TRI-COUNTY HEALTH NETWORK

Position: **Care Coordinator**
Supervisor: **Care Coordination Manager**
Status: **Full-Time, Non-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 various 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 plus and adults with disabilities to community resources.

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. Administer person-centered, comprehensive in-home assessments to determine client goals and needs, including but not limited to functional, environmental, and physical needs
   b. Identify programs and services that the client is eligible for and offer unbiased information, assistance, and referrals on available services and support in the client's respective community
   c. Assist clients in completing service applications
   d. Following up with the client to ensure services are received and assess client satisfaction
   e. Document all assessments, referrals, client contacts, and complaints.
2. Provide indirect and direct care coordination to identified clients
   a. Schedule and complete assessments, follow-up as needed, track results, referrals, and recommendations in the database
   b. Meet with clients in public spaces or places of residence when appropriate to the client's needs
   c. Accurately document interactions in the population health data system.
   d. Coordinate care with providers, community partners and other patient navigators to provide outreach, referrals, and support for Medicaid clients
   e. Complete documentation and reporting as required by the program and supervisor
3. Participate in required training, and continuing education requirements (as applicable).
4. Attend local networking and collaborating meetings
5. Assist in the regular updating of a local Resource Guide that includes identifying available local and regional resources and verifying the accuracy of information
6. Other duties as required to ensure the success of the program and TCHNetwork

EDUCATION AND EXPERIENCE REQUIRED

1. A 4-year college degree OR 4 years of progressive related experience working with diverse populations, communities, or in a healthcare setting.
2. One year of direct experience working in case management or client care coordination.
3. Experience working with field teams or working remotely to achieve identified goals.
4. Strong presentation and communication skills

5. Experience/comfort working and communicating with diverse communities from different socioeconomic backgrounds. Culturally competent and aware of race, gender, class, sexuality, ability, etc.
6. Demonstrated commitment to equity and social justice and the ability to think critically about how external systems impact the community.
7. Must have an aptitude for computers and working with various software and be proficient in MS Word, MS Excel, Outlook, and OneDrive or a similar shared file system.

PREFERRED QUALIFICATIONS:

1. Bilingual/bicultural is strongly preferred.
2. Knowledge or ability to learn and practice trauma-informed principles and practices.
3. Knowledge of community resources.
4. Ability to assess crises and intervene appropriately.
5. Ability to participate in training such as Mental Health First Aid, safeTALK, Motivational Interviewing, Core Competencies for Peer Workers, Privacy Act, etc.
6. Effective written and verbal communication skills.
7. Ability to give, receive and analyze information, formulate work plans, maintain confidentiality, prepare written materials, and articulate goals and action plans.
8. Must have a clear understanding of HIPAA, confidentiality, and personal boundaries and be self-assured in a variety of situations.
9. Ability to recognize and de-escalate crisis situations and remain calm.
10. Energetic with a positive and creative attitude.

PERSONAL ATTRIBUTES:

1. Must possess demonstrated ability to relate to individuals of varied ethnic, cultural backgrounds, ages, and economic circumstances.
2. A 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; flexible thinker with an ability to quickly adapt to a changing environment.
8. Ability to exercise forethought, to look ahead, and to anticipate events.
9. Excellent critical thinking and consultative problem-solving skills
10. Ability to receive and utilize constructive feedback regarding performance and presentation.
11. Understanding of health equity and experience working to address social determinants of health.

OTHER

Requires regular local and regional travel. Must have reliable transportation to travel as needed and comfortable traveling in inclement weather. A valid driver's license and car insurance are required. Ability to work a flexible schedule, including evenings and weekends. Must be able to lift 50+ pounds.

LOCATION:

This field position will work 4 days/week in Montrose and 1 day in Ouray.

Starting salary range is $19.23-$21.63 per hour, depending on experience