**Position:** Care Coordinator (Bilingual)  
**Supervisor:** Co-Ed of Community Programs  
**Status:** Full-time non-exempt (will entertain part-time employment request)  
**Location:** Hybrid San Miguel and Ouray County

---

**JOB SUMMARY:**
The Care Coordinator aims to raise awareness of available mental health resources and eliminate barriers to support and services. The CC 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) Connecting community members to mental health supports and services through Bilingual Behavioral Health Care Coordination in San Miguel County (2) Support youth voice and choice with the High-Fidelity Wrap Around process as a Family Support Partner to improve health outcomes for high-risk children and their families, as well as adults struggling with their health. Advocate for the underserved by ensuring that the clients are empowered to have their voice and choice heard.

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

1. Provide High Fidelity Wraparound Family Support, Partner Support, and Behavioral Health Care Coordination services for youth, families, and adults:
   a. Establish a trusting relationship with youth, family members, and other adults.
   b. Provide clients and their chosen natural supports an overview of the HFW and BHCC process, resources, supports, expectations, and goals.
   c. Assess the client’s changing needs and communicate this information to all involved, including Care Coordinators, community partners, physicians, and other appropriate individuals.
   d. Support clients by addressing social determinants of health that impact their daily life and linking them with resources to remove identified barriers to care.
   e. Keep the client actively engaged in the planning and implementing their wraparound care.
   f. Provide intensive, direct care coordination support. This may include making calls to service providers on behalf of clients, attending appointments with partner providers and clients, arranging transportation services, application assistance, documentation submission, and reminding the client of appointments, among other activities.
   g. Use a strengths-based approach—partner with the client to develop and implement wraparound plans addressing the client’s individual needs in a culturally appropriate way.
   h. Provide clients the tools they need to make their own choices about health by ensuring they have an awareness and understanding of the systems they are involved in and can act to change their lives in the way they choose.
   i. Connect clients with community resources to support their health and well-being.
   j. Identify obstacles to treatment and work with stakeholders to develop solutions.
2. Document assessments, client/family response to care coordination interventions at the time of the encounter in the appropriate management information system.

3. Participate in required training and continuing education requirements as applicable.

4. Maintain relationships with partners throughout the community.

5. Educate clinic and partner organizations staff about high-fidelity wraparound care coordination services.

6. Work with the Care Coordination team and Regional Health Connector to maintain accurate behavioral health and SDOH resource lists.

7. Assist with marketing behavioral health and social resources across the county.

8. Become certified as an instructor for various BH training (could include Mental Health First Aid, safeTalk, NAMI Family to Family) and conduct the minimum number of training each year to retain certification.


10. Coordinate and perform duties of communicating the mission and role of TCHNetwork to community associations, senior groups, ethnic clubs and groups, and churches.

11. Communicate client issues to appropriate community partners.

12. Participate in staff meetings, case conferences, and in-services. Maintain familiarity with all policies and procedures that impact decisions and care.

13. Attend regional meetings, conferences, and training as TCHNetwork assigns.

14. Other duties as assigned

REQUIRED QUALIFICATIONS:

1. Written and verbal fluency in both English and Spanish

2. Excellent verbal and culturally competent communication skills (in person, on the telephone, and through email correspondence)

3. Must have an aptitude for computers and working with various software and be proficient in MS Word, MS Excel

4. Willingness to work flexible hours to be responsive to your clients

5. Valid driver’s license with reliable transportation and car insurance with the ability to travel

6. Experience advocating on behalf of underserved communities and navigating health care and social services

7. Comfortable with “cold calling” 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.

9. Experience working with field teams or working remotely to achieve identified goals.

10. A former “child of the system”, someone who has personally endured the rigors of family separation, detention, foster care, homelessness, or other similar traumas and emerged intact could also be considered to have the real-life experience that appears to be such a critical characteristic of a successful FP.

11. Real-Life Experience – Parent of a child or children with mental illness or emotional disturbance who has survived the trauma associated with that environment and developed the insights and perspectives necessary to help other families who are struggling through the process. This experience should include interaction with the local school system, Office of Juvenile Affairs (OJA), and the Department of Human Services (DHS), the Education System, etc.

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. Valid driver’s license with reliable transportation and car insurance with the ability to do regional travel
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. Knowledge or ability to learn and practice trauma-informed principles and practices.
2. Knowledge of community resources.
3. Ability to assess crises and intervene appropriately.
4. Ability to participate in training such as Mental Health First Aid, safeTALK, Motivational Interviewing, Core Competencies for Peer Workers, Privacy Act, etc.
5. Effective written and verbal communication skills.
6. Ability to give, receive and analyze information, formulate work plans, maintain confidentiality, prepare written materials, and articulate goals and action plans.
7. Must have a clear understanding of HIPAA, confidentiality, and personal boundaries and be self-assured in a variety of situations.
8. Ability to recognize and de-escalate crisis situations and remain calm.

PERSONAL ATTRIBUTES:
1. Must possess demonstrated ability to relate to individuals of varied ethnic, cultural backgrounds, ages, and economic circumstances
2. Ability to remain non-judgmental
3. A trusted member of the community and ability to make new and lasting connections
4. Ability to maintain client confidentiality
5. Ability to work in a fast-paced environment, remain calm under pressure and be supportive of client needs
6. Advanced time management skills and ability to work independently
7. Strong work ethic, self-motivated, and collaborative style
8. Change agent demeanor; must be a flexible thinker, with an ability to quickly adapt to a changing environment
9. Ability to exercise forethought, to look ahead, and anticipate events
10. Excellent critical thinking and consultative problem-solving skills
11. Ability to receive and utilize constructive feedback regarding performance and presentation

SALARY Starting wage range is $21.00 - $25.00 per hour, depending on experience.
Great benefits: 100% paid comprehensive employer health and dental insurance coverage, 12 paid holidays, 10 days vacation, 48 hours of sick pay, up to 3% match individual retirement account (IRA) with immediate vesting, flexible spending account, employee referral program quarterly mental health days & continued professional development.

DIVERSITY, EQUITY, AND INCLUSION:
Tri-County Health Network is a nonprofit organization committed to collaborating with our communities to improve healthcare for everyone. Diversity, Equity, and Inclusion is at the core of our mission and work in the region.