EL DORADO COMMUNITY HEALTH CENTERS

JOB DESCRIPTION

JOB TITLE: Mobile Medical Unit (MMU) & Enhanced Care Management (ECM) Coordinator

REPORTS TO: Primary Care Operations Manager

DIRECT REPORTS: None

JOB SUMMARY: As a member of the Mobile Medical Unit (MMU) team, the MMU & ECM Coordinator serves as a resource for community partners and EDCHC clinical staff serving patients of the MMU. This position serves as a point of contact for new and established patients seeking services provided on the MMU and acts as a liaison to the services offered at EDCHC. The MMU & ECM Coordinator facilitates collaboration between the host organizations, the assigned MMU staff and clinical care team, to support the healthcare needs of patients. This position partners with the clinical care team, (Provider, RN, and/or MA) to resource needs of patients and link patients to services within the local communities; debriefing with clinical team as appropriate.

The MMU & ECM Coordinator also provides administrative support to the MMU Care Team supporting patient registration processes and tracking patient demographics for those served by the MMU and transition of care to PCPs within EDCHC clinics for primary and specialty care services.

In addition, the MMU & ECM Coordinator assists in the delivery of Enhanced Care Management (ECM), a statewide Medi-Cal benefit under California's CalAIM initiative. In this capacity, the coordinator supports identification and engagement of MMU patients who meet ECM Population of focus criteria (e.g., individuals experiencing homelessness, serious mental illness, substance use disorder, or high-utilization/complex chronic conditions), and assists with coordination of the ECM core service components in partnership with the clinical care team, Medi-Cal Managed Care Plans (MCPs), and community-based organizations.

ESSENTIAL DUTIES AND RESPONSIBILITIES

MMU Coordination

1. Establishes the MMU scheduling of clinical and administrative staff in collaboration with other management staff.
2. Generates a monthly calendar of assignments and confirms schedule with participants in advance of the MMU dates.
3. Coordinates with community entities on dates of MMU service each week, month, and quarter.
4. Transports medications between the pharmacy and assigned MMU sites.
5. Responsible for MMU location logistics, i.e. power, placement, internet connection, public announcements/notification, etc.
6. Ensures interpretation services are available as determined by the patient population (LEP) needs.
7. Establishes and maintains relationships and communications with various El Dorado County Agencies and entities, including public service agencies and non-profit organizations that mutually serve populations who may benefit from a mobile healthcare option.
8. Engages EDCHC Patient Services staff for patient outreach to assist in identifying resources to support patient needs.
9. Partners with the Finance Department, supports grant tracking activities including drafting reports, maintaining mileage logs/records for the van, completion of EDCHC incident reporting as needed, etc.
10. Plans for community health fair and health education events sponsored by the MMU and team.
11. Directly engages with all other EDCHC services as needed to support the needs of patients served by the MMU, including front office, patient services, referrals, telemedicine, behavioral healthcare, etc.
12. Reports any technical and/or operational issues involving the MMU to the RN Project

Manager and/or others (HIT) for resolution.
13. Administers new and returning patient self-report and satisfaction questionnaire.
14. Adheres to and monitors compliance with EDCHC policies and procedures, including upholding a safe work environment on and near the MMU.
15. Follows all safety procedures and reports and/or resolves unsafe conditions.
16. Adheres to infection control procedures in the field.

Enhanced Care Management Coordination

17. Assists with proactive ECM outreach, engagement, and enrollment for MMU patients identified as eligible under CalAIM population of focus criteria, using in-person, phone, and community-based engagement strategies.
18. Assists with comprehensive, member-centered health risk assessments and individualized ECM care plans in partnership with the RN and provider, addressing physical health, behavioral health, and social needs.
19. Assists with and documents delivery of the ECM core service components: outreach and engagement; comprehensive assessment and care management; enhanced coordination of care; health promotion; comprehensive transitional care; member and family support; and coordination of and referral to community and social support services.
20. Assists in warm hand-offs and referrals to Community Supports (CS) services and community-based organizations to address identified social drivers of health, such as housing instability, food insecurity, and transportation barriers.
21. Assists in accurate and timely ECM enrollment, encounter, and outcome documentation in the EHR/care management platform to support billing, reporting, and audit readiness.
22. Serves as liaison with Medi-Cal Managed Care Plans (MCPs) to verify member eligibility, obtain required authorizations, and submit ECM program reporting on schedule.
23. Monitors ongoing ECM member engagement and conducts re-engagement outreach for members who become lost to contact or disenrolled, per program requirements.
24. Participates in ECM case conferencing, interdisciplinary care team meetings, and quality improvement activities, escalating complex cases to the RN/provider as needed.

