# Care Coordinator

## Instructions

This job template provides an overview of the Care Coordinator's role within the organization and qualifying characteristics and skills. You should plan to adapt the job description to meet the needs of your organization, your Care Team, and your target population.

**Position Title:** Care Coordinator
**Reports to:** Program Director/Clinical Supervisor
**Work in collaboration with:** Patient Navigator(s), Program Director, health care/medical providers (primary care physicians, nursing staff, mental health workers)

## Position Summary

The Care Coordinator ensures patient navigation is implemented by managing client caseloads, conducting intake assessment and reassessment, and supervising Patient Navigators. Care Coordinators facilitate conversations between interdisciplinary Care Teams (including Patient Navigators, Care Coordinators, primary care physicians, and additional health care providers) and expedite client services referrals. The Care Coordinator is dedicated to providing support to staff in the field and is responsible for supervising Patient Navigators.

## Responsibilities

***Client caseload management:***

- Conduct intake assessment, needs assessment, treatment planning, and reassessment services
- Provide day-to day support, supervision, and performance reviews for Patient Navigators
- Reviews patient cases with Patient Navigator and provides advice, direction, and support as needed
- In most cases, organize or leads Patient Navigator training sessions
- In most cases, provide clinical supervision to Patient Navigators
- May meet with client along with Patient Navigator after primary care physician appointments to review and update care plan.
- Screen clients for eligibility for direct and support services and refer clients to needed services, such as mental health, housing, crisis, and employment assistance

***Organizational and administrative duties:***

- Facilitate Care Team meetings with Patient Navigators and health care providers to discuss client Care Plan and share information regarding referral sources
- Document client services in medical records
- Establish and retain client referral systems from care coordination systems
- Maintain documentation of all client encounters and complete reporting requirements according to organization standards
- Track client information, schedules, files, and forms in a confidential manner
- Initiate outreach and missed appointment procedures, as necessary
- Attend and represent the organization at professional conferences, in-service trainings, and meetings at the request of or with the approval of supervisor
- Conduct quality assurance and monitoring activities for service delivery and documentation

## Qualifications:

***Personal characteristics and skills:***

- Commitment to the mission of care coordination
- Good communication and interpersonal skills and ability to speak concisely to clients, Patient Navigators, and interact with Care Team members
- Strong knowledge of HIV care and patient navigation
- Organized with confidential client material, appointment tracking, and caseloads
- Ability to build relationships with different types of people, including clients, organization members, and members of the health care team

***Education and experience:***

- BA, LMSW/LCSW/LMHC or RN/LPN degree
- 2 years minimum of case management experience
- Strong understanding of cultural competency with the target population
- Computer literacy necessary
- Interest in working with HIV-positive clients
- Exposure to issues of death and dying

***Physical Requirements:***

- Physical demands associated with office work
- Some travel required

To apply, send a resume and cover letter to
[PROGRAM DIRECTOR NAME] at [EMAIL ADDRESS].