Care Coordinator

Job Title: Care Coordinator – Full Time with benefits
Starting Salary: $55,000-58,500 annually
Prepared Date: 9/21/2024

Mission Statement of the Grand County Rural Health Network is: "We work in partnership to advocate for and support the health of our community."

Position Summary:
Coordinate care for Grand and Jackson County residents to support access to care and reduce barriers to health. Outreach to Grand and Jackson County Medicaid clients identified as high need or high risk for medical or behavioral health needs and/or social determinants of health. Complete monthly reporting for program activities and timely documentation of case work. Good interpersonal skills required. Requires travel throughout Grand and Jackson Counties, with mileage reimbursement. Good interpersonal skills and ability to maintain healthy boundaries required. Must be highly skilled in Microsoft Office and internet. Only self-directed and motivated individuals need apply. Email lstokes@gcruralhealth.org for full job description. Starting salary: $55,000-58,500 annually DOE, plus benefits.

Applicants with a bachelor's degree in health-related field, MSW with health-related background, or other relevant health or human services education/experience preferred. Bi-cultural and bilingual Spanish speakers strongly encouraged to apply.

To apply, send letter of introduction and resume to: Lauren Stokes, Direct Services Program Director, Grand County Rural Health Network, P.O. Box 95, HSS, CO 80451; fax 970-725-3478; or email lstokes@gcruralhealth.org.

Supervision Received:
Reports to and receives general direction from the Navigation Program Manager. Works closely with other GCRHN staff, particularly the Health Navigation team and Direct Services Program Director.

Supervision Exercised:
None.

Essential Functions:

1. Provide a variety of indirect and direct care coordination/patient navigation to Grand and Jackson County residents, dually enrolled Medicaid/Medicare clients, and Medicaid clients identified as in need of supportive services. This includes:
   - Assist with research and case management (such as bill organization, benefits or resource application assistance, appointment scheduling, etc.).
   - Use data provided by Rocky Mountain Health Plans to outreach to clients enrolled in Medicaid.
   - Utilize and follow the Regional Accountable Entity Care Coordinator workflows.
   - Schedule and complete assessments, collaboratively create and implement care plans, follow-up as needed, and track results, referrals, and recommendations in database.
   - Meet with clients in public spaces or place of residence when appropriate to the client's needs.
   - Track and monitor referrals of clients for reporting.
   - Accurately document interactions in population health data systems within two business days.
   - Work closely with partner organizations such as Mountain Family Center, Public Health, and Social Services, to complete care plans.
   - Form trusting, collaborative relationships with patient navigators, mental health navigators, Regional Accountable Entity partner organizations, clients, and community partners.
   - Connect with clients, empathize, show compassion, perform assessments, provide individually tailored education, assist clients in development of a care-management plan, and advocate with and on behalf of clients to meet their needs and goals.
   - Coordinate with patient navigation team and other partners to provide outreach and referrals for clients.
2. Collaborate with patient navigation team to ensure all program deliverables are being met and advise Program Manager of any needs for meeting deliverables.
3. Collaborate with navigation team to support maintenance and organization of available resources related to client or community needs.
4. Identify common themes and issues that clients and community members are facing; report internally in real-time to inform organizational advocacy efforts as well as community organizing and collective impact.
5. Contribute to organizational fundraising activities or events as needed.
6. Assist with grant writing and reporting as needed.
7. Participate in regular staff meetings as well as internal and external meetings; as needed, provide overview information on program status, problems, or needs.
8. Assume responsibility for projects and assignments as assigned by the Program Manager, Program Director, Associate Director, or Executive Director.

Qualifications: To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The 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.

Requirements: Valid Colorado driver's license and reliable vehicle (mileage will be reimbursed for work-related travel). Bilingual and bi-cultural preferred, but not required.

Experience and Education:
Bachelor's degree in health-related field, MSW with health-related background, or other relevant health or human services experience.

Knowledge, Skills & Abilities:

- Ability to greet and meet public and professionals in a positive and professional manner.
- Skill in written communication to write case notes and communicate with clients, coworkers, providers, and partners.
- Skill in verbal communication to direct, facilitate and develop relationships with clients, coworkers, and partners.
- Knowledge of Grand County healthcare services and organizations.
- Ability to work independently without close supervision in an independent work environment.
- Ability to follow through on assignments as requested in a timely fashion with limited supervisor follow-up.
- Ability to respond to a variety of socioeconomic and ethnic backgrounds appropriately.
- Ability to maintain professional demeanor when dealing with difficult individuals and situations.
- Ability to formulate a plan, actions steps, goals, objectives and follow-up to address client needs.
- Ability to read and interpret physicians' orders, notes from clients, and entries on computer screen as well as respond to them verbally and in writing.
- Skilled in use of Microsoft Word, Excel, and Internet. Experience with database usage preferred.

Physical Demands: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this Job, the employee is regularly required to sit and talk or hear. The employee is frequently required to use hands to finger, handle, or feel. The employee is occasionally required to stand; walk and reach with hands and arms. The employee must occasionally lift and/or move up to 25 pounds.

Work Environment: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Care Coordinator works in a shared office space. The noise level in the work environment is normal to a shared office.

