Title: Care Manager
Reports to: Manager of Care Management
Classification: Individual Contributor
Location: Boston
Job description revision number and date: V2.0; 6.12.2023

Organization Summary:

Community Care Cooperative (C3) is a 501(c)(3) non-profit, Accountable Care Organization (ACO) governed by Federally Qualified Health Centers (FQHCs). Our mission is to leverage the collective strengths of FQHCs to improve the health and wellness of the people we serve. We are a fast-growing organization founded in 2016 with 9 health centers and now serving hundreds of thousands of beneficiaries who receive primary care at health centers and independent practices across Massachusetts. We are an innovative organization developing new partnerships and programs to improve the health of members and communities, and to strengthen our health center partners.

Job Summary:

As an integral member of the care management team the Community Health Worker (CHW) will have the opportunity to make a profound impact on the lives of individuals living with complex and/ or chronic conditions, many of whom also face multiple barriers accessing care and need support to succeed with achieving health care goals. This position requires flexibility and may vary from day-to-day to meet members where they are. Outreach methods may vary based on the needs of the organization and may include telephonic or in person support in a variety of potential settings such as but not limited to, the community, home, facility, or health center.

The CHW Float Pool Position is hybrid though primarily remote and will cover CHW care management vacancies at C3 affiliated FQHC's and affiliated provider groups.

Responsibilities:

- Works under the guidance of the Licensed Care Manager or Program Leaders (Leads, Supervisor, Manager or Director)
- Conducts initial outreach calls to encourage member/representative and caregivers to participate in care management programs
- Develop and implement outreach plans in collaboration with team colleagues, based on individual, family, and community needs, strengths, and resources
- Identify and share appropriate information, referrals, and other resources to help individuals, families, groups, and the primary care team meet their needs
- Gather and combine information from different sources to better understand clients, their families, and communities
- Initiate and sustain trusting relationships with individuals, families, social networks, and primary care teams
- Use a range of outreach methods to engage individuals and groups in diverse settings

- Share community assessment results with colleagues and community partners to inform planning and health improvement efforts
- Act as a cultural mediator by educating and supporting providers in working with clients from diverse cultures and help clients and community members interact effectively with professionals to promote health, improve services, and reduce health care disparities
- Coaches and guides member to meet both personal and clinical goals
- Assists in scheduling appointments on behalf of member
- Work with individuals, family, community members, primary Care Managers (CM), and primary care team to address issues that may limit opportunities for healthy behavior including completion of Social Drivers of Health (SDOH) screening and other tactics to obtain support for members
- Provide care coordination, which may include but not limited to facilitating care transitions, supporting the completion of referrals, and providing or confirming appropriate follow-up
- Helps member access community and government-based service agencies including completing paperwork for the member
- Helps teach the member and/or care giver about symptom response plans
- Participates in the integrated care team meetings and rounds as required
- Complies with reporting, record keeping, and documentation requirements in one's work
- Use appropriate technology, such as computers, for work-based communication according to C3 and health center requirements
- Creates and maintains a comprehensive inventory of local community resources, improving accessibility for patients and providers, and linking patients with the appropriate support services
- Establishes relationships with community agencies, resources and supports that are relevant to a Medicaid Population
- Assist with Medicaid applications, food, and nutrition benefits, housing applications, coordinating transportation, etc.
- Travel throughout assigned area and engage members at their homes/ hospitals/community-based locations and or accompany members to appointments as appropriate
- As needed, cover other areas in person or via telephonic support
- Other duties as assigned

Required Skills:

- Experience within the ACOs member population preferred including Medicare/Medicaid
- Demonstrated success in working as part of a multi-disciplinary team including communicating and working with Providers, Nurses, Social Workers, and other health care teams
- Bi/multi-lingual preferred or experience with Language Translation Services
- Experience working with patients with chronic medical and behavioral health needs
- Must be flexible and adaptable to change
- Demonstrate the ability to work independently
- Must demonstrate excellent interpersonal communication skills
- Additional desirable qualities include enthusiasm and passion for helping patients, genuine spirit, kind, and empathetic nature, and one who embraces a 'go with the flow' mentality
- Experience using appropriate technology, such as computers, for work-based communication, according to organizational requirements
- Experience and proficiency with Microsoft Office and online record keeping
- Must be able to remain in a stationary position 50-75% of the time

COMMUNITY CARE COOPERATIVE

Desired Other Skills:

- Familiarity with the MassHealth ACO program
- Familiarity with Federally Qualified Health Centers
- Experience with anti-racism activities, and/or lived experience with racism is highly preferred

Qualifications:

- Minimum 2-5yr experience as a Community Health Worker (CHW), Medical Assistant (MA), Engagement Specialist, Care Coordinator or Care Advocate
- A valid driver's license and provision of a working vehicle

***** In compliance with Covid-19 Infection Control practices per Mass.gov recommendations, we require all employees to be vaccinated consistent with applicable law. *****