

## Care Coordinator (Non-Clinical)



Care Coordinators lead care management activities for a panel of patients. These staff coordinate services for their patients and conduct activities such as coordinating with patients' providers, conducting needs assessments, developing patient focused care plans, providing health education and managing staff assigned to assist them with these tasks. Similar job titles include care manager, case manager.

(Primary Care Development Corporation, 2015)

### Examples of Care Coordinator Duties<sup>iii</sup>

- Establishing accountability and agreeing on responsibility.
- Communicating/sharing knowledge.
- Helping with transitions of care.
- Assessing patient needs and goals.
- Creating a proactive care plan.
- Monitoring and follow-up, including responding to changes in patients' needs.
- Supporting patients' self-management goals.
- Linking to community resources.
- Working to align resources with patient and population needs.
- Reach out to and engage patients;
- Provide comprehensive assessments of patients' needs;
- Link patients to resources;
- Coordinate care;
- Lead care planning;
- Provide health coaching;
- Respond quickly and effectively to changes in patients' conditions to keep patients from using unnecessary services.

## Care Coordinator Core Competencies<sup>iii</sup>

The core competencies found below are examples what employers look for in care coordinator candidates.

- Oral Communication Skills
- Written Communication Skills
- Problem Solving
- Ability to make independent decisions
- Good Judgement
- Patient Centered Care skills
- Project Management
- Care Coordination
- Health Coaching
- Culturally Competent
- Assessment Skills
- Triage Skills
- Organization Skills
- Medication Reconciliation skills
- Computer skills
- Knowledge of chronic conditions
- Ability to multi-task
- Ability to access resources for patients
- Field safety skills
- Attention to detail
- Crisis Management
- Team Work
- Exercise professional boundaries

## Knowledge and Experience<sup>iv</sup>

Employers are looking for candidates who have provided linkage and support to patients in the following categories:

- Knowledge of geographic areas
- Persons with Substance Abuse disorders
- Homeless Persons
- Persons with disabilities
- Immigrant/Refugees
- Older Adults
- Persons at risk of or living with HIV/AIDS
- Pregnant women
- Adolescents
- Infants/children
- Migrant workers
- LGBTQ persons
- Domestic and Sexual Violence survivors
- Person with mental illness
- Previously incarcerated individuals
- Chronic Disease
- Social Determinants of Health
  - Economic Stability
  - Neighborhood and Physical Environment
  - Education
  - Food
  - Community and Social Context
  - Health Care System
- Prevention Programs

## Education Requirements

- Associate's Degree
- Bachelor's Degree

## Capital Region Care Coordinator Wage

[NYS Department of Labor Job Code: 21-1022](#)

Entry \$41,080

Average \$60, 850

## Tools and Resources

### [Care Management in New York State Health Homes](#)

This NYS Health-funded report, prepared by Joslyn Levy & Associates, examines some approaches in New York State to expand and improve care management for health home members—patients who have multiple chronic conditions and intensive, high-cost service needs.

The report examines how New York health homes are working to innovate, collaborate, test, and refine care management strategies. It identifies nine topics that impact the design and delivery of care management in health homes, including the health home network structure, staff member training, caseload balance, and collaboration with care providers.

### [Managing the Practice- American Pediatric Academy](#)

There are no absolute models for managing a pediatric practice. Regardless of the size and/or location, each practice requires planning and creative management to successfully meet the needs of patients and sustain a viable work environment. Besides physicians and other providers, pediatric practices employ other staff to manage various functions. A list of common staff positions/job descriptions is provided.

### [The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care.](#)

In this brief, we first describe the goals of care coordination and the central role for primary care, followed by the specific activities involved in care coordination. Next we summarize the evidence on the effectiveness of different care coordination activities that PCMHs and ACOs can pursue. Finally, we suggest roles for PCMHs and ACOs in coordinating care and summarize key points

### [Care Coordination Quality Measure for Primary Care \(CCQM-PC\)](#)

The Care Coordination Quality Measure for Primary Care (CCQM-PC) is a survey of adult patients' experiences with care coordination in primary care settings. The CCQM-PC builds on previous AHRQ work to develop a conceptual framework for care coordination and fills a gap in the care coordination measurement field. It was developed, cognitively tested, and piloted with patients from a diverse set of 13 primary care practices to comprehensively assess patient perceptions of the quality of their care coordination experiences. The CCQM-PC is designed to be used in primary care research and evaluation, with potential applications to primary care quality improvement. Guidance regarding the fielding of the survey is provided in addition to the full survey, which is in the public domain and may be used without additional permission.

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<sup>i</sup> [Who's Going to Care? Analysis and Recommendations for Building New York's Care Coordination and Care Management Workforce](#)

<sup>ii</sup> [Care Coordination-Agency for Healthcare Research and Quality](#)

<sup>iii</sup> [Who's Going to Care? Analysis and Recommendations for Building New York's Care Coordination and Care Management Workforce](#)

<sup>iv</sup> [Community Health Worker Initiative of Boston: Career Pathway Models](#)