Olympic Area Agency on Aging
Job Description
Health Homes Care Coordinator

Salary Range: 28 **Last Update:** 10/01/2023
Reports To: Nursing Services Manager **FLSA Status:** Non-Exempt

Position Mission Statement: Provides support for designated health home 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. Expected to maintain a minimum caseload of 50 clients per FTE. Provides/arranges for support to clients for effective improved self-management skills, enhanced client-provider communication and care transitions. Will facilitate interdisciplinary consultation, collaboration and care continuity across care settings.

Critical Duties, Responsibilities, and Standards of Performance:

1. Engage clients in care coordination activities designed to promote improved utilization of health care services.

   Standards of Performance:
   - Has the ability to clearly explain the Health Home Program to potential clients by phone, in person and via written correspondence. Contacts potential clients to explain the benefits of the Health Home Program to each client with the goal of building caseload.
   - 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, GAD-7.
   - Provides/arranges for transition support services, generally based on the Coleman model of Care Transition Intervention.
   - May coach 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.
   - Provides teaching/coaching re: self-management of the client's chronic health condition and provides resource links to ongoing chronic disease self-management support services.

2. 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.

   Standards of Performance:
   - 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 and introduce them to the patient-centered Personal Health Record.

- Coordinates follow-up activities and referrals with other programs including Case Management, Information & Assistance, Family Caregiver Support Program, etc.
- Develops and maintains relationships with community agencies and organizations that have the potential to provide resource support to the program or to individuals.
- As applicable, 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 long term services and supports, which includes family caregiver programs, nutrition programs, in-home care and case management, etc.
- Works collaboratively with multi-disciplinary teams involving nurses, case managers and case aides.

3. 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.

   Standards of Performance:

   - Tracks coaching-related metrics and reports on intervention progress.
   - 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.
   - Prepares correspondence, memos, and client related written materials, as appropriate.
   - Participates in continuing education and training programs.
   - Attends required meetings and trainings.

Essential Qualifications:

Master's Degree in behavioral or health science and one year paid on the job social service experience, or Bachelor's Degree in behavioral or health sciences and two years of paid on the job social service experience, or Licensed Practical nurse licensed to practice practical nursing under chapter 18.79 RCW with at least two years of related job experience, or Bachelor's Degree and four years of paid on the job social service experience.

Training in Coleman CTI or other coaching modality is preferred. Experience working on cross disciplinary, cross-organizational teams. Experience meeting and working with people in homes and other medical and community settings. Demonstrated working knowledge of supportive services. Area knowledge of community resources for the elderly, disabled adults and caregivers.

Well-developed human relations skills and ability to work in a team based environment. Knowledge of social service or human service issues, pertaining to elders and people with disabilities preferred.

Ability to research and propose solutions to a variety of problems presented by clients.

Ability to communicate with public, both orally (in person and on the telephone) and using written materials. Hear and speak clearly on the telephone. Excellent communication skills, oral and written.

Equipment and Software Requirements:

Experience with PC-based word processing, spreadsheet and data base applications. Ability to utilize other PC-based computer programs and systems that may be specific to particular positions or duties. Knowledge of Microsoft Word, EXCEL, and Outlook Email programs. Ability to acquire proficiency in respective MCO client documentation platforms.

Essential Requirements of this Position:

Valid/Current Washington State Driver's License.

Current Automobile Insurance.

Ability to pass background checks.

Ability to read, speak, write and comprehend the English language.

Ability to drive independently between O3A office locations and various meetings off site.

Ability to travel to client's homes or community agencies or to work at a desk up to eight hours a day using computer and telephone.

Ability to climb stairs and to make home and residential client visits in settings that may not be accessible or may not meet prevailing community standards.

Ability to maintain records and files of clients and services. Ability to document services, review and write on paper forms. Ability to use a computer keyboard to enter and retrieve information.

Ability to establish and maintain effective working relationships with clients, families, caregivers, service providers and staff.

Skill in interviewing clients in person, on the telephone, and others involved as relevant, in order to elicit information and impact client situation.

Other Duties As Assigned:

The statements contained herein reflect general details to describe the principal functions of this position, the level of knowledge and skill typically required, and the scope of responsibility. This job description 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 to balance the work load.

This job description does not constitute an employment agreement between the employer and employee and is subject to change by the employer as the needs of the employer and requirements of the job change.

Working Environment and Physical Requirements:

This position requires an ability to perform office functions in a normal office environment. Work involves sitting and working in front of a computer terminal for extended periods of time. While performing the duties of this job, the employee is frequently required to stand and walk, use hands and fingers to handle, feel or operate objects, tools or controls, reach with hands and arms, talk and hear both in person and over the telephone. The employee is occasionally required to sit, climb or balance, stoop, kneel, crouch or crawl. The employee must lift and/or move up to 25 pounds occasionally, and/or up to 10 pounds frequently, and/or a negligible amount of force constantly to

move objects. Specific vision abilities required by this job include close vision and the ability to adjust focus.
Reasonable accommodations will be made to enable individuals with disabilities to perform the essential functions of this position.

O3A is an equal opportunity employer and does not discriminate in employment decisions or policies in violation of law on the basis of race, color, national origin, creed, religion, sex, age, marital status, physical or mental disability, sexual orientation, or status as a Vietnam-era or special disabled veteran. This policy applies to all terms and condition of employment, including hiring, placement, promotion, termination, reduction in force, recall, transfer, leaves of absence, compensation, and training.

OLYMPIC AREA AGENCY ON AGING JOB DESCRIPTION APPROVAL:

Title of Job Description: Health Homes Care Coordinator

Approved by: _____
Laura Cepoi, Executive Director

Date: 9/28/2023