Job Description:
Care Coordinator II

Care Coordinator: Key Roles & Responsibilities

Position Overview

The *Care Coordinator* will outreach and assessment to Routt County residents, specifically those enrolled in Medicaid and Medicare. This position will serve as a liaison between clients, healthcare providers, including specialty providers and human service agencies to reduce barriers to care and assure clients receive the care they need when they need it. Works with clients to identify barriers to care, and develop a comprehensive goal oriented care plan.

The successful candidate will exhibit the following:

- *Culture Champion* – Commitment to the Partnership's mission and working with diverse partners.
- *Results Producer* – A results-focused orientation with a proven track record of exceeding goals.
- *Agility* – Ability to think strategically, foresee opportunities and challenges and adapt as needed.
- *Strong Communicator* – Excellent written and oral communication skills.
- *Organization* – Exceptional capacity to manage details, monitor progress and adjust accordingly.
- *Action Oriented* – Enjoys working hard, tackling challenges and is not afraid to take ownership of a situation.

Supervision Received:

The Care Coordinator is based out of the Steamboat office and is supervised by the Director of Population Health of Northwest Colorado Community Health Partnership.

Supervision Exercised:

NO

Essential Duties:

- Provide a variety of indirect and direct care coordination to clients identified as in need of services. This includes:
    - Form trusting collaborative relationships with clients and partner organizations.
    - Schedule and complete assessments, follow-up as needed, track results, referrals and recommendations in database.
    - Meet with clients in public spaces or place of residence when appropriate to the clients' needs.
    - Track and monitor referrals of clients for reporting as requested.
    - 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.
    - Work closely with partner organizations such as Horizons, Lift Up, Department of Human Services and other members of the Navigation Network to complete care plans.
    - Ability to 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.
    - Coordinate care with providers, community partners and other patient navigators to provide outreach, referrals and support for Medicaid clients.

    - Complete documentation and reporting as required by program and supervisor.
- 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.
- Co-create patient specific goals, objectives and measures that meet the patient's needs and that have been identified through assessment.
- Collaborates with other Care Coordinators to ensure all program deliverables are being met and advise supervisor or CCT Coach of any needs for meeting deliverables.
- Conduct program evaluation surveys within program requirements.
- Participate in regular staff meetings.
- Performs assigned work safely, adhering to organization and program established safety rules and practices.
- Performs all other duties as requested.

Team Player:

- Engage in cross-organization efforts, connecting project work to the broader Partnership.
- Share unique skills and expertise with NCCHP team.

Education/License:

- Bachelor's Degree, minimum
- Health or Human Services experience preferred

Experience:

Working with clients, clinical practices, community social service providers, complex medical patients and knowledge of health service delivery preferred.

Requirements:

- Must provide proof of a valid driver's license and adequate insurance coverage totaling at least $300,000 per occurrence.

Skills:

- Independent travel throughout the county, including during inclement weather.
- Ability to communicate effectively with diverse audiences including clients, community members, professional partners, funders and government agencies.
- Proficiency with Microsoft Outlook, Word, Excel, and PowerPoint.
- High level of organizational skills with a focus on problem solving, detail oriented and follow through.
- Active listening, motivational interviewing techniques, and the ability to support clients during intense emotional periods.

Abilities:

- Can support non-clinical community care team.
- Commitment to inclusiveness, social justice, health equity and reduction of health disparity.
- Identifying and using data for data informed decision making, and to enhance collaborative work.

- High tolerance for ambiguity and ability to problem solve and appropriate course of action.
- Knowledge of Maternal Child Health including screenings tools, developmental milestones, immunizations, etc).

Working Conditions:

- Up to 50% time traveling and working remotely.
- Work location for administrative activity is in an accessible office environment.
- Daily activity is 70-80% sitting, 20-30% walking/standing with occasional stooping, bending, reaching, twisting, and typing.
- Office equipment would include telephone, computer, printer, copier on a daily basis.
- Position meets the criteria for Category 3 of OSHA's guidelines for exposure to biohazards.

Compensation: 0.9FTE Hiring range is $17-$20 per hour depending on experience