TOIYABE INDIAN HEALTH PROJECT, INC.

POSITION DESCRIPTION

POSITION: Community Health Representative (CHR)/ Case Manager

SALARY RANGE: TSS 6

WORK STATION: Bishop **SUPERVISOR**: PHN/Public Health Director

NON-EXEMPT

POSITION SUMMARY: Under qualified direction, assist with identifying health problems of Native American patients; educate individuals, families and groups about health and assist with health care under the direction of health professionals to meet these needs. Working cooperatively with Toiyabe departments and outside agencies, the CHR/Case Manager will address the primary prevention of diabetes in the Native American population of the Toiyabe service area through ongoing education, outreach, assessments and case management.

QUALIFICATIONS:

1. High school diploma or equivalent required.
2. Two (2) years of college education in a health-related field required.
3. Minimum of 1 year experience working in a patient care setting that involves direct patient contact and interaction. Experience in Case Management preferred.
4. Must possess good communication skills, including the ability to conduct group and community presentations.
5. Must be computer proficient in Microsoft Office Suite programs, (Word, Excel, Outlook, etc). Experience with data collection, reporting, and spreadsheets desired.
6. Must possess good organizational and time management skills with the ability to work independently.
7. Possess a valid drivers license and be insurable with company insurance.
8. Must be willing to undertake a CHR basic training course. Must have a flexible schedule to accommodate after-hours work, presentations, home visits/transports, and attend training as required.
9. CPR and First Aid certification within three months of hire.
10. Must be sensitive and possess an awareness and keen appreciation of Indian traditions, customs, and socioeconomic needs of the Indian community.
11. American Indian preference in accordance with Indian Preference Act (Title 25, U.S. Code, § 472 & 473).

DUTIES & RESPONSIBILITIES:

1. Make home visits routinely, making the client the focus of the visit (on emergency basis as needed), taking and recording vital signs.

2. Maintains a file of all eligible Native American clients in their geographical service area.

3. Assists with medical regime under supervision of LVN or PHN, follow care plans and maintain records of all encounters.

4. Acts as client advocate identifying and document health, social and economic needs of the communities while identifying individual eligibility for third-party benefits and assisting with application.

5. Provides basic health education stressing preventive aspects of health. Interprets instructions from assigned provider (physician, nurse, etc.) to help the family understand. Knows signs and symptoms of diseases and assists the family in identification of illness and social problems.

6. Under Toiyabe's Transportation Guidelines, helps arrange transportation to the Clinic, hospital or other agencies as needed. Responsible for the maintenance of clinic vehicle as assigned.

7. Assists with pre-natal, newborn,and post-partum visits.

8. Assists with prescribed medication, pickup, delivery and education of medication.

9. Attends all assigned educational programs and conferences as well as Clinic sponsored in-service training.

10. Attends regularly scheduled Clinic and departmental meetings.

12. Participates in Clinic sponsored community education programs and screenings.

13. Observes all Clinic policies and procedures including that of **utmost confidentiality** regarding client information.

14. Assists with the surveillance of communicable disease and follow-up referrals pertaining to immunizations, with a report to the LVN or PHN.

15. Other job related duties as assigned.

EXPANDED CASE MANAGEMENT RESPONSIBILITIES:

1. Identification and enrollment of participants for prediabetic and prenatal/family groups served by the grant. These participants will be referred from CHRs, Medical providers, WIC staff and other departments.

2. Provides care coordination of families and individuals in conjunction with CHRs, PHN and clinical providers.

3. Monitors progress of the participants in meeting goals and help with follow up and referral.

4. Development and implementation of education programs which will be used to support the grant goals in conjunction with PHN, dietician and other staff.

5. Communication and collaboration with other departments and programs that are contributing to care of participants.

6. Coordination and assistance with advisory board meetings, including meeting documentation and records for grant purposes.

7. Assist with data collection of applicable demographic and clinical data for reporting and documention of progress.

8. Assistance with preparing grant reports.

9. Other job related duties as assigned.