Building Medical Homes for Multiply Diagnosed HIV-Positive Homeless Populations

Sample Frontline Staff Job Descriptions - 2018

Family Health Center of San Diego (FHCSD)
SPNS CASE MANAGER
JOB DESCRIPTION

Under general supervision, performs duties providing Case Management services to assigned individuals. Participates in, and supports, the planning, development, implementation, and evaluation of services in accordance with contractual and departmental requirements and guidelines. Specific assignments vary depending on program, grant, and patient demographics, with a focus on providing community-based healthcare services to the medically underserved. The Case Manager offers more intensive Case Management services to clients, including creating case plans and formalized goal setting. Intensive support may be required depending on level of client need (such as accompanying to appointments, assisting with housing, etc.).

EDUCATION/CERTIFICATIONS/LICENSES/REGISTRATIONS

- 1 year of work experience providing human services to high risk, medically underserved, or relevant community health populations required.
- Ability and means to travel as needed in a timely manner within San Diego County. DRIVER REQUIREMENTS: Requires an active Class C California driver's license, proof of liability insurance at $100,000, on vehicle used. No more than 2 points in past 12 months; No suspensions in last 2 years for moving violations; No DUI, reckless or felony Driving within 5 years. No license revocation in 7 years.
- Bachelor's degree in Social Science field, Public Health, Healthcare Administration, or closely related field required.
- Or equivalent combination of education and experience that provides the skills, knowledge and ability to perform the essential job duties, and which meets any required state or federal certification requirements.

EXPERIENCE/SPECIALIZED SKILLS (including Language)

- Ability to work well in both a team-based environment and independently.
- Basic computer literacy ability to comply with department needs and expectations (i.e., electronic medical record documentation, obtaining background information and reports on patients, following up on appointments, etc.).
- Basic counseling skills, such as reflecting, active listening, and paraphrasing.
- Basic organizational skills, attention to detail, time-management skills, and motivation to meet deadlines and achieve goals.
- Bilingual in English/Spanish may be required depending on assignment.
- Demonstrated ability to be culturally sensitive and respect diversity.
- Excellent interpersonal and customer service skills.
- Excellent written and verbal communication skills.
- Knowledge of the community resources, health and social service systems in San Diego County and skill in establishing working relationships with community partners.

RESPONSIBILITIES:
CASE MANAGER

- Completes all required documentation accurately, in a timely manner, and thoroughly in accordance with department standards. Assists in preparing reports as required.

- Conducts initial and on-going assessment of client's health and/or support service needs. Sets level of client need.
- Creates formalized case plans and goals with clients. Develops a written care-plan with the client, identifying problems and needs. Plan includes areas assessed intended interventions, and expected results in measurable terms, with short and long term goals. Updates plan as client's needs change.
- Performs other duties as assigned.
- Provides basic and intensive individual support, based on client need. Support may include providing interventions, providing internal and community services referrals, and more intensive support may include accompanying clients to housing services, appointments, social services, etc.

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People Assisting the Homeless (PATH)

CARE NAVIGATOR

SUMMARY:

Care Navigator will assist clients in breaking the cycle of homelessness by transitioning clients from street to housing, and accessing and maintaining necessary services among health care and social services through a coordinated system, acting as Lead Case Manager at Connections Housing Downtown San Diego, where this position will be stationed. Care Navigator will provide individualized client support throughout this entire journey by helping each client develop a plan to address barriers, support health needs, increase income, and maintain and sustain housing. As part of the plan, the Care Navigator will identify each area in which clients will need assistance to accomplish the outlined goals and objectives (i.e. scheduling appointments, applying for public benefits, etc.) and the Care Navigator will focus on housing and health as necessary outcomes for success.

RESPONSIBILITIES:

SUPPORTIVE SERVICES

- Coordinate intake and individualized needs assessment for all clients and work with clients to develop Individualized Service Plans (ISP) that address barriers to obtaining services/housing and appropriate health care needs.
- Create relationships and systems that strategically coordinate efforts to engage and retain individuals in care that meet their complex needs and ensure adherence to treatment.
- Assist clients in obtaining ID, Birth Certificate, Social Security Income, Disability, etc.
- Provide information, referrals, linkages, and advocacy to assist clients in accessing services and resources
- Monitor and evaluate each client's progression through their Individual Service Plan (ISP), and develop corrective action revisions to the plan as needed
- Assist clients with housing applications, complete supportive and subsidized housing paperwork, survey rental market for affordable housing, and advocate for clients with prospective landlords; Identify appropriate permanent housing options for clients

