; providing treatment for behavioral health issues such as substance use disorders and mental illness; managing the care of adults with intellectual disabilities; preventing unnecessary nursing home stays; and services that prevent homelessness and provide shelter and housing for families and individuals.

Why DHS?

- It is innovative. Most recently, the national attention and awards we've gotten are for how DHS integrates data and uses them to improve the safety and well-being of children through tools that support front-line staff in making decisions (using predictive analytics).
- DHS is diverse, but we strive to be even more inclusive. Our director has made it his top priority that DHS is "the kind of place where a diverse group of talented people want to come, grow, and do their best work." This includes equity in hiring and advancement, as well as in unleashing the creativity and ideas of staff at every level of DHS.
- It has strong, assertive leaders. We do not hire yes-people.

You can make a big impact here. We stand out as one of the best human services organizations in the country. But we need problem-solvers, innovators, and terrific leaders to make sure we are smart in how we use our funding so that we reach the people who most need our help to make their lives better.

"DHS strives to be the kind of place where a diverse mix of talented people want to come to grow and do their best work."

-From the organization's statement on Equity and Inclusion

AN EQUAL OPPORTUNITY EMPLOYER - M/F/V/D