EQUALITY HEALTH

JOB DESCRIPTION

Position Title: **RN, Transition Care Coordination – Phoenix**
Reports To: **Manager, Transition Care**
Division: **Q Point**
Department: **Care Coordination**
Classification: **Exempt**
Revision Date: **March 11, 2019**

Position Summary:
Equality Health is an Arizona-based population healthcare company focused on improving care delivery for underserved populations through culturally-sensitive programs that improve access, quality, and patient trust. Our mission is to ensure diverse populations receive quality healthcare that improves and enriches their lives. We have developed our product portfolio around centralized technology, services and network designs intended to organize a better healthcare delivery system for cultures that have struggle with integrating into the tradition one-size-fits-all U.S. healthcare system.

The RN, Transition Care Coordination is primarily responsible for leading transition care coordination post discharge from the hospital or emergency department, based on structured assessment and sound clinical judgment. This individual evaluates care for specific patient populations, identifying cultural and ethnic requirements in the nursing process of assessment, planning, implementation and evaluation.

Equality Health designates this position as safety-sensitive and a position that includes tasks and duties that Equality believes could affect the safety or health of the employee performing the job or others.

Responsibilities:
- Assess patients at various sites including hospital and medical centers, emergency departments, homes, and post-acute facilities
- Perform structured assessments including quality of life, physical, mental, spiritual, cultural, social and health literacy
- Assess clinical needs, medication reconciliation and barriers to care
- Create patient and family compatible care plans after completion of assessments
- Communicate plans with primary care or managing physician
- Create and track follow up appointments
- Document in concise SBAR format
- Communicate care plan with caregiver(s) and family with patient consent
- Refer patients to community and programs and services
- Promote self-efficacy and self-management plans
- Engage patient and family in culturally competent manner
- Monitor execution of care plans, follow up appointments and self-management plans
- Meet weekly with Leadership and Care Management teams

Required Education & Experience:
- RN or BSN degree

- Active and current licensure from the AZ State Board of Nursing
- Minimum two (2) years of work experience in hospital or home health nursing; experience should include working in a community health setting
- Demonstrated knowledge of nursing policies, procedures, protocols, treatments, standards of care and the Nurse Practice Act (NPA)
- Ability to receive and maintain DPS Level 1 Fingerprint Clearance Card and BLS/CPR certification within 60 days of hire
- Proficient using Microsoft Office applications and web-based technologies
- Must have current AZ driver's license and be able to pass a DMV background check

Highly Preferred Skills & Qualifications:

- Bilingual; able to read, write and speak Spanish and English proficiently
- Demonstrated experience with care coordination and case management
- Ability to communicate with physicians and facility administrators to solve problems
- Commitment and passion to improving healthcare delivery and alleviating disparities

Physical Requirements:

- Comfortable using keyboards, mouse, tablet and other electronic and portable devices for documentation
- Walking, standing, sitting, lifting 15 lbs. frequently
- Frequent screen reading
- Must be able to perform patient assessments in private homes, which may have allergens or odors such as pet dander or tobacco smoke
- Must be able to travel by personal vehicle to multiple locations each workday