WILLIAMSON HEALTH AND WELLNESS CENTER

Position: Community Health Worker

Status: Full-time

Description: Responsible for care coordination activities as part of a care team with healthcare staff and providers. CHWs will work with patients diagnosed with or at-risk of developing diabetes or heart disease. CHWs utilize telehealth and provide weekly home visits to improve health outcomes, reduce complications and to improve communication between patients and care teams. The CHW will help to put the patient in the driver seat of their own health and update patient care plans to reflect patient centered goals, working through successes and barriers together. The CHWs promote patient self-management skills, assist in coordinating access to specialty health care providers, remind patients of upcoming appointments, link the patient to numerous community resources, complete screenings and assessment in the clinic, and promote ongoing goal setting in the care plans.

Responsibilities

Bridge the gap between communities and the health and social service systems

- Aiding communication between provider and patient to clarify cultural practices.
- Educate community members about how to use the health care and social service systems.
- Educate the health and social service systems about community needs and perspectives.

Navigate the health and human services system

- Increase access to primary care through culturally competent outreach.
- Make referrals and coordinate services.
- Teach people the knowledge and skills needed to obtain care.
- Enroll clients into programs such as health insurance and public assistance.
- Link clients to and inform them of available community resources.

Advocate for individual and community needs

- Articulate and advocate needs of community and individuals to others.
- Be a spokesperson for clients when they are unable to speak for themselves.
- Map communities to help locate and support needed services.

Provide Direct Services

- Promote wellness by providing culturally appropriate health information to clients and providers.
- Educate clients on disease prevention.
- Assist clients in self-management of chronic illnesses and medication adherence.
- Refer and link to preventive services through health screenings and healthcare information.

Build Individual and Community Capacity:

- Build individual capacity to achieve wellness.
- Build community capacity by addressing social determinants of health.
- Identify individual and community needs.
- Mentor other CHWs – capacity building.
- Seek professional development (continuing education).

Other Duties as Assigned

Employment Qualifications: A minimum of three or more years living in the community and excellent communication skills with reliable transportation and valid vehicle insurance. Licensed Practical Nurse (LPN) preferred.