**POSITION DESCRIPTION**

**AIDS RESOURCE CENTER of WISCONSIN, INC.**

Position Title: Clinic Case Manager  
Department: Social Services  
Location: Statewide  
Reports to: Case Manager Supervisor

**Position Purpose:** The Clinic Case Manager provides a wide range of intensive, client-centered services to persons with HIV/AIDS within a clinic setting to ensure access to and retention in health care, and to address medical, psychosocial, and/or other issues that present obstacles or barriers to care. The Clinic Case Manager is part of a care team that includes physicians, nurses, nurse practitioners, behavioral health therapists, dental care providers, and other care providers. The Clinic Case Manager is an integral part of ARCW’s Medical Home, working as Care Coordinator and Team Leader for enrolled patients.  
This full-time position is located in Green Bay, WI.

**Scope of Responsibilities:** The AIDS Resource Center of Wisconsin, Inc. (ARCW) is Wisconsin’s largest provider of prevention, care and treatment services with a budget exceeding $68 Million. The unique, nationally recognized ARCW HIV Medical Home model of care assures that everyone with HIV has access to medical, pharmacy, dental, behavioral health, and social services and provides the best opportunity for patients to achieve high quality health outcomes. ARCW also provides aggressive prevention services to gay men, injection drug users, and others at the highest risk for HIV infection.  
Responsibilities include but are not limited to the following:

1. Within an HIV Medical Home environment, work with a team of physicians, nurses, and other practitioners to optimize access to care by persons with HIV infection and to provide necessary education, support, referral, and guidance so that patients can more readily improve their health status.

2. Provide HIV medical case management services, in compliance with State and agency standards, to persons with HIV infection within the clinical setting. This includes:
   a. Comprehensive assessment to determine health and psychosocial needs;
   b. Assessment of benefits, insurance, and other payer status and provision of assistance to access benefits programs;
   c. Development of an individualized service/care plan to improve patient’s health status and plan monitoring to assess progress towards goals;
   d. Coordination of and referral to needed medical treatments or specialty care and follow-up to these;
   e. Provision of assistance, advice, and/or referral (when appropriate) to Community Case Managers or Housing staff to address housing needs.
   f. Provision of treatment adherence counseling;
   g. Provision of interventions needed to retain the patient in care;
   h. Provision of HIV, chronic disease and general health education to expand the patient’s health literacy and improve general health;
   i. Maintaining compliance with case management standards for clients/patients assigned, including performing reviews and reassessments as required, updating service plans, and maintaining contact as required by client’s acuity level.

3. Meet with patients/clients immediately before or after their medical appointments to address any identified needs; all patients are eligible for this brief review, regardless of their eligibility for formal case management services.
4. Collaborate extensively with Medical Home team and clinic personnel to identify and address issues, to ensure that patients obtain appropriate and timely access to care, and to maximize adherence to and retention in care. Coordinate communication with clinical staff, clinical support staff, and external disease management as appropriate.

5. Educate, assess, and enroll eligible patients in Medical Home; coordinate care for enrolled patients on the provider team, to ensure that monthly touches, team staffings, care plan development and monitoring, SBIRT activities, and annual assessments are accomplished and that patients are retained in care.

6. Through training, become “specialized” in a particular area of interest(s) connected to department and client/patient need, thereby becoming an expert and lead in said specialization(s). Such specializations include 340b, SBIRT, New Patient Orientation, specialty referrals, among others.

7. Maintain appropriate client/patient files and timely documentation of services utilizing electronic case management and/or medical software such as Provide Enterprise and EPIC.

8. Participate in 24-hour case management coverage system, based on needs in the service area. This may include evening and weekend on-call duties.

9. Contribute as an active member of the Social Services Department and Health Services care team by participating in staff meetings, patient/client staffing, Health Services planning activities, Medical Home meetings, SBIRT supervision, in-service trainings and workshops, department or agency planning activities, assisting with special projects, and providing support, peer mentoring and training to co-workers as needed.

10. Establish and maintain effective working relationships with appropriate community resources, especially those providing HIV testing and health, behavioral health and social services to underserved and target populations. Interface with community Case Managers of medical patients who receive case management services at other CBOs, in order to provide updated information as needed for optimum client care.

11. Inform clients/patients of the services available through ARCW and in the community and link clients/patients to them as appropriate. At times this may include providing or assisting with the provision of support services such as support groups, food pantry, housing assistance, holiday gifts and school supplies for kids, volunteer services, transportation assistance, and financial assistance.

12. Update and maintain a strong working knowledge of HIV/AIDS, treatment options, risk reduction techniques, chronic diseases, mental health issues, case management, and other related issues through self-study and participation in trainings, workshops, and in-services and in consultation with supervisor.

14. Any other duties as assigned.

**Required Qualifications**

1. Baccalaureate or graduate degree in social work, health care, or a human service discipline from an accredited college or university.
POSITION DESCRIPTION
AIDS RESOURCE CENTER of WISCONSIN, INC.

2. Minimum of two years’ experience offering direct client contact in a community based social service or health service agency.
3. Ability to establish and maintain effective public and working relationships with culturally diverse populations from a wide range of life circumstances and backgrounds.
4. Demonstrated effective written and verbal communication skills, including counseling and assessment skills.
5. Ability to maintain effective organization and keep clear records.
6. Willingness to travel within the designated territory and willingness to work evenings and weekends as needed.
7. Valid Wisconsin Driver’s License, Insurable Driving Record, and access to a reliable insured vehicle.
8. Computer skills that include at minimum a working knowledge of word processing, Windows or similar operating system, and Internet.
9. Ability to stoop, bend, and on occasion lift up to 30 pounds of food items for distribution to clients through Pantry operations.
10. Pre-employment TB Test and annual Influenza vaccination is needed.

Potential exposure to Infectious Material: ___ High  _X_ Low

Preferred Qualifications

1. Extensive knowledge of HIV disease and related issues, disease progression, and treatment options.
2. Extensive knowledge of medical, social and mental health delivery systems.
3. Working knowledge of Spanish language (bilingual) is a plus.

Signed by employee  Date  Signed by supervisor  Date