313 Jefferson Ave
Toledo, OH 43604
419.720.7883 ext. 212

CARE COORDINATOR

Reports to Care Coordination Manager

GENERAL FUNCTION:

Under general supervision of the Care Coordination Project Manager, the Care Coordinator serves as a trained advocate from the organization that empowers individuals to access community health and social service resources through education, outreach, home visits, and referrals. This is a grant funded position. Continuation of this position is contingent upon grant funds as well as worker competency.

The Care Coordinator is a member of the PCMH Care Team All members of the PCMH Care Team will work cooperatively with and interact with the patients and other team members to coordinate patient care and achieve the stated patient and PCMH Team goals and objectives. PCMH goals and objectives include increased access to patient care, high quality patient care, and patient self-management of care.

DUTIES:

- Attends and participates in the pre-visit Team Huddle. Team Huddles will generally include a review of the patient schedule, last visit notes, and any known updates such as labs, reports, and any preventive services (vaccinations, pap smears, mammograms, colonoscopy, etc.) that are needed.
- Attends and actively participates in the monthly team meetings. Monthly Team Meetings might include reviewing: high risk patient populations including hospitalizations and no shows, staff schedules & defining work to be done, clarifying roles, team building exercises, quality improvement process changes or performance measures.
- Utilizes the established PCMH Patient Flow Chart in the provision of patient care. The Patient Flow Chart was designed to reduce delays, improve patient outcomes, and reduce the cost of care

OUTREACH AND CARE COORDINATION:

- Serves as a central resource for community questions and referrals for target population and providers, building relationships with community resources, public health, schools, churches, and other social service

organizations to identify, refer and develop resources that remove consumer barriers to accessing needed health and social services;

- According to grant and organizational guidelines, connects with identified individuals to inform them about NHA services and related community resources and assists clients and families in accessing needed care that facilitates: individual and family health, care coordination, continuity of care, and case management;
- Works with clients and families to determine need for and encourage individuals to obtain needed care and resources and utilizes follow-up strategies to ensure needed services are obtained;
- Completes and maintains required client records; providing accurate and timely documentation according to program and grant guidelines.
- Implements and manages client plan based on individual needs, providing referrals to appropriate services.
- Promotes healthy lifestyle choices by encouraging clients to manage and reduce health risk factors.
- Provides appropriate health and developmental educational information to target population.
- Completes required program documents using appropriate agency protocols.
- Serves as a team member to develop multidisciplinary solutions to client problems.
- Performs basic clerical, computing and office duties.

MISCELLANOUS AND SPECIAL ASSIGNMENTS:

- As assigned by the Care Coordination Project's designated manager, attends and represents the Care Coordination Project at appropriate community or networking meetings to facilitate outreach and gathers information necessary to increase consumer access to a permanent medical home;
- Participates in appropriate and required training, as assigned.
- Attends agency and program meetings when appropriate.
- Is familiar with the Center's Fire and Disaster Plan and the role of the Care Coordinator in that plan.
- Regular attendance is a requirement of this position.
- Additional duties as assigned by NHA management.

ATTENDANCE:

- Regular physical attendance at the worksite(s) is an essential function of this position as client interaction cannot be performed remotely.

QUALIFICATIONS:

- Must have CHW certification or an associates or bachelors degree in Social Work.
- Certified Community Health Worker certification thru the Ohio Nursing Board required
- A valid Ohio driver's license and auto insurance with an acceptable driving record.
    - Reliable transportation and willingness to travel extensively throughout Lucas County.
- Must be sensitive to cultural, religious, and ethnic diversity.
- Possesses a pleasant demeanor and the personal maturity and emotional intelligence to be able to manage working under demanding and challenging clinical circumstances.
- Exhibits patience, understanding and consideration.
- Effective organizational, communication, writing and listening skills.
- Ability to communicate ideas in caring for patients.
- Follows oral and written instruction.
- Knowledge of basic computer functions (Microsoft Windows, Word)
- Ability to work closely and effectively as a team player with NHA staff, community leaders and health professionals.
- Ability to maintain patient confidentiality.
- Shows initiative and ability to use sound judgment in the absence of specific orders.
- Must be able to work independently or as a member of a group.
- Possesses a neat and professional appearance.

Benefits: Health, Dental, Vision, Life Insurance and 403(b) Retirement Plan

Paid Holidays (10 per year)

Full Time position (37.5 hours per week)

Monday – Friday (8:00am to 4:30pm); summer hours (8:00am to 5:30pm M-TH and 8:00am to 11:30am Friday)

Hourly position: $12.00 ($16.00 C-CHW Certified)