TRI-COUNTY HEALTH NETWORK

Position: **Care Coordinator**
Supervisor: **Care Coordination Supervisor**
Status: **Full-Time (Part-Time considered), Non-Exempt**

JOB SUMMARY

The Medicaid Care Coordinator provides person-centered, community-based care coordination for individuals enrolled in Medicaid. This position supports clients by conducting outreach, completing assessments, reducing Social Drivers of Health (SDOH) barriers, and connecting individuals to essential services, including medical care, behavioral health, housing, food resources, transportation, and benefits.

The Care Coordinator conducts both phone and in-home visits, schedules follow-ups, coordinates with providers, and ensures accurate, timely documentation. The role strengthens relationships with community partners, increases awareness of TCHNetwork's services, and supports program workflows and quality assurance expectations set by the Care Coordination Supervisor and Manager.

DUTIES & RESPONSIBILITIES

Person-Centered Assessments

- Conduct person-centered, comprehensive assessments (phone or in-home) to identify client needs, goals, strengths, and Social Drivers of Health (SDOH) barriers.
- Provide care coordination and navigation, including unbiased information on services, benefits, and community resources.
- Assist clients with completing applications for Medicaid services, Long Term Services and Support resources, food assistance, transportation, and other programs.
- Complete follow-up contacts to ensure services were received and assess client satisfaction.
- Document all assessments, referrals, client contacts, concerns, and complaints in the required systems.

Medicaid Care Coordination

- Manage an active caseload, ensuring timely assessments, follow-ups, documentation, and care planning.
- Meet clients in homes, clinics, libraries, or other community settings, depending on client needs and safety.
- Accurately document all interactions, referrals, and follow-ups in the population health or Care Coordination database.
- Coordinate care with health care providers, behavioral health agencies, social service partners, and internal staff to support client needs.
- Track progress toward Medicaid Care Coordination metrics such as outreach attempts, completed assessments, and follow-up timelines.
- Ensure all documentation meets program, funder, and organizational requirements.

Outreach & Community Engagement

- Participate in community outreach efforts to increase awareness of TCHNetwork programs.
- Support referral pathways by maintaining relationships with clinics, hospitals, and community agencies.
- Assist in updating and maintaining the TCHNetwork Resource Guide, verifying accuracy of local and regional resources.

Training & Professional Development

- Attend required trainings, including trauma-informed care, motivational interviewing, safety protocols, documentation standards, and Medicaid program updates.
- Maintain required certifications and participate in continued education as directed by the Supervisor or Manager.
- Adopt and model TCHNetwork's equity-centered, person-first approach.
- Program Support and Other Duties
- Support data tracking, reporting needs, and quality assurance reviews.
- Assist with workflow improvements, resource development, and special projects.
- Perform other duties as required to support TCHNetwork and the Community Programs department.

Qualifications

Required

- 1 year of direct experience in case management, care coordination, or client support.
- Experience working with remote or field-based teams.
- Strong communication and presentation skills.
- Demonstrated ability to engage diverse communities with cultural humility.
- Commitment to equity, social justice, and understanding how systems impact health.
- Proficiency in MS Word, Excel, Outlook, OneDrive, and comfort with databases and technology.

Preferred

- Bilingual/bicultural strongly preferred.
- Bachelor's degree OR 4 years of experience working with diverse populations or in a healthcare, community health, or social service setting
- Knowledge of trauma-informed practices and comfort working with clients in crisis.
- Familiarity with community resources, Medicaid benefits, and SDOH barriers.
- Ability to participate in trainings such as Mental Health First Aid, safeTalk, Motivational Interviewing, etc.
- Experience with HIPAA, confidentiality, boundaries, and crisis de-escalation.
- Strong written and verbal communication skills and ability to prepare clear documentation.

Personal Attributes

- Ability to build trust and rapport with individuals of different cultures, identities, and socioeconomic backgrounds.
- Calm, grounded approach in fast-paced or stressful situations.
- Strong time management and ability to work independently.
- Self-motivated, dependable, and flexible.
- Comfort with change and willingness to adapt to new workflows or processes.
- Strong critical thinking and problem-solving abilities.
- Openness to feedback and commitment to ongoing growth.
- Understanding of health equity and motivation to address Social Drivers of Health (SDOH) barriers.

Additional Details

- Travel: Frequent local/regional travel; occasional statewide/national travel. Must have reliable transportation, a valid driver's license, and insurance.
- Hybrid Position: Travel across Montrose (including West End), Ouray, and San Miguel counties. Minimum two in-office days per week in one of the regional offices.
- Schedule Flexibility: Occasional evenings or weekends based on staff needs, meetings, or community events.

Compensation And Benefits:

The starting salary range is $21.00– $ 23.00 per hour, depending on experience.

Benefits Package:

- 104 hours of vacation, 12 paid holidays, and up to 48 hours of sick leave annually.
- 100% employer-paid medical and dental insurance after 90 days.
- 3.5% 401k contribution match
- Flexible Spending Account after 90 days, Employee Referral Program, Mental Health Wellness Program, and Professional Development Opportunities.

Staff Signature _____ Date: _____

Care Coordination Manager_____ Date:_____