Example of Care Navigator Job Description

Our company is growing rapidly and is looking for a care navigator. We appreciate you taking the time to review the list of qualifications and to apply for the position. If you don't fill all of the qualifications, you may still be considered depending on your level of experience.

Responsibilities for care navigator

- Assists patients as needed to schedule primary care, specialty care and other appointments as identified in the care plan
- Actively monitors incoming calls, conducts outgoing calls, and responds to voice mail requests in a timely manner
- Supports all PHM department programming in efforts to ensure we are meeting our Model of Care
- Documents all actions taken in the patient medical record
- Other duties as determined by the management team
- Conduct outbound calls to patients recently discharge from hospital or ER to ensure appropriate follow-up with primary care providers
- Conduct outreach and follow up in regards to patients that are high risk, have a gap score and gaps in care
- Complete a standard assessment for clinical, behavioral and community needs, triage for additional support by licensed clinical staff and complete referrals to additional resources as needed
- Collaborate with providers and practice teams to communicate patient's needs and develop solutions to overcome barriers
- Collaborate with the payer systems and payer Care Coordinators on specific patient care needs to include encouraging them to work with their applicable payer Case Manager, Disease Manager or Wellness Program designee

Qualifications for care navigator

- Excellent interpersonal skills, good judgment, flexibility, initiative and ability to use critical thinking skills to problem solve
- Bachelor's Degree Preferred in Social Work or Psychology
- Graduation from an approved, accredited school of nursing
- RN licensure with BSN or MSN, or MSW required
- 2 years of rehabilitation or case management experience preferred