NEGRC
Northeast Georgia Regional Commission

Nursing Home Transition Coordinator
(Announcement)
April 27, 2023

The Nursing Home Transitions Coordinator is responsible for managing eligible participants' successful transition from an institutional setting (i.e., Skilled Nursing Facility, Hospital) back into the community. Transition Coordinators leverage NHT Transition Services, community-based services, and expanded circles of support to achieve the transition from these institutions based on a proscribed care plan and maintain support for 365 days after the day of transition.

Required:

- Education: Bachelor's Degree, Associate's Degree, or a Registered Nurse.
- Experience: A minimum of one year in a Human Services position is required. Prefers a candidate with experience in Nursing Home Transition, Care Transitions, Information & Referral/Assistance, Options Counseling, or related fields.

Preferred:

- Identify patient/family needs and ensure that patient/family members have adequate information to participate in transition planning.
- Initiate and maintain communication and collaboration with social workers, staff nurses, other caregiving disciplines, and patients/families to develop, implement, and evaluate a transition plan of care for each patient.
- Assess the complexity of care needs and potential/actual issues or gaps in care.
- Arranges post-discharge medical and community referrals for patients with health problems requiring further evaluation and/or additional services.
- Advocates for patients and families within the health care system with community providers and across the continuum of care.
- Comfortable with technology such as mobile platforms and data systems.
- Knowledgeable of Nursing Home operations.
- Experience with managing caseloads and/or projects of comparable size and scope.
- Knowledge of Community Medicaid resources (Waivers).
- Understanding of Person-Centered Philosophy, Person Directed planning and/or case management.
- Establishes and maintains a culture of productivity, team effort, and strong positive work ethic.
- Function as the communication link for the Aging and Disability Resource Connection Department on issues that relate to Nursing Home Transition.
- Prepares and submits, as appropriate, all necessary department reports to include employee time sheets, leave requests, and monthly/quarterly departmental reports.
- Develops and implements an ongoing program of marketing and outreach to the AAA's target population(s) including people who are isolated or otherwise hard to reach, to inform them of the availability of services.

This position will report to the NEGRC's Aging and Disability Resource Connection Senior Manager. The range for starting annual salary is $49,335– $59,202 based on experience and qualifications. A competitive benefits package is provided.

To Apply:

Send a complete resume and cover letter to: Amber Bailey, NEGRC Human Resource Manager, at frontdesk@negrc.org. Applications can also be mailed to: NEGRC, Attn: Amber Bailey, Human Resource Manager, 305 Research Drive, Athens, GA 30605-2795.

Review of received resumes will begin on June 13, 2023, and continue until the position is filled. No telephone inquiries are accepted.

The NEGRC is an Affirmative Action/Equal Opportunity Employer.

NURSING HOME TRANSITION DUTIES AND RESPONSIBILITIES

- Establishes and maintains a culture of productivity, team effort, and strong positive work ethic.
- Functions as the communication link for the Aging and Disability Resource Connection Department to the Regional Commission on all appropriate information flow.
- Prepares and submits, as appropriate, all necessary department reports to include employee time sheets, leave requests, and monthly/quarterly departmental reports.
- Assuring the office staff's training and educational requirements are maintained and/or addressed as appropriate.
- Accurate and timely maintenance of employee performance evaluations as per human resources requirements.
- Updates and maintains all written office procedures.
- Identify patient/family needs and ensure that patient/family members have adequate information to participate in transition planning.
- Initiate and maintain communication and collaboration with social workers, staff nurses, other caregiving disciplines, and patients/families to develop, implement, and evaluate a transition plan of care for each patient.
- Assess the complexity of care needs and potential/actual issues or gaps in care.
- Arranges post-discharge medical and community referrals for patients with health problems requiring further evaluation and/or additional services.
- Coordinates and delegates as appropriate monthly community meeting attendance.
- Performs initial and follow-up telephone screening to assess functional abilities and to gather personal and financial information.
- Refers clients to appropriate resources based on their requests and/or their individualized needs.
- Documents requests for services and fulfillment of requests, referral sources, and refusal of services.
- Re-screens all clients on the waiting list everyone hundred and twenty days by updating the entire DON-R to determine continued eligibility for services.
- Maintains and updates the waiting list for aging services.
- Maintains records of all referrals received through Aging and Disability Resource Connection line, mail, facsimile, or walk-in.
- Collaborates with computer specialist(s) to create databases and information technology required for processing referrals.
- Conducts cross-training for agency staff.
- Conducts community education sessions to consumers, provider and community groups.
- Collaborates with the AAA Resource Specialist to maintain an accurate, up-to-date database of available community resources for all older adults including mental health and developmental disability resources.
- Maintains confidentiality of consumer information.
- Collaborates with the Lifelong Planning Specialist to provide long-term care counseling services, such as futures planning on long-term care needs for families.
- Develops and implements an ongoing program of marketing and outreach to the AAA's target population(s) including people who are isolated or otherwise hard to reach, to inform them of the availability of services.