

United States Jobs Expertini®

Transition Coordinator - QP (Multiple Counties)

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Company: Vaya Health

Location: United States

Category: other-general

LOCATION: Remote – must live in or near Rowan, Stokes, Rockingham, Caswell, Person, Granville, Vance, Franklin, Alamance or Chatham County, NC.

GENERAL STATEMENT OF JOB:

The Transition Coordinator QP (TC) is responsible for providing proactive coordination of services to persons residing in or being diverted from institutionalized settings prior to their transition to home and community-based services. These services prepare members/recipients for discharge and assist during adjustment period immediately following discharge from an institution. This is a mobile position with work done in a variety of locations. The Transition Coordinator QP will work with members/recipients in their communities.

Note: This position requires access to and use of confidential healthcare information or protected health information (PHI) as described in laws addressing patient confidentiality, including, but not limited to, the federal HIPAA law, the Confidentiality of Alcohol and Substance Abuse Patient Records law, 42 CFR Part 2, and various state laws. As such, the individual filling this position shall be required to be trained regarding such laws and shall be required to observe those laws in his/her capacity as an employee of Vaya Health. The individual filling this position shall also sign a confidentiality statement as an employee of Vaya Health.

ESSENTIAL JOB FUNCTIONS:

Benchmarks:

Transition Planning

Must be able to manage an active caseload of member/recipients/recipients in transition planning.

Will work with manager to create a yearly target number of successful transitions based on state benchmark.

Ensure that the Pre-Quality of Life survey is completed prior to lease signing date.

Educate providers of tenancy support about their respective roles and responsibilities and of the TC's role and restrictions.

Adheres to boundaries within the In Reach, Transition, Diversion policy and does not provide services or supports outside of the scope of work.

Monitoring

Ensure that monthly updates are received for transitioned members/recipients and submit auditing tool by deadline.

Work alongside community providers (i.e., tenancy support, medical health, etc.) to ensure they are providing needed services

Transition Planning:

Transition Planning Process:

The Transition Coordinator QP will work alongside the Transition Coordinator LP to ensure that any member/recipient who wishes to move to a more inclusive setting, from the adult care home or state psychiatric hospital, is provided with clinically indicated and appropriate behavioral health services and supports and In Reach staff, care management, and other Vaya departments necessary to ensure transition/discharge planning begins at admission to the facility. The Transition Coordinator QP will assist in developing the transition team.

To facilitate a successful transition, the Transition Coordinator QP:

Meet with the member/recipient, conduct clinical record review, and ensure completion of necessary assessments as needed. An assessment includes but is not limited to: diagnostic assessments, comprehensive clinical assessments, and psychological evaluations.

Assists the member/recipient in developing an effective written plan which will include linkage to necessary treatment and crisis planning to enable the member/recipient to live

independently in an integrated community setting;

Networks with the member/recipient and the member/recipient's family and supports to develop a thoughtful, organized, holistic transition plan that addresses his/her community-based support needs;

Ensures discharge/transition planning is developed and implemented through person-centered planning processes in which the member/recipient has a primary role and is based on the principle of self-determination while considering safety and well-being;

Coordinate with the member/recipient, his/her family and supports to identify and secure the Community resources necessary to transition. Following basic hierarchical needs this includes but is not limited to: housing, behavioral health services, medical care, financial management, safety and security, and other community supports that are needed for community living;

Develop diagnostic impression prior to linkage of services to ensure clinically appropriate services are in place during transition.

Use motivational interviewing techniques to ensure a thorough North Carolina Person Centered Plan (NCPCP) is developed;

Foster communication with institutions, provider agencies, and other community and natural supports that will be involved in the transition.

Diversion:

Transition Coordination function assumes responsibility for being responsive to the transition needs identified through the Department of Justice diversion process, ensuring a member/recipient requiring diversion from an Adult Care Home via the Referral Screening Verification Process (RSVP). The Transition Coordinator QP then assists the member/recipient through the transition planning process. This requires brokerage with high end stakeholders such as hospitals, institutions, and other community stakeholders.

Each transition experience is unique and may require multiple meetings of the team members or ongoing communication to ensure the transition process occurs in an organized, timely manner. In collaboration with the member/recipient and the transition team, the Transition Coordinator is responsible for establishing a transition team planning meeting schedule

that effectively meets the needs of the particular transition. Use of therapeutic intervention may be necessary to evolve and stabilize a member/recipient's transition experience.

The Transition Coordinator QP has responsibilities throughout the transition, including on transition day. He/She must be available to the transition team, including in person participation and will ensure move-in logistics have been arranged either directly or in partnership with other teams within the LME/MCO (i.e. Housing specialists).

Follow along is also part of the transition process. Follow along should be sufficient to ensure that a person's clinical and basic needs are identified and addressed in a timely way that ensures the member/recipient does not lose critical services or housing.

Documentation

The Transition Coordinator QP is responsible for clear and concise documentation of the transition process for each member/recipient. This documentation will serve to inform the local organization, state, and federal government. All contacts and interventions will be documented in the member/recipient's administrative health record.

Collaboration:

The Transition Coordinator QP will have ongoing, respectful communication with all members/recipients involved in the transition process. The Transition Coordinator QP will work closely with the In Reach staff, care coordination, hospital liaisons and other Vaya departments necessary to create, implement and fulfill successful transition planning with members/recipients. The Transition Coordinator QP will also be involved in education with members/recipients, families, providers, and stakeholders associated with Transitions to Community Living.

Other duties as assigned.

QUALIFICATIONS & EDUCATION REQUIREMENTS:

Bachelor's degree in a Human Services field and two (2) years of post-bachelor's degree accumulated experience with the population served, or a bachelor's degree in a field other than human services and four (4) years of full-time, post-bachelor's degree accumulated experience with the population served.

PHYSICAL REQUIREMENTS:

Close visual acuity to perform activities such as preparation and analysis of documents; viewing a computer terminal; and extensive reading.

Physical activity in this position includes crouching, reaching, walking, talking, hearing and

repetitive motion of hands, wrists and fingers.

Sedentary work with lifting requirements up to 10 pounds, sitting for extended periods of time.

Mental concentration is required in all aspects of work.

KNOWLEDGE, SKILL & ABILITIES:

A high level of diplomacy and discretion is required to effectively negotiate and resolve issues with minimal assistance. This will require exceptional interpersonal skills, highly effective communication ability, and the propensity to make prompt independent decisions based upon relevant facts. Problem solving, negotiation, and conflict resolution skills are essential to balance the needs of both internal and external customers. Must be highly skilled at shifting between macro and micro level planning, maintaining both the big picture and seeing that the details are covered.

The Transition Coordinator QP must have considerable knowledge of the MH/SU/IDD service array provided through the network of Vaya providers. Additional knowledge in Vaya Medicaid B and C waivers and accreditation is helpful.

The employee must be detail oriented, able to organize multiple tasks and priorities, and to effectively manage projects from start to finish. Work activities quickly change according to mandated changes and changing priorities within the department. The employee must be able to change the focus of his/her activities to meet changing priorities.

Proficiency in Microsoft Office products (such as Word, Excel, Outlook, PowerPoint, etc.) and Vaya information system is required.

RESIDENCY REQUIREMENT:

This position is required to reside in North Carolina or within 40 miles of the North Carolina border.

SALARY: Depending on qualifications & experience of candidate. This position is non-exempt and is eligible for overtime compensation.

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