POSITION DESCRIPTION

CARE COORDINATOR – REGISTERED NURSE

PURPOSE OF POSITION

The Care Coordinator (Registered Nurse) will provide care coordination services to clients in the Care Coordination and Supplementary Services Program (CCSS). The Care Coordinator (Registered Nurse) may also provide coordination-based NDIS funded services and coordination-based multidisciplinary team programs.

The chronic disease management program also known as the Integrated Team Care (ITC) program or CCSS is pivotal in supporting Aboriginal and Torres Strait Islander clients, assisting General Practice and other health professionals and support services in providing improved coordinated care to people with severe chronic disease and complex needs. The care coordinator will work closely with the CCSS Team, as well as clients and their GP and health care providers to support chronic disease and self-management. The position will incorporate the development, implementation and promotion of the specific HPC Model of Care.

The primary purpose of clinical coordination-based NDIS funded services is to provide clinical support to eligible participants of the NDIS working alongside support teams to break down barriers and reduce the complexity of navigating health services.

The position supports the strategic objectives of Hunter Primary Care (HPC) by supporting client's access to the right services, to assist them to maintain and or improve function and work towards optimal health and wellbeing opportunities.

REPORTS TO

- Clinical Team Leader

DIRECT REPORTS

- Nil

SCOPE OF PRACTICE

- Must operate within the scope and delegation of all Hunter Primary Care policies and procedures and demonstrate the values and uphold ethical responsibilities guided by AHPRA practice standards and code of ethics. Registered Nurses must be registered with the Nursing and Midwifery Board AHPRA and meet the Board's registration standards, in order to practise in Australia and meet the requirements for ongoing education in accordance with registration requirements.

- Current registration with AHPRA applies https://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement.aspx
- The Registered Nurse will be expected to provide advice and apply knowledge/theory relevant to their professional background and training within the designated boundaries identified by the Team Leader and within the scope of their position description, specific qualifications and professional expertise

- Through assessment (including ongoing risk assessment) and coordination the Registered Nurse will engage with clients/participants to understand their needs, including their relationship with significant others and the wider community to ensure they are linked with appropriate services and providers.
- Provide advice to General Practices and their staff within the designated boundaries identified by the Clinical Team Leader and within the scope of their position description, specific qualifications, service objectives (e.g. CCSS, Clinical Support Coordination and other funding opportunities if they arise) and professional expertise.

KEY RESPONSIBILITIES

- Provide support for CCSS (clients) and/or NDIS participants and/or consumers in pilot programs
- Receive and action incoming referrals in accordance with the referral management procedures, including recording all client / participant contacts and supports ensuring up to date and comprehensive records / progress notes are maintained;
- Maintain accurate data collection within the client management software to inform outcomes of the role;
- Attend home visits and complete necessary health alert and other risk assessments as per policy and procedures;
- Actively participating in the development and implementation of the program/s.
- Promotion of the programs to suitable clients, GPs, general practice staff and other health service providers.
- Providing direct care coordination/support coordination service delivery and support to patients, GPs and practices and or NDIS.
- Achievement of the program objectives and deliverables as determined by HPC management.
- Maintaining contemporary knowledge of best practice chronic disease management patient care, service delivery, and effective systems and processes.
- Manage a case load of clients who may present with increasing complexity, multiple co-morbidities or disabilities, functional limitations across multiple areas of their life.
- Utilise a strengths-based, client centred approach to support clients to identify their goals and utilise a capacity building approach towards achievement and long term sustainability of these goals.
- Understand the principles and philosophy of NDIS as an insurance-based model.
- Ability to work in a dynamic and evolving interdisciplinary team based environment to achieve optimal client outcomes.
- Provide information and skills and capacity building training to clients, their families and support workers from other agencies as needed in order to achieve NDIS, health and or client goals.
- Liaise with and provide therapy and progress reports relevant stakeholders such as but not limited to NDIS, GPs, Support Coordinators, external organisations and other referrers/funding bodies as required.

- Provide accurate, high standard timely documentation and communication which meet the needs of HPC, the funder/insurer, referrer and or client's needs.
- Adhere to the National Disability Insurance Scheme (NDIS), Commonwealth Guidelines program guidelines (CCSS), HPC models of care and policies and procedures guidelines and other relevant governing body.
- Develop and maintain effective, collaborative relationships with key stakeholders that result in effective interactions, minimal service delivery issues and appropriate referral and client management. Key stakeholders include, but are not limited to:
    - Clients and their families, carers and or guardians
    - NDIS and NDIS providers
    - Relevant services and or suppliers
- Respond to all enquiries from clients and other stakeholders in a timely and helpful manner.
- Use the most appropriate methods of communication with clients and other stakeholders that supports their goals: for example face to face, off-site, home visits, telephone, email, video link etc.
- Utilise peer support within the team for client clinical support.

