Community Bridges envisions a thriving community where every person has the opportunity to unleash their full potential. Our family of ten programs delivers essential services, provides equitable access to resources, and advocates for health and dignity across every stage of life.

POSITION DESCRIPTION:
Under the direction of the Enhanced Care Management (ECM) Program Manager, and working as part of an interdisciplinary team, the Community Care Navigator is responsible for coordinating person-centered services and comprehensive care management with Medi-Cal recipients who have complex medical and social needs. The Community Care Navigator engages community members and helps individuals navigate/access community services and resources, and adopt healthy behaviors. The ECM program is a community-based care coordination program addressing social determinants of health to bridge service gaps and improve health outcomes for Medi-Cal recipients.

DUTIES AND RESPONSIBILITIES:

Case Management:
- Provides direct care management services to clients in the Enhanced Care Management program.
- Forms authentic alliances with clients, uncovering what impedes better health outcomes, and actively works to find solutions.
- Engages potential clients in health promotion and self-management.
  - Engages clients and builds trusting relationships
  - Screens for and identifies social and behavioral health needs
Arranges/assists with linkages to care, including appointments, transportation, etc.

- Meets clients where they are – in their homes, at health care offices, in the community
- Assists with facilitating clients’ use of technology to conduct virtual visits when needed
- Supports clients in developing health literacy; provides health promotion materials
- Advocates for clients with health care professionals; encourages treatment adherence; collaborates and coordinates with health care providers
- Works collaboratively with interdisciplinary team of nurses, social workers, and therapists
- Participates in case conferences and interdisciplinary team meetings to improve clients’ health outcomes.
- Maintains care management records, including assessments, home visits, person-centered care plans, periodic reassessments, and progress notes in the electronic health record.

**Outreach and Community Connection:**

- Builds and uses a community resource network for support with housing, food insecurity, employment, child care, etc., develops and implements creative and resourceful strategies to meet client’s needs.
- Conducts a variety of outreach activities to connect with potential clients

**Professional Conduct:**

- Maintains confidentiality and treats participants and staff with dignity and respect at all times.
- Communicates effectively and respectfully with people from diverse racial, ethnic, and cultural groups and from different backgrounds and lifestyles; demonstrates compassion and sensitivity to their needs.

*Job descriptions are intended to be illustrative only; they are not designed to be restrictive or to define each and every assigned duty and responsibility. In an organization of this nature, each employee is expected to perform such duties as necessary to fulfill the stated goals of the agency.*

**MINIMUM QUALIFICATIONS:**

**Required:**

- Must have at least one of the following:
  - CHW Certificate
  - Bachelor’s in social work, health and human services, or other related discipline*
  - Relevant experience to fulfill the duties of the position*
- Understanding of person-centered services and social determinants of health
• Ability to plan, implement, and evaluate care plans
• Ability to be persistent, creative and resourceful in locating meaningful community resources and implementing care management plans
• Demonstrates a high level of tolerance and empathy for individuals who present for services with urgent multiple care management and health needs; strong interpersonal skills
• Ability to grow and learn along with the program
• Bilingual English/Spanish

*Must obtain CHW certificate within two years if not held at time of hire

Preferred:
• Experience with chronic illness
• Familiarity with motivational interviewing techniques

Other requirements:
• Must pass a TB test before first day of employment.
• Must receive an annual influenza vaccination or be willing to wear a protective face mask during government regulated influenza season.
• Must be fully vaccinated against COVID-19, including a booster when eligible.
• Must have a valid CA driver’s license, drive a motor vehicle incidental to the performance of the work and be insured.
• Must be able to work at a computer for full workdays; some routine lifting and reaching requirements.
• Must pass a criminal background check and maintain a clean record.

We screen all applicants, require background checks on final candidates consistent with funding regulation requirements and are a Drug-Free Work Place.

UNION:
The Community Care Navigator position is represented by the SEIU bargaining unit.

RATE OF PAY & HOURS:
• This is a regular, non-exempt, 40 hour per week position.
• This position will be offered at a pay rate between $21.10-$23.23/hour, depending on education and experience, (plus a $.40/.10 per hour bilingual/biliterate differential after passing a test administered by the HR department).
• This position is both on-site and in the field, and may allow some remote work.
• Hours of work are typically Monday-Friday between 9-5, however some evening and weekend work may be required.
BENEFITS:

- For employee: shared cost medical, dental, vision, life insurance and Employee Assistance Program. This benefit package is valued at $9,766.92/year
- First year: 16 vacation days and 11 holidays, with accrual based on 40 hr/wk.
- Sick leave: Eight hours/month, with accrual based on 40 hr/wk.
- May be eligible to earn up to 4 Wellness Floaters per year after satisfying all eligibility requirements.
- 401(k) Retirement Plan: Agency matches employee contribution up to 5% of annual salary, effective during open enrollment period.
- Flexible Spending Account (FSA).
- Dependent Care Reimbursement Program.
- Paid lunch.

TO APPLY:

- Please submit your application through the Community Bridges careers web site (https://communitybridges.org/careers/)
- Resumes can be submitted but will not be accepted in lieu of an employment application.
- If applicable, please submit any college transcripts, licenses, and/or certificates as an attachment to your application.

COMMUNITY BRIDGES IS AN EQUAL OPPORTUNITY EMPLOYER. Applicants shall not be discriminated against because of age, ancestry, color, religious creed, denial of Family and Medical Care Leave, disability (mental and physical), marital, familial or parental status, medical condition, genetic information, military and Veteran status, national origin (including language use restrictions), race, sex (which includes pregnancy, childbirth, breastfeeding and medical conditions related to pregnancy, childbirth or breastfeeding), gender, gender identity, and gender expression, political affiliation or sexual orientation.