Patient Navigator
Job Description

Job Title: Patient Navigator – Full time 30 hours/week, including benefits, with the potential to expand to full time (37.5 hours per week), depending on funding, availability, and need.
Hiring Range: Depending on Experience and Licensure, up to $32 per hour
Reports To: Program Manager
Prepared Date: February 20, 2019

Mission Statement of the Grand County Rural Health Network is "we work in partnership to improve the future of healthcare through programs and services that educate the community on health issues and ensures accessibility and efficiency of the healthcare system."

Position Summary: Serves as a liaison between patients, healthcare providers, and human service agencies to reduce barriers to care, address social determinants of health, and assure the patient receives the care they need when they need it. Works with the patient to identify barriers to care and develop a comprehensive and goal-oriented plan. Facilitates patient appointments as needed, including those made with healthcare providers, labs, diagnostic areas, specialty physicians, and human service organizations. Accesses local and state-wide resources, in collaboration with clients and providers, and provides assistance with clinical and supportive care services offered within Grand and Jackson Counties and partnering healthcare communities.

Job Advertisement: Patient Navigator, FT (30 hrs/week) with benefits. CO Licensed RN or BSN preferred. Applicants with bachelor's degree in health-related fields or MSW with health-related background can also apply. Works with the patient and healthcare team to identify patient needs, goals and actions. Educates patient on disease management. Microsoft Office and Internet competency required. Good driving record; own transportation required. Must be self-directed with the ability to work with teams. Pay DOE.

Bilingual Spanish speakers strongly encouraged to apply.

To apply, please send a cover letter and resume to: Jen Fanning, Executive Director, Grand County Rural Health Network, P.O. Box 95, Hot Sulphur Springs, CO 80451; fax to 970-725-3478; or email jfanning@gcruralhealth.org.

Supervision Received:
Reports to and receives general direction from the GCRHN Program Manager. Works closely with other GCRHN staff, especially the Patient Navigator team.

Supervision Exercised:
None.

Essential Functions:

1. Provide a variety of indirect and direct coordination and navigation to patient navigator program clients, dually enrolled Medicaid/Medicare clients, and Medicaid clients identified as in need of services. This includes:

- Assist patients in understanding their diagnosis, treatment options, and the resources available, including educating eligible patients about appropriate community services, clinical research studies, technologies, and medications. Examples include teaching blood pressure monitoring and recording and interaction of medication and well-being.
- Schedule and complete assessments, follow-up as needed, and track results, referrals and recommendations in database.
- Meet with clients in public spaces or place of residence when appropriate to the client's needs.
- Accurately document interactions in population health data systems within two business days.
- Work closely with partner organizations such as Mountain Family Center, Horizons and Social Services, to complete care plans.
- Form trusting, collaborative relationship with care coordinators, mental health navigators, Regional Accountable Entity partner organizations, and community partners.
- Ability to connect with clients, empathize, show compassion, perform assessments, and assist clients in development of a self-management plan.
- Coordinate with patient navigation team and other partners to provide outreach and referrals for clients.
- Utilize the Regional Accountable Entity Care Coordinator work flow as best practice.
- Complete intake of high-risk patients, working with the patient, family and other members of the healthcare team as needed, to assess and prioritize patient's physical needs, mental status, family support system, financial resources, and available community and government resources.

2. Determine with the patient specific goals, objectives, and measures that meet the patient's needs and that have been identified through assessment. The plan will be action-oriented and time-specific. Maintains contact with the patient's providers to inform of case progress, referrals and primary care provider's care plan. Ensures the most cost-effective plan of care is being carried out and appropriate services and resources are being utilized.
    - Serve as an essential link between patients and all other care providers. Represents patient/family by advocating, intervening, negotiating and promoting their concerns. Problems requiring advocacy may include individual and class inequities or inadequate and non-existent hospital and/or community resources (i.e., insurance benefits, housing, transportation, etc.).
    - Serve as a liaison, or ombudsman, between patients and all other care providers.
    - Develop patient education programs and tools specified per patient's learning ability, style and self-activation level, in collaboration with the Network's full patient navigation team.
    - Follow patients through the care continuum, including inpatient admissions and discharge planning, and collaborates with inpatient care management resources.
    - Triage patient using hands-off nursing skills to recognize when a patient needs emergent or urgent medical care or welfare check. Notifies appropriate first responder agency.
    - Provide specific information on how to communicate with healthcare providers to better utilize resources and increase understanding of the disease process. Occasionally accompany patients to appointments when specific self-advocacy deficits are noted.
    - Educate patients and families regarding various symptoms and consequences related to specific diseases, conditions and hospitalization.
3. Attend trainings and workshops as necessary. Travel throughout region as needed.
    - Provide factual information based on current knowledge and research, to provide support and assist the patient/family in coping with their disease to improve their overall healthcare management.

