Sawtooth Mountain Clinic

Together Through Life

a 501©(3) not-for-profit organization

JOB DESCRIPTION

JOB TITLE: Health Care Home Coordinator, 2019

Exempt (Y/N):	**No**
Standard Hours:	**Up to 40 hours/week**
Location:	**Grand Marais, MN**
Supervisor:	**Clinical Nurse Manager**

Sawtooth Mountain Clinic's mission is to provide access to high quality, comprehensive primary and preventive healthcare to all users, regardless of financial ability to pay, throughout SMC's service area of Cook County, Minnesota and the Grand Portage Band of Lake Superior Chippewa Reservation.

Core Values

"We believe that quality healthcare is a right, not a privilege. We are here with you, *together through life,* dedicated to providing a medical home and medical care that is respectful of you, your family, and your desire to thrive in this community".

Job Summary:

The Health Care Home (HCH) Care Coordinator collaborates with primary care physicians, clinic staff and other Health Care Home team members to identify needs, organize activities, and coordinate plans of care for identified patients. The care coordinator is an advocate for the patient and depending on patient need, may link them with health and community resources that provide a range of services, promote self-management, improve health and reduce disparity. The care coordinator assists patients to achieve health goals and improved health care outcomes.

A. Functions and Responsibilities:

1. Assess the Health Status of Patients:

a. Reviews SMC's Chronic Disease Registry monthly reports to identify patients who qualify for Enhanced Care Coordination Services (ECC) and consults with medical provider. (per Policy 200-22.3)

b. Plans, coordinates and provides patient-specific health education based on the chronic or associated conditions identified.

2. Develop and Maintain a Care Plan:

a. Works with the ECC patient, providers, and HCH Care Team members to develop and maintain an individualized clinical Care Plan for the patient if necessary.

b. Collaborates with the provider and HCH Care Team to ensure Care Plan data is up-to-date and complete.

c. Assists patients with the identification, selection, monitoring and documentation of self-management goals.

d. Follows up with the patient to ensure the patient's responsibilities are being followed and met. Monitors the patient's progress toward goal achievement and modifies as needed.

e. Schedules follow-up appointments or makes phone contact to ensure the patient is receiving needed services, that outcomes are improving, and to determine if progress is being made towards defined goals.

3. Care Management:

a. Follows the prescribed care coordination workflow to comply with HCH certification requirements.
b. Interacts and coordinates care with team members, providers, and coordinates appropriate referrals to specialists, and community resources to ensure comprehensive care for the patient.
c. Serves as an advocate for the patient to understand needs (i.e. shelter, transportation, child care, safety) and arrange or coordinate applicable services.
d. Collaborates with the nursing staff for pre-visit planning.
e. Conducts regular, periodic care plan review with the patient and/or family. Arranges for interpreter services if needed.
f. Reviews care coordination patient's records to determine when patients should be seen by their primary care provider for any one or more of their applicable chronic conditions and works with the patient to schedule an appointment.
g. Notifies the primary care provider if patients decline or choose to leave the program. Keeps the provider informed on care coordination progress via EHR documentation.
h. Discusses end-of-life situations, health care directives, and coordinates with the HCH team members.
i. Identifies and/or updates the patient's primary care provider (PCP) in the EHR.
j. Discusses external care plans that other providers or services may have developed, incorporates that information into the care plan, and works with the patient to coordinate any supplemental or overlapping services.

Job Qualifications:

a. Current Minnesota Nursing License
b. Prefer a Bachelor of Nursing from an accredited school.
c. Three to five years of experience in a health care setting, preferably primary care, and working with underserved and at-risk populations.
d. Ability to work both independently and collaboratively as an effective member of a health care team.
e. Proven strong interpersonal skills.
f. Experience with an electronic health record system preferred.
g. Ability to work comfortably at a computer for long periods of time.

Salary: Commensurate with educational background and experience.

Benefits: As defined in Sawtooth Mountain Clinic's Employee Handbook.

Sawtooth Mountain Clinic, Inc. is an equal opportunity/affirmative action employer.

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Employee Signature **Date**

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Print Name