



Murray County Medical Center Position Description

Classification:	Patient Care Coordinator
Department:	Hospital
Location:	Murray County Medical Center
Reports to:	Quality Manager
FSLA Classification:	Hourly/Non-exempt – Temporary

Position Purpose

The Patient Care Coordinator serves as the central point of coordination across clinical care, community-based services, and social support systems. This role supports patients in managing chronic health conditions, engaging in their care, accessing community resources, and navigating healthcare and social service systems.

The Patient Care Coordinator works collaboratively with patients, families, providers, clinical staff, community organizations, and social service agencies to identify patient needs, coordinate appropriate services, facilitate care transitions, and promote timely follow-up. This position supports patient engagement, education, care coordination, and connection to resources that address medical and social needs.

The Patient Care Coordinator also maintains appropriate data, tracks patient outcomes and activities, and supports reporting requirements related to care coordination and community-based services.

Essential Duties and Responsibilities

1. Chronic Disease Management Support

- Support patients with chronic disease management through education, care coordination, and follow-up.
- Assist patients in understanding their care plans, treatment recommendations, and available resources.
- Coordinate communication between patients, providers, clinical staff, and other members of the care team.
- Monitor patient needs and follow up with patients as directed by the care team.



- Assist patients in identifying barriers to managing chronic conditions and connect them with appropriate resources.
- Support adherence to recommended appointments, testing, treatment plans, and follow-up care.

2. Patient Engagement and Education

- Establish trusting relationships with patients and families to encourage active participation in their healthcare.
- Provide patient education and information within the scope of the position and established protocols.
- Assist patients in understanding healthcare recommendations, available services, and next steps in their care.
- Encourage patients to participate in preventive care, chronic disease management, and recommended follow-up.
- Use appropriate communication strategies to engage patients who may experience barriers to accessing or participating in care.
- Document patient contacts, education, and care coordination activities appropriately.

3. Social Needs Screening and Referral Coordination

- Assist with identifying and screening for social needs that may impact a patient's health and ability to access care.
- Identify barriers such as transportation, food insecurity, housing, financial concerns, social support, or other needs as applicable.
- Coordinate referrals to appropriate community resources, social service agencies, and support programs.
- Maintain knowledge of available community resources and programs.
- Follow up with patients regarding referrals and connections to community resources.
- Communicate identified needs and concerns to appropriate members of the healthcare team.

4. Care Transitions and Follow-Up



- Assist patients transitioning between hospital, clinic, specialty care, rehabilitation, home, and community-based services.
- Coordinate follow-up appointments, referrals, testing, and other services following transitions in care.
- Contact patients following hospitalizations, emergency department visits, or other identified transitions in care as assigned.
- Identify barriers to successful transitions and communicate concerns to the appropriate healthcare team member.
- Assist patients in understanding discharge instructions, follow-up recommendations, and available support services.
- Track and document follow-up activities and patient outcomes.

5. Community Program Coordination

- Develop and maintain working relationships with community organizations, social service agencies, and other community-based resources.
- Coordinate patient connections to appropriate community programs and support services.
- Maintain current information regarding community resources available to patients.
- Participate in community outreach, education, and engagement activities as assigned.
- Collaborate with community partners to support patient access to services and resources.
- Assist with identifying gaps in available community services and communicate opportunities to appropriate MCMC leadership.

6. Data Tracking and Reporting

- Maintain accurate and timely documentation of patient care coordination activities.
- Track referrals, patient contacts, care transitions, community resource connections, and follow-up activities.
- Collect and maintain data related to care coordination, patient engagement, and program activities.
- Prepare reports and summaries as requested.



- Monitor assigned measures and identify opportunities for improvement.
- Maintain confidentiality and comply with HIPAA and organizational requirements related to patient information.

7. Other duties assigned.

Job Activities

Major Activity	Percentage
Chronic Disease Management Support	20%
Patient Engagement and Education	20%
Social Needs Screening and Referral Coordination	20%
Care Transitions and Follow-Up	20%
Community Program Coordination	10%
Data Tracking and Reporting	10%
100% Total	100%

Qualifications

- Associate's degree – Preferred in Licensed Social Worker, LPN or MA.
- Experience in healthcare, patient services, care coordination, community services, social services, or a related field preferred.

Requirements

- Demonstrate excellent interpersonal, communication, organizational, and customer service skills.
- Skill in organizing work, defining tasks, setting priorities, working independently, and following through on all projects and assignments with minimal direction.
- Ability to establish trusting and effective relationships with patients, families, healthcare providers, community organizations, and social service agencies.
- Ability to meet deadlines. This job requires making daily decisions and determining how and when tasks should be completed. Continuously works with moderate detail and deadlines.
- Knowledge of chronic disease management, healthcare navigation, community resources, and social support services preferred.
- Ability to educate and engage patients using clear, respectful, and understandable communication.



- Ability to identify patient needs and connect patients with appropriate healthcare and community resources.
- Ability to work effectively with individuals experiencing social, financial, transportation, or other barriers to care.
- Experience with electronic medical records and computer systems preferred.
- Must maintain patient confidentiality and comply with HIPAA requirements.
- Able to deal with constant change in healthcare, community resources, and patient needs.
- Must be able to consult with supervisor and clinical staff for guidance and final approval when appropriate.
- Accuracy is essential in all job duties.

Working Conditions and Physical Demands

- Work is primarily conducted in a climate-controlled clinic environment but may include community-based settings.
- Requires working in stressful situations, where multiple patients, projects, deadlines, and competing needs are a factor.
- Requires frequent communication with patients, families, healthcare providers, community organizations, and social service agencies.
- Requires frequent sitting, standing, walking, and movement throughout the clinic and community settings.
- Seldom required to lift and/or move items greater than a few pounds.
- Keyboarding and repetitive computer movement is frequent.
- Hearing is required for normal conversations and telephone work.
- Specific vision abilities required by this job include close vision and the ability to adjust focus due to computer work and reviewing patient information and documentation.
- May involve exposure to communicable diseases and other healthcare-related hazards.



- May require travel to community locations as assigned.

Equipment Operation

- This position utilizes the full complement of business and clinical office equipment with extensive use of computers.
- Proficiency with specialized and standard office computer programs is required.
- Proficiency with electronic medical record and care coordination systems is preferred.
- Proficiency with Windows operating systems is required.
- Uses telephone systems, fax machines, scanners, printers, and other standard office equipment.

Supervisory Responsibilities

No direct supervisor responsibilities.

Employee Signature: I have read and agree that I can perform the essential functions of this position.

Print Name

Signature

Date

Manager or HR Rep. Signature

Date