Community Health Worker/Chronic Care Health Worker Job Description

Position Type: Grant funded position for two years with possibility for continuation should goals and objectives be met. Four (4) FTEs to be funded by the Behavioral Health Initiative Grant and Medical Capacity/Expanded Services Allocation.

General Job Statement: The goal of the integrated patient-centered/population health pilot is to improve individual and community health outcomes. As an integral member of the BCHN Community Health Promotion and Education Program (CHPEP) and the health centers' interdisciplinary patient care teams, the Community Health Worker/Care Coordinator/Case Manager (CHW) will serve as the bridge between the patient's health center care team and his/her community and home. In this role, the CHW will provide support for designated patients, to follow care plans, set health goals, track progress and access required social support services required for successful goal attainment. He/she will use evidence-based motivational techniques to actively engage participants in self-management.

CHWs will also conduct health promotion, education and outreach activities to specific assigned target populations to raise awareness about chronic disease risk factors, prevention strategies, access to quality, comprehensive health care and affordable public health insurance options.

The CHW will have dual accountabilities: to the assigned health center interdisciplinary team leader/physician and to the BCHN CHPEP/CHW Supervisor.

Qualifications: Masters in Public Health, Health Education, Public Administration/Public Service
CHWs will be:

- Trained to provide appropriate levels of support to a panel of patients and to understand professional boundaries
- Valued members of the patient's interdisciplinary health care team and included in care planning rounds/meetings
- Assigned a panel of patients, with defined care plans, who can benefit from individual or group intervention strategies and support in the community/home
- Able to motivate patients to set goals
- Able to access resources (social determinants of health) to facilitate the patient's ability to work towards health goals
- Able to track and follow-up on patient's use of resources/responses
- Expected to have regular reporting schedules to the care team and know when to seek the team's assistance

CHW Training:
The comprehensive CHW training program is didactic and experiential (on the job, field work) with the following curriculum modules:

- Orientation to BCHN, the health centers, ERs
- Overview of the Bronx (demographics, health indicators, economy, social structures, culture, immigration, etc.)
- Job description orientation-roles, responsibilities, accountabilities (BCHN and care team), work schedules
- Health and disease, mental health first aid (modules at appropriate levels)
- Medical terminology (as appropriate)
- Communication, interviewing, assessment, motivational skills
- Outreach strategies
- Community engagement, team building, group leadership, advocacy
- Safety-community and home visiting
- Assessment of household; adult & pediatric

- Community resources
- Other
- Regular peer group support and continuing development (monthly CHW meeting

Training is done by BCHN, consultants and other field experts; includes role play, pre- and post-tests, module evaluation, student self- and instructor- assessment.

Training should include members of the interdisciplinary care team whenever feasible.

Core Responsibilities:

- Convey the purposes and anticipated impact of BCHN's programs and services to the user population.
- Build and maintain positive working relationships with community organizations and members.
- Identify strengths and needs of the targeted neighborhoods/populations and engage community leadership in health promotion strategies to effect systems, policy, environmental change promote facilitate referrals to appropriate resources.
- Participate in community activities (meetings, forums, etc.) to continuously expand knowledge and understanding of community human and program resources.

- In collaboration with the primary care team, follow-up designated patients (e.g.: multiple chronic conditions; fallen out of care) and maintain/reconnect to care.
- Coordinate care between primary care and specialty providers and other social and human services providers.
- Help patients navigate the healthcare and related systems.
- Interpret, translate, or provide information or cultural mediation related to health services

- Coordinate/conduct health screenings, health fairs, individual and group educational workshops, and other health events. Advise community members on issues related to diagnostic screenings; self-management and improving general health.
- Assist in assembling health educational materials including flyers, brochures, or other informational and educational documents. Disseminate them to inform community members.
- Motivate community members to be active, engaged participants in their health.
- Help community members develop health management plans and goals and provide support to help them meet their goals.

- Facilitate outreach and enrollment assistance activities in a culturally and linguistically appropriate manner.
- Identify community members without a health insurance or PCP and link them to BCHN health centers.
- Conduct public education activities to raise awareness about the Marketplace.

- Other duties as assigned.

<u>Administrative:</u>

- Successfully complete all required training, including NYS state consumer assistance training.
- Complete and submit reports on a timely basis.