# **Functional Statement**

# **Health Care Navigator**

# **<INSERT ORGANIZATION NAME>**

**This document can be used by SSVF Grantees seeking guidance on developing a position description for SSVF health care navigator positions.**

## **1. GENERAL DESCRIPTION OF ASSIGNED DUTIES**

SSVF Health Care Navigators are employed by SSVF Grantees to provide services that include connecting Veterans to VA health care benefits or community health care services where Veterans are not eligible for VA care. SSVF health care navigators provide case management and care coordination, health education, interdisciplinary collaboration, coordination, and consultation, and administrative duties. SSVF Health Care Navigators work closely with the Veteran’s primary care provider and members of the Veteran’s assigned interdisciplinary treatment team.

The health care navigator possesses excellent judgment and has at least two years of experience in a health care or social services area of practice. The health care navigator will act as a liaison between the SSVF Grantee and the VA or community medical clinic and works with a population of Veterans with complex needs who require assistance accessing health care services or adhering to health care plans.

The SSVF health care navigator works closely with the Veteran’s assigned multidisciplinary team, including medical, nursing, and administrative specialists, and case management personnel. The SSVF Health Care Navigator works within this team to provide timely, appropriate, Veteran centered care equitably. The SSVF Health Care Navigator works collaboratively with the team and the Veteran to identify and address systems challenges for enhanced care coordination as needed.

## **2. FUNCTIONS OR SCOPE OF ASSIGNED DUTIES**

### ****A. Non-Clinical Assessment****

The incumbent conducts assessments of the Veteran in collaboration with the interdisciplinary treatment team, the Veteran, family members, and significant others. The purpose of the assessment is to understand the Veteran’s situation, potential barriers to care, the causes, and the impact of such barriers on the Veteran’s ability to access and maintain health care services. The assessment should highlight the Veteran's strengths, limitations, risk factors, and internal/external supports and service needs to optimize the Veteran's ability to access and maintain health care services. The initial assessment will be completed as specified by the policy of the SSVF Grantee. An assessment may be accomplished through virtual technology.

### ****B. Health Care Team and Veteran Communication****

The SSVF Health Care Navigator works closely with Veterans to assist them in communicating their preferences in care and personal health-related goals to facilitate shared decision making of the Veteran’s care. The SSVF Health Care Navigator serves as a resource for education and support for Veterans and families and helps identify appropriate and credible resources and support tailored to the needs and desires of the Veteran.

The incumbent may participate in the development of the Veteran’s care plan; however, the health care navigator’s emphasis is on community services, outreach, and referrals needed for the Veteran. The plan is developed in collaboration with the interdisciplinary treatment team, the Veteran, family members, and significant others, and incorporates measurable goals. The incumbent regularly reviews care plan goals with the Veteran, conducts regular non-clinical barrier assessments, and provides resources and referrals needed to support adherence. The incumbent also periodically evaluates the effectiveness of the resources and referrals provided and makes appropriate modifications to ensure the provision of high-quality care and interventions. The SSVF health care navigator monitors Veteran’s progress, maintains comprehensive documentation, and provides information to treatment team members when appropriate.

The incumbent reiterates provider recommendations using clear language to support the Veteran and family members or caregivers. The SSVF health care navigator assists Veterans in identifying concerns or questions about their treatment or medications to develop open communication with the provider or treatment team.

### ****C. Specialized Case Management and Care Coordination****

The incumbent provides comprehensive case management and care coordination across episodes of care—the incumbent acts as a health coach by proactively supporting the Veteran to optimize treatment interventions and outcomes.

The SSVF health care navigator modifies services to meet the needs of Veterans best and coordinates services with other organizations and programs to assure such services are complementary and comprehensive; directs activities to maximize effectiveness, efficiency, and continuity of care for Veterans; provides case management services to Veterans serves as the liaison to VA and community health care programs, and represents the program in contacts with other agencies and the public.

The incumbent helps coordinate supportive and additional services with the Veteran. The incumbent ensures and links Veterans and caregivers to supportive services, which include, but are not limited to, housing, financial benefits, transportation.

The SSVF Health Care Navigator serves as the subject matter expert on community resources related to the needs of the Veteran. The health care navigator collaborates with other providers in the ongoing reassessment of the Veteran’s health care needs. The health care navigator is responsible for educating the Veteran and caregiver of the available services and assisting them in establishing the appropriate referrals based on the Veteran’s preference.

The incumbent will determine the needs, strengths, limitations, and preferences of each Veteran and will engage in problem-solving to identify and reduce barriers to care. The health care navigator will educate the Veteran and family on the available options for acquiring knowledge and skills for managing health and wellness.

The incumbent coordinates referrals to VA, community health clinics, and other programs needed to ensure access to health care. The incumbent follows the care plan to facilitate adherence, and collaborates with community providers to maximize the use of VA and community resources.,

The incumbent acts as an advocate for the client, integrating the Veteran’s cultural values into their care plan. The health care navigator assists the Veteran in identifying methods to monitor progress toward meeting health goals and provides ongoing follow up.