25. Other duties as assigned.

Safety

1. Maintain current knowledge of policies and procedures and legal requirements as they relate to safe work practices.

2. Follow all safety procedures and report or resolve unsafe conditions to ensure an injury-free work environment.

3. Use appropriate ergonomic measures to reduce risk of work-related injuries.

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of:
    - EDCHC clinic policies and procedures, health care clinic management and administrative practices.
    - Medical terminology as well as appointment scheduling.
    - Must maintain strict confidentiality and comply with all HIPAA regulations and policies.
    - California consents to treat laws as applicable to a primary care setting.
    - CalAIM Enhanced Care Management (ECM) program requirements, DHCS policy guidance, and Medi-Cal Managed Care Plan (MCP) referral and reporting processes.

- Social drivers of health screening tools (e.g., PRAPARE) and local community resources and referral networks.

- Skills in:
  - Effective oral and written communication, as well as excellent customer service.
  - Effective organization, multi-tasking, priority setting of work, and attention to detail.
  - Database and records management.
  - Discretion and confidentiality.
  - Using a computer and various software applications, such as spreadsheets and databases to assemble, manipulate and/or format data and for e-mail.
  - Trauma-informed care, motivational interviewing, and cultural humility when engaging in high-need, high-risk populations.
  - Individualized care plan development and interdisciplinary care coordination.

- Ability to:
  - Share the EDCHC mission and work well in a team-based care environment.
  - Ability to adapt to change within the workplace.
  - Ability to work effectively with people regardless of their age, gender, race, ethnicity, religion, or job type.
  - Ability to make decisions or take actions to solve a problem or reach a goal.
  - Ability to effectively build relationships with customers and co-workers.
  - Engage effectively with individuals experiencing homelessness, serious mental illness, substance use disorder, and other complex chronic conditions.
  - Assist in accurate, timely documentation sufficient to meet ECM billing, reporting, and compliance standards.

QUALIFICATIONS:

To qualify for this position, an individual must possess any combination equivalent to sufficient experience and/or education that would likely produce the required knowledge, skill, and ability requirements listed above. A typical way to acquire the required qualifications would be:

Experience:

- One-year minimum of medical office experience with scheduling and administrative duties, which included organization and coordination at progressively responsible levels.
- Experience within a Federally Qualified Health Center (FQHC), Community-Based, health or social services environment, and project management is highly desirable.
- Experience providing care coordination, case management, or community health worker services to high-need, high-risk populations (e.g., individuals experiencing homelessness, serious mental illness, substance use disorder, justice-involvement, or complex chronic conditions) strongly preferred.
- Prior experience with CalAIM Enhanced Care Management, Whole Person Care, Health Homes Program, or similar care management model highly desirable.

Education and Certification Requirements:

- High school diploma or GED required.
- Two or more years of college preferred.
- Associates or Bachelors in Nursing or Social Work strongly preferred.
- Bilingual Spanish/English preferred.
- Community Health Worker (CHW) certification, Certified Case Manager, Certified Care Manager, or similar care management credential preferred.
- Active California RN License in good standing preferred.
- Ability to obtain CPR Certification required.

OTHER
Transportation:

Must possess a valid California driver's license, have reliable transportation, a clean driving record and insurance as required by the state.

Physical Requirements:

Normal health center/interior office environment: see, hear, talk, walk or move about, sit and/or stand for long periods of time, reach, stoop, bend, lift up to 50 lb.; repetitive hand movement; use and view a computer; use a calculator, operate fax, copier, telephone; read and write English. This position will also support services provided at field locations and on the MMU and may be exposed to inclement weather and environmental hazards. ECM duties may require travel to community-based settings such as member homes, shelters, encampments, and other non-clinical locations for outreach, engagement, and care coordination purposes.

FLSA Status: Non-exempt

Note: The above statements are intended to describe the general nature and level of work being performed by the person assigned to this job. They are not intended to be an inclusive list of all duties, responsibilities and skills required of incumbents. In accordance with the Americans with Disabilities Act (ADA) and the California Fair Employment and Housing Act (FEHA), reasonable accommodation will be provided to enable qualified individuals with disabilities to perform the essential job functions.

Salary Range: $25.32 - $59.86 (based on experience, level of education, and professional licensure)