Job Description

Position Title: RN/ LPN Care Coordinator
Non-Exempt
Reports to: Local Program Coordinator
Supervisory Responsibilities: None

SUMMARY:

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 will not involve providing direct care or treatment.

ESSENTIAL FUNCTIONS:

- Coordinates follow-up activities and referrals with other programs including the Family Caregiver Support Program and ALTC/HCS/DDA Medicaid Case Management.
- Identifies and addresses barriers to overcome and impediments to accessing health care and social services.
- 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.
- Works with supervisors and other health care 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.
- 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 which includes family caregiver programs, nutrition programs, in-home care and case management.
- 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.

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 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 relationship 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.
- Computer and software skills including Word, Excel and database systems; ability to operate general office equipment; work at a desk using phone and computer for up to a full day's work schedule.

- 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.
- 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.
- Ability to travel to and from client's homes and other community agencies which might not be ADA accessible.

Minimum Qualifications:

- Graduate of an accredited school of nursing. Current and unencumbered license to practice as a Registered Nurse or Licensed Practical Nurse in the State of Washington
- Maintain CEU's for license to practice as a Registered Nurse or Licensed Practical Nursein the State of Washington
- 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.

Preferred Qualifications:

- Two years nursing experience, including one year direct patient care in a community setting.
- Home health and psychiatric nursing background preferred but not required.
- Training in Coleman CTI or other coaching modality is desired.
- Experience working on cross disciplinary, cross-organizational teams.
- Experience meeting and working with people in homes and other medical and community settings.
- Experience using motivational interviewing or other empowerment-based approaches is desired.

Working Conditions and Physical Effort:

- While performing assessments in varied residential environments, the employee travels by automobile and is exposed to changing weather conditions.
- A portion of the work is in a typical interior/office work environment with significant travel to complete home visits.
- While performing the duties of this position, the employee is regularly required to talk, hear, stand, walk, sit, stoop, use hand to finger, handle or feel objects, tools, or controls, grasping and reach with hands or arms.
- The employee occasionally lifts or moves up to 25 pounds and/or a negligible amount of force frequently or constantly to lift, carry push, pull or otherwise move objects.
- Specific vision abilities required by this job include close vision and the ability to adjust focus. Repetitive motions to operate computer equipment while typing on keyboard and viewing computer screen.

- Duties are performed in an office setting and include daily home visits to clients and their families where conditions of the home environment may not be always be ideal or predicted.
- 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 case managers may have home visits scheduled during inclement weather.
- Requires being to work in a timely fashion, able to respond to public with good customer service skills, ability to exercise good judgment as it relates to client care, following rules and regulations.
- Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Date: September, 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.

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SE WA ALTC ensures equal employment opportunities regardless of a person's sex, race, national origin, religion, age, disability, marital status, creed, political belief, sexual orientation, veteran's status or any other protected status under federal or state statute. Disabled applicants may request accommodation to participate in the job application and/or selection process for employment. In compliance with the Immigration Reform and Control Act of 198, SE WA ALTC will only hire United States citizens and aliens lawfully authorized to work in the United States.