Volunteers of America®
NORTHERN CALIFORNIA & NORTHERN NEVADA

POSITION DESCRIPTION

Position:	Health Care Navigator		
Program:	Supportive Services for Veteran Families (SSVF)	Status:	Non-Exempt
Reports to:	Program Director	Date Created:	09/2020

POSITION SUMMARY:

The Health Care Navigator works to connect eligible veterans and beneficiaries to VA health care benefits and community health care services in the assigned counties. This position provides case management coordination, health education, interdisciplinary collaboration and coordination, and assist with some administrative duties. Health Care Navigators work closely with the client's primary care provider and members of the client's assigned interdisciplinary team to help the client eliminate barriers to successful permanent housing, gainful employment, and overall healthy living. This individual will work within an assigned VA Medical Center area, often covering large geographical regions. The Health Care Navigator will perform much of their work with clients remotely, but is expected to travel on occasion to VA medical centers and other community health centers to assist in collaborative client efforts.

A. Responsible for performing daily work requirements to achieve established objectives of the department.

1. Conducts assessments of veterans in collaboration with the larger interdisciplinary treatment team including the veteran, their family members, medical, nursing, clinical, case management, and administrative staff.
2. Identifies strengths, limitations, risk factors, internal and external supports and service needs, and potential barriers to health care, including assisting in the identification of the cause of the barrier(s.)
3. Works closely with clients to assist them in communicating their preferences regarding health care and personal health goals to facilitate shared decision making of the client's care.
4. In collaboration with the interdisciplinary team, helps create a tailored health care plan for assigned clients.
5. Regularly reviews care plan goals, conducts barrier assessments, and provides resources and referrals needed to help the client adhere to the established plan.
6. Periodically reviews the effectiveness of the resources and referrals provided, and makes appropriate modifications to ensure the provision of high-quality care.
7. Monitors client progress, creates and maintains comprehensive documentation, and provides information to the treatment team when appropriate.
8. Helps veteran clients and family members communicate questions, needs, and plan modifications to the treatment team.
9. Acts as a health coach by proactively supporting veterans to optimize treatment interventions and outcomes.
10. Provides comprehensive case management and care coordination across episodes of care.
11. Acts as the subject matter expert on community resources related to the needs of assigned clients. Collaborates with the treatment team when reassessing the veteran's health care needs, and modifies as appropriate.
12. Assists in identifying the Veteran's and family's health education needs and provides education services, materials and referrals to specialized health educators that match the health literacy level of the Veteran.
13. Coordinates referrals to VA, community health clinics, and other programs needed to ensure access to health care. The health care navigator follows the care plan to facilitate

adherence, and collaborates with community providers to maximize the use of VA and community resources.

14. Demonstrates an understanding of the different roles within the interdisciplinary team and acts within professional boundaries. The health care navigator will adhere to ethical principles about confidentiality, informed consent, compliance with relevant laws, and agency policies (e.g., critical incident reporting, HIPAA, Duty to Warn).
15. Additional duties as assigned by supervisor.

EDUCATION AND EXPERIENCE:

Master's degree in social work or psychology preferred. Licensure preferred. One year experience in a social service environment required. At least one year performing outreach and making referrals to services preferred. Experienced in the operation of PC's and Apple devices, including web searches, MS Word, email, and the operation of remote platforms such as Zoom or GoToMeeting. Broad working knowledge of services within the local area required. Knowledge of native culture and language, as well as a deep familiarity with the veteran issues relevant to this area. Excellent organizational and time-management skills. Veteran status preferred, but not required. This position requires CPR and First Aid training within ninety (90) days of employment date and recertification as necessary and T.B. testing annually. A valid California driver's license and ability to meet organizations insurance carrier guidelines are required.

SPECIFIC SKILLS REQUIRED:

1. Ability to work with a diverse population of adults and children, including those with physical and mental disabilities and addictions and those who are in, or need to be in, recovery.
2. Ability to work with clients who have significant barriers to include but not limited to legal barriers, prison or long-term incarceration.
3. Ability to work independently, with minimal supervision.
4. Ability to conduct a general assessment of the physical, mental, and emotional health of individual clients, and clearly and concisely document that assessment.
5. Ability to maintain client confidentiality and personal boundaries.
6. Ability to collaborate effectively, and ability to demonstrate an understanding and appreciation for diverse opinions, including an ability to modify one's own professional opinion when presented with new factual information.
7. Strong ability to use remote computer technology. Required intermediate to advanced skills in MS Office, and experience working with remote and cloud-based technologies like SharePoint, Dropbox, Google Docs, and remote platforms like Zoom or MS Teams.
8. Excellent people skills, including the ability to motivate and lead while maintaining a positive cooperative rapport with other staff. Ability to positively engage and motivate challenging clients.
9. Excellent communication skills, including writing that is accurate in grammar, spelling, and punctuation.
10. Ability to develop relationships and collaborative partnerships with representatives in other agencies.
11. Ability to organize and interpret data and information relative to clients and program.
12. Ability to form and work within an effective work team.
13. Ability to work in a stressful, multi-task environment and interact with clients in varying states of mental and physical health.
14. Excellent organizational and time management skills.
15. Positive attitude.

PHYSICAL REQUIREMENTS:

Lift and move up to 25 pounds
Stand, walk and sit frequently
Climb stairs as needed
Bend and stoop occasionally

NATURE OF SUPERVISION RECEIVED:

Daily activities are performed independently with guidance and direction from the Program Director. Must be able to work independently toward attainment of operational goals and contract compliance.

SUPERVISION EXERCISED:

The position does not supervise, however, may be delegated training and lead responsibilities as the program needs may require.

RESPONSIBILITIES FOR BUSINESS CONTACTS:

This position requires daily contact with county/state/city and business entities, clients, and all levels of staff. The Health Care Navigator is responsible for promoting company image and providing advice on company practices and procedures, while establishing and maintaining good working relationships with all clients. Tact, discretion, and resourcefulness are required at all times.

NUMBER OF EMPLOYEES:

No employees report to this position.

This Health Care Navigator job description does not constitute a written or implied contract and may be changed as business needs arise.

Indicate anything that would keep you from meeting the job duties as outlined above.

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Employee Signature_____ Date Signed _____