Position: Community Health Worker SDOH Coordinator

POSITION SUMMARY

The Community Health Worker/Promotora Social Determinants of Health Coordinator (SDOH) serves as a member of the interdisciplinary team and will provide comprehensive and coordinated care to achieve optimal patient outcomes to meet the Patient-Centered Medical Home accreditation. The Community Health Worker/ Promotora SDOH Coordinator assists with coordinating community health care systems and HMS resources to provide culturally and linguistically appropriate services to provide a seamless model of access and care that benefits the patients and family members based on their individual needs.

The delivery of quality service and positive interaction with our customers is critical to completing all tasks within this job description, thus the employee is responsible for establishing and maintaining interpersonal relationships with customers, visitors, and HMS employees in a courteous, respectful, and professional manner. Guidelines include all HMS policies and procedures.

POSITION RESPONSIBILITIES

1. Ensures understanding of the Patient-Centered Medical Home (PCMH) model to patients.
2. Performs all functions and activities within the guidelines and philosophy outlined in Hidalgo Medical Services Strategic Plan, policies, mission, goals, and vision.
3. Advocates or facilitates patient access to health care, specialty care or second opinions; assists in coordination of care under the direction of the primary care provider to meet the patient's goals.
4. Advocates or facilitates social determinants of health and works to meet the social needs of the patient.
5. Identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care with the interdisciplinary team.
6. Assists the patient with enrollment services such as Medicaid, Medicare, HMS Sliding Fee, NM Health Insurance Exchange, and other insurance programs.
7. Assists patients with enrollment in social service programs such as TANF, SNAP, housing, and other local agency programs.
8. Assists the patient's application process for medication assistance.
9. Encourages patients to follow clinical guidelines for care management by reminding patients of appointments, coordinating non-clinical services, and maintaining appropriate documentation of patient contact.
10. Timely response to patient referrals.
11. Reviews Electronic Health Records to ensure that health needs are met per clinical guidelines.
12. Participates as a member of various teams as needed.
13. Actively participates in and completes training provided by HMS and other agencies.

14. Plans and organizes health fairs and other public events.
15. Attends conferences as directed and required.
16. Reduces stigma and other barriers to initiating or continuing health care by providing good information to community members and providers.
17. Review indicators of access and comprehensiveness of care focusing on performance improvement with the clinical care team to guide the work based on the need for outreach services within the community.
18. Plan and lead group health education sessions and discussions on assigned health topics.
19. Provide navigation services to patients with chronic diseases such as diabetes and cardiovascular diseases in coordination with the clinical care team.
20. Outreach efforts to increase the awareness of behavioral health resources, including 988 Crisis Line, in our communities and understanding of behavioral health and wellness resources, including providing accurate information about the 988 Crisis Line in our communities.
21. Communicate effectively with community members through culturally and linguistically relevant resources and messaging. Use empathetic, collaborative conversations to guide conversations, including raising awareness and destigmatizing mental and behavioral health issues, and sharing information regarding community resources, including the 988 Crisis Line and other local resources.
22. Other duties as assigned.

MINIMUM QUALIFICATIONS

1. High School Diploma or equivalent.
2. Must obtain State PE determiner certification within 90 days of hire to enroll patients in Medicaid programs.
3. Information Technology skills include laptops, Smartphones, Internet/online application systems, Microsoft Office, etc.
4. Must obtain Federal Healthcare Guide certification within three months of hire to enroll patients in NM Health Exchange programs.

PREFERRED QUALIFICATIONS:

Bilingual speaking English and Spanish languages.

TO APPLY:

Completed HMS Employment Application may be emailed to jobs@hmsnm.org or
Dropped off or mailed:
1105 N. Pope Street, Building C, Silver City, NM 88061
or
530 De Moss Street, Lordsburg, NM 88045

For more information call 575-247-6036