The Francisco Homes

Community Health Worker Job Description

Vision

Guided by faith-inspired principles, The Francisco Homes encourages our community to acknowledge the worth and dignity in all people, opening the door of opportunity for conciliation and healing; building a society in which the re-entry process becomes restorative.

Through our community based housing facilities, The Francisco Homes, offers hope and multi-faceted, holistic support to formerly incarcerated individuals aspiring to re-integrate back into the community.

Our Service Model

1. Offer housing and basic support for immediate residential and personal needs.
2. Connect and empower residents to network with community job readiness centers, employers, volunteer organizations, local colleges/vocational training programs and/or benefit services.
3. Affirm residents in their confidence toward healthy choices for their lives and their community through support groups and mentoring.
4. Provide resources for residents to be active, productive and enrolled in service-oriented projects in the community
5. Facilitate and guide the establishing of interdependent healthy relationships. Residents reconnect to their family, friends and community.
6. Assist and instruct in the use of technology in communication, etiquette, and integrity in its use.
7. Provide steps toward permanent housing.

Community Health Worker Responsibilities

□ **OUTREACH**

a. Connect and engage participants in activities and services

□ **ASSESSMENT**

a. Guide participants, participants' significant others, and other team members in the development of a services and supports plan, which addresses the participant's goals and any medical, behavioral health and/or substance use treatment needs
b. Assist participants in setting goals related to housing, benefits establishment, employment and self-sufficiency, and other topics which support the program participant in gaining more control over their lives and their health

c. In conjunction with other team members and each participant, assist with evaluating progress towards goals and make adjustments in the case management plan to facilitate progress toward goals
d. Collaborate, weekly, with Clinical Intern to compile all necessary and required documentation, for the express purpose of entry in the Case Management Platform, known as CHAMP.
e. Maintain participant confidentiality and privacy by protecting participant health information

□ **COACHING AND SOCIAL SUPPORT**

a. Establish a trusting and open relationship with participants
b. Accompany participants to appointments as needed and appropriate
c. Collaborate with Clinical Intern to assist participants in building social support systems; this includes connecting participants to support and recovery groups
d. Collaborate with Clinical Intern to provide coaching for housing, employment, and other interviews and address participants' anxieties related to these activities

□ **CARE COORDINATION, CASE MANAGEMENT, AND SYSTEM NAVIGATION**

a. Provide intensive resident support services (case management) for a determined period of time
b. In collaboration with Clinical Intern, provide warm hand-offs and supported referrals to necessary supports and services, including housing, education, employment, substance use treatment, etc.
c. Engage with participants in the most appropriate and accessible location, which may include: the street, participants' homes, the hospital, or other community sites
d. After consultation with Clinical Interns, connect participants to needed resources within the Departments of Health Services, Mental Health and Public Health, and other health and social service providers
e. In collaboration with Clinical Interns, link participants to other Community Health Workers working at the family, group, community and policy levels
f. Arrange or provide transportation to services as needed
g. In collaboration with Clinical Interns, support participants to prepare for and complete needed medical and social service appointments
h. Provide timely notification to Program Manager of "intent to discharge participant".
i. Coordinate and collaborate with Clinical Intern and Program Manager on timely "discharge planning".
j. Advise Clinical Intern of any need for identification and securing of appropriate community-based residential placements such as board and care, skilled nursing, substance use treatment or mental health treatment facilities for participants
k. Link to the Coordinated Entry System (CES) as part of discharge planning process.
l. Assist participants to make a solid connection to another source of support before termination of ODR RICMS services

□ **CULTURAL MEDIATION AND EDUCATION OF THE HEALTH AND SOCIAL SERVICE SYSTEM**

a. Assist participants, families and significant others in understanding the ODR RICMS program, and gaining their acceptance of and participation in the program
b. Communicate information about the health and social service systems, including medication regimes and system processes, in a culturally appropriate manner
c. Continue to follow-up with participants to encourage engagement and ongoing participation in and commitment to the program
d. Build trusting relationships and collaborate with other members of the team who may include social workers, nurses, physicians, psychiatrists, service providers, etc.
e. In both formal and informal settings, educate and inform other health and social service professionals about strengths and needs, as well as cultural worldviews, experiences and perspectives of the community or communities in which the CHW lives and works
f. Work with other team members especially at a regional level to adapt systems and services to be more culturally centered and appropriate
g. Participate in all program meetings, site-specific all staff meetings, and team huddles as directed by the Supervisor
h. Respectfully and professionally represent the Office of Diversion and RICMS Program

□ **ADVOCACY**

a. Serve as an advocate on behalf of the participant within clinical and community-based settings to help participant achieve health and life goals and to secure necessary services and supports, promoting participant's recovery
b. Assist the participant to learn to advocate for him/her/themselves

Necessary Qualifications

Education and Training

- Lived experience, meaning having been incarcerated in the criminal justice system at some point.
- A minimum of 1-year post incarceration.
- High school diploma or equivalent.
- Basic computer skills – Working knowledge of email, internet and Microsoft office

Valuable Knowledge and Skills for this Position

□ Member of the community, close affiliation, or shared life experience with the community being served
□ Ability to work appropriately and effectively within the program
□ Potential or demonstrated community leadership
□ Experience working with medically and socially complex individuals

- ☐ Existing relationships and trust within communities of focus
- ☐ Familiarity working with or navigating within the health and social services system, preferably as a result of lived experience
- ☐ Ability to build and maintain trusting relationships with community stakeholders and health and social service providers
- ☐ Ability to work independently in a constantly changing environment
- ☐ Personal strength, resilience, and stability to allow the CHW, with support of supervisor and work team, to face very challenging situations and avoid re-traumatization and vicarious trauma

To apply: Please forward a Cover Letter detailing your experience and a current resume to:
Maya DeNola – Director of Resident Services: maya@thefranciscohomes.org.