PUEBLO OF JEMEZ
JOB ANNOUNCEMENT
2026-015
JEMEZ HEALTH AND HUMAN SERVICES
TRIBAL CAREGIVING PROGRAM MANAGER

Position Title:	Tribal Caregiving Program Manager	**Pay Level:**	$74,629.73-$111,944.59
Position Open Date:	3/10/2026-until Filled	**Classification:**	Exempt
Position Status:	Full-Time	**Location:**	Health & Human Services
Supervisor:	Nurse Case Management Director		

POSITION SUMMARY:

The Tribal Caregiving Program Manager is responsible for oversight of the Tribal Caregiving Program (TCP) and supervises/manages staff and operations for personal care in the home. Responsible for performing relevant case management, utilization review, quality assurance, and discharge planning for all clients in the TCP. Responsibilities specific to Case Management include assessment, planning, implementing, coordinating, monitoring, and evaluating needs to meet the health, human services, and social service needs of the client in both the home and primary care settings. Serves as an advocate, provides resource management, and maintains communication with the client and family to promote safe, quality care, interventions, and outcomes for clients and their families. Responsibilities specific to Utilization Review include review processes applicable to patients being discharged from acute/extended care settings. Assist patients with reintegration back to their home environment through case management and assessment. Responsibilities specific to Quality Assurance include performing surveillance and data collection as directed for trend recognition and development of effective actions/plans. Counsels patients and family members for a wide variety of concerns, including depression, grief, adjusting to significant life changes, impending death, confused elderly, homelessness, appropriateness of a home situation for an elder or disabled person, and debriefing patients who fall under a critical incident stress category. Functions as a contact person for patients, family, community resources, and health care team members internal to JHHS and referred care outside of JHHS case management, discharge planning, and continuity of care.

This job description indicates, in general, the nature and levels of work, knowledge, skills, and other essential functions expected of the incumbent. It is not designed to cover or contain a comprehensive listing of activities, duties or responsibilities required of the incumbent. Incumbent may be asked to perform other duties required.

QUALIFICATIONS:

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required.

EDUCATION & EXPERIENCE:

Associate's degree in Nursing: AND four (4) years of experience as a Registered Nurse OR Associate's degree in Nursing; AND (2) years of relevant experience as a Clinical Care Coordinator/RN Case Manager or Home Healthcare Nurse.
Prefer experience in home health care and case management: Bilingual skills in English and the Towa language; Prior working experience with the Indian Health Services or Tribal Healthcare.

REQUIRED CERTIFICATES, LICENSES TRAININGS, AND REGISTRATIONS:

New Mexico Driver's License
Valid New Mexico Registered Nurse License
Background Investigation
Basic Life Support certificate

PHYSICAL DEMANDS & WORKING ENVIRONMENT:

The physical demands described herein are representative of those that must be met by an employee to successfully perform the essential functions of the job. Reasonable accommodations may be made enable individuals with disabilities to perform the essential functions.

Mobility to work in a typical office and clinical setting; agility and dexterity to use standard office and medical equipment; stamina to sit and stand for extended periods of time; strength and agility to lift and carry up to 20 pounds; vision to read printed materials and a computer screen, and hearing and speech to communicate in over the telephone and in person.

ESSENTIAL FUNCTIONS:

- Uses the nursing process to conduct a comprehensive needs assessment to assess the patient's level of function, including developmental, physical, environmental, cognitive, behavioral, psychological, economic, social, cultural, and spiritual factors.
- Conducting periodic reassessments of client needs and revising the plan of care as necessary.
- Performs monthly phone calls with clients and quarterly in-home visits for reassessment or as needed.
- Participates in the development of the individualized plan of care, involving the patient and family, and attends regularly scheduled interdisciplinary group meetings, assisting the team in recognizing the effects of the psychosocial stresses on the patient and family, including terminal illnesses.
- Completion of the assessment includes interviews with the patient, family, or other caregivers, and chart information.

