



Care Coordination Patient Navigator Navigation Coordinator

REPORTS TO: Care Coordination Associate Manager

SUPERVISEES: Peer Educators

EMPLOYMENT STATUS: Full-time Regular, Non-Exempt

PRIMARY FUNCTION/PURPOSE: Navigation Coordinator provides all home-based health promotion, adherence education, support and skills building services to HIV/AIDS patients on a quarterly, monthly or weekly basis. Helps patients stay connected to care; links patients to community resources; provides escort services, identifies and helps remove barriers to care.

DUTIES AND RESPONSIBILITIES:

- Interacts regularly with client and client caregivers to ensure continuity of care, patient adherence to care plans, and identifications of barriers preventing adherence to care plan.
- Tracks all medical, behavioral substance use and other network referrals made for clients and ensures clients follow up on referrals and attend scheduled appointments, through accompaniment when necessary.
- Provides phone and physical outreach to clients who have been non-adherent to necessary treatment appointments or have missed appointments for initial visits with new providers. Makes reminder phone calls to patients for all appointments.
- Provides outreach to clients to ensure appropriate follow up regarding self-care, medication refills, Care Plan adherence, scheduled office visits, test results/lab work, and all other pertinent psycho-social issues.
- Ensures that relevant team members receive important client alerts, including ER visits, hospitalization admission/discharge information and other urgent care notifications.
- Tracks/monitors client progress through a combination of written work, agency databases, health home data system and case conferences with the Care Team. Documents and maintains case records in agency database and completes all data entry in a timely fashion.
- Monitors client entitlements, insurance, and other benefits to ensure they remain active and in place. Alerts Care Manager if benefits/entitlements lapse to assist team members with reinstatement of said benefits.
- Reviews Care Plan with Associate Manager and confirms intensity level of identified client to ensure service needs are met.
- Performs other duties as required to meet the needs of the Care Coordination team, Client Services Department or Agency.
- Attend a minimum of two agency events for clients and one agency fundraising event every 12 month period.

QUALIFICATIONS: Bi-lingual Spanish required. Applicants should have a strong knowledge of HIV/AIDS as well as entitlements and resources available to individuals living with HIV/AIDS in the NYC –metro area. Field work is heavy. Must be able to navigate the city by mass transportation. Must be able to visit a 5th floor walk-up. Must be able to pass a Hospital Health and Drug screening. Knowledge of Microsoft Word is a must. This position requires a team player who has very good writing and time management skills. A Bachelor's Degree in a health-related field is preferred.