### ****D. Health Education****

The incumbent assists in identifying the Veteran and family's health education needs and provides education services and materials that match the health literacy level of the Veteran. The health care navigator provides ongoing education support as needed to the Veteran and family member. The incumbent assists in identifying VA and community resources to prevent disease and promote self-care. For specialized health education outside of the incumbent’s scope of practice, the health care navigator will refer Veterans and families to the appropriate interdisciplinary team member for identified health education needs.

### ****E. Interdisciplinary Collaboration, Coordination and Consultation****

To ensure the best possible care, the incumbent collaborates with other disciplines involved in providing care. The incumbent regularly consults with other team members and appropriately assesses and addresses the needs of the Veteran. The incumbent understands the different roles within the interdisciplinary team and acts within professional boundaries. The health care navigator will adhere to ethical principles about confidentiality, informed consent, compliance with relevant laws, and agency policies (e.g., critical incident reporting, HIPPA, Duty to Warn).

### ****F. Administrative Duties and Systems Improvement****

The incumbent participates in expanding the knowledge related to health care navigators and the Veteran population. The health care navigator identifies systemic barriers within the organization, communicates with organizational leadership about these barriers, and works collaboratively to find viable solutions. The health care navigator assists in developing policy, procedures, and practice guidelines related to the specialty program using knowledge gained from research or best practices. The incumbent develops relationships with community leaders, VA staff, and other referral networks. The health care navigator provides subject matter expert consultation to staff and community providers on the specialty area of practice. The incumbent may develop evaluation components and outcomes indicators and report those evaluation results to VA and organizational leadership.

## **3. QUALIFICATIONS:**

Master’s level social worker or equivalent education and experience is preferred.

## **4. SUPERVISORY CONTROLS**

The <INSERT SUPERVISOR> provides supervision and guidance to the health care navigator. The incumbent is expected to function independently, exercising initiative and judgment in day-to-day activities, based on expertise accumulated through education, training, experience, and reference to relevant professional literature. The incumbent will seek consultation with the supervisor as appropriate and needed. The incumbent will receive task supervision and assignments from the SSVF Program Manager.

## **5. CUSTOMER SERVICE REQUIREMENTS**

The health care navigator participates effectively in team meetings, case conferences, and related activities. Collaborates with multidisciplinary team members in a manner that enhances the coordination of comprehensive Veteran care.

Effectively communicates with and utilizes community agencies to facilitate continuity of care. With few exceptions, gives evidence of having regular contact and interaction with a variety of community agencies and resources. Collaborates with a variety of community agencies and engages in problem resolution activities.

The employee’s relationship with supervisors, co-workers, patients, visitors, and the general public is consistently courteous and cooperative and contributes to the effective operation of the case management program. Any failure in this area is limited, minor, and has no significant adverse impact on the Service. He/she anticipates and avoids potential causes of conflict, and activity promotes cooperation among co-workers.

## **6. AGE, DEVELOPMENT, AND CULTURAL NEEDS OF PATIENTS REQUIREMENTS**

The primary age of Veteran participants cared for are generally at the middle age adult level, i.e., 40 years of age or older. However, occasionally there may be younger Veterans between the ages of 18-40 years of age that require care. Sensitivity to all Veterans' individual needs concerning age, developmental requirements, and culturally related factors must be consistently achieved.

The incumbent takes into consideration age-related differences of the various Veteran populations served:

a) *Young adulthood (20-40)*. Persons, in general, have normal physical functions and lifestyles. Establishes relationships with significant others and is competent to relate to others.

b) *Middle age (40-65)*. Persons may have physical problems and may have lifestyle changes because children have left home or transition in occupation goals.

c) *Older adulthood (65-75)*. Persons may be adapting to retirement and changing physical abilities. Chronic illness may also develop.

d) *Middle old (75-85)*. Persons may be adapting to a decline in the speed of movement, reaction time, and sensory abilities. Also, persons may have increasing dependence on others.

e) *Old (85 and over)*. Increasing physical problems may develop.

## **7. COMPUTER SECURITY REQUIREMENTS**

Incumbent protects printed and electronic files containing sensitive data following the provisions of the Privacy Act of 1974 and other applicable laws, organization policy. Incumbent protects the data from unauthorized release or loss, alteration, or unauthorized deletion. Incumbent follows applicable regulations and instructions regarding access to electronic files, the release of access codes, and the use of electronic information.

The employee uses word processing software to execute several office automations functions such as storing and retrieving electronic documents and files; activating printers, inserting and deleting text, formatting letters, reports, and memoranda; and transmitting and receiving e-mail.

## **8. SAFETY**

The incumbent appropriately uses equipment and supplies; maintains a safe and orderly work area; reports any accidents to self or patients and completes appropriate documentation; follows Life Safety Management (fire protection) procedures; reports safety hazards, accidents, and injuries; reviews hazardous materials/Material Safety Data Sheets (MSDS)/waste management; follows Emergency Preparedness plan; follows security policies/procedures; complies with federal, state, and local environmental and other requirements preventing pollution, minimizing waste, and conserving cultural and natural resources; and demonstrates infection control practices for disease prevention (i.e., hand washing, universal precautions/isolation procedures, including TB requirement/precautions).

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