- Coordinates discharge planning from skilled nursing facilities, acute care facilities, and hospitals in coordination with the nurse care coordinator.
- Assesses Durable Medical Equipment needs and assists clients in navigating the health system by maintaining continuity of care at the JHHS clinic and referred providers.
- Provides intervention necessary as indicated by the case management assessment based on the identified needs. Arranging help such as PCA, or contracted help to allow the patient to remain in their own home, ordering of Durable Medical Equipment (DME) necessary for patient recovery or convenience as ordered by the physician. Services may also include arrangement of placement in either a Residential Care Facility, Assisted Living, or a Skilled Nursing Facility based upon patient/family wishes and doctor's order.
- Serves as a resource person for patients referred to the primary care provider clinic. Contact the appropriate agency or community program to meet the patient's social, emotional, and spiritual needs. Provides continuity of care as the level of care changes.
- Establishes and maintains relationships with referral providers and hospitals.
- Aids in patient recovery, understanding, discharge, and/or management of an acute, chronic, or terminal conditions; assistance may include education, referrals to JHHS clinic or community services, assistance with insurance coverage, acquisition of medical equipment, and information and referrals.
- Provides information in response to queries from the public, doctor's offices, families and outside facilities. Establishes and maintains an appropriate network of professional contacts.
- Obtains necessary orders from medical providers to initiate home health referrals, personal care services, medical equipment, and continuity of care.
- Takes referrals for Personal Care Attendant (PCA) services and assigns the PCA worker with consideration of the patient's choice.
- Supervises PCAs who do minor housework, laundry, food shopping, meal preparation, and assist with activities of daily living.
- Assigns personal care attendants to clients, schedules services, and monitors the implementation of the care plan.
- Facilitates a comprehensive welcome visit with the client and their family to effectively communicate and outline the TCP policies, ensuring clarity and fostering a respectful understanding of the guidelines and processes.
- Maintain client safety and follow up on any concerns.
- Hiring, competency testing, and training staff in policies, procedures, and regulations. Onboards and mentors new staff.
- Coordinates multidisciplinary care planning, including patient care conferences, to help resolve treatment decisions.
- Maintains confidentiality when interacting with patients, families personnel, and the public.
- Provides information regarding Advance Directives and assists in filling out the forms.
- Assists patients in transitioning into the in-home Hospice level of care.
- Identifies through Purchased Referred Care Services census review, referral, and risk screening appropriate patients requiring care coordination and case management. Assess the patient/family needs concerning the medical diagnosis, treatment, and resources, and provide treatment options for the continuity of care.

- Collaborate with other departments such as Patient Registration, Medical Records, Billing and Purchase Referred Care to update patient application and information and to determine patient eligibility for care.
- Make additional notes and documents for conversations with other members of the interdisciplinary team. These notes may also include conversations with caregivers, families and other support systems involved with the care of the patient.
- Responds promptly to requests from inter-disciplinary team members, physicians and their office staff, administration, industrial medicine, and public agencies.
- Perform surveillance and data collection as directed for trend recognition and development of effective actions/plans.
- Services as a team member in Complex Patient Rounding.
- Maintains compliance with State/Federal Guidelines and accreditation standards.
- Assists with data collection and analysis for quality improvement.
- Participate in continuing Education and other pertinent and appropriate learning experiences to maintain and increase personal and professional growth that is relevant to the field of expertise of current practice.
- Assists in establishing and revising TCP policies and procedures.
- Follows HIPAA guidelines, Privacy Act, applicable laws such as patient confidentiality, abuse reporting, principles of consent, and advanced medical directive, and other appropriate confidentiality standards, upholding the highest standards of privacy and confidentiality.
- Represents the Pueblo with dignity, integrity, and a spirit of cooperation in all relationships with staff and the public.

REQUIRED KNOWLEDGE AND SKILLS:

Knowledge of:

- Methods and techniques of medical case management and care coordination, community resources, and programs.
- Theory, principles, practices, and methods of providing nursing care and services at the level of a registered nurse.
- Strong knowledge of medical terminology and healthcare systems.
- Knowledge in patient care coordination, chronic disease management, and tracking.
- Prompt reporting of any significant changes.
- Laws, codes, and regulations related to work in healthcare.
- Medical record keeping, documentation on charts, and other medical records.
- Proper technique for documentation of assessments and referral process.
- Community services and resources.
- Health care insurance and benefits.
- Risk and protective factors related to clients.
- Ethics involved in casework.
- Legal provisions and resources.
- Engagement of stakeholders in relation to client needs.

- Working knowledge of the Indian Self-Determination and Education Assistance Act as it pertains to Tribes, Tribal Organizations, and Rules and Regulations of Federally Qualified Health Centers (FQHCs).
- This position requires an awareness and keen appreciation of Native American/American Indian traditions, customs, and socioeconomic needs and the ability, at all times, to meet and deal effectively in contacts with Indian organizations the require tact, courtesy, discretion, resourcefulness, and sound judgment in handling functions of a sensitive nature.
- Ability to maintain high moral standards both at work and in the community.

Skill in:

- Managing, developing, and mentoring all personal care assistants.
- Assessing cases appropriately and utilizing the most appropriate community and welfare resources to provide effective client services.
- Coordinating the healthcare of patients between multiple health facilities.
- Preparing clear and concise reports, correspondence, and other written materials.
- Analyzing, interpreting, and applying to clinical staff, support staff, patients, and family concerns.
- Techniques for dealing with a variety of individuals form various socioeconomic, ethnic, and cultural backgrounds.
- Organizing work, setting priorities, and meeting critical deadlines.
- Using tact, discretion, and prudence in dealing with the elderly, disabled, and families contacted in the course of the work.
- Experience with Electronic Health Record systems.
- Contributing effectively to the accomplishment of team or work unit goals, objectives and activities.
- Working independently and as part of a team.
- Proficient in Microsoft Office Suite.
- Excellent written and verbal communication skills.
- Strong organizational and time management abilities.
- Empathy and commitment to patient advocacy.

To apply for the position posted, please apply as follows
Send;
Pueblo of Jemez Job Application
To;
humanresources@jemezpueblo.org
Or;
Pueblo of Jemez-Attention Human Resources Department
PO Box 100
Jemez Pueblo, NM 87024