Example of Care Navigator Job Description

Our innovative and growing company is hiring for a care navigator. Please review the list of responsibilities and qualifications. While this is our ideal list, we will consider candidates that do not necessarily have all of the qualifications, but have sufficient experience and talent.

Responsibilities for care navigator

- Communicate with other members of the health care team regarding the patient's needs, plan, and response to care
- Provide continuum of quality care through telephonic and field based outreach, education, crisis intervention and other clinically based activities to plan members as specified in their treatment plans
- Assist Case managers and Service Coordinators with the development of case management and crisis plans for medical treatment and/or behavioral modification within the scope of practice
- Coordinates, with oversight by Case Managers and Service Coordinators, all information and referral functions from those calls including initiation of care plans to ensure continuity and integration of services
- Maintains logs and other data bases regarding care coordination activities
- Track aftercare outpatient appointments following inpatient or acute levels of care of assigned caseload
- Assist members in accessing care by educating providers, members and providing/arranging transportation as necessary
- Obtain signed releases of information from members via on site collaboration with providers
- Primary point of contact for designated “Most Vulnerable” Chronic Special Needs Plan Medicare Advantage customers/other identified “high risk” Medicare Advantage customers needing care management services
- Mails, collects, scans and telephonically assists customers to complete health

Qualifications for care navigator

- Knowledgeable on how to navigate all aspects of medical care and managed care system
- Two (2) years of experience working in health and wellness promotion required
- You may register online
- Must be able to collaborate and communicate with Care Managers and interdisciplinary team as needed in planning follow-up care and appointments
- Must be able to collaborate with Health Coach and interdisciplinary team in planning follow-up care, as needed
- Must be able to communicate with patients regarding pre-visit planning, follow up after discharge, and scheduling urgent appointments and referrals to specialists