NORTHWEST PEDIATRIC CENTER
Job Description

Job Title: **Pediatric Care Coordinator**

Employee Name:
Wage: **Hourly**
Approved By:

Department: **Nursing**
Supervisor: **Nurse Supervisor**

Primary Function: Provides Pediatric Care Coordination for clinic patients following established standards and practices under the direction of the nursing supervisor.

Reporting Structure: Reports directly to the Nursing Supervisor

Physical Demands: Requires sitting for long periods of time. Working in an office environment. Working under stress and use of telephone required. Manual dexterity required for use of computer keyboard and fax machine.

Job Summary:

The Pediatric Care Coordinator facilitates population health and chronic care management in a large, single specialty private practice. This role collaborates with primary care providers (PCPs) and Behavioral Health Consultants (BHCs) and serves as a central link to an identified population of our patients. Through skilled assessment, education, collaboration and coordination of health care and community resources, the care coordinator supports patients and their families in enhancing their self-efficacy/management skills, achieving optimum functional health status, and their best quality of life. The Pediatric Care Coordinator develops effective partnerships with patients/families, staff and systems to create an environment of high quality, evidence-based, cost-effective care and patient-focused outcomes. In addition to the duties and responsibilities noted in this job description, the Pediatric Care Coordinator assumes additional duties as assigned in support of the overall function and mission of the practice.

Primary Duties:

- Provides advocacy, guidance, and support for patients with chronic conditions and/or complex disease states as they receive care throughout the care continuum. Uses knowledge of illness, diagnoses and treatments in comprehensive assessments of patients. Performs patient teaching, patient self-management/self-efficacy coaching and planning in care management. Ensures safe transitions of care and coordination for specialty and other sites of care as necessary
- Utilizes appropriate resources to gather data and assess patient care needs
- Performs ongoing assessments of the patient and family's biological, cognitive/emotional and spiritual aspects of managing life with chronic disease
- Proactively identifies problems that could lead to an emergency/crisis situation and takes appropriate action to de-escalate
- Assesses the need for specialty care/consultations and provides timely recommendations to the PCP and care team; Establishes effective strategies with patients and families in coordinating specialist/consultation visits
- Communicates assessment data to appropriate care team members
- Assesses learning needs of patients/families. Provides individualized interventions to support these needs, and to foster development of self-care and self-advocacy skills. Establishes and implements patient directed learning and disease self-management

plan for patient/family; Provides teaching to patients/families related to patient's diagnosis, pathology, medical and nursing treatment plans, discharge needs and health goals

- Documents assessment data according to clinic standard
- Collaborates with PCPs and the care team to develop and implement care plans while managing a panel of patients with chronic/complex disease(s)
- Plans interventions appropriate to each patient's medical diagnosis, age, abilities, and resources
- Documents care planning process according to organization standards
- Documents each element of care per organizational standards
- Demonstrates accountability in following established guidelines for attendance, punctuality and overall dependability. Accountable for effective performance and follow-through of all assigned responsibilities and for completing responsibilities within agreed upon time frames
- Assists with and anticipates health care transition steps from adolescence to adulthood
- Supports behavioral health staff in patient care coordination, including follow-up calls to schools, treatment centers and help with coordination of transportation and housing issues if needed
- Facilitates population health management in helping the practice to reduce patient's emergency room utilization through education, follow-up phone calls, identification of high ED utilizers, and use of a registry
- Performs other duties as assigned

Qualifications

1. Required

- Education: Bachelor of Science in Nursing or Masters in Social Work
- Licensing/credentials – (For RNs only) Active Registered Nurse license, State of WA

2. Related skills and abilities

- Excellent patient assessment skills
- Demonstrated ability to work collaboratively in a team setting, including establishment of cooperative relationships with peers and leadership team members to review and implement new ideas
- Current working knowledge of electronic medical records
- Familiarity with local community resources
- Experience in addressing and improving social determinants of health
- Outstanding written and verbal communication skills
- Excellent time management skills, including agility in multitasking
- Demonstrated ability to proactively identify opportunities for process improvement

3. Preferred

- Licensing/credentials –
- (For Social Workers only) Active Social Worker license, State of WA
- Certification in Care Management (preferred)

- Experience – Familiarity in working with complex patients including those with advanced, chronic and/or behavioral health conditions in an outpatient setting; experience with case management of complex patients

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Competencies

- Proficient use of EMR system (Office Practicum)
- Ability to conduct health assessments over the phone, effectively communicating and assessing patient's needs telephonically
- Knowledge of social determinants of health (SDOH)
- Knowledge of care management, patient self-management principles and evaluating patient outcomes