The Care Coordinator supports and promotes LACHC’s mission to follow Christ by loving and serving our neighbors through comprehensive, quality healthcare. The Care Coordinator will work with clinic patients to coordinate the full range of physical health, behavioral health, and community-based services, including long-term services and supports (LTSS). The Care Coordinator is accountable for assessing clients’ needs, coordinating with indicated entities in order facilitate authorization as required and access to identified needed physical health care, behavioral health care, and community-based supportive services, including LTSS, as necessary to support the achievement of individualized health action goals.

**ESSENTIAL DUTIES and RESPONSIBILITIES** include:

- **Outreach/Engagement Activities:**
  - Use evidenced based outreach strategies to locate clients and link them to care.
  - Use effective communication skills such as active listening and reflective listening to build rapport with vulnerable and difficult-to-engage clients, including clients who are homeless.

- **Assessment:**
  - Interview and assess clients to identify biological, psychological, social, and economic factors which may interfere with attaining stability and optimum health.
  - Evaluate each client’s past, present, and future medical, psychological, social, and economic functioning as indicated.
  - Assess each client’s stage of change and readiness for self-management.

- **Care Planning:**
  - Utilize information obtained from completed assessments as well as client input to formulate and develop comprehensive, individualized, and person-centered care plans that are based on the needs and desires of each client and that incorporates each client’s physical health needs, behavioral health needs, social service needs, including any community-based LTSS;
  - Monitor status and completion of care plan objectives; and
  - Reassess individualized care plans based on each client’s progress and/or changes in their needs.

- **Care Coordination:**
  - Utilize appropriate motivational interviewing interventions to effectively address each client’s current stage of change.
  - Apply clinical and behavioral interventions, such as motivational interviewing, that decrease and, if possible, prevent complications as well as optimize disease control and patient well-being.
  - Promote self-management skills in order for each client to demonstrate an ability to effectively engage with health and service providers as well as to achieve self-directed, individualized health goals that promote recovery, improved functional and/or health status, and/or prevent or slow declines in functioning.
  - Engage in care coordination activities as indicated, which may include:
- Medication monitoring:
- Monitoring and encouragement of treatment adherence/compliance by clients;
- Managing referrals, coordination, and follow-up for identified services and supports, including DME.
- Coordinating discharge/transition of care, which can include working with hospitals to create a process for prompt notification of each client’s admission or discharge to/from an emergency department, hospital inpatient facility, residential/treatment facility, or other higher-level of care facility.
- Ensuring appropriate care at level of care transitions by providing evidence-based transition planning, which may include:
  - Obtaining a summary care record or discharge summary;
  - Reconciling medications;
  - Planning related to the timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners; and
  - Supporting clients and each client’s support system during discharge from hospital and institutional settings.
- Assisting clients with linkage and access to vital and appropriate resources per eligibility status, such as:
  - Housing;
  - Substance abuse treatment;
  - Mental health care; and
  - Public benefits.
- Housing navigation:
  - Assisting clients with accessing temporary and/or permanent housing;
  - Providing assistance with completing applications for permanent housing, which includes completing and submitting VI-SPDATs or an update to an existing VI-SPDAT per established CES protocols.
- Substance abuse referrals:
  - Complete substance abuse referrals for the indicated level of care, such as detox, outpatient individual/group treatment, and residential treatment, per existing protocol.
- Mental Health referrals:
  - Complete mental health referrals for the indicated level of care/service, such as FCCS and FSP.
- Public Benefits:
  - General Relief (GR);
  - CalFresh (food stamps);
  - IHHS;
  - CBEST;
  - Supplemental Security Income (SSI);
  - Social Security Disability Insurance (SSDI);
  - Medi-Cal enrollment; and
  - Veterans Administration benefits for eligible homeless individuals.
- Providing client assistance with requesting copies of birth certificates and other identification as needed.
- Assisting each client, as indicated, with locating and obtaining transportation to/from appropriate medical and/or social service appointments.
  - Health Promotion/Education
    - Ensuring that each client is knowledgeable about their condition(s), by providing culturally-appropriate information that meets health literacy standards, in order to encourage and promote their adherence to treatment.
      - Providing health education on appropriate and condition-related topics, such as: nutrition, disease management, and treatment compliance.
    - Advocating for each client to identify and obtain needed resources that support their abilities to meet their individualized goals, including:
      - Providing education and support for each client and identified support system to attain and improve self-management skills.
    - Assisting each client with goal-setting and problem-solving behaviors for improved self-management.

- Continuity of Care
  - Participate in case conferences to:
    - Ensure that all identified biopsychosocial areas, including environment factors, are addressed with care coordination and medical treatment planning;
    - Ensure that each client’s care is continuous and integrated among all service providers; and
    - Coordinate activities and communication among each client’s multi-disciplinary treatment team.
  - Promote timely processing of each client’s:
    - Specialty/subspecialty referrals;
    - Communicating with internal department and/or outside care agencies as well as IPA/health plans, as applicable, to initiate referrals and to ensure appointment obtainment; and
    - Record requests for these referrals/appointments.
  - Coordinate with authorizing and prescribing entities as necessary to reinforce and support each client’s health action goals;
  - Accompany identified clients to critical appointments;
  - Enter all appropriate data into the Homeless Management Information System (HMIS), following the criteria set out by HUD for data elements and the workflows set by the Los Angeles Homeless Services Authority (LAHSA);
  - Attend community meetings, such as CES case conferencing, as indicated; and
  - Document all evaluations, care plans, interventions, and referrals performed per established EHR processes.

- Other duties as assigned.

QUALIFICATIONS
To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.
- CPR Certification required.
• Bi-lingual Spanish preferred

**EDUCATION and/or EXPERIENCE**
Bachelor’s degree in social work or related field from a four-year college or university. Two years of social work experience is preferred. Prior case management experience is preferred. Prior experience working with the homeless, substance using, or chronically mentally ill individuals is preferred.

**COMPUTER KNOWLEDGE**
Experience with *Electronic Health Records*, Microsoft Word, Microsoft Access, and Microsoft Excel is preferred.

**LANGUAGE SKILLS**
Familiarity with medical terms and operations of clinics is useful. Proficiency in English required, Bi-lingual/ Bi-literal Spanish is preferred.

Full-time, Non-Exempt position with Medical, Dental, Vision, and 403B Retirement Plan with Employer match. We are an equal opportunity employer and will consider candidates with criminal histories.