Job Announcement: Health Homes Care Coordinator
Date: July 22, 2021

General Description

This position is responsible for providing care coordination services to eligible patients enrolled in the Health Care Authority Health Home Program. Provides support for designated clients which includes coordinating an array of services designed to improve the health of high needs, high risk clients. Care coordination responsibilities will include assessment, care planning and monitoring of client status, and implementation and coordination of services. Provides support to clients for effective care transitions, improved self-management skills and enhanced client-provider communication. Will facilitate interdisciplinary consultation, collaboration and care continuity across care settings.

This position reports to the Health Homes Supervisor.

Essential Functions and Responsibilities include the following:

- Engages clients in care coordination activities designed to promote improved utilization of health care services, including the creation and ongoing maintenance of a patient-centered, goal oriented Health Action Plan.
- Assesses activation level for self-care through use of the Patient Activation Measure® (PAM®).
- Provides evidence-based health assessments and screenings such as; BMI, PHQ-9, Katz ADL, PSC-17, GAD-7, AUDIT or DAST.
- Provides transition support services that coaches the client to build confidence and competence in four conceptual areas, or "pillars": medication self-management, use of a patient-centered health record, primary care and specialist follow-up, and knowledge of red flags of their condition and how to respond.
- Performs facility visits, home visits, and follow up telephone calls to develop critical coaching relationships, to empower clients to take an active and informed role in their discharge planning.
- Coordinates and communicates regarding the client's post-discharge status with all involved health care providers including, but not limited to: primary care, mental health, specialty care, and pharmacy.
- Identifies and addresses barriers to overcome impediments to accessing health care and social services.
- Provides referrals and advocacy for clients and their caregivers to community based services and supports.
- Provides teaching about self-management of the client's chronic health condition and provides resource links to ongoing chronic disease self-management support services.
- Develops and maintains complete and concise client files in compliance with policy to appropriately document activities performed for the client and all elements required for specific programs.
- Maintains all required documentation related to services provided and conforms to monthly deadlines.

- Participates in staff meetings, public education and provider training sessions, as appropriate.
- Develops and maintains relationships with community agencies and organizations that have the potential to provide resource support to the program or individuals.
- Prepares correspondence, memos, and client related written materials, as appropriate.
- Participates in continuing education and training programs.
- Works collaboratively with multi-disciplinary teams involving nurses, case managers and case aides.
- Attends required meetings and trainings.

Environmental Factors:

Duties re performed in an office setting and include daily home visits to clients and their families where conditions of the home environment may not always be ideal or predictable. Some homes are potentially hazardous, to include unrestrained animals, inadequate housing situations, clients or family members with hostile behaviors and second hand tobacco smoke. Driving conditions may be in rural settings and care coordinators may have home visits scheduled during inclement weather.

Physical Demands:

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Ability to drive to home visits as needed using personal vehicle, and is exposed to changing weather conditions. Driving demands average 150 to 300 miles per month depending on client needs. Ability to work on computers and the telephone for long stretches of the day, frequent typing for up to 5 hours per day. Must have speech, visual, and hearing skills sufficient to interact with staff and the public. Must have finger dexterity to operate computers. Occasional periods of writing. Infrequent bending, stooping and lifting. Frequently stands, walks, sits, and grasps with hands. Must have the ability to lift 15 pounds on a regular basis (computer case with laptop and files on home visits).

Skills, Knowledge and Abilities

- Proficient with Microsoft Word, basic skills with Excel and databases.
- Direct functional assessment, service planning and implementation experience.
- Demonstrated client advocacy skills and sensitivity to the needs and values of diverse groups.
- Knowledge of the long term care system and services, issues related to aging and disability, and case management.
- Knowledge of local in-home and community options and resources for the elderly and adults with disabilities and their caregivers.
- Ability to communicate verbally in the English language in face-to-face one-on-one settings, in group settings, by personal computer, or using a telephone.
- Ability to work independently in the field, with good judgment and a minimum of supervision.

- Ability to work effectively as a team member with a wide range of diverse staff and community members and to establish and maintain effective working relationships.
- Work effectively with colleagues and other customers by practicing punctuality, respect for deadlines, collaborative problem solving and honest communication.
- Build trusting relationships by acting with integrity, courtesy and responsibility, even in the face of stress or demanding workplace conditions.
- Ability to plan, organize, prioritize and coordinate work assignments and/or projects.
- Ability to work under pressure, within short timelines to implement service plan.
- Ability to establish and maintain effective working relationships with clients, families, caregivers, diverse service provider network, medical personnel, and Agency staff.
- Ability to defuse difficult situations recognizing the need for sensitivity as well as assertiveness.
- Demonstrated ability to maintain a high level of confidentiality.
- Ability to produce written documents with clearly organized thoughts using proper English sentence construction, punctuation, and grammar.
- Ability to maintain paper and electronic records and files of clients and services provided and to report those accordingly.
- Display empathy and positive regard for others in written, verbal and non-verbal communications.

Minimum Qualifications

Master's Degree in Social Work and a minimum of one year of social services experience. Bachelor's Degree in social services with two years or more of social services experience can be substituted. (Experience may be paid or volunteer experience within a social service agency.) Possession of a valid driver's license and minimum state-required vehicle insurance and have use of reliable transportation. Successful completion of criminal background check upon hire, and annually.

Prefer:

- Experience working with older adults and/or people with disabilities.
- Specialized education and experience in addiction, mental health.
- Experience with Motivational Interviewing, coaching and the Coleman Care Transition Intervention Model.
- Experience in applying observation and analytical techniques in evaluating situations and formulating conclusions.

Deadline to apply: August 6.

Start pay: Pay Level 6-A, $45,903 or Pay Level 6 placement at the closest step approximately 5% above current pay of $45,903 or higher.