CATHOLIC SOCIAL SERVICES
JOB DESCRIPTION

TITLE:	SSVF Healthcare Navigator
PROGRAM:	Homeless Family Services
STATUS:	Full-time / Non – Exempt
SUPERVISED BY:	HFS (SSVF) Program Manager
UPDATED:	09/2020

Job Summary: The Healthcare Navigator position provides services that include connecting Veterans to VA health care benefits or community health care services where Veterans are not eligible for VA care. This position provides case management and care coordination, health education, interdisciplinary collaboration, coordination, and consultation, and administrative duties. SSVF Healthcare Navigators work closely with the Veteran's primary care provider and members of the Veteran's assigned interdisciplinary treatment team. This position is based in Anchorage, however, candidate would spend about 25% of time working with clients in the Mat Su Valley.

Minimum Qualifications: The ideal candidate for the SSVF Healthcare Navigator position will be an individual with at least a Master's Degree in Social Work and 2-3 years of experience in the field of (preferably VA) health care. They will have experience working with low income and/ or homeless populations. The candidate will possess proficient computers skills, including Microsoft Office Suite. The candidate will have experience working in diverse setting with people across the socio-economic spectrum and a wide variety of personalities and roles.

Competencies:

Knowledge of social service resource systems and self-help intervention strategies.
Knowledge of Integrated Behavioral Healthcare or other VA based mental health models
Knowledge of VA documentation protocols (e.g., how to effective write VHA ROIs)
Knowledge and skills in handling substance abuse and mental health issues.
Knowledge of public benefits and financial resources available in the community.
Ability to successfully develop relationships utilizing motivational interviewing techniques.
Crisis intervention and conflict resolution skills including use of motivational interviewing, harm reduction approach, and trauma-informed care.
Knowledge of family budgeting and money management.
Thoroughness and accuracy with data collection, entry and quality control in a web-based database.
Patience/tolerance and tact/diplomacy.
Knowledge of family budgeting and money management.
Clear/firm-yet-flexible boundaries, consistent energy level and positive demeanor.
Thoroughness and accuracy with data collection, entry and quality control in a web-based database.
Professionalism: high level of integrity and strong ethical values show capacity to maintain highest standards of confidentiality with all records, including organizational and individual information.
Strong oral/written communication and listening skills.

Self-motivated and accountable for work time and other agency resources.
Quality control: demonstrates accuracy and thoroughness, monitors own work to ensure quality and applies feedback to improve performance.
Well organized: able to effectively manage multiple assignments to meet project deadlines.
Familiar with health care systems, specifically within the Veteran's Health Administration / VA.
Must be able to travel independently throughout Anchorage and transport persons in their own vehicle.

Duties & Responsibilities:

- Conducts assessment of the Veterans in collaboration with the interdisciplinary treatment team, the Veteran, family members, and significant others.
- Acts as a liaison between the SSVF grantee and the VA or community medical clinic and other healthcare providers, coordinating care for a population of Veterans with complex needs who require assistance accessing health care services or adhering to health care plans.
- Works closely with the Veteran's assigned multidisciplinary team, including medical, nursing and administrative specialists, and case management personnel.
- Works within SSVF team to provide timely, appropriate, Veteran centered care in an equitable manner.
- Works collaboratively with healthcare team and Veteran to identify and address system challenges for enhanced care coordination as needed.

N ON-CLINICAL ASSESSMENTS

- Conducts assessments of the Veteran in collaboration with the interdisciplinary treatment team, the Veteran, family members and significant others. The purpose of the assessment is to understand the Veteran's situation, potential barriers to care, the causes and the impact of such barriers on the Veteran's ability to access and maintain health care services.
- Assessments should highlight the Veteran's strengths, limitations, risk factors and internal / external supports and service needs in order to optimize the Veteran's ability to access and maintain health care services.

H EALTH CARE TEAM AND VETERAN COMMUNICATION

- Work closely with Veterans to assist them in communicating their preferences in care and personal health-related goals, in order to facilitate shared decision making of the Veteran's care.
- Serve as a resource for education and support for Veterans and families and help identify appropriate and credible resources and supports tailored to the needs and desires of the Veteran.
- Participate as needed in the development of the Veteran's care plan; with emphasis on community services, outreach, and referrals needed for the Veteran.
- Review care plan goals with Veteran and conduct regular non-clinical barrier assessments and provide resources and referrals to address barriers as needed.
- Periodically review effectiveness of resources and make modifications as needed.
- Monitor Veteran's progress, maintains comprehensive documentation, and provides information to the treatment team members when appropriate.
- Use clear language to communicate recommendations to support the Veteran and family members or care givers, as well as identify questions Veterans and their families may have about their treatments.

S PECIALIZED CASE MANAGEMENT AND CARE COORDINATION

- Provide comprehensive case management and care coordination across episodes of care—acting as a health coach by proactively supporting the Veteran to optimize treatment interventions and outcomes.
- Coordinate services with other organizations and programs to assure such services are complementary and comprehensive; directing activities to maximize effectiveness and a continuity of care for the Veteran.
- Serve as a liaison to VA and community health care programs, and represent the SSVF program in contacts with other agencies and the public.
- Assist in coordinating supportive and additional services with the Veteran, which includes linking Veterans and caregivers to supportive services, which include, but are not limited to housing, financial benefits and transportation—in collaboration with their SSVF housing Case Manager.
- Serve as the subject matter expert on community resources related to the needs of the Veteran.

I NTERDISCIPLINARY COLLABORATION, COORDINATION AND CONSULTATION

- Collaborate with other disciplines involved in providing care to the Veteran.
- Regularly consult with other team members and appropriately assess and address the needs of the Veteran.
- Understand the different roles within the interdisciplinary team and acts within professional boundaries.

- Adhere to ethical principles about confidentiality, informed consent, compliance with relevant laws and agency policies (i.e. critical incident reporting, HIPPA, Duty to Warn).

Physical Requirements: Ability to climb stairs and to lift a minimum of 20 lbs.

Training Requirements: Attend agency and department orientation; 1st aid/CPR; de-escalation techniques; blood borne pathogens. Attend all staff meeting and in-service training as required.

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not to be construed as an exhaustive list of all responsibilities, duties, and skills required of personnel so classified. All personnel may be required to perform duties outside of their normal responsibilities as needed.

Employee Signature_____ Date_____

Supervisor Signature_____ Date_____