POSITION DESCRIPTION

POSITION TITLE: **Social Prescribing System Navigator**

RESPONSIBLE TO: **Chief Operating Officer**

GENERAL ACCOUNTABILITIES:

*The **Social Prescribing System Navigator** serves as a champion of Compass Community Health's Vision and Mission and promotes an environment that is consistent with the Health Centre's Statement of Values and Principles. The Social Prescribing System Navigator is an essential member of the client-centered professional team and will provide ongoing support and assistance to the Health Promotion team in development, planning, implementing and evaluating the effectiveness of social prescribing initiatives, referring people to a range of local, non-clinical services, complementing clinical interventions and seeking to address clients' social needs through community partnerships and collaboration to support clients toward a life of optimal health and prosperity.*

SUMMARY OF FUNCTIONS:

The Social Prescribing System Navigator will develop and deliver a culturally safe and culturally specific social prescribing model that connects, links, and supports newcomer individuals and their families with navigation of the health, social, and community support systems in a determinants of health philosophy. Specifically, the Social Prescribing System Navigator will focus on the needs of newcomer and racialized clients and refer them to a range of local, non-clinical services that complement clinical interventions and seek to address the client's social needs through community partnerships and collaboration. The Social Prescribing System Navigator will strengthen and develop local partnerships in order to introduce clients to culturally relevant community groups, activities and services, and follow-up to ensure they are receiving support. The Social Prescribing System Navigator also works with the client to consider how they can be supported through social prescribing to maintain or regain independence through life skills, adaptations, enablement approaches, and simple safeguards.

SPECIFIC ACCOUNTABILITIES:

1. Develop and implement model of social prescribing accessible for newcomers, while integrating data-collection and evaluation to ensure all programs are client centered, culturally safe, relevant and address health inequities and fit within in a determinants of health framework.
2. Using a social prescribing model, integrate clinical and social aspects by linking primary care providers with community programs and services to form a stronger bridge between social and medical interventions for clients to improve health outcomes.
3. Develop and implement a formal social prescribing referral process within an Electronic Medical Record (EMR) system to engage both clinical and non-clinical staff across departments to refer and track clients engaged in social prescribing, and to ensure client follow up.
4. Receive and manage referrals from clinical and non-clinical staff in order to connect clients with diverse needs to a range of supports, accurately and confidentially tracking and recording program data.

5. Develop, deliver or recommend culturally relevant and client-centered health promotion programs and services that eliminate barriers to health and well-being and meet the unique and diverse needs of newcomer and racialized clients, using language that newcomers understand.
6. Maintain knowledge of local resources, expand existing community partnerships, and build new, strong, and sustainable relationships with external agencies and community partners that would be beneficial to newcomer clients and their needs.
7. Act as a resource to other teams performing community needs assessments where appropriate and coordinate, develop, implement, monitor, and evaluate programs to respond to those needs;
8. Identify and engage social economic barriers and upstream health promotion and prevention services to address health inequities and improve the client's experience through an integrated system of care;
9. Ensure all recruitment, program promotion and evaluation is carried out effectively;
10. Establish and maintain positive and supportive relationships with adult volunteers, program participants, and with Health Centre staff in a team environment;
11. Ensuring alignment with Health Centre's Policies regarding Occupational Health and Safety, Privacy and Confidentiality and duty to report;
12. Act as an ambassador for the Health Centre, discussing programs and services and promoting healthy lifestyles;
13. Other duties as may be assigned.

QUALIFICATIONS:

1. Knowledge of, and proficiency in, community development activities, organization and outreach programming, program development, implementation, monitoring, and evaluation;
2. Knowledge of the newcomer experience and their needs either through working with newcomer and racialized individuals and families or through lived experience. Proficiency in a second language is considered an asset.
3. Familiarity with social/health services and systems in Hamilton and surrounding regions that support newcomer and racialized group and individuals;
4. Good communication and interpersonal skills, with demonstrated ability to work with colleagues, clients and community partners to ensure an effective and efficient working environment;
5. Commitment to working within a client-centered, social determinants of health framework;
6. Experience working effectively with culturally, economically, and socially diverse clients;
7. Computer literacy, combined with strong administrative and data entry skills;
8. Demonstrated ability to work independently, to be flexible and possesses excellent organizational and problem-solving skills;
9. Ability to work flexible hours in order to meet the needs of the community, including early mornings, evenings, and weekends;
10. Valid Driver's License and access to a reliable vehicle.

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I understand the requirements, essential functions and duties of the position.

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Date

Ratified: July 2023