4. Perform assigned work safely, adhering to organization and program established safety rules and practices. Reports to supervisor, in a timely manner, any unsafe activities, conditions, hazards, or safety violations that may cause injury to oneself, patients, or other partners. Reports to supervisor any potential safety risks to oneself, patients, or other partners.
5. Collaborate with patient navigation team to ensure all program deliverables are being met and advise Program Manager of any needs for meeting deliverables.
6. Contribute to fund raising events as needed.
7. Assist with grant reporting as needed.
8. Participate in regular staff meetings and provide overview information on program, problems, or needs.
9. Assume responsibility for projects and assignments as assigned by the Program Manager or Executive Director.

Qualifications: To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and/or Experience: Active CO Licensed RN, BSN, or LSW preferred. Familiarity with the community and experience working with underserved populations is paramount and could supersede professional licensures.

Knowledge, Skills & Abilities:

- Licensure in nursing or social work.
- Knowledge of state, federal and private insurance systems.
- Knowledge of chronic diseases, treatment process and effect of illness on patient population, and ability to articulate this pathway to patient and family.
- Requires problem solving, decision making and critical thinking. Ability to strategize, organize and plan using medical knowledge, advocacy and problem solving
- Requires excellent written and verbal communication and excellent interpersonal skills.
    - Ability to relate to people like and different from self, including across socioeconomic status and cultures.
    - Ability to practice supportive and active listening.
    - Ability to support patients during an intensive emotional state (examples include angry, sad, frustrated, etc.) while experiencing a medical diagnosis or chronic disease.
    - Ability to support patients with mental illness and substance use disorders.
- Skill in written communication to write case notes.
- Skill in verbal communication to direct, facilitate and develop relationships with clients, coworkers, and partners.
- Knowledge of Grand County healthcare services and organizations.
- Ability to work independently without close supervision in an independent work environment.
- Ability to follow through on assignments as requested in a timely fashion with limited supervisor follow-up.
- Ability to respond to a variety of socioeconomic and ethnic backgrounds appropriately.
- Ability to maintain professional demeanor when dealing with difficult individuals and situations.
- Ability to formulate a plan, actions steps, goals, objectives and follow-up to address client needs.

- Ability to read and interpret physicians' orders, notes from clients, and entries on computer screen as well as respond to them verbally and in writing.
- Skilled in use of Microsoft Word, Excel, and Internet. Experience with database usage preferred.

Physical Demands:

- Physical Strength
- Manual Dexterity
- Motor Coordination
- Form Perception
- Environmental Conditions
- Environmental Hazards
- Physical Demands: talking and hearing, vision, stooping, kneeling, crouching, reaching, handling, feeling, and fingering.

Machines, Equipment, Work Aids which may be representative, but not all inclusive of those commonly associated with this type of work: computer (laptop/printer), typewriter, calculator, telephone, copy machine, fax machine and other general office equipment. Drivers License in good standing required.

Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Work Environment: The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is normal in shared office.

More Information / Summary: Navigation services guide patients through the healthcare system and community resources to help ensure the patient gets the healthcare they need when they need it. According to the National Institutes of Health, a patient navigator is "someone who helps assists patients overcome barriers to care." Common barriers to care, especially for the low-income and elderly populations, are: financial and economic status; language and cultural issues; communication; gaps in healthcare system; access to healthcare; geographical location; transportation; fear; lack of insurance; and health literacy levels (i.e. misunderstanding, misinformation, hesitancy, resistance, or fear of diagnosis or treatment).

A patient navigator can help residents, specifically underserved populations, in navigating through the fragmented healthcare system in Grand County and link them to needed resources. Patient navigators can also help residents identified with a chronic illness, such as cancer, heart disease, diabetes, and asthma, in overcoming barriers to obtaining prompt diagnostic and treatment services. The patient navigator focuses on empowering and coaching, versus case management. The patient navigator model is also known as care coordinators, health advocates, community health workers, case managers and *promotora*.

A patient navigator also helps patients communicate with their healthcare provider. This could include, but is not limited to, assisting the patient with questions for the provider, attending the visit with the patient and provider, coordinating translation services. The patient navigator could also be an *ombudsman* to act as a liaison between patient and provider by fielding quality complaints from the patient, or communicating with the provider regarding patient payment status.

Patient navigation is provided by a culturally competent professional or peer in variety of settings. The patient navigator works in close collaboration with healthcare providers, human service organizations and the community and serves to link all resources to the patient's individualized needs. The program will be designed to be directed by, and to meet the needs of, the patient and their family in the context of their community and healthcare environment.

In Grand County, the patient navigator is a registered nurse, although familiarity with the community and experience working with underserved populations is paramount and could supersede professional licensures. The patient navigator creates immediate interpersonal relationships, trust, and receptiveness to education and advocacy by patients and providers, in a way no other qualifications can.

The patient navigator works as part of a program team with care coordinators to remove barriers to care, focusing on social determinants of health, while educating clients on medical needs. The patient navigator also works with Network partners and community members. This program has been in place in Grand County since January 2011 and has since expanded to include a nurse patient navigator at Middle Park Medical Center clinics and two care coordinators at the Network offices focusing on removing basic barriers to care such as transportation and finances.

The Network is committed to improving health equity and addressing the social determinants of health. A willingness to understand the impacts of race, poverty, geography, and other determinants on the health of the community is necessary.