Position Title: Care Coordination	**Department:** Care Coordination
Reports To: Supervisor, Care Coordination	**Status:** Non-Exempt

Position Summary

The care coordinator has an overall responsibility and accountability for coordinating all aspects of the individual's care, including but not limited to health and behavioral healthcare, community supports, and other services required to meet the needs of the individual. For individuals who are enrolled in the health home, the care coordinator will take a holistic approach to care by utilizing the core standards of service. These include:

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services
- Use of Health Information Technology (HIT) to Link Services

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Position Responsibilities

- Completes required assessments using person centered planning techniques, as well as gathers and incorporates all other relevant assessments.
- Develops a comprehensive, person-centered Life Plan with the individual and their circle of support, as well as their entire service provider team.
- Supports the individual in the planning process to ensure that the individual directs the process to the maximum extent possible and can make informed decisions and choices.
- Reviews the Life Plan with the individual's entire interdisciplinary team no less than annually, and every time there is a life changing event. This review must occur during a face to face meeting, no less than annually.
- Accountable for coordinating all aspects of an individual's care.
- Effectively manage a tiered caseload, while tailoring services to individual needs.
- Completes program enrollment and eligibility document.
- Completes and secures consents and authorizations to share information.
- Develops and maintains appropriate records.
- Completes and reviews paperwork necessary for case files and reports.
- Completes documentation and billing in a timely manner.
- Meet with individuals in their homes, physician/provider offices, and other public places in order to conduct assessments and provide services.
- Accompanies individuals to appointments in accordance with Person Centered Services policy.
- Collaborates with providers and service support team members.
- Initiate incident reports and follow-up to ensure compliance with regulations.

- Monitors individual satisfaction with supports and services.
- Ensures case files are in compliance with regulation and policy.
- Provide quality driven, cost effective, culturally appropriate services.

- Commits to a respectful, just, and supportive environment for individuals and coworkers aligning with the company's commitment to diversity, equity, and inclusion.
- Other related duties, as may be assigned by the Care Coordinator Supervisor or Director of Care Coordination.

Knowledge, Skills, and Abilities

- Knowledge of developmental disabilities, chronic disease and social determinants of health.
- Strong knowledge of OPWDD funded services and supports.
- Experience with motivational interviewing.
- Experience writing SMART goals.
- Knowledgeable of person-centered planning regulations.
- Ability to build relationships and effectively communicate.
- Encourages community integration.
- Demonstrates cultural competence.
- Demonstrates ethical and professional responsibilities and boundaries.
- Demonstrates capacity to use Health Information Technology to link services and facilitate communication.
- Knowledge of confidentiality regulations.
- Organizational and time management skills
- Ability to prioritize.
- Proactively approaches professional responsibilities.
- Completes work in a timely manner.

Position Requirements

- Bachelor's degree with 2 years relevant experience OR a Licensed Registered Nurse with 2 years relevant experience OR A Master's degree with 1-year relevant experience *required*.
- Valid Driver's License *required.*

Employee Signature: _____

Supervisor Signature: _____