NHC Member Position Description
2016-2017

SERVICE POSITION DESCRIPTION
Please complete one service position description for EACH member you are requesting, using this template. The service position description is used in the recruitment and matching process. Each service position description must be sent electronically to complete an application.
HOST SITE NAME & LOCATION: Maria de los Santos (MDLS) Health Center, 401 W Allegheny Ave, Philadelphia PA 19133
MEMBER POSITION/TITLE: Care Navigator
SITE SUPERVISOR ASSIGNED TO SUPPORT MEMBER: ***Please include, name, title, phone number, email address and fax number.*** *Zoe Laureano, Health Center Manager, LaureanoZ@dvch.org, office: 215-291-2585, fax: 215-291-2587* *Julia DeJoseph, MD, Medical Director Adult Medicine, DeJosephJ@dvch.org; same as above*
SITE CONSIDERATIONS
Is the site accessible via public transportation (if yes, what line/route)?: Septa bus lines 47 and 57
Does this position require a personal vehicle? No
How will your organization reimburse the member for transportation costs? If this is not covered by the program, Delaware Valley Community Health, Inc., (DVCH) would cover the cost of a transit pass.
Organization dress code: Business casual (excludes shorts, leggings, jeans, and open-toed shoes).
Expected service schedule: M-F 8:30-5
ORGANIZATION DESCRIPTION & MISSION: Maria de los Santos is one of 6 practice sites of Delaware Valley Community Health, Inc., (DVCH) a Federally Qualified Health Center in the greater Philadelphia area. DVCH is a community-focused health care organization providing affordable and accessible primary medical, dental and behavioral health care. Services are provided in a fiscally responsible manner to all patients regardless of their ability to pay. **ORGANIZATION DESCRIPTION & MISSION:** MDLS is one of 6 practice sites of Delaware Valley Community Health, Inc., (DVCH) a Federally Qualified Health Center in the greater Philadelphia area. DVCH is a community-focused health care organization providing affordable and accessible primary medical, dental and

behavioral health care. Services are provided in a fiscally responsible manner to all patients regardless of their ability to pay.

As a reflection of our commitment to the community, we:

- believe in the dignity of each individual, and therefore provide a qualified, competent, health care delivery team that is culturally sensitive, friendly and respectful;
- promote a supportive, team-oriented work environment, with opportunities for growth and continuing education;
- recognize that environmental, emotional and social factors affect the health and well-being of the individuals we serve, and offer comprehensive services in collaboration with other community agencies; and acknowledge and respond to the need for urban-based medical training opportunities through affiliation agreements with graduate medical education programs, medical schools, nursing schools and allied health institutions.

MEMBER ROLE:

Describe the specific program(s), project(s), or initiative(s) that the member will serve with? What will the member's specific role be with this program/project/initiative? How will the member's primary activities align with the NHC's performance measures?

PROGRAM OR PROJECT NAME ***(INCLUDE % TIME OVER TERM MEMBER WILL SPEND WITH THIS PROGRAM)***	**MEMBER ACTIVITIES (List the key activities the member will be responsible for, for each program/project listed)**	**MEMBER OUTPUTS (How many classes, workshops, clients, patients etc. will the member conduct/serve under each activity)**	**NHC PERFORMANCE MEASURE(S) THIS ACTIVITY FALLS UNDER *(if any)*.**
55% Care Outreach & Education	• Using population health management software, the member will identify patients due for specific preventive health or chronic care services (i.e. "care due"), and develop outreach plans (may include mail, text, DVCH's patient portal, or telephone calls) • The member will educate about and enroll patients in DVCH's patient online portal to facilitate timely and electronic communication with the health center and their providers • Member will provide patient education	• The member will provide outreach to an average of 50-75 patients weekly for care due reminders • The member will educate and enroll 10-20 patients per week on patient portal	Health Care Service Enrollment and Scheduling; Preventative Health Care Service Use

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	on reasons for remaining up to date on preventive/chronic care services • Identify any barriers to "care due" services		
20% Care Coordination & Navigation	• The member will support the Care Coordination Nurse in coordinating non-medical needs for high risk patients (transportation, appointment scheduling) • The member will conduct outreach to patients using ER departments for non-urgent conditions in order to redirect back to the health center for primary care services- this could include the identification of barriers to health center utilization vs. emergency room utilization	• The member will conduct outreach to 10 patients a week regarding non-urgent ER utilization, and schedule primary/preventative care appointments when applicable; Remind patients of other methods of access to providers (on-call provider & patient portal)	Health Care Service Enrollment and Scheduling; Social Service Navigation; Preventative Care Service Use; Primary Health Care Service Use
20% Group Visits Education	• The member will collaborate with health center staff to plan and implement group visits for patients who suffer with chronic conditions and are in need of preventive/routine care • The member will Lead/teach a portion of group visits on patient education	• Member will plan and implement 4-6 Patient Group Education sessions (where each session consists of 4-6	Health Education: Prevention; Health Education: Disease/Condition Management

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	topics	weeks of 1 group visit/week)	
5% Resource Allocation	• Member will research and identify community-based resources for patients suffering with chronic disease or related needs, and build electronic resource file for staff reference	• Member will create/update an electronic file of community-based resources for staff use • The member will train and educate 50% of health center staff on availability/eligibility of community-based resources over the course of the service term.	Capacity Building

Please complete this section to describe the type of individual best suited to fulfill the service description and who will serve most effectively within your organization

Please describe the traits that will help a member succeed in this position (e.g. outgoing, analytical, patient, good with children).
The successful Care Navigator will have a patient, open, and welcoming disposition toward patients and enjoy speaking with people of diverse backgrounds. A pleasant telephone manner is also important. The role will be most gratifying to an individual seeking to make a measurable public health impact on a population: we anticipate that these efforts will lead to measurable differences in clinical quality outcomes for our patients in need of evidence-based clinical services.

Please list the skills and/or experience that will help a member succeed in this position (e.g. customer service, language skills).
Excellent oral Spanish language skills are essential to this role, as >80% of the patient population speaks Spanish as their first language. In addition, the

ability to communicate clearly in written English in the electronic health record is essential to the quality of the patient record.
What types of training will you provide to the member to support them in successfully completing their service activities? DVCH will provide formal training in documenting in the electronic health record, and in using the population health management tools, as well as extensive orientation to the health care landscape around MDLS. In addition, as staff trainings in motivational interviewing or customer service skills arise, the member will be invited to join those.