

Section 3.1 Design

Care Coordinator Sample Job Description

This tool provides a sample job description for a care coordinator (CC) serving in a community-based care coordination (CCC) program.

Time needed: 1 hour to review tool; 2-5 hours to create a job description specific to the CCC program

Suggested other tools: CCC Program Staffing Models; Planning Matrix for Care Coordination-Related Activities and Staff Roles; Population Risk Stratification and Patient Cohort Identification; CCC Maturity Assessment; Setting and Monitoring Goals for CCC

How to Use

1. **Review** the *CCC Program Staffing Models* and *Matrix of Care Coordination Related Activities and Staff Roles* tools in this Toolkit, as well as the *Care Coordinator Sample Job Description* (this tool).
2. **Consider** the CCC program needs with respect to the primary cohort of patients being served and related care coordination roles within the broader program to determine the credentialing requirements for a care coordinator that best fit the goals of the CCC program.
3. **Develop** a job description for a care coordinator as the basis for hiring or appointing a person to serve the CCC program.

Note: This is a *sample* job description only. Specific position requirements are contingent upon the needs of the community-based care coordination (CCC) program, the cohort of patients being served by the program, and related roles within the broader CCC program team.

SAMPLE JOB DESCRIPTION CARE COORDINATOR

Job Title: Care Coordinator

Reports to:

Schedule: Monday – Friday with some early meetings required (7 a.m.)

FTEs Needed: (1) FTE Care Coordinator will conduct 1,200 in-office patient visits per year (five patient visits per workday). The average patient may have between three and six interactions per year; some patients will decline such services, and others, depending on their self-management interests and/or current health risk status, will require considerably more interactions. Therefore, the Care Coordinator will work with a population of approximately 300-400 chronically ill patients.

- For communities serving 10,000 or fewer total lives: .5 FTE
- For communities serving more than 10,000 total lives: 1 FTE

Summary of Position

The Care Coordinator works in collaboration and continuous partnership with chronically ill or “high-risk” patients and their family/caregiver(s), clinic/hospital/specialty providers and staff, and community resources in a team approach to:

- Promote timely access to appropriate care
- Increase utilization of preventative care
- Reduce emergency room utilization and hospital readmissions
- Increase comprehension through culturally and linguistically appropriate education
- Create and promote adherence to a care plan, developed in coordination with the patient, primary care provider, and family/caregiver(s)
- Increase continuity of care by managing relationships with tertiary care providers, transitions-in-care, and referrals
- Increase patients’ ability for self-management and shared decision-making
- Provide medication reconciliation
- Connect patients to relevant community resources, with the goal of enhancing patient health and well-being, increasing patient satisfaction, and reducing health care costs

A typical day for the Care Coordinator will entail spending half of the day conducting one-on-one extended patient meetings (approximately 30-45 minutes long). The other half of the day will be spent on follow-up with patients, family/caregiver(s), providers, and community resources via secure email, phone calls, text messages, and other communications.

Success in this position will lead to improved health for the patient and reduced health care costs for the managed population of patients.

Essential Duties & Responsibilities

- Serve as the contact point, advocate, and informational resource for patients, care team, family/caregiver(s), payers, and community resources
- Work with patients to plan and monitor care:
 - Assess patient’s unmet health and social needs
 - Develop a care plan with the patient, family/caregiver(s) and providers (emergency plan, health management plan, medical summary, and ongoing action plan, as appropriate)
 - Monitor adherence to care plans, evaluate effectiveness, monitor patient progress in a timely manner, and facilitate changes as needed
 - Create ongoing processes for patient and family/caregiver(s) to determine and request the level of care coordination support they desire at any given point in time
- Facilitate patient access to appropriate medical and specialty providers
- Educate patient and family/caregiver(s) about relevant community resources
- Facilitate and attend meetings between patient, family/caregiver(s), care team, payers, and community resources, as needed
- Cultivate and support primary care and specialty provider co-management with timely communication, inquiry, follow-up, and integration of information into the care plan regarding transitions-in-care and referrals
- Assist with the identification of “high-risk” patients (the chronically ill and those with special health care needs), and add these to the patient registry (or flag in EHR)
- Attend all Care Coordinator training courses/webinars and meetings
- Provide feedback for the improvement of the Care Coordination Program

Education / Experience

- Licensed and credentialed [Registered Nurse / Nurse Practitioner / Physician’s Assistant with prescribing privileges / Social Worker / Community Health Worker / Other]
- 3-5 years’ experience in clinical or community resource settings; Care coordination and/or case management experience is desirable
- Evidence of essential leadership, communication, education, and counseling skills
- Proficiency in communication technologies (email, cell phone, etc.)
- Highly organized with ability to keep accurate notes and records
- Experience with health IT systems and reports is desirable
- Local knowledge about and connections to community health care and social welfare resources is desirable
- Ability to speak a relevant second language is desirable

Special Skill Requirements

- Core values consistent with a patient- and family-centered approach to care
- Demonstrates professional, appropriate, effective, and tactful communication skills, including written, verbal and nonverbal
- Demonstrates a positive attitude and respectful, professional customer service
- Acknowledges patient's rights on confidentiality issues, maintains patient confidentiality at all times, and follows HIPAA guidelines and regulations
- Proactively acts as patient advocate, responding with empathy and respect to resolve patient and family concerns, and recognizes opportunities for improvement to meeting patient concerns
- Proactively continues to educate self on providing quality care and improving professional skills

Salary

Salary or hourly compensation based upon education and experience

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For support using the toolkit

Stratis Health • Health Information Technology Services

952-854-3306 • info@stratishealth.org

www.stratishealth.org