CONTRACT MANAGEMENT

- Gain proficient knowledge of Multiply Diagnosed HIV Positive Homeless Populations
- Maintain client related data tracking systems, including case notes and complete HMIS entries
- Prepare case-related reports including but not limited to: outcomes, successes and challenges
- JOB DESCRIPTION (continued) Care Navigator
- *P.A.T.H is an Equal Opportunity Employer* Care Navigator Page 2 of 2 Rev 11/2012
- Generate client data for reporting
- Maintain complete and accurate documentation of service objectives and outcomes as well as other services in accordance with Federal, State, County and PATH guidelines
- Complete follow-up and retention services, as necessary, and provide back-up documentation in client file

OUTREACH AND RELATIONSHIP MANAGEMENT

- Outreach to community based organizations, housing resources, and service providers to identify new and existing opportunities and build strong relationships to better assist clients in accessing resources, supportive services, health care and benefits, and housing opportunities
- Mediate disputes between homeless persons and neighborhood residents, as needed
- Attend collaborative meetings, as assigned by supervisor
- Network with other agencies, coalitions, and local community meetings
- Actively participate in staff meetings and trainings
- ***Other duties as assigned***

QUALIFICATIONS

- Possesses a minimum of an Associate's Degree, Bachelor's Degree preferred or equivalent experience in a related field.
- Have at least two years in Case Management experience.
- Project a professional demeanor and interpersonal skills
- Able to work independently and as part the team and exercises mature judgment
- Strong written and verbal communication skills.
- Must have knowledge of maintaining and executing confidential information.
- A highly motivated self-starter and ability to coordinate multiple projects/task
- Ability to work with diverse communities
- Good problem solving and conflict resolution skills.
- Computer skills with proficiency in Microsoft Office software, HMIS training a plus
- Motivated self-starter, with proven ability to develop creative solutions.
- Strong planning and organizing skills
- Flexible, adaptable and have the capability to work in a fast paced, professional environment.
- Maintain regular attendance.

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Attachment A: SPNS Navigator and SPNS Housing Case Manager Job Descriptions

SPNS Network Navigator (1.0 FTE)

Scope of Work:

The SPNS Network Navigator works with the staff and management of Cascade AIDS Project (CAP) to provide high-quality, coordinated, strengths-based social services consistent with the agency's mission; this position is embedded at the Multnomah County HIV Health Services Center (HHSC). The individual assists People Living with HIV/AIDS (PLWHA) who are experiencing homelessness or are at risk of homelessness and have mental health and/or substance abuse disorders. The individual will work across agencies and systems to assure access to services through CAP and HHSC as well as through other social services providers.

Responsibilities include: collaborating with medical case managers, medical teams and other support services providers in developing individual goal plans and providing intensive, community-based support to clients in carrying out the activities to achieve their goals; developing a comprehensive knowledge of the HIV continuum of care as well as non-HIV specific services available in the Portland metro area; educating service providers outside of the HIV continuum of care about HIV and HIV-specific services; outreach and education to people experiencing homelessness about the availability of HIV testing and services; completing forms and entering data into the HHSC and CAP databases in a timely and accurate manner. The Client Network Navigator works collaboratively and communicates effectively with clients, volunteers, CAP and HHSC staff, and community partners.

The person in this position is sited at the Multnomah County HHSC clinic in downtown Portland and will travel throughout the six-county service area for meetings and client home-visits. Evening and weekend work is required. This is a non-management, union-represented position.

Minimum Qualifications:

- ✓ Bachelor's Degree in human/social services field (social work, public or community health, psychology) or at least two years of related experience
- ✓ Demonstrated computer and keyboard proficiency using Microsoft Office software (Word, Excel, Outlook) and working knowledge of the internet
- ✓ Excellent written and oral communication skills
- ✓ Successful experience working with ethnic, racial, economic and sexually diverse populations and persons who have experienced homelessness, persons with a mental illness and/or substance addiction
- ✓ Demonstrated ability to effectively collaborate with community stakeholders
- ✓ Excellent organizational and time management skills
- ✓ Ability to work independently with accountability

- ✓ Available to work occasional evenings and weekends

Preferred Qualifications:

- ✓ Previous professional or volunteer experience working with people living with HIV
- ✓ Knowledge of social services in the Portland Metro Area
- ✓ Knowledge of benefits programs available to people with HIV
- ✓ Verbal and written fluency in English and Spanish
- ✓ Familiarity with Critical Time Intervention, Assertive Community Treatment or Intensive Case Management models of service

