LIVINGSTON COMMUNITY HEALTH
Care for all. Salud para todos.

Job Description
Care Coordinator

Department	**Care Integration**
Classification	**Non-Exempt**
Reports to	**Director of Care Integration**

Summary:

The Care Coordinator, in alignment with the goals of PCMH (Patient Centered Medical Home) and Livingston Community Health standards will be primarily responsible for patient care management. The coordinator will function as a patient advocate in the team based model of care and will communicate information to and from the patient care team. This position will help to develop and maintain positive relationship with patients by providing ongoing support for the patient and family through the team based model. The coordinator is responsible for developing, establishing and maintaining multiple working relationships with; providers, medical assistants, health educators, front office and health coaches to ensure optimal quality health care. The coordinator will work operation in conjunction with Quality Improvement personnel. The coordinator will work closely with primary care providers, clinic staff, and health team members to assist with patient self-management, patient panel management, data collection efforts, reporting and analysis, low level case management, chronic care coordination, visits and referral coordination. The Coordinator will develop and create report criteria as well as coordinate running reports, evaluating data form reports and communicate as directed. Regularly share quality performance reports with clinic staff to perpetuate quality improvement projects as it relates to improving patient health outcomes.

Essential Functions:

1. Develops and establishes working relationships with multiple departments to ensure cohesive communication, direction and completion.
2. Work in collaboration with team members to identify care needs as directed as well as underdeveloped care needs.
3. Versed in patient education and Pre and Post care instructions to patient in direct correlation to provider orders and defined plan of care
4. Population Health Management - Provide telephone outreach and education based on direct monthly registry list; (i.e. for high risk patients to review plan of care as indicated on provider's last note, review medication compliance, blood glucose monitoring, diet/exercise etc.)
5. Prepare all necessary reports, exam results, physician notes and other related documents (5) days in advance prior to visitation.
6. If labs are indicated contact patient for further instructions and preparation.
    a. Follow up and close any open orders and/or referrals.
    b. Assemble reports for; provider (hospital records, specialist reports, imaging etc.)
7. Establishes relationships as liaison with health plan case managers as indicated.
8. Participates in community outreach activities as determined by the organization's needs.
9. Liaison with pharmacies to communicate discontinued medications, medical compliance etc.

10. Ensures continuity of care by making follow up contact with patient after provider visit using established guidelines and provider directives.
11. Collaborates with other members of the care team in policy and procedure development related to patient and staff education.
12. Participates in daily huddles with members of the care team.
13. Reviews care standards to evaluate effectiveness of quality as indicated.
14. Attends and actively participates in all meetings including CQI and educational updates and other activities as required or assigned.
15. Attends workshops/seminars as necessary to increase skills and knowledge to provide effective care, treatment and leadership.
16. Compiles statistical data and writes narrative reports summarizing quality assurance findings and report those findings to Operations.
17. Frequent patient contact in person and via telephone.

Competencies:

1. Communication
2. Consultation.
3. Critical Evaluation.
4. Ethical Practice.
5. Global & Cultural Awareness.
6. Relationship Management.

Required Education and Experience:

1. Bilingual English/Spanish.
2. Minimum of 2 years' experience in clinical settings/FQHC.
3. California Code of Regulations; Title 22.
4. Current CPR certification.
5. Leadership.
6. Communication with persons of all; ages, socio-economic backgrounds.
7. Maintain a solid sense of privacy and confidentiality.
8. Problem solving and conflict resolution.
9. Customer service.
10. Time management/Prioritization.
11. Familiar with chronic health conditions.
12. Adapt to changing environments.
13. Knowledge of basic anatomy.

Supervisory Responsibility:

This position has no direct supervisory responsibilities.

Work Environment:

This job operates in a professional office environment. This role routinely communicates verbally and on a face to face basis with others.

Typical Physical Demands:

Requires standing/walking for up to 30% to 60% at a time, sitting for up to 30% to 60% at a time, lifting and carrying 0% to 20% at a time, lifting or carrying of up to 40 pounds 0% to 5% at a time, reaching 30% to 70 % at a time, bending and stooping 30% to 80 % at a time, squatting/crouching 5% to 15 % at a time, handling/grasping 25% to 80% at a time.

Travel:

Travel is primarily locally during the business day.

Other Duties:

Please note this job description is not designed to cover or contain a comprehensive listing of activities, duties or responsibilities that are required of the employee for their job. Duties, responsibilities, and activities may change at any time with or without notice.

I have read the above job description, reviewed it with my supervisor, and agree to perform the responsibilities as described above. I understand that this job description is intended to describe the general nature and level of work performed. It is not intended to serve as an exhaustive list of all duties, skills and responsibilities required of personnel as classified.

_____ _____

Employee Signature Date

_____

Print Employee Name

_____ _____

Supervisor Signature Date