Position: **Community Health Worker**

Direct Supervision: **Community Health Programs Manager**

Status: **Exempt, Full-Time**

To Apply: **Submit Cover Letter & Resume to info@tchnetwork.org**

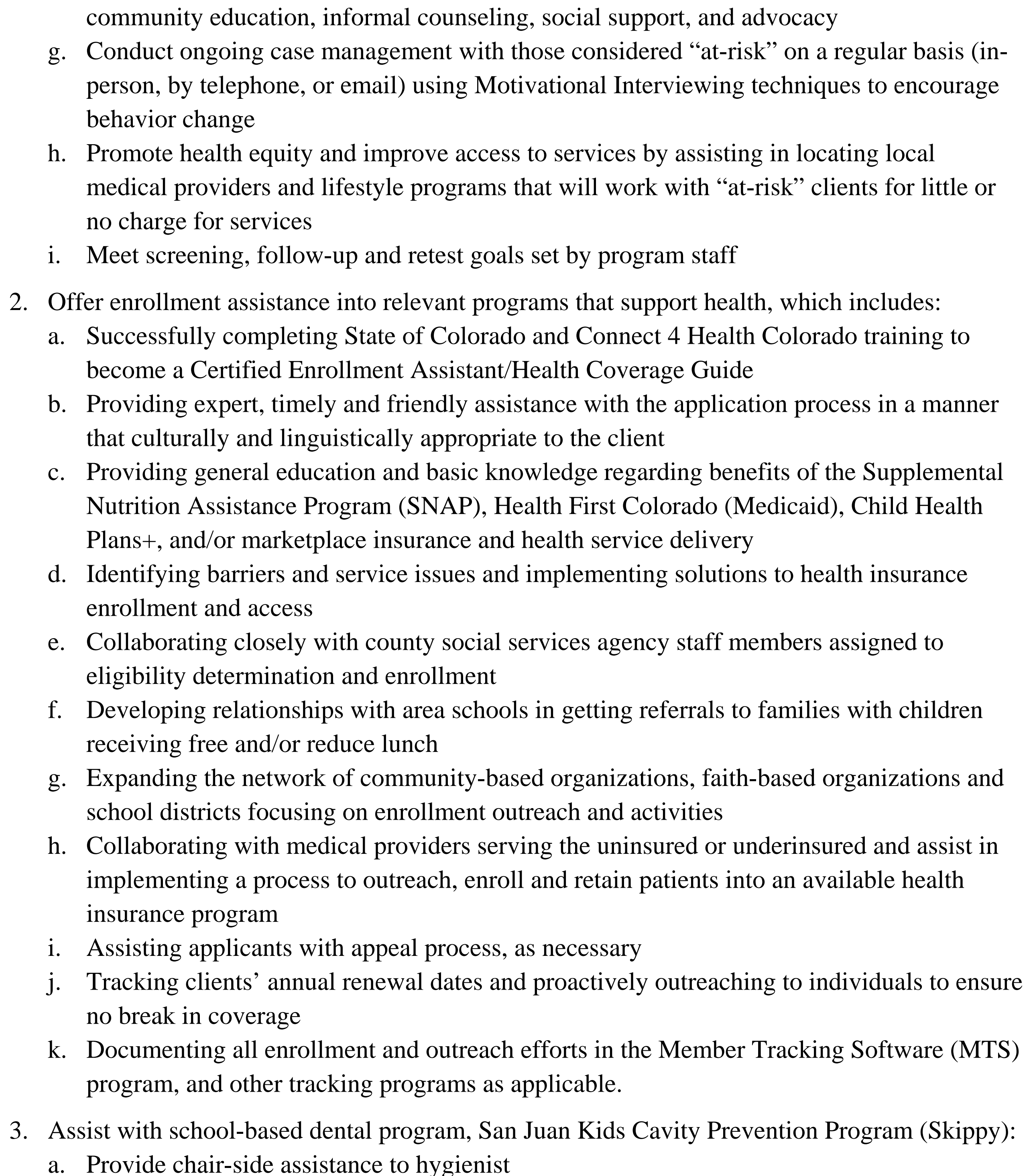
JOB SUMMARY:

Under the general direction of the Community Health Program Manager, the Community Health Worker (CHW) is a field-based position that works directly with members of his/her respective community to provide wellness and chronic disease screenings, outreach, education, and enrollment support. To address barriers to health, CHWs target underserved populations and employers to provide health screenings and create action plans based upon individual needs and goals. Connecting people with local community resources, enrolling individuals into relevant programs, and providing support are some ways that CHWs make positive impacts in their community.

DUTIES AND RESPONSIBILITIES:

May include the following, and other duties as assigned.