Benefits:
Employees of the Grand County Rural Health Network are also eligible for our benefits program, which includes **medical insurance beginning the first day of the month after you start, retirement account with employer contribution, vacation time, sick pay, flex hours, and up to 30% working from home,** and other benefits which will be described in more detail in both the employee handbook and orientation package.

Trial Period:
New employees will be on a trial period for 90 days, during which you may not take vacation (unless pre-approved at time of hire) or work from home. This is to ascertain, for both you and the company, if this is truly the right fit. During and after this period, your supervisor will closely observe your job performance. Upon completion of the first 90 days of employment, employees become eligible for certain benefits, including accrued paid vacation and working from home option up to 30% of the time.

Core Competencies: The following core competencies are required for this position.

- **Client centered care:** You identify, respect and care about clients' and leaders' differences, values, preferences, and expressed needs. You empathize with their experiences, both easy and hard. Your role is always to coordinate care and look at the big picture, or social determinants of health, and how they impact the client's health and well-being. You listen to, clearly inform, and share decisions with the client. You continuously advocate for disease prevention and management, wellness, and the promotion of healthy lifestyles. You also understand the importance of population health, or the health of the entire community.
- **Medical home approach:** You understand the importance of every person having a medical home, or primary medical, dental, and mental health provider that understands and knows the person. The medical home is patient-centered, comprehensive, and accessible to the client. You know that each client might need something different based on their own philosophies. Similarly, each provider might practice differently based on their philosophies. You work with the client to help them identify an appropriate medical home, and whenever possible a local medical home.
- **No wrong door approach**: You understand that health is more than health care. This is a client-centered approach where you can answer any questions a client might have to navigate the fragmented system of health care and human services.
- **Continuous learning and reflection:** There's always more to know out there, and you're hungry for it. You absorb information from your colleagues, your work, and from keeping up with your field. If something doesn't make sense, you ask questions until it does, and you apply what you learn in your work. You are not afraid to take risks even though it means that you will make mistakes. And you *WILL* make mistakes. You are reflective about your own practice, and give yourself the grace to make mistakes, name them, and learn from them. With your continuous learning and reflection practice, you grow from your mistakes and make yourself and the organization better for it. This practice is encouraged and supported. When you give yourself grace to make mistakes and strength to learn from it, we give you grace and support your strength.
- **Initiative and ingenuity:** You leverage resources creatively to solve problems and dive right in to take a concept from idea to implementation. You often consult with others, but you can also propose solutions in the best interest of the people we serve and the organization and get things rolling without much guidance. You provide timely and complete updates to your

supervisor and/or team, even when that means there is little movement. By doing this, you illustrate your initiative and ability to work on a high functioning team.

- **Relationship-building:** Part of your job is connecting with people from many different backgrounds. You find (and even create) opportunities to deepen connections and build authentic, mutual relationships across lines of difference, such as race or other identities. You truly welcome viewpoints that differ from your own, and you're able to "sit with" discomfort when people express themselves in ways that aren't familiar to you.
- **Teamwork**: You actively participate in the work of team by voluntarily taking on different roles and responsibilities. You work cohesively with other team members and encourage the efforts and contributions of others. Together we are better and you always work to lift up your teammates. You communicate clearly and respectfully with co-workers. You ensure that your communication was received and understood, which often means understanding the different styles of communication each person needs to receive information. You assume best intentions in others. You ensure that team goals are achieved through fair and reasonable sharing of responsibilities, opportunities for participation, and adequate resources and other supports. You understand everyone has a role to play and contribute to the team's goals, and you contribute your share. You understand others' skills, experience, knowledge and creativity and consistently speak highly of others to contribute to team spirit.
- **Adaptability and problem solving:** You are always ready to take advantage of unexpected opportunities and address obstacles. You look for the root of both simple and complex problems, so you can seek solutions. You approach work with a spirit of "yes" and adapt as things change, which they often do.

History and Background

Rocky Mountain Health Plans (RMHP) has elected to participate in the Colorado Medicaid Accountable Care Collaborative as the Region 1 Regional Accountable Entity (RAE). Integrated Community Care Teams (ICCTs) in Northwest CO are a critical component of the RMHP partnership's approach, which honors local intelligence and leadership to drive community-level vision and innovation aimed at improving the health and well-being of all community members served by Medicaid.

The Grand County Rural Health Network contracts with The Health Partnership (formerly Northwest Colorado Community Health Partnership) to implement the ICCT in Grand and Jackson Counties.

The Northwest Colorado ICCT builds capacity and infrastructure in the Health Neighborhood by providing care transition services, care coordination, and complex case management, ICCTs are typically housed within an Anchor Organization (Grand County Rural Health Network), which will provide the infrastructure for the ICCT staff, including a supervisor and human resources support for the team; management of payroll, benefits and compensation; access to HIPAA-secure electronic devices like computers, laptops, tablets or mobile phones; work space (if needed); compensation for mileage and other necessary and usual infrastructure supports.

ICCTs are multi-disciplinary and can be comprised of nurses, licensed behavioral health professionals, Certified Addiction Counselors (CAC), social workers, and highly trained and experience non-credentialed professionals that serve as community health workers. Care

coordinators meet with Members in safe locations, like homes, homeless shelters, hospitals, and other public meeting places, or via a telehealth tool, available to all ICCT staff.