Pacific Rim Community Connector for NEW Social Prescribing Program **April 1, 2025**
Job Description

We are seeking a Community Connector who is a compassionate professional equipped with a diverse set of skills and attributes for the Pacific Rim Hospice Society's new Social Prescribing Program. Community Connector will work 25-35 hours per week for $25-$30/hr.

The Community Connector must have strong knowledge of issues and challenges that seniors/Elders face in relation to healthy aging, experience supporting or working with older adults with different backgrounds, and knowledge of their community's resources, supports, and programs relevant to seniors.

An ideal Community Connector...

- Listens actively and empathizes with the participant
- Is exceptional at communication
- Can build and foster trusting relationships
- Can build and grow community networks/facilitate community meetings
- Is passionate about addressing social determinants of health
- Has experience supporting older adults and Elders
- Is a self starter and works well independently
- Is attuned to equity, diversity and inclusion
- Can speak English well and is sensitive to local cultures

Connectors will interact with participants with complex health and social needs, they will be provided with training to strengthen their communication skills, in areas such as developing rapport, trust building, active listening, the use of open and closed questions, and motivational interviewing techniques.

Connectors should be respectful, non-judgmental, and empathetic, and should understand the importance of establishing personal boundaries to prevent dependency, and how to ensure privacy and confidentiality.

PR Community Connector:

The Pacific Rim Community Connector plays an integral role in bridging the gap between healthcare and social care. Responsible for the Social Prescribing program, you partner with community organizations to provide non-medical support to older adults/Elders, improving their overall health and well-being. The goal of this position is to assist older adults to age safely in place by providing them with the social connections they require and build and maintain partnerships and connections of community-based seniors' services in the area. You will work with seniors and Elders referred from Health Care Professionals and community partners, as well as our partner's senior's programs to connect with community supports and services through referrals, applications, advocacy, and introductions. In a supportive, creative, self-directed, and flexible manner, you make meaningful connections as you discern individual's unique needs.

Key Duties and Responsibilities

Community Development

1. Builds and maintains networks within community and strengthen relationships within the community-based senior serving (CBSS) sector.
2. Uses an asset-based community development approach to identify and mobilize individuals, and organizations to provide support to older adults.
3. Engages and participates in learning opportunities such as in community of practice meetings (COP), planning tables or networking events.
4. Leads the local Healthy Aging Community Collaborative group, and represents PR Better at Home and PRHS as the host agency at external events.

Assessment and management of referrals

5. Connects, liaises, and establishes partnerships with local health care professionals to create and maintain referral pathways.
6. Maintains an active caseload of seniors with short-term needs through referrals from health care professionals and community agencies.
7. Prioritizes referrals to meet individual participant's needs.
8. Understands hospital discharge procedures and assists with supporting seniors transitioning back home following discharge.
9. Implements safety precautions when visiting seniors in the community, including their personal residence.
10. Completes intake process to assess strengths, needs, abilities, and risks using motivational interviewing techniques such as active listening, conflict resolution and observing behaviour.
11. Uses various assessment tools to determine challenges, needs and risks related to healthy aging and develop routines, structures, and resource referrals to reduce risk of frailty.
12. Interprets participants' complex physical requirements and social needs.
13. Maintains a high level of confidentiality in all matters related to clients and community partners.

Wellness Plan development

14. Supports seniors to access appropriate range of activities and suitable community resources by developing individual wellness plans.
15. Using a "what matters to you" approach refers seniors to community-based services, observes and assesses the participant's engagement with resources including (example: emotional, psychological, and functional status), and modifies activities to meet the participant's changing needs.
16. Provides information regarding appropriate community resources to socially support the participant and their families.
17. Effectively collaborates within the Agency's and community's Seniors Services to provide multidisciplinary care for the best interest of the senior.
18. Assists with connection to a primary care provider.
19. Engages and participates in educational training for seniors on topics such as healthy aging and other relevant topics.

Documentation of referrals

20. Documents participant's interactions, wellness plans, reports, and other administrative duties as required.
21. Provision of follow-up note to continuing community health care provider if requested.
22. Uses Zoom, Outlook Calendar, Microsoft Teams, Salesforce or other programming required by PRBH to maintain records and statistic as requested by the ED or Coordinator. Ensures all required documentation is accurate, complete, and timely.
23. Creates and maintains marketing materials for the program including brochures, handouts, posters, and making suggestions for the website. This includes taking photographs, to create promotional materials.
24. Remains current with agency and program updates.
25. Checks e-mail, texts and voicemails regularly.
26. Adheres to PRHS's policies and procedures Manual related to records of persons served.
27. Participates in training on cultural diversity and promotes PRHS's commitment to diversity and respect for cultural diversity in how we interact with clients and colleagues.

