Care Coordinator

1. Establish and maintain a trust relationship with those followed in the care coordination program. This is the cornerstone of Care Coordination (CC).

2. Provide daily assistance for the ongoing coordination of care for patients involved in the CC Program.

- Includes fielding phone calls from patients and outside entities for the necessary daily flow of CC.
- Includes availability for warm handoffs from providers making referrals, especially in immediate crisis situations.
- Coordinating first contact with the RN Care Manager for needs assessment on new referrals.
- Following through on the plan of care with patients identified as needing on-going, regular contact.
- Connecting patients and coordinating referrals to outside resources when a need is identified by the Care Coordinator, Nurse Care Manager, or a provider. Must maintain knowledge of community resources and relationships with those providing the services.
- Provide medication reconciliations and medication refills when needed.
- Ongoing phone follow-up of patients in the CC program when identified in the plan of care.
- Participate in identified coordination of care activities with other agencies in the community, i.e. Community Resource Team meetings with Mountain Valley Mental Health.
- Meet directly with patients, when needed, to assist with the follow through with the plan of care. Includes med reconciliations, education about and connection to community resources, assist in filling out paperwork for things such as Social Security, Advance Directive assistance, etc.
- Various other Care Coordination activities unique to the individual patient or family.

3. Participate in the on-going development and evolution of the Care Coordination Program through involvement in the CC Committee, staff and community education regarding the role of

CC, and involvement in the implementation of CC Team Projects (ER tracking and utilization).

4. Ongoing advocacy for patients and families.

5. Assist in identifying new needs with current patients or identifying when the plan of care is not effective. Discuss or schedule with the Nurse Care Manager to move towards a new plan.

6. Consistent chart documentation to ensure effective communication and continuity of care.