

Transition Coordinator

School of Medicine Position Summary Template

Position Summary: *Provides coordination of services related to transition age patients, which include assessments, case management, referrals and overall program development. This role will be a liaison between pediatric and adult sickle cell program, and ensuring the continuity of care of young adults with sickle cell disease.*

Core Responsibilities: *Enter as many responsibilities and associated tasks as needed including percent of work effort. These would become the employee's goals in Talent upon hire.*

Intervention/Case Management Responsibilities (_60_ %): *Enter the percent of work effort and describe the general responsibility.*

- Conduct biopsychosocial assessments on all transition aged patients
- Conduct Transition Readiness assessments on transition aged patients (age 18-25) which includes assessing stress thresholds, understanding of chronic disease, disease management knowledge, and case management needs. This assessment is done for all incoming patients and must be repeated on an annual basis.
- Conduct assessments for anxiety, depression, trauma, and potential substance abuse using:
 - o Adverse Childhood Experience survey
 - o PHQ-9
 - o GAD-7
 - o AUDIT-C or DAST-10
- Based on assessments, intern will make necessary learning objective plans with each patient as needed, treatment recommendations, referral to therapy and/or other social services and community-based organizations
- Conduct on-going support groups for transition age patients to assist in processing difficult emotions related to transfer of care
- Conduct educational workshops for transition age patients to include topics such as: disease management, Sickle Cell 101, healthy relationships, grief processing, trauma responses, substance abuse, social services, anger management, etc
- Act as a liaison between transition age patients and adult sickle cell medical team as needed
- Provide supportive counseling for transition age patients when appropriate
- Document all assessments, referrals, and supportive counseling notes in Redcap
- Work alongside Patient Navigators to assist transition aged patients in orienting to the adult sickle cell clinic, locations, processes, and care team when needed
- Work as a member of a multi-disciplinary team to collaborate with providers and patient navigators in ensuring improved patient care and outcomes.
- Effectively communicates and navigates systems to include health care, social services, education and community resources to assure patients access and appropriate use of these services
- Identify problems and resources to help clients solve their problems with the goal of empowering the patient/family/others how to navigate
- Work in a community and hospital settings, or other designated settings, to ensure that the patients' needs are properly identified. This will include, but not limited to, home visitations, hospital visits, ED visits, other medical appointments and all other approved locations to work efficiently with the patient to provide stability. Currently this is a Hybrid model.

- Establish and maintain a social media platform for patients and families.
 - Program Management and Support (_20_ %): *Enter the percent of work effort and describe the general responsibility.*
 - Is knowledgeable of the Patient Centered Primary Care Medical Home and assists the interdisciplinary teams in promoting patient centered care.
 - Work with interdisciplinary teams while patient is hospitalized to prepare for discharge and ensure medical follow-up is secured and provided for the patient's needs.
 - Works with patients to empower them to become an active participant in their health care.
 - Demonstrate skills in patient advocacy to assure access to care.
 - Performance Competency and Standards (_10_ %): *Enter the percent of work effort and describe the general responsibility.*
 - Provides a supportive environment for patient to discuss issues that need addressed through bi-monthly support groups and activities (hybrid and in-person, COVID-19 permitting).
 - Completes all documentation as required by the VCUHS team
 - Attend all scheduled trainings, workshops and additional workshops as indicated by supervisor
 - Documents and is competent in listening, share information 1:1 or in larger groups using establishes written and oral communication systems
 - Reports to program manager or medical director for any pertinent observation or information
 - Administrative (_10_ %): *Enter the percent of work effort and describe the general responsibility.*
 - Attend all scheduled trainings, workshops and additional workshops as indicated by supervisor
 - Performs other duties as assigned/or participates in special projects in order to support the mission of VCUHS and the department
 - Planning for absences by ensuring coverage for patients
 - Accepts alternate assignments as required, graciously
- Minimum Hiring Standards:** *List required standards for the position.*
- Bachelor degree in social work or related field required.
 - Minimum of two years of case management required
 - Required to have skills to establish and maintain social media platforms.
 - Demonstrated experience working in and fostering a diverse faculty, staff, and student environment or commitment to do so as a staff member at VCU.

Preferred Qualifications: *List any preferred qualifications for the position.*

- Master degree in social work, psychology or health related field

- Experience working with sickle cell population for a minimum of one year.
- Knowledge of health care systems for a minimum of one year.