

## Instructions

This job template provides an overview of the Patient Navigator's role in the field, responsibilities within the organization, and qualifying characteristics and skills. You should plan to adapt the job description to meet the needs of your organization, your Care Team, and your target population.

**Position Title:** Patient Navigator

**Reports to:** Care Coordinator

**Work in collaboration with:** Care Coordinators, Program Director, medical/health care providers (primary care physicians, nursing staff, mental health workers)

## Position Summary

The Patient Navigator provides field-based case management services to clients enrolled in STEPS to Care. This person is the main point of contact for clients. The Patient Navigator builds strong relationships with HIV-positive clients in order to help clients stay engaged in medical care and adhere to their medications. Patient Navigators are committed to removing the client's barriers to care by identifying critical resources for clients, helping them navigate through health care services and systems, and promoting client health. They work closely with the Care Team, which may include doctors, nurses, and other clinical staff to support positive client health outcomes.

## Responsibilities

### *Field-based direct care to clients with HIV/AIDS:*

- » Establishes close relationships with and serves as primary point of contact for clients
- » Visits clients' homes on a regular basis
- » Accompany clients to medical appointments, when required
- » Deliver in-home weekly or monthly health education and promote HIV self-management to clients
- » Communicate with Care Team members (Care Coordinators, primary care physicians and other health care providers) to facilitate client care
- » Observe, report, and assess client self-administration of medication
- » Identify resources for clients to overcome barriers to care, such as transportation, housing, and childcare arrangements
- » Remain aware of current services offered by service providers, such as mental health, housing, and employment assistance
- » Maintain strict confidentiality in accordance with agency policies
- » May meet with clients after primary care physician appointments to review and update care plan with the Care Coordinator

### ***Organizational duties:***

- » Meet with Care Team (including, but not limited to, Care Coordinator and primary care provider) to discuss client care issues and needs and facilitate client health care
- » Maintain documentation of all client encounters and complete reporting requirements according to organization standards
- » Track client information, schedules, files, and forms in a confidential manner
- » Track client attendance at medical appointments and patient navigation sessions and initiate outreach and missed appointment procedures, as necessary
- » Attend and represent the organization at professional conferences, in-service trainings, and meetings at the request of or with the approval of supervisor

### **Qualifications**

#### ***Personal characteristics and skills:***

- » Commitment to the mission of care coordination
- » Passionate, trustworthy, and empathetic when working with clients
- » Ability to build relationships with different types of people, including clients, organization members, and health care providers
- » Good communication and interpersonal skills and ability to speak concisely to clients and Care Team members
- » Organized with confidential client material and appointment tracking
- » Flexible and adaptable in response to changing client and health care providers' needs
- » Interest in working with HIV-positive clients

#### ***Education and experience:***

- » Minimum high school degree or some college education
- » Strong understanding of cultural competency with the target population
- » Bilingual (English/Spanish) preferred
- » Computer literacy desirable
- » Exposure to issues of death and dying

#### ***Physical requirements:***

- » Physical demands associated with office work
- » Extensive local travel
- » Some evening and weekend work required

To apply, send a resume and cover letter to  
**[PROGRAM DIRECTOR or CARE COORDINATOR NAME]** at **[E-MAIL ADDRESS]**.