TRI-COUNTY HEALTH NETWORK

Position: **Outreach Coordinator**
Supervisor: **Community Programs Manager**
Status: **Full-Time, Exempt**

JOB SUMMARY:

The Outreach Coordinator is responsible for increasing community and partner knowledge of Tri-County Health Network's (TCHNetwork) programs and services, building strategic relationships, conducting a variety of outreach activities and presentations, and recruiting volunteers to support TCHNetwork's programs and services in his/her respective community. The Outreach Coordinator will also provide direct services to clients. These services include (1) conducting in-home assessments and connecting adults age 60 and over and adults with disabilities to community resources; (2) educating and enrolling eligible individuals and families into Medicaid/CHP+, Colorado's health insurance marketplace, and SNAP; (3) providing care coordination to Medicaid recipients; and (4) supporting the completion of portable Skippy Dental clinics.

DUTIES AND RESPONSIBILITIES: *May include the following, and other duties as assigned.*

1. Outreach to and educate the community-at-large and potential partners about TCHNetwork services. Specific responsibilities include:
    a. Implementing annual community outreach plan and assisting in the development of the plan
    b. Identifying key events for TCHNetwork participation, coordinating participation through the use of an Event Planning Worksheet, and representing TCHNetwork at events
    c. Participating in relevant councils, roundtables, and committees
    d. Assisting in the identification and recruitment of community volunteers
    e. Distributing promotional flyers throughout community and tracking distribution
    f. Championing TCHNetwork as a community resource
    g. Identifying, initiating, and deepening relationships with various community stakeholders
    h. Organizing meetings and/or presentations with existing and new partners and providing information about TCHNetwork and partner services
    i. Attending non-TCHNetwork sponsored programs and events to better understand community interests and activities
    j. Coordinating special community events
    k. Assisting in the regular updating of a local Resource Guide
    l. As requested, conduct Chronic Disease Self Management Program (CDSPM), Cooking Matters (CM), and other community trainings.
2. Perform home-based options counseling and service assessment assistance that include:
    a. Identifying eligible community members in-need and accepting referrals from partner organizations

b. Contacting individuals referred to program to inform clients of potential services and schedule a time to meet with the community member in his/her home
c. Administering person-centered, comprehensive in-home assessments to determine client goals and needs, including but not limited to functional, environmental, and physical needs
d. Identifying programs and services that the client is eligible for and offering unbiased information, assistance, and referrals on available services and supports in the client's respective community
e. Assisting clients in completing service applications as necessary
f. Providing printed materials to clients on identified services/benefits
g. Following up with the client to ensure services are received and assess client satisfaction
h. Meeting assessment, reassessment and outreach goals as determined on an annual basis.

3. Offer enrollment assistance, which includes:
    a. Successfully completing State of Colorado training to become a Certified Enrollment Assistant / Health Coverage Guide
    b. Providing expert, timely and friendly assistance with the application process in a manner that culturally and linguistically appropriate to the client
    c. Providing general education and basic knowledge regarding benefits of Medicaid, CHP+, and/or marketplace insurance and health service delivery
    d. Identifying barriers and service issues and implementing solutions to health insurance enrollment and access
    e. Collaborating closely with county social services agency staff members assigned to eligibility determination and enrollment
    f. Developing relationships with area schools in getting referrals to families with children receiving free and/or reduce lunch
    g. Expanding the network of community-based organizations, faith based organizations and school districts focusing on enrollment outreach and activities
    h. Collaborating with medical providers serving the uninsured or underinsured and assist in implementing a process to outreach, enroll and retain patients into an available health insurance program
    i. Assisting applicants with appeal process, as necessary
    j. Tracking clients' annual renewal dates and proactively outreaching to individuals to ensure no break in coverage

4. Provide Skippy Dental Clinic Navigation at assigned schools twice per semester and as needed
    a. Transport, set up, and break down clinical equipment as directed by Community Programs Manager to complete clinics at participating schools
    b. Complete pre-clinic outreach, enrollment and preparation in timely and organized manner
    c. Engage parents, schools, local providers in outreach and education
    d. Assist with clinical procedures including charting, radiographs and post clinic follow up
    e. Document patient needs in Electronic Dental Record and Member Tracking System

5. Offer Care Coordination services to Medicaid recipients, which may include:
    a. Assessing the changing needs and conditions of clients and communicating this information to all involved Care Coordinators, community partners, physicians and other

appropriate individuals

b. Participating in Interdisciplinary Care Coordination team meetings
c. Assisting clients in establishing a primary care provider and through care transitions within required time frames
d. Providing navigation, education, and assistance to identified members about services and behaviors that can enhance their health
e. Developing a plan in collaboration with clients to help clients address their individual needs and accomplish their health-related goals
f. Managing difficult to reach and non-compliant clients, which includes serving as the direct personal contact in the community to members who are unable to be reached through phone calls

6. Participate in required trainings, continuing education requirements (as applicable), and monthly program calls. Disseminate notes to program team
7. Document all efforts in the required management information system accurately and within prescribed timeframes
8. Other duties as required to ensure the success of the program and TCHNetwork.

SKILLS AND QUALIFICATIONS:

1. Excellent verbal and culturally competent communication skills (in person, on the telephone, and through email correspondence)
2. Must have aptitude for computers and working with various software and be proficient in MS Word, MS Excel
3. Willingness to work flexible hours (some nights/weekends)
4. Strong public speaking and presentation skills
5. Valid driver's license with reliable transportation and car insurance with the ability to travel up to 90 miles to perform duties related to this position.

PERSONAL ATTRIBUTES:

1. Must possess demonstrated ability to relate to individuals of varied ethnic, cultural backgrounds, ages and economic circumstances
2. Trusted member of the community and ability to make new and lasting connections
3. Ability to maintain client confidentiality
4. Ability to work in a fast-paced environment, remain calm under pressure, and be supportive of client needs
5. Advanced time management skills and ability to work independently
6. Strong work ethic, self-motivated, and collaborative style

7. Change agent demeanor; must be a flexible thinker, with an ability to quickly adapt to a changing environment
8. Ability to exercise forethought, to look ahead and anticipate events
9. Excellent critical thinking and consultative problem-solving skills
10. Ability to receive and utilize constructive feedback regarding performance and presentation.
11. Must be able to lift 50+ pounds

PREFERRED QUALIFICATIONS:

1. Resident of the community for at least the past 2 years
2. Knowledge and experience working in/with clinical or social service agencies in rural communities
3. Experience working with disadvantaged/underserved populations.