Employee Position Description

Position Details		
Position Title: Care Navigator	**Department:** Medical Services	**Reports To:** Manager, Care Navigators Program
Primary Work Site: Central office at Doncaster, though will involve working from multiple sites across Eastern Melbourne	**Is travel between sites required?** ☒ Yes ☐ No	**Is hybrid working available for role?** ☒ **Yes** ☐ No
Employment Status ☐ Permanent ☒ Max Term June 30th 2026 ☐ Casual		**Does the role have direct reports?** ☐ Yes ☒ No
Enterprise Agreement: HEALTH AND ALLIED SERVICES, MANAGERS AND ADMINISTRATIVE WORKERS (VICTORIAN STAND-ALONE COMMUNITY HEALTH SERVICES) (MULTI EMPLOYER) ENTERPRISE AGREEMENT 2022 – 2026 NURSES AND MIDWIVES (VICTORIAN PUBLIC SECTOR) SINGLE INTEREST EMPLOYER AGREEMENT 2024-2028		**Classification:** Grade 2 **Classification:** Community Health Nurse (Sole)

Position Primary Purpose
Care Navigators are skilled and experienced professionals who will play a crucial role in providing additional support to both General Practitioners (GPs) and patients with mild to moderate and severe mental health conditions. This will involve motivational interviewing, social prescribing and making referrals to appropriate services, in addition to working alongside GPs and other professionals to streamline patient triage and case management. Care Navigators will provide an integrated care navigation service that is co-located and embedded within GP practices across the Eastern Melbourne Primary Health Network (EMPHN) catchment and work to enhance multidisciplinary communication and care navigation with GPs and other service providers in primary care and community settings. Key aspects of the role include developing, implementing and reviewing collaborative care plans, maintaining regular contact with the care team, facilitating well-structured care team meetings, providing support and guidance at critical points and monitoring to ensure tasks are completed within agreed timelines. Care Navigators will be involved in the establishment and implementation of the Care Navigators Program.

Key Accountabilities	
Focus Area	**Responsibilities**
Direct Service Delivery	The Care Navigator will work collaboratively for individuals with complex healthcare needs and will have knowledge of mental health, AOD and related services and be skilled in working collaboratively with external service providers across the health and community services sector. They will: • adopt a holistic model that connects people with the supports they need to address the underlying causes and predictors of poor mental health and wellbeing, as identified through their Link-me Assessment; • employ the principles of welcome, hope and empathy to engage each person, build their self-awareness of their mental health, and understand their individual goals, preferences and needs; • deliver a safe, welcoming and trauma-informed, culturally considerate, inclusive service and assist clients to navigate service systems utilising client centred approaches and service coordination; • offer warm referrals to services, record and follow up on referrals, close the loop with the GP and build capacity for self-advocacy through coaching; • provide services in both face-to-face and telehealth modalities; • work within the scope of practice defined for the role and as agreed with the Care Navigators Program Manager; • conduct clinical risk assessments and implement risk management plans as appropriate. The team will be integrated into our medical team, receiving support from our Senior Manager Medical and a Care Navigators Program Manager and will access professional development and supervision from our Medical Director and mental health, nursing clinical leaders.
GP Partnership and Networking	• Work closely with practice leaders and GPs to support patient identification, engage identified patients**,** build their understanding, and obtain informed consent for participation. They will offer immediate/rapid access through drop-in sessions in the practice and proactive engagement and will be supporting an average of five GP practices • Participate in shared care with internal and external services, including attendance at care team meetings, case coordination and clinical reviews as required • Provide integrated, team-based care through supported pathways by establishing and strengthening relationships with mental health services, GPs, AccessHC and partner health services, social services and EMPHN Support Connect • Support the establishment of referral pathways and connections with key stakeholders, including GPs, hospitals, AOD, primary care, mental health and community services • Represent the service as required in a professional and ethical manner
Performance and evaluation	• Ensure that service targets and KPIs are met • Collect and share relevant information about consumers in compliance with relevant legislation and program guidelines • Assist in the general review and evaluation of the Care Navigators Program • Participate in other program development and project work as required • Contribute to the team and participate in a supportive team culture • Contribute to the planning, monitoring and evaluation of the services at AccessHC

