TRI-COUNTY HEALTH NETWORK

Position: **Care Coordinator**
Supervisor: **Care Coordination Supervisor**
Status: **Full-Time, Exempt**

JOB SUMMARY:

The position supports the continued growth and development of Tri-County Health Network's (TCHNetwork) programming by providing direct case management and care coordination to Rocky Mountain Health Plan Medicaid Members. The Care Coordinator will facilitate calls to member lists to complete care coordination based on the identified needs of the member. Members in need of detailed follow up will be placed in Case Management where more detailed coordination, follow up, in-person check-ups, and warm hand offs to local services will be completed based on the need of the member. The Care Coordinator will also be responsible for coordinating resource lists, outreaching to local providers, expanding TCHNetwork's community partners in their community, and completing advocacy activities as needed for the member. This role will also attend regional meetings to build on the network and educate others on TCHNetwork programming and services.

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

1. Serve as the direct personal contact in the community to Medicaid members
2. Conduct member assessments:
    a. Assess the changing needs and condition of the client and communicate this information to all involved Care Coordinators, community partners, physician and other appropriate individuals, according to department policies and procedures.
    b. Document assessments, client/family response to care coordination interventions at the time of the encounter. Meet departmental standards and deadlines for timely completion of all required documentation and meet current agency productivity standards and coordinating care to overcome identified social determinants of health.
    c. Assist clients in establishing a primary care provider, transitioning of care, complete member outreach within required time constraints, and complete necessary reporting requirements in Essette.
3. Respect confidentiality and maintain confidences as described in the Confidentiality Security Agreement.
4. Participate in Interdisciplinary Care Coordination team meetings.
5. Serve as community liaison and maintain relationships with key individuals in the community and serve as an advocate by coordinating linkages or referrals to improve health, social, and environmental conditions for members.
6. Educate staff at clinics and other partner organizations about care coordination services.

7. Coordinate and perform duties of communicating the mission and role of the organization to community associations, senior groups, ethnic clubs and groups, and churches.
8. Provide navigation, education, and assistance to identified members about behaviors that can enhance their health.
9. Facilitate access to preventive and disease management health services.
10. Manage difficult to reach and non-compliant members.
11. Develop a plan of management associated with health care goals for each member addressing the diverse needs in a culturally appropriate way.
12. Communicate member issues requiring interventions to appropriate departments and providers.
13. Maintains confidentiality and uses only the minimum amount of protected health information (PHI) necessary to accomplish job related responsibilities. Maintain confidentiality of patient information.
14. Participate in staff meetings, case conferences, and in-services. Maintain familiarity with all policies and procedures that impact decisions and care.
15. Attend regional meetings, conferences and trainings as assigned by TCHNetwork.
16. Responsible for expanding TCHNetwork's resources and mission in Montrose.
17. Other duties as assigned

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.
6. Experience advocating on behalf of underserved communities and navigating health care and social services
7. Comfortable with "cold calling" members to offer Care Coordination and connect them to community-based services over the phone and in person if needed.
8. Proficient with member tracking systems (MTS), especially Essette a plus.
9. Experience working with field teams or working remote to achieve identified goals
10. Experience with meeting facilitation and public speaking

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.
4. Written and verbal fluency in both English and Spanish