Essential Job Functions:

1. Develop and maintain collaborative professional relationships with agencies that serve people living with HIV/AIDS; provide mental health; substance abuse; and psychosocial support services.
2. Work collaboratively with medical case managers, CAP housing case managers, and other service providers to develop individual client goal plans and provide intensive support to clients in carrying out their goal plan.
3. Attend medical team huddles and semi-monthly case consult meetings with the Multnomah County HHSC staff; some workdays will begin at 8:00 AM to accommodate the HHSC standing meeting schedule.
4. Assess clients' involvement in HIV services, identify barriers to care and readiness to access care, including: client knowledge of HIV status, coping resources, social support, substance use and mental health issues.
5. Establish rapport with clients and work with them to facilitate engagement and retention in medical care and other services that support engagement in care.
6. Accompany clients to appointments to facilitate access to medical care, substance abuse treatment, mental health services, housing and other needed services.
7. Collect, maintain and distribute updated information about mental health, substance abuse treatment, psychosocial support and HIV specific services available in the community.
8. Maintain a strong working knowledge of HIV medical treatment and the progression of HIV disease.
9. Design and produce written materials in support of the program either as an individual or as a member of the team.
10. Meet all contract requirements and provide supporting documentation, including program performance data and reports, as required.

11. Participate in appropriate community, department, and agency meetings as assigned.

12. Provide accurate, complete, and current written and database records/files.

13. Other duties as assigned.

SPNS Housing Case Manager (1.0 FTE)

Scope of Work:

The Housing Case Manager works with the staff and management of Cascade AIDS Project (CAP) to provide high-quality, coordinated, strengths-based social services consistent with the agency's mission. The individual works in Cascade AIDS Project's Housing and Support Services Programs to provide services that include home-based housing case management, goal planning, information and referral services, advocacy with and on behalf of clients, and eviction prevention for individuals and families.

Responsibilities include: working with clients to develop housing plans, assisting clients in locating and securing affordable housing, mediation with landlords, completing forms, and entering data into the agency database in a timely and accurate manner. The Housing Case Manager works collaboratively and communicates effectively with clients, volunteers, CAP staff, and community partners. Other duties as assigned.

The person in this position is stationed in the CAP main office but will travel frequently throughout the six-county service area for meetings and client home-visits. Evening and weekend work is required. This is a non-management, union-represented position.

Minimum Qualifications:

- ✓ Bachelor's Degree in human/social services field (social work, public or community health, psychology) or related field or two years' experience relevant to the position
- ✓ Prior experience providing case management (or similar) services
- ✓ Demonstrated computer proficiency using Microsoft Office software (Word, Excel, Outlook) and working knowledge of the internet
- ✓ Excellent written and oral communication skills
- ✓ Successful experience working with ethnic, racial, economic and sexually diverse populations and persons who have experienced homelessness, persons with a mental illness and/or substance addiction
- ✓ Demonstrated ability to effectively collaborate with community stakeholders
- ✓ Good organizational and time management skills

- ✓ Ability to work independently with accountability
- ✓ Able to travel throughout the service area on a frequent basis
- ✓ Valid driver's license and access to a reliable vehicle
- ✓ Available to work occasional evenings and weekends

Preferred Qualifications:

- ✓ Master degree in human/social services field (social work, public or community health, psychology) or related field
- ✓ Verbal and written fluency in English and Spanish
- ✓ Knowledge of housing laws and local housing resources
- ✓ Experience working with persons exiting County, State or Federal Corrections
- ✓ Previous experience working with people with HIV

Essential Job Functions:

1. Provide housing placement, supportive case management, and eviction prevention with and on behalf of clients who are homeless or at risk of becoming homeless using a supportive strengths-based model that promotes client self-determination and independence
2. Work in collaboration with medical case managers, medical providers, or other providers involved in client care, to provide coordinated comprehensive care to PLWHA with a focus on housing stability
3. Carry an active client panel of approximately 70 program eligible clients, assisting with eviction prevention, housing planning, advocacy, mediation, and information and referral
4. Complete comprehensive housing assessments, goal planning, linkage to services, and advocacy for and with clients
5. Makes appropriate referrals to mental health, substance abuse, HIV prevention, or other community partners as needed to support client self sufficiency
6. Fax, mail or hand deliver a copy of each client's housing plan to the medical case manager and provide regular updates as to the progress of each client towards achievement of their goals
7. Establish professional relationships with landlords to create new housing resources and share the information with colleagues

