Community Health Worker
Job Duties

Description:
The Community Health Worker (CHW) is a part of an inter-disciplinary clinical care team at a health center who helps increase access to health services for people through outreach, encouraging engagement, education, and peer support.

Core Scope of Work

1) Perform an initial assessment based upon the reason provided for contact (No care with PCP during current year, Health Risk Assessment completion, inappropriate ED use, recent hospitalization, gap in routine care, connection to community resources to address SDOH issues). This will be accomplished by using a variety of methods including coordinated text messaging, phone calls, mail and in-person visits at home, other care settings or community events as needed.
2) Coach and motivate patients to engage in primary care to effectively manage their chronic disease or engage in preventive care as appropriate.
3) Actively collaborate with other members of the primary care team including Care Managers, Support Staff and PCPs.
4) Address Social Determinants of Health (SDOH) issues identified during patient contacts and eliminate barriers to care as appropriate.

Core Job Duties:

1. **Overall Outreach and Tracking**
   a. Review MCHN provided monthly outreach list for each covered Health Plan and develop a plan for prioritized outreach following MCHN best practices workflow.
   b. Document all outreach attempts in MCHN provided documentation tool and provide results monthly to allow for aggregate reporting to Health Plans.
   c. Provide direct education or engagement with contacted patients or connect to other resources for education as appropriate based upon initial assessment. Typical engagement would include education on appropriate use of health services, assisting with federal, state and local programs that provide or financially support the provision of medical, social, educational, housing, or other related services, and addressing identified factors affecting health (e.g., social, housing, educational).
   d. Assist the Health Center in maintaining its assigned patient panels with covered Health Plans including helping patients change their primary care provider and supporting the Center in removing patients that are not served by the Center from its panels

2. **Patient and Community Engagement**
   a. For assigned members without a current primary care visit, attempt to schedule a primary care appointment to include helping the patient clear common barriers to care as needed or update Health Plan records to reflect patient actual PCP.
   b. For newly assigned patients, coordinate a graduated intensity outreach program to engage patient in care. Share information as needed about the Health Center and its services and what they can expect in their first visit. Ensure documentation of outreach attempts follows MCHN workflow to allow for patient reassignment by Health Plan at appropriate point.
   c. Contact at least 25% of patients weekly who are deemed to be at high risk by a stratification methodology and engage the individual in care management and coordination services/programming provider by the Health Center.

3. **Healthy Michigan Plan Health Risk Assessment**

a. Attempt to contact identified patients in need of completion of a Healthy Michigan Plan Health Risk Assessment.
b. Assist contacted members with completion of assessment and address triggered interventions

4. **Inappropriate and Preventable ED Utilization**
   a. Contact assigned Health Plan members identified as either high or inappropriate utilizers of the emergency department and encourage engagement with PCP.
   b. Provide education and resources to these members along with encouragement to contact PCP any time they believe they need urgent services to provide the opportunity to address need through Health Center services.
   c. Address identified barriers to care that led to the utilization of ED rather than Primary Care services.

5. **Gaps in Care**
   a. Utilize individual and MCHN provided reports to prioritize patient outreach attempts to close gaps in care (e.g. missing preventive service, poor chronic disease outcome etc.).
   b. Facilitate scheduling of required visit / testing and eliminate barriers to care as appropriate.

6. **Community Resources/Social Determinants of Health (SDOH)**
   a. Conduct SDOH screening and assessment using tools identified by MCHN to uncover individuals needs and connecting members with available community resources addressing, but not limited to, the following SDOH:
      - Food (issues with providing or accessing food for self and family)
      - Housing (adequate, safe affordable housing for self and family)
      - Transportation (non-medical, for employment and daily activities)
      - Economic Stability (poverty, unemployment, budgeting and financial literacy)
      - Social and community connectedness
      - Neighborhood and built environment (access to foods that support healthy eating patterns, crime and violence environmental conditions, community support)
      - Health and healthcare (access to primary and preventive care, access to health care generally, and health literacy).

Administrative Functions and Reporting

- Report the appropriate detailed documentation below to MPCA by the 3rd work day of each month utilizing the patient tracking report:
  - Outreach attempts
  - Services provided
  - Education provided
  - Referral monitoring and maintaining
  - Other pertinent program data
- Complete accurately, and in a timely manner, all-necessary forms, case recordings and statistical reports, and submits such documentation supervisor within designated timelines.
- Maintain confidentiality and follows HIPAA standards in safeguarding patient information.

Ongoing Education

- Participate actively in regular supervisory and team meetings and training sessions below:
    - Monthly one-on-one calls with MPCA liaison/staff
    - Monthly group community health worker team calls
    - In-person or online webinars / training as required
    - Participate at least once a month on CHW online peer to peer system
- Successful completion of the paraprofessional CHW Training Program within 180 days of hire

Knowledge, Skills, and Abilities:

- Must be well-organized, detail-oriented, and have the ability to multi-task in a demanding and constantly changing environment
- A strong commitment to serving the underserved and vulnerable populations of the local community.
- Strong interpersonal communication skills and the ability to communicate easily with others, including demonstrating active listening skills
- Ability to navigate the health care system and advocate for others
- Demonstrate flexibility in addressing changing community needs and program environment
- Display empathy, respect, and understanding of community resources, clinical core measure goals, and understanding of health center's values and processes
- Ability to maintain confidentiality
- Experience in community work, education, or health care strongly recommended
- An ability to gain respect and build rapport with community members