Evaluation

28. Participates in evaluation of programs including collection of participant data, reporting at regular intervals, and attending communities of practices.
29. Makes recommendations to the ED regarding program development, policy and procedure formulation, and program evaluation.
30. Strives to maintain an up-to-date knowledge in the field. Actively participates in the performance evaluation process and in training opportunities.
31. Contributes to a learning organization by self-reflecting on their practice, sharing ideas and contributing to planning and discussions about service, and seeking input and support when concerns or questions arise.
32. Follows relevant guidelines and other relevant legislation or regulation.
33. Maintain an up-to-date practice knowledge of all safety and emergency procedures outlined in Policies and Procedures Manual and Worksafe BC regulations.
34. Provides coverage for Better at Home Coordinator when they are away.
35. Performs other related duties as assigned.

Required Qualifications

Education, Training and Experience:

- A bachelor's degree in social service or related Human Services field, or equivalent experience
- Strong knowledge of seniors'/Elders' issues and challenges related to healthy aging, especially in rural and remote communities
- Familiarity with local healthcare systems and community resources
- Experience with program development and grant writing
- Minimum two (2) years of recent experience working with seniors and diverse populations
- Excellent communication skills, including the ability to interpret human behaviour and ability to clearly explain instruction to others

- Strong computer, organizational and time management skills, including completing reporting, follow-ups and evaluations.

Job Skills and Abilities:

- Well-developed demonstrated ability to connect with and support seniors/Elders
- Demonstrated skills in the areas of crisis intervention and conflict resolution
- Demonstrated ability to recruit and supervise volunteers
- Strong collaborative skills and proven ability to establish and maintain effective working relationships with all internal and external contacts
- Ability to work independently and as part of a professional team

Additional Information and Requirements

- Criminal Record Check renewable every 5 years
- Sign and adhere to a Confidentiality Agreement
- Valid Class 5 license
- Valid Work Safe BC approved First Aid Certificate an asset
- Use of safe, well maintained personal vehicle is required, with appropriate insurance
- Ability to work a flexible schedule

To Apply:
Please send your resume and cover letter Attn: Tarni Jacobsen, Executive Director, to executivedirector@pacificrimhospice.ca

We are an equal opportunity employer who encourages and supports a diverse and inclusive working environment. We promote a healthy, supportive and balanced workplace. We offer flexible work hours location and competitive living wages.

Applicants will be interviewed on an ongoing basis until a successful candidate is found.
We appreciate your time and effort to apply for this position, however, not all candidates will be contacted.

Background:

What is Social Prescribing?

Social prescribing is a means for healthcare providers and other trusted individuals in health and community settings to connect participants to a range of non-clinical services in the community to improve their health and well-being. Rather than simply treating symptoms of illness, social prescribing can help to address underlying causes of health and well-being issues. Social prescribing is a holistic, person-centred, community-based strategy aimed at addressing the social determinants of health.

How does Social Prescribing Work?

Social prescribing always involves a structured pathway that is adaptable to the strengths and needs of each community and targeted population. In Canada, this pathway varies across provincial, regional, and local initiatives. However, most social prescribing programs allow healthcare providers and other "identifiers" to refer their patients or clients to a specialized link worker, who will work with each participant to identify their non-medical needs and co-produce the personalized social prescription.

The Community Connector role comprises two main components: supporting older adults through social prescribing, and engaging in community development activities. In UK models of social prescribing, link workers typically allocate approximately 60% of their time to working directly with social prescribing participants and 40% to developing networks and partnerships in their communities. For UWBC Community Connectors, while many may adhere to this workload division, the role is designed to be adaptable to each community's unique needs and priorities. For instance, in a community with limited awareness of social prescribing, the Connector might first prioritize building relationships with healthcare providers.

Community asset mapping is a strength-based approach to community and social development. The goal of asset mapping is to identify and document a community's existing resources, strengths, and skills. This information may be visualized as a map or infographic but can also be an inventory or spreadsheet. Assets can be broken down into 6 main categories: 1. Physical space, such as parks, gardens, forests, playgrounds 2. Economic, such as jobs and businesses that provide livelihood. 3. Institutions, such as schools, libraries, museums, non-profits, social services 4. Associations, such as fitness clubs, religious groups, support groups, AA 5. Individual gifts, skills, knowledge, capacities of community members 6. Stories of community histories, resilience, and community development