Outreach Coordinator
(Access to Care Program, Suffolk County, NY)

The Outreach Coordinator (OC) is responsible for providing outreach and engagement activities for clients referred by the Health Home, network partners or other sources. The Outreach Coordinator identifies, screens, and enrolls eligible clients to ensure access to Options care coordination program which promotes linkage development and monitors the effectiveness of linkages with other service providers. The OC provides support for the team and is responsible for ensuring that documentation and billing records for outreach/engagement and care coordination activities are complete and up to date.

Responsibilities

- Conduct client outreach and engagement monthly;
- Take the lead in tracking and coordinating clients outreach activities;
- Conduct screening for Health Home eligibility, initial intakes and health risk assessments for eligible clients to document strengths, needs, goals, and resources within Health Home timelines;
- Maintains a caseload of clients that are either newly enrolled or transitioning between Care Coordinators.
- Ensure all client contacts, home visits and back up documentation are completed in a timely manner according to program standards;
- Plan and evaluate service plans and monitor objectives in a consistent manner;
- Write progress notes daily; enter into the electronic medical records management system in a timely manner in accordance with Health Home standards;
- Educate client and family on health and human service resources, assist in obtaining services, and follow-up on service delivery on a weekly basis;
- Maintains effective communication with service providers, family, and collateral resources in a professional manner;
- Assist client with completing applications and/or letter writing on a regular basis;
- Appropriately intervene in situations requiring immediate attention (i.e. crisis planning and intervention) to ensure safety of clients and family;
- Assist clients with problem-solving activities;
- Attend community meetings, events and networking opportunities;
- Maintain at least the minimum billing standards for the Health Home (i.e. perform 1 core service per month as necessary);
- Serves as a member of a Care Coordination team, including interacting frequently with the members of the team to ensure coordinated activities; attending and participating in team meetings to provide feedback/input regarding client status, update plans and goals, review outcomes to further program goals;

- Participate in quality improvement initiatives as appropriate;
- Must use own vehicle to travel to meet clients.

Qualifications and Requirements

- Bachelor's degree in healthcare or human services and at least two years of qualifying experience.* A master's degree in healthcare or human services may be substituted for one year of experience.
- Experience conducting outreach is preferred.
- Spanish speaking preferred.
- A valid driver's license and safe driving record are required.
- Must maintain valid First Aid/CPR and Narcan certifications.

*QUALIFYING EXPERIENCE: verifiable full or part-time case management or case work with persons with HIV, AIDS, mental illness, homelessness, chemical dependence, chronic illnesses, or other populations of persons in need.

Work Schedule:

Monday through Friday (35 hours/week); some evenings and weekends on occasion
8:00 am – 4:00 pm,
8:30 am – 4:30 pm, *or*
9:00 am – 5:00 pm

Benefits

Full-time Employees are eligible for:

- Medical, Dental, and Vision Insurance
- Tuition Assistance
- Flexible Spending Account
- Long-term and Short-term Disability
- Supplemental Specified Illness Coverage
- Supplemental Hospitalization Coverage
- Life Insurance
- 4 Personal Days, 10-22 Vacation Days, 8 Sick Days, 10 Paid Holidays-yearly
- 403(b) retirement plan with employer match

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