## Position Description:
## Countywide Benefits Entitlements Services Team

## Community Health Worker:

These positions serve as the support to the Countywide Benefits Entitlements Services Team (CBEST) and are supported by and report directly to The CBEST administrative team at Housing for Health. They provide connections to direct services; care coordination and system navigation; coaching and social support; education about the health and social service system; advocacy; outreach; assessment; and capacity building for MediCal beneficiaries who are members of six highly marginalized communities across the eight (8) SPAs.

### Responsibilities

- **IN-REACH AND OUTREACH**
    a. Provide in-reach and/or outreach to MediCal beneficiaries who have complex physical and behavioral health issues in order to support them to improve their health; this includes linking them to various services.
    b. Connect and engage participants in activities and services.
    c. Build and maintain trusting and open relationships with community organizations, leaders and resources.

- **ASSESSMENT**
    a. Conduct initial assessment of participant strengths and needs. This includes but is not limited to administering appropriate screening and/or assessment tools.
    b. Guide participants, participants' significant others, and other team members in the development of a services and supports plan, which addresses the participant's goals and any medical, behavioral health and/or substance use treatment needs.
    c. Assist participants in setting goals related to housing, benefits establishment, employment and self-sufficiency, and other topics which support the program participant in gaining more control over their lives and their health
    d. In conjunction with other team members and each participant, assist with evaluating progress towards goals and make adjustments in the case management plan to facilitate progress toward goals.
    e. Assess participant eligibility/suitability for special programs.
    f. Complete all necessary and required documentation, which includes use of the Care Management Platform, known as CHAMP.
    g. Compile and report summary program data on regular intervals as directed by their Supervisor
    h. Maintain participant confidentiality and privacy by protecting participant health information.

- **COACHING AND SOCIAL SUPPORT**
    a. Establish a trusting and open relationship with participants.
    b. Accompany participants to appointments as needed and appropriate.
    c. Help participants to build social support systems; this includes connecting participants to support and recovery groups.

d. Provide coaching for housing, employment, and other interviews and address participants' anxieties related to these activities

- **CARE COORDINATION, CASE MANAGEMENT, AND SYSTEM NAVIGATION**
  a. Provide intensive case management for a determined period of time.
  b. Provide warm hand-offs and supported referrals to necessary supports and services, including housing, education, employment, substance use treatment, etc.
  c. Engage with participants in the most appropriate and accessible location, which may include: the street, participants' homes, the hospital, or other community sites.
  d. Connect participants to needed resources within the Departments of Health Services, Mental Health and Public Health, and other health and social service providers.
  e. Link participants to other Community Health Workers working at the family, group, community and policy levels.
  f. Arrange or provide transportation to services as needed.
  g. Assist with obtaining, completing, and submitting applications, and appeals processes.
  h. Support participants to prepare for and complete needed medical and social service appointments.
  i. Facilitate connection to and engagement with a geographically and culturally appropriate primary care home**.**
  j. As needed, assist other members of the health and social service team in identifying and securing appropriate community-based residential placements such as board and care, skilled nursing, substance use treatment or mental health treatment facilities for participants.
  k. Arrange for supportive services such as home health care, in home supportive services, or durable medical equipment as needed.
  l. Link participants experiencing homelessness to the Coordinated Entry System (CES).

- **CULTURAL MEDIATION AND EDUCATION OF THE HEALTH AND SOCIAL SERVICE SYSTEM**
  a. Assist participants, families and significant others in understanding the WPC program, and gaining their acceptance of and participation in the program.
  b. Communicate information about the health and social service systems, including medication regimes and system processes, in a culturally appropriate manner.
  c. Continue to follow-up with participants to encourage engagement and ongoing participation in and commitment to the program.
  d. Build trusting relationships and collaborate with other members of the team who may include social workers, nurses, physicians, psychiatrists, Medical Case Workers, service providers, etc.
  e. In both formal and informal settings, educate and inform other health and social service professionals about strengths and needs, as well as cultural worldviews, experiences and perspectives of the community or communities in which the CHW lives and works.
  f. Work with other team members especially at a regional level to adapt systems and services to be more culturally centered and appropriate.
  g. Participate in all program meetings, site-specific all staff meetings, and

team huddles as directed by the Supervisor.
h. Respectfully and professionally represent the CBEST program

- **ADVOCACY**
  a. Serve as an advocate on behalf of the participant within clinical and community-based settings to help participant achieve health and life goals and to secure necessary services and supports, promoting participant's recovery.
  b. Assist the participant to learn to advocate for him/her/themselves.

- **CAPACITY BUILDING**
  a. Use motivational interviewing and popular education to motivate and activate the participant to set and achieve personal goals.
  b. Move participants forward in their recovery and reduce the number of days spent in high acuity facilities and treatment.
  c. Provide connection to appropriate programs, including both social service programs and organizations that conduct community building and organizing, to facilitate empowerment, self-determination, and engagement in the community.

- **OTHER DUTIES AS ASSIGNED**
  a. Complete assignments and other duties as delegated in a competent and timely manner.
  b. Assure that all CBEST, state and federal guidelines and criteria are met.
  c. Communicate clearly, professionally and effectively with fellow CHWs, and all site-specific colleagues.
  d. Participate in team building efforts to promote positive interpersonal relationships with team members.

## Minimum Requirements

### Training and Experience

Six months of full-time experience working with the public or with community groups performing duties such as interviewing clients or patients concerning health or social service matters, answering questions**,** and providing information about health, mental health, and social services to clients or patients -OR- Six months of experience at the level of the Los Angeles County class of Mental Health Peer Advocate.

## Necessary Qualifications

### Relevant Work and Lived Experience

- Lived experience in one or more of the communities of focus: people with disabilities, people experiencing homelessness or at risk of homelessness, veterans with disabilities, people coming out of incarceration, people with substance use disorder and people with mental illness.
- Member of the community, close affiliation, or shared life experience with the community being served.
- Ability to work appropriately and effectively within one or more of the communities of focus for CBEST.
- Potential or demonstrated community leadership.

- Experience working with medically and socially complex individuals.

**Valuable Knowledge and Skills for this Position**

- Existing relationships and trust within communities of focus.
- Familiarity working with or navigating within the health and social services system, preferably as a result of lived experience.
- Ability to build and maintain trusting relationships with community stakeholders and health and social service providers.
- Ability to work independently in a constantly changing environment.
- Personal strength, resilience, and stability to allow the CHW, with support of supervisor and work team, to face very challenging situations and avoid re-traumatization and vicarious trauma.