Today's Date: May 2, 2024

Job Listing: Care Coordinator (RN/LPN), Behavioral Health Clinic

Summary: The Care Coordinator is responsible for assessing, planning facilitating and advocating for options and services through a continuum of care. The Care Coordinator performs this role in such a manner as to meet the individual's health needs while promoting quality and cost effective outcomes. The position emphasis will be on care coordination, communication and collaboration with all members of the health care team to pace the care toward optimal outcomes within the appropriate level of care. The Care Coordinator will advocate for the patient and family by identifying and valuing patient choice, spiritual needs, cultural, language and socioeconomic barriers to care transitions. In addition, the Care Coordinator will protect confidentially while striving to achieve high levels of patient satisfaction.

DUTIES AND RESPONSIBILITIES:

1. Improve patient outcomes, and deliver quality care within practice areas as assigned. Ensure all clinical care is delivered in a manner that meets or exceeds goals and expectations for clinical outcomes, quality assurance standards, and patient satisfaction.
2. Participates in quality strategies to evaluate compliance with standards and to identify opportunities to improve patient outcomes.
3. Perform an assessment based on the patient's diagnosis, reason for entry into system and care needs. Utilize the nursing process to plan, perform, delegate and evaluate the delivery of nursing care.
4. Stay current with knowledge, concepts, practices and skills appropriate for the clinical area assigned.
5. Ensure all patient charts and related documentation are maintained current and relevant at all times.
6. Ensure all care and nursing practices are conducted consistent within current, relevant standards, as well as state and local laws and regulations, and related professional standards.
7. Demonstrate competency in practice and knowledge of current standards of practice. Maintains credentials and performs current nursing practice expectations within established guidelines.
8. Provides care in a manner that respects the patient's rights and choices in a multi-cultural setting.

9. Develops and maintains favorable internal relationships, partnerships with co-workers, including clinic managers, nursing staff, physicians and administrative office staff.
10. Develop and maintain favorable external relationships with vendors, contractors, referral agencies and related resources.
11. Contribute to team success: Supports established goals and objectives.
12. Ensure all actions, job performance, personal conduct and communications represent the organization in a highly professional manner at all times.
13. Uphold and ensure compliance and attention to all corporate policies and procedures as well as the overall mission and values of the organization.
14. Maintain accountability for delegation to unlicensed assistive personnel (clinic assistants/interpreters).
15. Complies with Corporate Compliance Program policies and code of conduct, and all laws, rules and regulations relating to the position. Has a duty to report any suspected violations of the law or the standards of conduct to his/her immediate supervisor, the HR Director, or the Compliance Officer.

PRIMARY TASKS & DUTIES

1. Provide direct care to patients as assigned and qualified to perform.
2. Assess, review, and develop nursing plans to ensure maximum patient outcomes
3. Provide counsel, support, advice, and support to patients and their families
4. Complete all patients charting, and ensure all patient records are current and complete.
5. Attend meetings, patient conferences, planning sessions, related to quality assurance, patient care, and other related topics within the clinic.
6. Attend seminars and maintain all licensure requirements for continuing education and best practices
7. Participates in quality strategies to evaluate compliance with standards and to identify opportunities to improve patient outcomes.

CARE COORDINATOR TASKS & DUTIES

1. Implements, coordinates, monitors, and evaluates options and services to meet patient's health needs and ensures appropriate use of clinical resources.
2. Implement Patient Centered Medical Home (PCMH) Standards for Care Management and Support.
3. Monitors delivery of care across all markets.
4. Coordinate with facilities and care transitions.
5. Expedites and coordinates appointments for assigned hospitalized patients.
6. Keeps all providers involved with member's care updated on appointments, condition, and additional clinical support needed.
7. Requests and gathers necessary medical records.
8. Maintains accurate and complete documentation in EMR.
9. Complex care review of patient status.
10. Develops an understanding of referral sources.

