NEW RIVER VALLEY AGENCY ON AGING
JOB DESCRIPTION

POSITION TITLE: Care Coordinator / Options Counselor

SUPERVISED BY: Aging and Disability Services Supervisor

JOB SUMMARY: Care Coordination is a direct service position with the primary emphasis on a comprehensive assessment of client's need for social and health services, developing care plans, arranging for service delivery and working with clients to monitor and reassess to determine if needs are being met.

Options Counseling provides person centered needs assessments, counseling and referrals, preliminary care planning and short term tracking based on consumer needs, preferences and situational context for persons in need of long term care supports.

JOB REQUIREMENTS:

- This position requires confidentiality in the handling of all client files, both paper and electronic, as outlined in the Agency's Privacy Protection Policies & Procedures.
- The person in this position is a mandated reporter of suspected abuse and neglect.
- The person in this position must have the ability to safely lift up to 50 pounds of materials and/or supplies as needed.
- The person in this position must have a valid driver's license and be able to drive within the New River Valley and outside of the New River Valley as needed for job related work.
- The person in this position is subject to criminal background checks and pre-employment drug screenings.

KNOWLEDGE, SKILL AND ABILITIES REQUIRED FOR POSITION:

- Aging and the impact of disabilities and illness on aging.
- Conducting client assessments (including psycho-social, health and functional factors) and knowledge of their uses in care planning.
- Interviewing techniques.
- Consumer rights.
- Local human and health service delivery systems, including support services and public benefits eligibility requirements.
- The principals of human behavior and interpersonal relationships.
- Effective oral, written and interpersonal communication principles and techniques.
- General principles of record documentation, both paper and electronic.
- Service planning process and the major components of a service plan.
- Negotiating with consumers and service providers.
- Observing, recording and reporting behaviors.
- Identifying and documenting a consumer's needs for resources, services and other assistance.
- Identifying services within the established services system to meet the consumer's needs.
- Coordinating the provision of services by diverse public and private providers.
- Analyzing and planning for the service needs of elderly persons.
- Demonstrate a positive regard for consumers and their families.
- Be persistent and remain objective.
- Work as a team member, maintaining effective inter- and intra-agency working relationships.

- Work independently, performing position duties under general supervision.
- Develop a rapport and to communicate with different types of persons from diverse cultural backgrounds.
- Ability to learn the services and programs offered by the Agency on Aging.
- Ability to effectively use the Agency's electronic assessment tool, while conducting in-home assessments and reassessments.
- Ability to communicate effectively with persons of different socioeconomic backgrounds.
- Ability to learn the geography of the Planning District, to read maps and to drive.
- Ability to prepare statistical reports.
- Ability to perform computer functions; primarily but not limited to use of Microsoft Word, Excel, PowerPoint and specific software used to capture client information.

EDUCATION AND/OR EXPERIENCE LEVEL:

- A Bachelor's Degree in a health & human services field or Bachelor of Social Work (BSW) degree (preferred) or Registered Nurse or Licensed Practical Nurse.
- A minimum of one year experience working with older adults and/or individuals with disabilities.
- Experience communicating with individuals who have complex medical needs, the elderly, individuals with physical disabilities, and/or those who may have communication barriers.
- Good listening, interviewing and communication/interpersonal skills.
- Excellent computer skills.

DUTIES:

- Client follow-up regarding changes in service.
- Assesses the needs of potential clients for health and social services and prepare a plan for clients.
- Maintain the required records for operation of a central care coordination file to assure follow-up, reassessment, and as necessary, adjustment of client services.
- Maintain timely documentation in electronic client files.
- Refer individuals to other needed social and medical services as appropriate.
- Take referrals, as needed, for older adults and individuals with disabilities in need by responding to telephone calls, walk-in or e-mail inquiries from family and friends, social service and community agencies, hospitals and physicians.
- Participate in staff meetings.
- Maintains case load of clients receiving comprehensive case management services.
- Maintains required documentation, both paper and electronic, for case management system and Care Transitions Intervention Program.
- Ongoing professional development (trainings, seminars, in-services).
- Provide some Care Transitions Coaching to Medicaid clients. This additional training would be provided by the agency.
- Other duties as assigned.

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09/2018