POSITION DESCRIPTION

Senior and Disability Services
Hospital Transition Coordinator

Hospital Transition Coordinator
EMPLOYEE NAME: _____
Position Title: Hospital Transition Coordinator
Division/Unit: Senior and Disability Services / Case Management
Classification/Salary Range: Hospital Transition Coordinator / SEIU Range 17.92
Supervisor: Unit Manager
FLSA Status: Non-Exempt, Overtime eligible
Representation: SEIU
Position Location: Schaefers: 1015 Willamette, Eugene, OR, or S&DS satellite offices, at hospital sites, in-home, at facilities, or other locations as needed

Position Purpose

The Hospital Transition Coordinator provides long term care service intakes, case coordination, and transition services to eligible seniors and people with disabilities who are patients of, or located in PeaceHealth Sacred Heart Hospital, University District or Riverbend. The PeaceHealth hospital Care Management team will identify and prioritize patients in need of the Hospital Transition Coordinator's dedicated support. This is a specialized position that will work closely with the hospital staff, Coordinated Care Organizations (CCO) partners, long term care facilities, natural supports, and other community-based resources to help patients access long term care service plans and placements.

Note: Essential competencies of this job are described under the headings below. They may be subject to change at any time. The omission of specific statements of duties does not exclude them from the position, if the work is similar, related, or a logical assignment to the position. The job description does not constitute an employment agreement between the employer and employee.

Position Essential Functions

Takes lead on full Case Management and transition services to hospital patients that are eligible for Aging and People with Disabilities (APD) long term care benefits. This includes service planning, placement search, and all aspects of case coordination associated with achieving a successful transition from the hospital setting.

Assists the consumer and/or representative(s) to develop an individualized transition plan.

Facilitates care conferences with client and/or representative or guardian, medical providers, social workers, therapists, and other providers to support an appropriate service plan.

Works with Hospital staff daily and travels to local hospital sites as needed to support expedited discharges.

Provides services by telephone and in person and in a variety of settings (e.g., hospital, office, client's home, licensed long-term care facility).

Collaborates with hospital social work and medical teams, community partners, and S&DS case management staff to address barriers to the discharge plan.

Coordinates with the Complex Case Team at APD Central Office to support appropriate placements for consumers who have complex care needs. This process involves working closely with specialized providers throughout Oregon who have an enhanced care or specific needs contract with the state.

Assists S&DS service intake team, as needed, to ensure timely expedited hospital intakes. This includes comprehensive initial needs assessments of client functioning and benefit eligibility.

Meets with prospective clients and/or their families; provides thorough explanation of services, policies, and assistance available; performs comprehensive assessment of client functioning, resources, and needs; assesses client's ability to perform daily living activities, medical issues, and needs and develops an initial care plan.

Ensures that all necessary forms are fully completed, signed, and dated; provides explanation of applicant's rights and responsibilities.

Locates qualified providers locally and across the State of Oregon who can meet the consumers' needs. Contacts service providers to initiate a care plan and negotiates payment for services provided.

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Completes and routes all necessary authorizations for state payment to in-home providers, community-based facilities, and nursing homes.

Enters client's psychosocial assessment into state computer system; provides complete description of client's functional status and care plan.

Maintains accurate records to ensure proper evaluation and documentation of services. Enters thorough, objective, and timely progress notes that capture the most pertinent information for each client contact.

Uses a significant number of computer programs and prepares a variety of records and reports to meet program requirements.

Provides consultation and training, as needed, to departments within the hospital and to Sacred Heart Home Health Services.

Attends weekly meetings with the social work department to discuss all difficult discharges, and staffs cases with specific social workers as needed.

Responds to a high volume of daily phone calls.

Responds to Hospital Care Management information requests within 48 hours.

Provides empathetic, trauma-informed case management services that are sensitive to underlying causes of challenging behaviors. Meets clients where they are in service plan development and implementation.

In cases of suspected abuse, exploitation, or neglect, determines the need for referrals to Adult Protective Services and, when warranted, makes referrals.

Provides advocacy and direct support services including crisis intervention and short-term counseling. Helps to resolve problems or emergencies affecting the

availability or quality of services and makes appropriate community referrals to support client well-being.

Remains current on other agencies, community resources, service organizations, and programs available in the area, and provides resource and referral support to clients and partners.

Maintains up-to-date knowledge of a broad array of agency, state, and federal rules, regulations, policies, and procedures; reviews manual releases and/or memos (on-line or in hard copy form) for accurate processing; obtains clarifications as needed.

Acts as liaison between S&DS and community partners; establishes and maintains effective working relationships and promotes S&DS programs, as appropriate.

Other Duties of Position

Works with other project staff, policy teams, and/or resource developers to recommend and implement strategies to minimize barriers to adequate participant services.

Attends S&DS meetings, applicable hospital meetings, and local and state training programs.

Represents S&DS on community and inter-agency committees.

Is available by cell phone.

Provides on-going education and occasional training to hospital employees.

Provides back-up support to other positions in the office in case of absence or work overload.

Commitment to working effectively and collaboratively with clients and colleagues from diverse backgrounds, in support of an inclusive and respectful environment.

Works to participate in the learning environment within the division.

Regular and on-time attendance.

Other duties as assigned.

Minimum Qualifications

Any combination of education and experience that provides the applicant with the skills, knowledge, and ability required to perform the job. This may be demonstrated in many ways, which may include a Bachelor's degree in social work or related field, and three years of progressively responsible experience working within Senior and Disability Services or DHS working with seniors or people with disabilities.

Valid Oregon State driver's license.

Passing a background check is required for this position.

Knowledge, Skills & Abilities

Demonstrable skill serving at-risk populations.

Working knowledge of community resources to support clients with complex behavioral health needs.

Demonstrable skill with risk assessment and crisis management.

Ability to document client interactions objectively and thoroughly.

Excellent written and oral communication skills.

Ability to think creatively and respond to a changing environment.

Organized and able to manage time wisely.

Cooperative and collaborative attitude.

Ability to establish and maintain effective working relationships.

Ability to work independently and as a member of a team.

Demonstrates sensitivity to the issues associated with low income, disability, diversity, and aging.

Ability to communicate effectively with participants, volunteers, and community members to promote their participation or resolve their concerns with professionalism and respect.

Ability to organize, plan, and coordinate multiple tasks with attention to detail; handle multiple interruptions, maintain focus on tasks, and produce accurate work.

Signatures

Employee signature and date_____

Manager signature and date_____

Human Resources signature and date_____