8. Maintain current information on housing opportunities, community resources and applicable laws and share the information with colleagues

9. Compile and coordinate information on local alcohol and drug, mental health, food, clothing, and other resources for clients and share the information with colleagues

10. Assist in the development of culturally appropriate programs and the recruitment of clients for those programs

11. Design and produce written materials in support of the program either as an individual or as a member of the team

12. Provide accurate, complete, and current written and database records/files

13. Meet all contract requirements and provide supporting documentation, including program performance data and reports, as required

14. Work collaboratively with and communicate effectively with CAP staff, volunteers, community partners, and clients

15. Attend trainings and educational opportunities to remain current on housing, HIV, case management, and other relevant professional issues

16. Other duties as assigned

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Care Coordinator

General Description:

The Care Coordinator will provide a range of care coordination activities and individualized recovery and treatment support to clients in the program focusing on providing a medical home for HIV positive individuals who are multiply diagnosed with mental health and/or substance abuse disorders and are homeless or at risk of homelessness.

Specific Responsibilities:

- Provides intensive care coordination for assigned clients.
- Completes psychological assessments and diagnosis.
- Develops and helps clients implement individualized care plans based on assessed needs and barriers.
- Provides necessary therapeutic treatment and care for mental health and/or substance use disorders.
- Manages necessary communication with clients.
- Documents client information and encounters according to protocols.
- Works closely with both internal and external medical and social service providers to ensure follow up, linkage and adherence to the treatment plan.
- Facilitates multidisciplinary care team meetings.
- Works closely in a team environment, collaborates on cases and provides feedback on service delivery model.
- Collects and documents outcomes as well as challenges and barriers as directed by supervisor.
- Provides therapeutic crisis intervention and emergency services as required.

Agency specific

- Performs other duties essential to project implementation and success.
- Complies with agency policies and procedures – program and personnel.
- Performs other duties as assigned by supervisor.

Reports to:

- Program Director.

Direct Reports:

- None

Required Knowledge, Skills and Abilities:

- Knowledge and understanding of counseling theories, practices, methods, procedures, and standards.

- Demonstrated ability to effectively implement evidence based interventions including but not limited to: Motivational Interviewing, Cognitive Behavioral Therapy, Harm Reduction and Intensive Case Management.
- Ability to conduct interviews and psychological assessments.
- Demonstrated ability to work collaboratively in a team environment.
- Computer literacy – Microsoft packages, windows environment, and web-based applications.
- Excellent verbal and written communication skills.
- Excellent interpersonal and organizational skills.
- Knowledge of community resources; demonstrated ability to network and build strong relationships with community organizations serving priority populations as identified by the agency and/ or funder.
- Demonstrated ability to working with clients with complex problems and needs.
- Demonstrated knowledge of working with clients with HIV/AIDS.
- Demonstrated knowledge and experience working with clients with mental health and substance abuse disorders.

Education and Experience

- Master's degree in social work or other social service discipline. LMSW, LCSW or LPC with current unrestricted Texas licensure is highly desired. Education may be substituted by significant job related experience.
- A minimum of three years providing Intensive Case Management or Care Coordination.
- A minimum of two years working with the homeless population.
- A minimum of two years working with clients with complex needs including mental health and substance abuse disorders.

Case Manager II

General Description:

The Case Manager II will serve clients assessed as high acuity and who have co-occurring mental health and substance abuse disorders or other significant challenges. The position will be responsible for helping clients to move towards readiness to enter necessary treatment, access medical care and other support services and resources, in addition to promoting long term adherence to medical care and treatment plans by focusing on behavioral health and other concerns.

Specific Responsibilities:

- Conducts new client intakes as required.
- Completes psychological assessments and diagnosis.
- Develops a comprehensive care plan based on an assessment of eligibility, needs, barriers, mental health and substance use status, acuity and established resources. Obtains all necessary consent forms and updates documentation as required.
- Works with clients to help them to achieve readiness to enter necessary treatment.
- Links clients to medical care, behavioral health and psychosocial support services; follows-up on referrals and facilitates access to services.
- Provides behavioral health support, links clients to treatment for mental health disorders and substance abuse as necessary and provides needed support after discharge.
- Provides necessary therapeutic treatment and care for mental health and/or substance use disorders.
- Identifies emerging barriers and needs and helps clients to address concerns through problem solving, education, referrals, partnership and advocacy.
- Maintains contact with clients based on acuity level and contact standards.
- Conducts home-based assessments and other off-site visits as appropriate.
- Follows established case management standards of care and agency procedures.
- Completes accurate and timely documentation of all client encounters as required and submits all necessary reports to supervisor on time.
- Assists with management of crisis situations related to clients.
- Other duties as assigned.

