TRI-COUNTY HEALTH NETWORK

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

JOB SUMMARY:

The Care Coordinator is responsible for increasing community and partner knowledge of Tri-County Health Network's (TCHNetwork) programs and services, building strategic relationships to identify and address barriers to good health, and conducting a variety of outreach activities. The Care Coordinator will also provide direct services to clients including (1) conducting both phone and in-home outreach and assessments for individuals enrolled in Medicaid; (2) performing in-home assessments and connecting adults age 60 and over and adults with disabilities to community resources; (3) providing diabetes and cardiovascular risk screenings and retests a variety of community locations; (5) identifying client barriers to health and connect clients to/enroll clients in relevant programs to promote health; and (4) facilitating Cooking Matters classes.

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

1. Perform home-based options counseling and service assessment assistance that includes:
    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
    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. Documenting all assessments, referrals, client contacts, and complaints in the required management information system accurately and within prescribed timeframes
    i. Meeting assessment, reassessment and outreach goals as determined on an annual basis.

2. Provide indirect and direct care coordination to identified clients of Rocky Mountain Health Plan that includes:
    a. Form trusting collaborative relationships with clients and partner organizations
    b. Schedule and complete assessments, follow-up as needed, track results, referrals and recommendations in database
    c. Meet with clients in public spaces or place of residence when appropriate to the clients' needs
    d. Track and monitor referrals of clients for reporting as requested
    e. Accurately document interactions in population health data system (ESSETTE) to include client visits, needed services, phone calls, written correspondence and communication in appropriate computer system within 2 business days
    f. Work closely with community based organizations to complete care plans

g. Connect with diverse client population, empathize, show compassion, perform assessments and develop and self-management plan in partnership with client and possibly other community partner agencies

h. Coordinate care with providers, community partners and other patient navigators to provide outreach, referrals and support for Medicaid clients

i. Complete documentation and reporting as required by program and supervisor

j. Complete in-takes of high-risk patients, working in partnership with patient, family and other members of the healthcare team as needed to assess and prioritize patient's physical needs, mental well-being, family support system, financial resources and available community and government resources

k. Co-create patient specific goals, objectives and measures that meet the patient's needs and that have been identified through assessment

l. Assist in the regular updating of a local Resource Guide that includes identifying available local and regional resources and verifying accuracy of information

3. Offer Heart Healthy screenings and evidenced-based trainings that includes:

   a. Conduct cardiovascular risk screening/retest includes a blood pressure check, finger-stick cholesterol and glucose test, and completion of a computerized health risk assessment screener

   b. Provide basic point of service counseling on medical and lifestyle recommendations (exercise program, dietary counseling, social service programs, etc.) for the reduction of cardiovascular disease risk factors

   c. Utilize OSCAR & CiviCRM software to enter data, generate health recommendations, and track client interactions

   d. Provide referrals for medical care or lifestyle changes for those considered "at-risk" for cardiac disease development through screening results

   e. Conduct ongoing case management with those considered "at-risk" on a regular basis (in-person, by telephone, or email) using Motivational Interviewing techniques to encourage behavior change

   f. Promote health equity and improve access to services by assisting in locating local medical providers and lifestyle programs that will work with "at-risk" clients for little or no charge for services

   g. Meet screening, follow-up and retest goals set by program staff

   h. Become trained as a diabetic retinopathy telescreener and perform biannual screens to diabetic patients of partner clinics

   i. Become trained in Cooking Matters and offer a minimum of one 6-week course each year

4. Identify client barriers to health, educate clients on programs to promote health, and provide assistance to enroll clients in relevant programs (*e.g.*, SNAP, LEAP, New Eyes)

5. Assist in the development of a marketing/outreach plan and conduct outreach to ensure programs are reaching target populations

   a. Identifying key events for TCHNetwork participation, coordinating participation through the use of an Event Planning Worksheet, and representing TCHNetwork at events

   b. Participating in relevant councils, roundtables, and committees

   c. Engaging in interagency collaboration and education regarding available regional

services and identifying gaps in services

d. Distributing promotional flyers throughout community and tracking distribution

e. Championing TCHNetwork as a community resource

6. Participate in required trainings, continuing education requirements (as applicable), and monthly program calls. Disseminate notes to program team
7. Document all efforts in assigned member tracking systems
8. Other duties as required to ensure the success of the program and TCHNetwork.

EDUCATIONAL AND EXPERIENCE REQUIREMENTS:

A 4-year college degree OR 4 years of progressive related experience working with diverse populations, community or faith-based organizations, or in a healthcare setting.

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

PREFERRED QUALIFICATIONS:

1. Resident of the community for at least the past 2 years
2. Knowledge and experience working in healthcare and/or with clinical and social service agencies
3. Experience working with disadvantaged/underserved populations
4. Comfortable with "cold calling" members to offer Care Coordination and connect them to community-based services over the phone and in person if needed

LOCATION:

This field position is located in the West End of Montrose/West End of San Miguel counties.

SALARY

$35,000–$39,000 based on experience