Are you ready to join a passionate community of people who are changing how health care is delivered? A place where you will find a career you love while truly making a difference building healthier communities. If this sounds like you, we would love to have you apply as a Mobile Crisis Case Manager with Medical Home Network (MHN)!

MHN is a not-for-profit collaborative that has fundamentally changed how care is delivered. Our proven model of care unites provider communities and diverse healthcare entities around a common goal: to redesign healthcare delivery and transform the way care is managed.

THE PERKS

- Fun, challenging, and collaborative work environment with passionate colleagues that care deeply about healthcare delivery.
- Recognized as One of the Best Places to Work in Healthcare by Modern Healthcare.
- Competitive benefits programs including Medical, Vision, Dental, HSA, FSA, and 401k.
- Fitness reimbursement, commuter benefits, and tuition assistance.
- Great work life benefits- Paid time off, sick time, and 12 paid holidays.

THE OPPORTUNITY:

The Behavioral Health Quality Team provides mobile care management on behalf of the ACO's medical homes. Mobile Case Managers will visit patients at acute and specialty care hospitals to ensure safe transitions of care from inpatient to the medical home setting. The Case Manager will work with the care teams at each hospital site and medical home. This is a community based position with some required in-office days and the ability to work from home.

WHAT YOU CAN LOOK FORWARD TO:

- Develop relationships with transition of care staff in inpatient behavioral health floors of hospitals and Medical Home Care Management staff.
- Engage with behavioral health patients during hospitalization focusing on reasons for hospitalization, reinforcing with the patient their care management plan of care, gathering new information to share with the Medical Home Care Manager.
- Collaborate with patients, Medical Home Care Managers, and other community-based service providers to create and execute plans to address patient needs related to social determinates of health.
- Serve as a bridge between patients and available resources, ensuring seamless access to essential support services.
- Completing care management assessment as appropriate, such as Health Risk Assessments, Comprehensive Risk Assessments and Transitions of Care Bundle.
- Gathering medical home information and sharing it with the hospital care team; sharing information about the hospital stay including appropriate discharge planning document with the medical home.
- Interfacing with the hospital care team staff responsible for utilization management and discharge planning as well as hospitalists, and the patient's family support network to identify issues that will need to be addressed to assure an efficient and complete transition of care.
- Educates and supports the patient in the areas of medication management, follow-up care, signs and symptoms of worsening conditions, functional needs and or home and community-based services and advance directives.

- Participates in care team meetings and Integrated Care Team collaboration as necessary.
- Works with the patient and medical home to secure a timely follow-up appointment.
- Communicates outcomes of the above functions to the patient's medical home care manager on a determined schedule.
- Completion of other duties as assigned.

WHAT YOU'LL NEED TO SUCCEED:

- Master's degree in social work, Psychology, or relevant humanities degree with 1-2 years of relevant experience (internships considered); or a bachelor's degree with 3-5 years of relevant experience (internships considered)
- Experience in working with multidisciplinary team including health care professionals.
- Demonstrated knowledge and experience in working with individuals with severe mental illness and substance abuse.
- Strong communication and interpersonal skills.
- Experience in patient advocacy desirable
- Valid Illinois Driver's License and access to an automobile
- Ability to work independently and as part of a team with a wide range of licensed and unlicensed individuals from a variety of care delivery sites and community agencies.
- Excellent organizational skills.
- A passion for working with individuals dealing with serious mental illness and substance use disorders.
- Proven ability to work autonomously and proactively, demonstrating strong self-motivation and initiative.
- In-depth familiarity with Chicago's social service landscape, particularly resources related to homelessness and substance use.
- Empathetic and non-judgmental approach when addressing sensitive issues.
- A strong desire to contribute to the betterment of the community by connecting individuals to vital services.
- Proficient computer skills