Reports to:

- Case Management Supervisor

Direct Reports:

- None

Required Knowledge, Skills and Abilities:

- Proficiency in Excel, Word, and Outlook.
- Ability to work in a positive and empathetic manner with persons who have HIV/AIDS.
- Working knowledge of medical/psychosocial resources and the medical and psychosocial complexities of HIV/AIDS.
- Demonstrated knowledge and experience working with clients with mental health and substance use disorders.
- Ability to effectively communicate in verbal and written formats.
- Ability to collaborate with community service providers.
- Ability to establish effective working relationships with clients.

Education and Experience

- Master's degree in social work or psychology.
- Texas licensure (LMSW or LPC) preferred.
- 2 years' experience providing case management for people living with HIV or other chronic conditions preferred.

Bilingual in English/Spanish is highly desirable.

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Case Manager

Job Description: Provide holistic and intensive mobile case management services to all clients which includes; benefit assessment, shelter/stabilization room placement and progress monitoring, housing referrals and applications, medical appointment monitoring, weekly case plan development, advocacy, money management and other necessary referrals.

Acuity Indexes: Case Management, Housing, Legal, Income and Personal Finance, Nutrition

Items	Complete	Notes
Complete necessary HOT Team consents • ROI • Consent for treatment • HIPAA		
Review Room Agreement/Rules and obtain signatures • Companion animal discussed		
Assess Benefits and Schedule appointment • SSI Apt. Secured/SS Card Obtained • GA Apt. Secured		
IHSS follow-up		
Medical visit reminder		
Housing Options Assessed • Shelter Secured • Temp stabilization room/treatment room • Permanent housing		
Housing Applications Completed w/Social Worker's Support		
Permanent housing applications		
Weekly Mobile Case Management Visits with RN • Discuss housing in relation to their medical needs		
Payee Services Secured		
Treatment plan goals reviewed		
Document all encounters		

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Medical Social Worker

Job Description: Conducts field-based assessments of client needs; conducts psychosocial and cognitive assessments; develops and updates collaborative client care plans. Provides referrals to health and psychosocial service resources and programs, provides informal, field-based short-term psychosocial counseling to address immediate client barriers to care, including mental health and substance abuse issues. Develops long term client transition plans coordinates all discharge planning.

Acuity Indexes: Behavioral Health, Alcohol and Drug Use, Navigation, Intimate Partner Violence

Item	Complete	Notes
Complete necessary A&PI Consents		
Obtain Letter of Diagnosis (LOD)		
MoCA Screening Conducted		
Initial Needs Assessment		
Mental Health Assessment		
Substance Use Assessment		
Assess for Intimate Partner Violence & Safety Planning		
Coordinate planning with ERs, hospitals and urgent care		
Care Coordination with clients care team		
Coordinate all aspects of discharge planning and send out summary		
Support client with achieving care plan goals		
Support Case Manager with DAH permanent housing		
Weekly Mobile Case Management Visits with MD		
Monitor medication adherence/DOT		
Last Medical Appointment		
Explore barriers to medication adherence		
Secure referrals to substance use and mental health services • Refer to ICM and Ensure Connection		
Document all encounters		

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Peer Navigator

Job Description: Connects clients to psychosocial services and primary care services. Engages in case-finding HIV-positive individuals who are not participating in services. Accompanies clients to appointments, advocates for clients with other service providers, supports clients and peer navigation team in building their own support networks, provides risk reduction counseling to high-risk clients.

Acuity Indexes: System Surfing, Health Literacy

Item	Complete	Notes
Explain the services/Check In		
Manage Client Appointments • Reschedule Missed Appointments • Remind them of upcoming appointments • Report Back to team • Give Client Calendars		
Assess Escort Needs/Secure Escort • Free Form 4B1733 • Request Birth Certificate		
ID Appointment Scheduled		
Room location/ Room cleaning? • Is IHSS Secured?		
Call Hospitals, Jails, Shelters for missing clients		
Home Visits • Assess the Room for Safety • Where are meds stored? • Where is food stored/bins?		
Disability Card Application		
Project Open Hand Forms		
Open Access Support (TACE & TransAccess)		
Check email daily		
Explain research study and schedule baseline and follow-up interviews (SPNS)		
Hot spots (where they hang out)		
Proof of Income		
Document all encounters		

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