AREA AGENCY ON
Aging & Disabilities
OF SOUTHWEST WASHINGTON

Job Description

Position Title: Care Coordinator
FLSA: Non-Exempt
Range: 20
($59,424 - $81,912 annually on a 14-step scale, candidates typically start at first step)
Reports to: Care Coordinator Supervisor
Supervisory Responsibilities: None

SUMMARY:

Provides support for designated clients/beneficiaries which includes coordinating an array of services designed to improve the health of high needs, high risk clients/beneficiaries. Care coordination responsibilities will include assessment, care planning and monitoring of client status, and implementation and coordination of services. Provides support to clients/beneficiaries for effective care transitions, improved self-management skills and enhanced client/beneficiary-provider communication. Will facilitate interdisciplinary consultation, collaboration, and care continuity across care settings.

ESSENTIAL FUNCTIONS:

- 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 (HAP).
- 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, GAD-7.
- Provides transition support services, generally based on the Coleman model of Care Transition Intervention.
- Works with supervisors and other healthcare providers, hospital discharge planners, skilled nursing facility staff, and staff at the client's health home to implement services and analyze the disposition of cases.
- Coaches the client/beneficiary 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/beneficiaries to take an active and informed role in their discharge planning and introduce them to the patient-centered Personal Health Record.
- Tracks coaching-related metrics and reports on intervention progress.
- Coordinates follow-up activities and referrals with other programs including the Family Caregiver Support Program and AAADSW/HCS Medicaid Case Management.
- Coordinates and communicates regarding the client's/beneficiary'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/beneficiaries and their caregivers to community long term services and supports, which includes family caregiver programs, nutrition programs, in-home care, and case management.
- Provides teaching about self-management of the client's/beneficiary's chronic health condition and provides resource links to ongoing chronic disease self-management support services.
- Develops and maintains complete and concise client/beneficiary files in compliance with policy to appropriately document activities performed for the client/beneficiary 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.

Knowledge, Skills, and Abilities:

- 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 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.
- Computer and software skills; ability to operate general office equipment; work at a desk using phone and computer for up to eight hours a day.
- 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.
- Ability to operate standard office equipment.
- Demonstrated strength in learning and mastering new job responsibilities.

- Ability to function in a multi-lingual, multi-cultural environment, including providing service with use of interpreters.
- Experience using motivational interviewing or other empowerment-based approaches is desired.
- Ability to travel to and from client's homes and other community agencies which might not be ADA accessible.

Minimum Qualifications:

- A Master's Degree or further advanced degree from an accredited school of social work or a degree deemed equivalent is preferred; OR a bachelor's degree in social work, human services, or related field with two years of paid on the job social service experience.
- Experience working on cross disciplinary, cross-organizational teams.
- Experience meeting and working with people in homes and other medical and community settings.
- Possession of a valid driver's license and minimum state-required vehicle insurance and have use of reliable transportation.

Working Conditions and Physical Effort:

Work is performed approximately 30% in an office environment and 70% in field client visits. Fully remote/telework options are available depending on location of position. Potential hazards include working with emotionally unstable, non-compliant or aggressive clients and complex family dynamics; significant travel; driving in inclement weather; secondhand tobacco smoke; aggressive animals, exposure to contagious diseases and exposure to repetitive stresses due to prolonged use of computers

Sufficient mobility is required for the use of office equipment such as computer laptops, telephones, files, and copiers as well as for performing in-home assessments of clients which may have limited accessibility. The ability to hear and communicate at a level sufficient to perform the essential functions of the position is required. Ability to lift and maneuver a maximum of 30 pounds.

Revised Date: February 6, 2023

The statements contained herein reflect general details as necessary to describe the essential functions of this job, the level of knowledge and skill typically required and the scope of responsibility but should not be considered an all-inclusive listing of work requirements. Individuals may perform other duties as assigned including work in other functional areas to cover absences or relief, to equalize peak work periods or otherwise balance the workload.