JOB DESCRIPTION

Job Title:	Hospital Housing Navigator
Reports to:	Director of Programs and Regional Supervisor
FLSA Status:	Non-Exempt

Summary

The Hospital Housing Navigator (HHN) is responsible for accepting referrals of people who meet eligibility for the program who are homeless and frequent utilizers of the healthcare and other systems. The HHN will complete intake assessments, arrange interim housing, and work with enrolled participants to access housing, health, substance use treatment, and behavioral health services using harm reduction and trauma-informed principles with the ultimate goal of placing people in permanent housing such as permanent supportive housing, board and care, shared living, or other placements. The HHN will support hospital and partnering agency staff to coordinate discharge plans and create housing and service plans for eligible parties and provide ongoing case management until person is placed in housing and connected to other adequate permanent supports or until the end of the program.

Essential Duties & Responsibilities:

<u>Relationships with Partners</u>

- Establish and maintain positive work relationships with hospital partners, including staff in the emergency rooms, social work, discharge planning, and any onsite homeless patient navigators to educate staff on the services available to this population and resources available within the Community Resources binder.
- Coordinate directly between hospitals and community providers, fostering relationships between organizations and facilitate transitions of care for individuals experiencing homelessness and coordinate discharge needs for homeless patients including obtaining medications and clothing for homeless patients and helping to arrange transportation as needed.
- Maintain a cooperative relationship among care teams with both inpatient and Emergency Department staff by communicating information, responding to requests, building rapport, and participating in team problem-solving efforts.
- Convene hospital partners and patient navigators for case conferencing and problem-solving and encourage hospital participation in relevant community collaboration meetings such as CES meetings.
- Coordinate and improve follow-up care and services for homeless patients by assessing their needs and schedule follow-up medical appointments and connecting patients to a PCP as appropriate.

<u>Assessment, Referral, and Service Connection</u>

- Conduct CES Assessments and update HMIS Records to facilitate interim and permanent housing placement.

- Use HMIS for service reconnections, including Outreach, Interim Housing, and Housing Navigation.
- Provide updates to Outreach staff whose clients are admitted to a hospital.
- Connect or reconnect patients to a medical home as appropriate.
- Actively collaborate with hospital patient navigators/social workers/discharge planners to:
    - Support the discharge planning process by providing information and helping to facilitate access to community-based providers and coordinate temporary hotel placements for participants enrolled in the FUSE Program;
    - Provide on-going supportive services to FUSE Program after discharge including outreach, referrals, interim housing placement visits;
    - Create housing plans for high acuity FUSE Enrollees;
    - Support accessing a higher level of care, i.e. Adult Residential Facilities, Skilled Nursing Facilities, etc.; serve as a point of contact during the referral and placement process; and
    - Maintain database and detail-oriented documentation of the services provided for each patient.
- Be thoroughly familiar with the policies and procedures guiding the work of this program and perform job functions in line with these policies and procedures.

Tracking and Data Management

- Document referrals thoroughly and on time.
- Document processes and best practices for shared learning.
- Identify data gaps and propose potential solutions.
- Ensure all team members are collecting and reporting data.
- Compile monthly program data.
- Prepare data and reports for submission to the funder.

Training and Education

- Educate hospitals’ patient navigators, social workers, and discharge planners on:
    - Problem-solving/diversion of homeless patients out of the ED,
    - Accessing the services and resources of the homeless services,
    - Review HHP eligibility and HHP screening form for completeness as accuracy.
    - Using the Universal Interim Housing Referral Form,
    - Completing verification of homelessness forms when needed for program referral/entry,
    - Providing Technical Assistance / “on-call support” to hospital patient navigators, social workers/discharge planners regarding homeless services, and
    - Identifying and providing additional training as needed.

Additional Responsibilities

- Participate in all safety programs and training required by the hospitals and TPC.
- Utilize a harm reduction model, trauma-informed care, and client-centered philosophies to improve the follow-up care and services provided to homeless patients and connect them with the appropriate resources.
- Maintain strict confidentiality and privacy practices and share information, as appropriate and legally allowed, to coordinate patient care.
- Maintain a safe and clean working environment.

- Other duties as assigned

Qualifications/Experience

- Bilingual (Spanish/English) preferred.
- Minimum of one year of experience working directly with homeless and/or underserved populations.
- Ability to interface with community agencies and hospital staff.
- Experience working as part of a health care team preferred.
- Knowledge of healthcare systems.
- Significant experience working with persons experiencing homelessness and having complex needs, conducting assessments of general patient information, developing short-term care plans, and providing necessary interventions identified during assessment.
- Previous experience working with persons experiencing severe and persistent mental illness and substance abuse.
- Able to work some evenings and weekends.
- Strong computer skills including MS Office Suite.
- Ability to work well as part of an interdisciplinary team.
- Excellent verbal and written communication skills.
- Excellent charting/documentation skills and data collection.
- Passion for and commitment to working with underserved and indigent populations.
- Ability to work well with a culturally diverse clientele, including LGBTQ individuals and those living with disabilities, serious mental illness, and substance use disorders.
- Skilled in non-violent crisis intervention.
- Ability to self-motivate, multi-task, and be flexible in a fast-paced environment.
- Must successfully pass fingerprinting and background checks before the start of employment.
- Possess a valid CA driver license, proof of insurance, and reliable transportation required for travel to perform job-related duties as needed

Education

Must have a minimum of a bachelor’s degree in a related field and/or 2 to 3 years of Case-Management experience.

Job Description Acknowledgment

I acknowledge I have received, read, and fully understand the expectations and job description for the Hospital Housing Navigator position, and have reviewed its contents with my manager. I also acknowledge that it is my responsibility to contact my manager with any follow up questions. I further understand that I am responsible for the satisfactory execution of the essential functions described therein, under any and all conditions as described, and nothing in this job description restricts management's right to assign or reassign additional duties and responsibilities at any time.

Employee Name______________________________ Date_________________

Employee Signature___________________