| Job Title | Community Health Worker – Social Determinants of Health |
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| Annual Salary | Commensurate with qualifications and experience. |
| Reports To | Population Health Manager |
| Travel Requirements | Local meetings and events, some state and federal conferences, local/regional patient service/education venues external to the health center. |
| Type of Position | Regular Full-Time (1.0 FTE) with full benefit package. |
| Overview | The SDoH Community Health Worker (CHW) will work dynamically with IHC's unique patient populations in accordance with the health center's Patient-Centered Medical Home (PCMH) model. The work of the CHW often extends to the wider community where their unique skillset makes them well equipped to identify persons in-need or at-risk and to connect them with the health center and other community services aimed with addressing the social determinants of health. The CHW encourages behaviors that promote both the wellness and health of the individuals and communities they serve, and provides a link between the community, health educators, and other healthcare and social service professionals. The CHW has a close understanding of the community she/he/ze/they serve(s) and is therefore able to act as a liaison between at-risk individuals and the health/social services available to them. |
| Minimum Skills, Experience, and Educational Requirements | • High school diploma or equivalent<br>• 1-3 years of experience preferred<br>• Strong analytical, quantitative, problem solving, and organizational skills<br>• Ability to coordinate multiple tasks, follow workflows, set priorities, and meet deadlines<br>• Brazilian Portuguese fluency highly desirable.<br>• Experience in public health, community clinics, or other safety net setting highly desirable.<br>• Experience with navigating electronic medical record platforms highly desirable.<br>• Proficiency in Microsoft Excel, Word, and PowerPoint. |

Responsibilities

(1) With the Population Health Manager, implement comprehensive programs that actively work to identify opportunities for improvement in addressing medical and social inequities
- Collaborate with the PHM to promote Population Health / SDoH initiatives and projects through consistent patient outreach, education and connection
- Build effective relationships through trust, respect and communication and ultimately, help members, patients and their families **navigate** and **access** community services and resources
- Conduct screenings and surveys that address access to the medical, behavioral and social needs of patients, in order to identify gaps in care and barriers to obtaining resources critical to the members'/patients' wellbeing
- Facilitate care coordination and care transitions for IHC patient populations (e.g. following an ED visit or inpatient stay, serving as a linkage between patient and provider)
- Ensure that all services are offered in a culturally and linguistically appropriate manner and that all needed accommodations are consistently made for members with disabilities
- Use information about data trends for self-directed learning and performance improvement
- Build capacity within the clinic and the community at large to address health issues

(2) Work in tandem with IHC Community Health Workers / Peer Recovery Coaches to address the social needs of all Island Health Care patients
- Proactive outreach to address needs relating, but not limited to, the social determinants of health
- Motivate patients to be active, engaged participants in their health
- Effectively work with people (staff, patients, providers, agencies, etc.) from diverse backgrounds in reducing cultural and socio-economic barriers between clients and institutions

- Efficiently and completely document all patient encounters in the Electronic Health Record
- Connect patients with relevant resources to improve agency and health outcomes
- Navigate IHC programs with patients and assist them in completing applications if needed (e.g. Sliding Fee Discount Program, Transportation Access Program)
- Provide ongoing support and follow-up to ensure that *all* of patients' needs are met
- With the larger CHW team, coordinate community outreach activities to increase awareness of the services offered by IHC and the community at large
- Continuously expand knowledge and understanding of community resources, services and programs provided; human relations and the procedures used in dealing with the public as part of a service or program; operations, functions, policies and procedures associated with the department or program area; procedures and resources available to handle new, unusual or different situations