PEOPLE'S CENTER CLINICS & SERVICES
JOB DESCRIPTION

JOB TITLE: Women's Health and Pediatric Care Coordinator

DEPARTMENT: Quality Improvement

EXEMPT: Yes

REPORTS TO: Quality Director

DATE REVISED: 9/1/2017

SUMMARY

Women's Health and Pediatric Care Coordinator collaborates with the Certified Nurse Midwife and OB/PED providers, clinic staff and other Health Care Home team members to identify needs, organize activities, and coordinate care for patients in this population. Women's Health and Pediatric Care Coordinator is an advocate for the patient and works to link them to resources that provide a range of services, promote self-management, improve health and reduce disparity. The Maternal and Child Care Coordinator assists patients to achieve health goals and improved health care outcomes. One of the main challenges of this position is working with multiple providers, staff and collaborative partners with differing needs and opinions to improve the care to typically diverse and underserved people. Normal working hours are Monday – Friday from 8:00 AM to 4:30 PM.

HCH Responsibilities and Duties:

Assess the Health Status of Patients

- Revises monthly reports and tracks gaps in immunizations, weight, nutrition, physical activity in pediatric patients
- Revises monthly reports and track mammograms, pap smears, to ensure quarterly, annual wellness visits and postpartum visits are done.
- Ensures quarterly and annual wellness visits are done.
- Enrolls and tracks high risk pregnancies to ensure patients are attending prenatal and specialty appointments
- Enrolls and track complex pediatric patients and ensure they are connected tor resources.
- Follows up on Emergency Room, deliveries, and/or Inpatient Discharges w/in 2 days
- Sets up visits with PCP for periodic check-in and assessment
- Sets up postpartum and newborn visits with both CNM and Peds PCP

- Accurately completes and documents patient health information and problems in the electronic health records (EMR) system, and enrolls patients in the Health Care
- Conducts an initial patient assessment including a PHQ-9, Patient Perception Survey, review of medications, lab and other test results, review of clinic scheduling policies, and review of Health Care Home program objectives.
- Reviews Health Care Home referrals and works with Certified Nurse Midwife and Peds providers to tier HCH patients.
- Plans, coordinates, and provides patient-specific health education/program (HOOYO) based on the conditions identified to HCH patients and reinforce plan of care.
- Determines and advise HCH patients on other potential services the patient may want/need.
- Serves as an advocate for the HCH patient to understand needs (i.e. shelter, transportation, child care, safety) and refer to the behavioral health therapists and/or case managers
- Informs HCH patients who are uninsured if there is a charge/minimum fee for health care home (non-billable) visits.
- Discuss with patient and update primary care provider (PCP) in the EMR if applicable.

Develop and Maintain a Care Plan

- Works with the HCH patient, OB/PED PROVIDERS, and HCH Care Team members to develop and maintain an individualized clinical Care Plan for the patient. (*See Care Plan Policy)*
- Collaborates with the OB/PED PROVIDERS and HCH Care Team to ensure Care Plan data is up-to-date and complete.
- Assists HCH patients with the identification, selection, monitoring and documentation of self-management goals.
- Follows up with the HCH patient to ensure the patient's responsibilities are being followed and met. Monitors the patient's progress toward goal achievement and modifies as needed.
- Schedules follow-up appointments at PCHS 30 days after enrollment or calls patients to ensure the patients are getting the services they need, outcomes are improving, and determine if progress is being made towards defined goals.

Care Management

- Reaches out to patients refusing preventative screening measures and providing education around the importance of IMMUNIZATIONS, PROPER NUTRITION, PHYSICAL ACTIVITY and other conditions wherever necessary
- Follows the prescribed care coordination workflow to comply with health care home certification requirements.
- Interacts and coordinates care with team members and providers, including clinic such as, social workers, pharmacist and nutritionist to ensure comprehensive care for the patient.
- Identifies clinic and community resources and coordinates appropriate HCH referrals.
- Conducts follow-up PHQ-9 questionnaire if applicable and responds accordingly.
- Collaborates with the clinical staff for pre-visit planning for annual checkups/physicals for HCH
- Works with the clinic front desk staff to schedule applicable clinic appointments.
- Conducts regular, periodic care plan review with the patient and/or patient.
- Arranges for interpreter services if needed.
- Reviews HCH patient's records to determine when patients should be seen by their OB/PED PROVIDERS and works with the patient to schedule an appointment.

Care Team Member Interaction

- The Care Coordinator has interaction with many people/departments within the clinic's Health Care Home environment. The Care Coordinator will periodically revise protocols and workflows to ensure compliance with HCH requirements. These can include:
    - Primary care providers
    - Medical assistants
    - Pharmacy
    - Lab
    - Nutrition
    - Dental
    - Behavioral health
    - Interpreters
    - Transportation
    -

Qualifications: The Care Coordinator shall have:

- 3-5 years' experience in a health care setting, preferably primary care (doula, OB/peds, medical interpreter or community health worker), and working with underserved and at-risk populations.
- Experience working with culturally diverse and low-income populations.
- Ability to work both independently and collaboratively as an effective member of a health care team.
- Proven strong interpersonal skills.
- Ability to work comfortably at a computer for long periods of time
- Associate degree or Bachelor's degree preferred
- Bilingual Somali-English preferred
- Notifies the primary care provider if patients decline or choose to leave the program. Keep the provider informed on HCH progress via Epic documentation-only encounter.
- Use the HCH patient registry, a virtual list based on a specific HCH diagnosis code or other designation, to create lists of HCH participants based on variable selection criteria.

Employee Name _____ Date _____

Employee Signature _____