JOB DESCRIPTION

JOB TITLE:	Care Coordinator	
EXEMPT:	Non-Exempt	
REPORTS TO:	Chief Quality Officer	**DATE**: _____

INTRODUCTION:
Central Neighborhood Health Foundation (CNHF) is a Federally Qualified Healthcare Center committed to the Triple Aim as described by the Institute for Healthcare Improvement.

Improving the US Health Care System requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an "integrator") that accepts responsibility for all three aims for that population.

SUMMARY:
The Quality Care Coordinator will conduct 1,200 in-office patient visits per year (five patient visits per workday). The average patient may have between three and six interactions per year; The Quality Care Coordinator will work with a population of approximately 60- 120 chronically ill patients.

ESSENTIAL DUTIES AND RESPONSIBILITIES

The Care Coordinator works in collaboration and continuous partnership with chronically ill or “high-risk” patients and their family/caregiver(s), clinic/hospital/specialty providers and staff, and community resources in a team approach to:

- Promote timely access to appropriate care
- Increase utilization of preventative care
- Reduce emergency room utilization and hospital readmissions
- Increase comprehension through culturally and linguistically appropriate education
- Create and promote adherence to a care plan, developed in coordination with the patient, primary care provider, and family/caregiver(s)
- Increase continuity of care by managing relationships with tertiary care providers, transitions-in-care, and referrals
- Increase patients’ ability for self-management and shared decision-making
- Provide medication reconciliation
- Connect patients to relevant community resources, with the goal of enhancing patient health and well-being, increasing patient satisfaction, and reducing health care costs. A typical day for the Care Coordinator will entail spending half of the day conducting one-on one extended patient meetings (approximately 30-45 minutes long). The other half of the day will be spent on follow-up with patients, family/caregiver(s), providers, and community resources via secure email, phone calls, text messages, and other communications.
- Serve as the contact point, advocate, and informational resource for patients, care team, family/caregiver(s), payers, and community resources
- Work with patients to plan and monitor care
- Assess patient’s unmet health and social needs
- Develop a care plan with the patient, family/caregiver(s) and providers (emergency plan, health management plan, medical summary, and ongoing action plan, as appropriate)
- Monitor adherence to care plans, evaluate effectiveness, monitor patient progress in a timely manner, and facilitate changes as needed

- Create ongoing processes for patient and family/caregiver(s) to determine and request the level of care coordination support they desire at any given point in time.
- Facilitate patient access to appropriate medical and specialty providers
- Educate patient and family/caregiver(s) about relevant community resources
- Facilitate and attend meetings between patient, family/caregiver(s), care team, payers, and community resources, as needed
- Cultivate and support primary care and specialty provider co-management with timely communication, inquiry, follow-up, and integration of information into the care plan regarding transitions-in-care and referrals
- Assist with the identification of "high-risk" patients (the chronically ill and those with special health care needs), and add these to the patient registry (or flag in EHR)
- Attend all Care Coordinator training courses/webinars and meetings
- Provide feedback for the improvement of the Care Coordination Program
- Oversee provision of Health Homes Program (HHP) services and implementation of Health Action Plan (HAP)
- Offer services where the HHP member lives, seeks care, or finds most easily accessible and within Medi-Cal Managed Care health plans (MCP) guidelines
- Connect HHP member to other social services and supports he/she may need
- Advocate on behalf of members with health care professionals
- Use motivational interviewing and trauma-informed care practices
- Work with hospital staff on discharge plan
- Engage eligible HHP members
- Accompany HHP member to office visits, as needed and according to MCP guidelines
- Monitor treatment adherence (including medication)
- Provide health promotion and self-management training
- Arrange transportation
- Call HHP member to facilitate HHP member visit with the HHP care coordinator

QUALIFICATION REQUIREMENTS:
To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. Requirements listed below are representative of the knowledge, skill and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION AND/OR EXPERIENCE:

- Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse
- 1 to 2 years' experience in clinical or community resource settings; Care coordination and/or case management
- Evidence of essential communication, education, and counseling skills
- Proficiency in communication technologies (email, cell phone, etc.)
- Highly organized with ability to keep accurate notes and records
- Experience with health IT systems and reports is desirable
- local knowledge about and connections to community health care and
- social welfare resources is desirable
- Ability to speak a relevant second language is desirable

SKILL AND KNOWLEDGE REQUIREMENTS:

- Excellent analytical, problem solving, and prioritization skills.
- Use statistical and graphic displays.
- Excellent verbal and written communication skills.
- High-level interpersonal skills. Able to work collaboratively and tactfully with multi-disciplinary and diverse teams that may include employees, customers, physicians.
- Effective computer skills, particularly Microsoft Office, Excel, PowerPoint, publisher, Paint, Word, etc.
- Work independent to complete assigned tasks.

- Team building
- Project Management
- Change Management
- Quality and Process improvement tools
- Project Execution

CONFIDENTIALITY

Maintains patient, employee and Foundation confidentiality at all times, discussing patient or employee business only with appropriate parties who have a bona fide need to know; and communicating only the minimum amount of information necessary with respect to protected health information (PHI) as defined by the Health Insurance Portability and Accounting Act of 1996 (HIPAA).

1. AGREEMENT AND ACCEPTANCE

2. **I HAVE READ THE ABOVE JOB DESCRIPTION AND FULLY UNDERSTAND THE REQUIREMENTS SET FORTH AND WILL PERFORM ALL DUTIES AND RESPONSIBILITIES TO THE BEST OF MY ABILITY.**

_____ _____
Employee Signature Date

_____
Print Name

SIGNATURE OF APPROVAL:

CEO: _____ Date: _____