11. Collaborates with other programs and departments including behavioral health integration.
12. Link patient to community resources.
13. Assists in the teaching needs for patient and families as needed
14. Serves as a liaison between physicians and patients to ensure timely and quality care.
15. Communicates daily with providers and clinical staff regarding the plan of care and progress towards goals (daily huddles to inform staff of patient care needs) ie PCMH, MU, UDS standards met and or provided.
16. Completes case management assessment of patients and support systems in order to facilitate the most appropriate and timely transition plan.
17. Identify patients with ED / Hospital admits and discharges.
18. Medication and chart reconciliation of patients seen outside of the clinic.
19. Assist with the identification of “at-risk” patients (the chronically ill and those with special health care needs), and coordinate care.
20. Work with patients to plan and monitor care:
    a. Assess patient’s unmet health and social needs
    b. Develop a care plan with the patient, family/caregiver(s) and providers
    c. Monitor adherence to care plans, evaluate effectiveness, monitor patient progress in a timely manner, and facilitate changes as needed
    d. Create ongoing processes for patient and family/caregiver(s) to determine the level of care coordination support they need.
21. Assist in developing new programs using the PDSA Rapid Change methodology and Chronic Care Model
22. Participates in quality improvement (QI) activities and opportunities using patient data/clinical outcomes; conducts evidence-based improvements.
23. Assist with tracking and reporting key measures.
24. Identifies system/organizational processes which may affect effective utilization of resources, timely scheduling of tests, appropriate level of care being given, etc., and collaborates with team members to improve upon the processes
25. Responsible for coordinating and leading patient support groups and/or shared medical appointments
26. Maintain current health promotion and patient education materials and resources that the providers have agreed on, using evidence based resources.
27. Plan and assist with public relations activities as needed, including health fairs, and other public events
28. Defines and directs patients and/or families to appropriate resource utilization
29. Educate patient and family/caregiver(s) about relevant community resources
30. Covers clinic staff vacancies when all other resources have been exhausted

ESSENTIAL FUNCTIONS/ KEY COMPETENCIES

- Demonstrate a high level of skill at building relationships and customer service.
- Demonstrate interpersonal savvy and influence skills in managing difficult clients and patients.

- Demonstrate high degree of knowledge and competency in the practice of medicine and associated charting requirements.
- Requisite skills and ability to perform certain medical tasks as assigned
- Demonstrate a high level of problem solving skill to better serve patients and staff.
- Strong attention to detail and accuracy.
- Ability to utilize computers for data entry and information retrieval.
- Excellent verbal and written communication skills.
- Ability to implement, and evaluate operational and administrative processes.
- Demonstrated ability to manage multiple tasks projects effectively.
- Ability to work independently.
- Ability to work efficiently in a fast-paced environment with changing priorities.

MINIMUM QUALIFICATIONS:

1. Education: Graduation from an accredited nursing program, Bachelor's degree preferred.
2. Current and active licensure as a Registered Nurse (RN) in the State of Iowa is preferred or a Licensed Practical Nurse (LPN) with minimum of 4 years of experience is required.
3. Maintain Nursing CEUs for continued active license
4. Good verbal and written communication skills. Must be able to speak and read the English language.
5. Demonstrated professional commitment to providing services to medically underserved persons
6. Ability to communicate effectively both orally and in writing
7. Computer literate in electronic mail, word processing and Electronic Health Record (EHR).
8. Certification in Basic Life Support (BLS).

Hours: Monday through Thursday, generally 7:00 a.m.-5:30 p.m. Schedule is subject to change at any time. Some travel required.

Supervisor: Behavioral Health Nurse Manager.

Deadline: Position will remain open until a pool of qualified applicants is received.

Submit cover letter, resume' and three references to Steve Haigh, HR Director at recruiting@riverhillshealth.org

Or, mail to:
River Hills CHC
PO Box 458
Ottumwa, Iowa 52501

River Hills CHC offers a competitive wage and full benefit package.