SERVICE LEVEL

- Provide clinical individualised practical support to clients and their families/carers in accordance with the client's goals and plan to increase client capacity to independently manage their plan
- Research service providers to gain understanding of services available to clients and what they offer
- Develop and maintain a comprehensive register of service providers including their capacity to provide services to clients with different needs/challenges
- Present service provider information and options to clients and their families/carers to enable them to make informed choices
- Actively assist clients to:
    - connect with health, clinical and community-based support services as outlined in the NDIS and/or GP Management/ Care Coordination plan
    - understand funding flexibility
    - reach decisions regarding services
    - reach agreement with providers
    - commence service and support new arrangements to optimise outcomes
    - link with providers
    - address barriers to participation
    - resolve service delivery issues, and
    - connect with and provide relevant documents and updates to their regular GP, to ensure clinical and social information is maintained for whole person centred care
- Complete all internal and external client referral requirements relating to each intervention that meets individual needs
- Create and update individualised case files in accordance with HPC procedures
- Record all client contact within agreed timeframes and standards
- Contribute to service development by identifying improvement areas and being actively involved in implementation of any agreed changes
- Work towards achievement of the program objectives and deliverables as determined by HPC

SELF-MANAGEMENT

- Behaviour is perceived to be consistent with the HPC values and code of conduct.
- Actions are in accordance with HPC policies and procedures and within the scope of the incumbent's expertise and role.
- Decisions are made in accordance with the HPC Board Delegation of Authority policy, program guidelines and organisational values.

PROFESSIONAL DEVELOPMENT

- Maintain and develop professional skills and knowledge through involvement in ongoing professional development activities and activity planning
- Maintain contemporary knowledge of best practice chronic disease management, client care, service delivery, and effective systems and processes.
- Maintain contemporary knowledge of best practice support services.
- Actively participate in performance feedback and reviews
- Participate in team and organisational meetings and activities to gain and maintain a sound understanding

WORK HEALTH AND SAFETY

- Take reasonable care of own health and safety and take reasonable care that own acts or omissions do not adversely affect the health and safety of other persons.
- Comply with any reasonable instruction by management and comply with HPC policies and procedures relating to health and safety.

SELECTION CRITERIA

ESSENTIAL CRITERIA

- Tertiary Qualifications in Nursing.
- Current unrestricted AHPRA registration.
- Strong knowledge, experience and understanding of the role.
- Demonstrated experience working with Aboriginal and or Torres Strait Islander people and/or communities;
- Demonstrated skills and ability engaging and working with clients who experience complex health and disability , their family and community members and service providers to identify solutions;
- Demonstrated understanding of person centred practice;
- Knowledge and experience in utilising appropriate assessments and report writing that match the client's needs
- Demonstrated effective interpersonal, oral and written communication skills necessary for good working relationships and client care.
- Ability to network and develop effective interdisciplinary team working relationships
- Ability to prioritise work, manage time and meet deadlines
- Experience in all Microsoft Office programs including Word, Excel, Outlook, data base navigation and data entry
- Demonstrated passion for lifestyle medicine models of care
- Excellent organisation skills and ability to work autonomously, use initiative and works well in a team;
- Excellent communication manner in dealing with members of the public;

- Self-motivated, flexible, empathic, responsible and reliable.

DESIRABLE CRITERIA

- Prior experience in case management/care coordination and/or providing professional and flexible assistance to individuals with chronic disease and or disabilities
- Knowledge of, and experience working with Hunter-based services within the Health, Disability, Aged and Social Services sectors
- Demonstrated effective understanding and experience working with Aboriginal or Torres Strait Islander people and communities;

POSITION CLASSIFICATION

- This position is classified as a Registered Nurse Level 2 position in accordance with the Hunter Primary Care Agreement 2021.

SPECIAL CONDITIONS

- Some out of hours work on evenings and weekends will be required (e.g. attendance at community forums or meetings) for which flexible working hours may be negotiated with manager.
- Regular travel required to and from client/provider sites
- National Police Check
- NDIS Worker Screening Check
- NSW Working with Children Check

ACCEPTANCE OF POSITION

I hereby accept the position as outlined in the above points and agree to abide by the HPC values, policies and procedures.

I understand this Position Description is designed to provide a guide to the responsibilities and activities to be undertaken in this position. This is not intended to be an exhaustive list and is not exclusive of additional responsibilities that may arise from time to time.

…… ……..
Signature Print Name

……
Date

Position Approved by: Claudine Ford - General Manager, NDIS & Chronic Disease, October 2024