Commitment to Access	• Work collaboratively with GP practices to ensure clients that may benefit from the Care Navigators Program are identified appropriately and are able to access the service provided appropriately and efficiently. • Support and facilitate cross referrals demand management and prioritisation of access whilst balancing capped target achievements and uncapped consumer directed care market opportunities. • Ensure that their personal Care Navigator appointment book is planned, monitored and managed to effectively and equitably provide services to the clients of the participating General Practices.
Collaboration & Innovation	• Work collaboratively with the Care Navigator Program stakeholders and other Access HC leaders and teams to identify and implement opportunities for innovation and integration of services to achieve better outcomes. • Opportunistically build and develop other partnerships across the geography that might support better outcomes for the Program and its participants.
Risk Quality & Safety	• Participate in regular staff meetings, operational (line management) supervision and professional development • Participate in regular clinical supervision, which includes self-reflection, self-care, risk management and identification of needs • Participate in quality and service improvement activities to continually improve consumer care • Administer clinical outcome measures and screening tools (such as the K10) to consumers as required • Report and document any clinical or other risk incidents which occur, and participate in incident investigation processes where required • Record all clinical notes, client contacts and outcome measures in electronic databases and reporting systems as required • Ensure all procedures and policies are followed to support safe and effective service delivery (including occupational health and safety standards) and participate in quality improvement where required • Ensure all legislative requirements (including those relating to mandatory reporting) are followed, and all clinical and OH&S incidents/hazards are accurately and promptly reported in the VHIMS Central database • Maintain a professional code of conduct and participate in on-going professional development in accordance with annual work plans

Beyond the key accountabilities specific to the role, all employees are expected to demonstrate the values of the organisation and the capabilities set out in the AccessHC Core Capability Framework (Attachment 1). The position description outlines the key accountabilities of the role but is not exhaustive. All employees will be expected to comply with their manager's directions when and as required, which may include completion of duties not listed in this document.

Selection Criteria	
Screening Requirements	☒ Police Check ☒ Working with Children Check ☒ Australian Driver's License ☒ International Police Check (if lived overseas in last 10 years) ☒ NDIS Worker Screening
Qualifications	• Qualifications in nursing, disability, aged care or mental health or alcohol and other drug field or similar discipline)
Experience	• Relevant work experience with a minimum of 3 years' experience working with clients with multiple and complex healthcare needs (including severe mental health, AOD and other co-occurring conditions) • Experience working effectively within an integrated care team delivering better client outcomes for complex clients, including appropriate involvement of mental health, AOD and social support services to develop collaborative care plans and provide holistic goal-directed care • Experience in clinical case management and conducting clinical risk assessments and implementing risk management plans with clients • Strong interpersonal and administration skills with the ability to work collaboratively with individuals and their families, GP Practices and other stakeholders • Excellent understanding of mental health treatment services and referral pathways, with particular focus on the Eastern Region • Proficiency with electronic health record systems, Medical Director and Best Practice and Microsoft Office programs (Word, Excel, Outlook and PowerPoint)
Demonstrated Skills and Knowledge	• Knowledge of mental health, AOD and related services and be skilled in working both collaboratively with external service providers and within an integrated care team across the health and community services sector • Excellent interpersonal and communication skills with the ability to rapidly win trust primarily with GPs, other external stakeholders and across the organisation • Possess an empathic, innovative and professional therapeutic style • Excellent organisation, time management and problem-solving skills • Ability to work creatively and safely with consumers from diverse backgrounds, including LGBTIQ, CALD and Aboriginal and Torres Strait Islanders. Bicultural workers welcomed. • Ability to work independently and as part of a multi-disciplinary team • Ability to organise workload, set priorities and meet performance targets and deadlines • Willingness to expand your current skillset to meet the needs of the service

Access Health and Community is an equal opportunity employer committed to providing an inclusive working environment that embraces and values all people, regardless of cultural background, age, gender identity, sexuality or lived and living experience. We value the diversity and strength of Aboriginal and Torres Strait Islander cultures and are committed to delivering on our vision for reconciliation through our recruitment and employment practices.

Authorisations	
Employee Name: **Signature:** _____ **Date:** / /	**Manager Name:** **Signature:** _____ **Date:** / /