1. Provide wellness screenings, which includes:
   a. Complete wellness screenings that include but are not limited to cardiovascular risk screening/retest includes a blood pressure check, finger- stick cholesterol and glucose test, personal medical history, basic demographic information, and completion of a computerized cardiovascular disease risk assessment
   b. Provide basic point of service counseling on medical and lifestyle recommendations (exercise program, dietary counseling, social service programs, etc.) with prompted messages provided by the Outreach, Screening and Referral (OSCAR) system for preventive services for the reduction of cardiovascular disease risk factors, as requested
   c. Utilize OSCAR and Essette, TCHNetwork's member tracking system, to enter data, generate health recommendations, and track client interactions
   d. Provide referrals for medical care or lifestyle changes for those considered "at-risk" for cardiac disease development through screening results
   e. Act as the liaison between health, social services, and community services while providing essential grant related clinical prevention services
   f. Promote and build individual and community relationships through: outreach,



community education, informal counseling, social support, and advocacy

g. Conduct ongoing case management with those considered “at-risk” on a regular basis (in-person, by telephone, or email) using Motivational Interviewing techniques to encourage behavior change
h. Promote health equity and improve access to services by assisting in locating local medical providers and lifestyle programs that will work with “at-risk” clients for little or no charge for services
i. Meet screening, follow-up and retest goals set by program staff

2. Offer enrollment assistance into relevant programs that support health, which includes:
   a. Successfully completing State of Colorado and Connect 4 Health Colorado training to become a Certified Enrollment Assistant/Health Coverage Guide
   b. Providing expert, timely and friendly assistance with the application process in a manner that culturally and linguistically appropriate to the client
   c. Providing general education and basic knowledge regarding benefits of the Supplemental Nutrition Assistance Program (SNAP), Health First Colorado (Medicaid), Child Health Plans+, and/or marketplace insurance and health service delivery
   d. Identifying barriers and service issues and implementing solutions to health insurance enrollment and access
   e. Collaborating closely with county social services agency staff members assigned to eligibility determination and enrollment
   f. Developing relationships with area schools in getting referrals to families with children receiving free and/or reduce lunch
   g. Expanding the network of community-based organizations, faith-based organizations and school districts focusing on enrollment outreach and activities
   h. Collaborating with medical providers serving the uninsured or underinsured and assist in implementing a process to outreach, enroll and retain patients into an available health insurance program
   i. Assisting applicants with appeal process, as necessary
   j. Tracking clients’ annual renewal dates and proactively outreaching to individuals to ensure no break in coverage
   k. Documenting all enrollment and outreach efforts in the Member Tracking Software (MTS) program, and other tracking programs as applicable.

3. Assist with school-based dental program, San Juan Kids Cavity Prevention Program (Skippy):
   a. Provide chair-side assistance to hygienist

b. Record oral exam on Skippy tablet as directed by hygienists; document sealants and exam results if received that day. Record treatments received, risk assessment, follow-up as needed.
c. Log kids in need of follow-up on “Referral” spreadsheet
d. Prepare take-home letter for parents
e. Assist in clinic set-up and take-down at school
f. Contact all parents with children needing referrals to explain the need for follow-up care and provide a list of dentists.
g. Follow-up with parents of children identified as not having insurance to determine if parents want to complete Medicaid/CHP+ application.
h. Document all outreach efforts to parents & progress on application assistance in MTS

4. Participate in required trainings, conference calls, and meetings as directed
5. Conduct required group trainings and additional screenings, as requested, to provide education and services to the community-at-large
6. Other duties as required to ensure the success of TCHNetwork

SKILLS:

1. Excellent verbal and culturally competent communication skills (in person, on the telephone, and through email correspondence).
2. Must have aptitude for computers and working with various software and be proficient in MS Word, MS Excel.
3. Good knowledge of the surrounding community; program policies; and some knowledge of health care systems.
4. Knowledge of and skill in obtaining a health history and performing screenings sufficient enough to determine if there is any deviation from normal, based on training and where applicable.
5. Ability to record accurately services rendered and to interpret and explain records, reports, and medical instructions.
6. Willingness to work flexible hours (some nights/weekends)
7. Valid driver’s license with reliable transportation and ability to occasionally travel to Denver, as applicable.
8. Must meet physical requirements: While performing the duties of this job, the employee is

frequently required to sit, stand, talk and hear. The employee is required to use hands to finger, handle or feel objects, tools or controls and to reach with hands and arms. The employee must occasionally lift and/or move up to 40 pounds.

PREFERRED CHW QUALIFICATIONS:

1. Bilingual (Spanish/English)
2. Resident of the community for the past 2 years.
3. Knowledge and experience working in/with clinical or social service agencies in rural communities.
4. Background in providing preventive chronic disease services and health education.
5. Experience working with disadvantaged populations.

PERSONAL ATTRIBUTES:

1. Must possess demonstrated ability to relate to individuals and families of varied ethnic, cultural backgrounds, ages and economic circumstances. Trusted member of the community and ability to make new and lasting connections.
2. Outgoing and confident personality as the position requires a significant amount of outreach and relationship building.
3. Ability to maintain client/patient confidentiality
4. Ability to work in a fast-paced environment, and is able to creatively tailor educational and prevention messaging to a variety of populations.
5. Strong work ethic, self-motivated, and collaborative style
6. Change agent demeanor; must be a flexible thinker, with an ability to quickly adapt to a changing environment
7. Ability to exercise forethought; to look ahead and anticipate events
8. Excellent critical thinking and consultative problem solving skills