DISCHARGE PLANNER

DISTINGUISHING FEATURES OF THE CLASS: This position exists at Willow Point Rehabilitation & Nursing Center and has responsibility for linking patients being discharged with outside resources as a means of offering follow-up healthcare services. The incumbent assists patients in developing a healthcare plan to make sure the patient receives ongoing healthcare maintenance after discharge to help the patient become more independent. Responsibilities also include working with insurance companies, professionals and agencies to coordinate coverage of continuity of care. Work is performed under the general supervision of Director of Nursing Home Social Services with leeway allowed for the exercise of independent judgement within established procedures. Supervision is not a responsibility of this position. Does related work as required.

TYPICAL WORK ACTIVITIES:

Meets with resident and/or resident representative upon admission to ascertain prior level of function, living situation and discharge goals to determine discharge planning needs;

Provides accurate assessments in order to identify discharge planning needs of patient;

Reviews necessary admission paperwork with resident and/or resident representative in ensure all required paperwork is completed;

Initiates, coordinates and facilitates efforts designed to improve the health of individuals;

Works with insurance companies to coordinate coverage of ongoing medical care, support services and counseling; as needed;

Serves as an advocate for resident when coordinating discharge services needed;

Addresses and monitors the psychological needs of the resident by one on one meetings with the resident and/or resident representative;

Reviews and discusses discharge plan with the resident, resident's families and interdisciplinary staff to ensure everyone understands and agrees with discharge plan;

Attends meetings with various parties to discuss discharge planning, review status goals, and insurance status and requirements;

Communicates with various community agencies as they relate to discharge planning and effectively communicate discharge plans to interdisciplinary team.

Maintains proper documentation within the Electronic Medical Records (EMR) on all matters as they relate to the resident;

Completes Minimum Data Set (MDS) Assessments in a timely manner;
After resident discharge, remains available to answer questions and provide new referrals if necessary

FULL PERFORMANCE KNOWLEDGE, SKILLS, ABILITIES AND PERSONAL CHARACTERISTICS:
Good knowledge of various insurance plans, policies and coverage;
Good knowledge of discharge requirements and services available;
Good knowledge of community services available in relation to discharge services;
Ability to communicate effectively both orally and in writing;
Ability to establish and maintain successful working relationships;
Ability to work effectively with teams;
Ability to organize work effectively and independently;
Ability to prepare a variety of reports;
Ability to determine appropriate course of action in complex situations;
Sensitivity to the reaction of others;
Good powers of observation and analysis;
Good time management skills;
Attention to detail;
Confidentiality;
Tact.

MINIMUM QUALIFICATIONS:
A) Graduation from a regionally accredited or New York State registered college of university with a Bachelor's Degree or higher in social work, human services or closely related field, and one year of discharge planning within a health-care setting; OR

B) Completion of a course of study approved by the New York State Education Department as qualifying for Registered Professional Nurse and licensure to practice as a Registered Professional Nurse in New York State and one year of discharge planning within a health-care setting; OR

C) An equivalent combination of training and experience as indicated within the limits of A) and B) above.