Employee Position Description

Position Details		
Position Title: Senior Chronic Disease Wellbeing Care Co-ordinator	**Department:** Adult Allied Health	**Agreement:** Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2020-2024
Reports To: Manager Podiatry, Dietetics and Diabetes Nurse Education	**Location:** Primary sites: Doncaster and Hawthorn. Ability to work from all sites.	
Direct Reports: Nil	**Employment Status:** Permanent Part Time 0.8 FTE	**Classification:** Community Health Nurse (In Charge) CN 6

Position Primary Purpose

Wellbeing Care Co-ordinators will provide client-centred assessment, referral co-ordination and education to support adult clients to self-manage chronic disease as part of a Chronic Disease program focussing on type 2 diabetes, respiratory and cardiac diseases. Assessment and intervention will aim to improve client's quality of life and reduce avoidable hospital admissions through referral and access to timely clinical and social services to enhance client confidence and participation in their own care. Client assessment and care may be delivered face to face in clinic, via telehealth or home visit, and will include engagement with clients, carers and support workers to support early intervention and complex disease management.

The Senior Chronic Disease Wellbeing Care Co-ordinator role will collaborate with Service Connection, General Practice, Medical Specialists, Credentialled Diabetes Nurse Educators, Allied Health and Mental Health professionals and connect with Social Prescribing services internally and externally to the organisation. The role will also provide practice guidance to internal chronic disease health coaches, and clinical supervision to enrolled nurses working in the chronic disease program.

In addition to clinical care, the Senior Chronic Disease Wellbeing Care Co-ordinator, will work with program managers to ensure successful program implementation, execution, data collection and evaluation, and maintain a documented and statistical record of their work. The role may also coordinate and participate in multi-disciplinary case conferencing and provide secondary consult to colleagues to inform and direct best practice care for chronic disease and supporting client health literacy.

Clients referred for chronic disease care co-ordination will primarily be funded under pilot funding from Diabetes Connect and Commonwealth Home Support Program (CHSP), however clients may also require care under alternative funding such as Medicare Benefit Scheme (MBS); Community Health (CH), Home and Community Care (HACC), Home Care Package (HCP), National Disability Insurance Scheme (NDIS) or Private Fee For Service. Therefore, knowledge of funding eligibility and an ability to navigate care in consideration of funding and client needs and means is required.

Decision Making Authority	Key Relationships
Decisions made independent of Manager • Inform and deliver clinical care including client and carer education and correspondence with internal and external health professionals or services • Daily prioritisation and triage of caseload demand, in consultation with manager as required • Delegation of agreed tasks to chronic disease health coaches	**Internal** • Manager Podiatry, Dietetics and Diabetes Nurse Education • Manager Community Access and Outreach • Senior Manager Allied Health • Service Connection and Customer Service teams • Allied Health and Nursing, Mental Health, General Practice and Community Health Service colleagues **External** • Diabetes Connect and Chronic Disease Program Community Partners • Referring medical practitioners or hospital services • External service and program providers

Key Accountabilities	
Focus Areas	**Responsibilities**
Provision of Clinical Service	• Work within professional scope of practice and service capability to provide timely, best practice and acceptable clinical care to clients for early intervention and self-management of chronic disease, including complications and co-morbidities • Optimise client's physical and mental health and social wellbeing through promotion of multi-disciplinary care, social prescribing and linkage to relevant community services and programs internal or external to AccessHC • Engage with clients and carers to support self-management and goal directed care planning • Liaise and correspond with relevant care providers such as referrers, general practitioners, diabetes specialists and allied health professionals; and escalate and advocate for services or intervention as relevant • Maintain privacy, confidentiality and compliance with electronic health record documentation and administrative requirements of funding streams, and relevant Access Health & Community policies and procedures • Meet key performance indicators as mutually agreed with manager and in line with AccessHC strategic plan • Delegate appropriate clinical and administrative tasks to chronic disease health coaches. • Comply with infection prevention and control standards in accordance with Access Health and Community's Infection Control policy and procedures.
Professional Development and Clinical Supervision	• Demonstrate commitment to continuous professional development (CPD) relevant to work at Access HC, and to maintain nursing registration with AHPRA

	• Proactively identify personal education needs and reference best practice guidelines and current literature to inform relevant and evidence-based service delivery • Participate in peer supervision, meetings and case presentations • Participate in annual performance planning and review.
Contribution to Allied Health and Nursing team	• Contribute to case conference or secondary consult with colleagues as part of multi-disciplinary care • Initiate and accept internal referrals to/from general practice and allied health team including co-ordination of client services • Share chronic disease management expertise to advocate for relevant services, programs, projects or funding opportunities, and through supervision of health coaches and/or enrolled nurses in the chronic disease program. • Contribute to continuous quality improvement activities and service delivery improvements, relevant to Allied Health and Nursing Service, especially those with a chronic disease focus.
Health Promotion	• Contribute to the provision of health promotion and prevention strategies to individual clients and their families. • Identify and target services to those most at risk.
Models of Care	• Understand and work within an Active Service Model and a Biopsychosocial model of health.
Access Health and Community Values	• Through actions and behaviour, demonstrate Access Health and Community (Access HC) values of ***Equity, Collaboration, Integrity, Accountability, Innovation*** and ***Excellence.***
Governance and Compliance	• Act in accordance with Access HC's policies, procedures and code of conduct. • Maintain updated and valid credentials in accordance with relevant legislation and industry requirements where applicable to the position. • Participate in mandatory training requirements to support the delivery of a safe and effective service.
Workplace Health and Safety	• Act in accordance with health and safety policies and procedures at all times. • Take reasonable care for personal health and safety and that of other personnel who may be affected by their conduct.

Selection Criteria	
Mandatory Selection Criteria • National Police Check / International Police Check • NDIS Worker Screening Check • Working With Children Check • Bachelor of Nursing (or equivalent) • Registered Division 1 Nurse with AHPRA • Driver's Licence • Current First Aid and CPR certification **Key Selection Criteria** • Minimum 5 years' experience working with clients with chronic disease in a community health, hospital outpatient and/or private practice setting • Clinical knowledge and experience in delivering client centred care for chronic disease including self-management principles • Demonstrated ability to work collaboratively in a multi-disciplinary service and team environment • Proven ability to relate to people from a diverse range of social, cultural and ethnic backgrounds • Proficiency in Microsoft Office and aptitude for learning and using relevant software such as TrakCare and Microsoft Teams	**Attributes** • Skills in utilising Health Coaching and/or Motivational Interviewing techniques • Understanding of social prescription and importance of social connection for wellbeing • Understanding of contemporary health landscape and funding models relevant to community health setting and chronic disease • Effective time management and clinical care prioritisation skills • Strong interpersonal, written and verbal communication skills • Demonstrated behaviours consistent with AccessHC values

Access Health and Community (AccessHC) is a Child Safe Organisation that values inclusivity and diversity. We encourage applications from people with disabilities, those with lived experience of mental health and/or alcohol and other drugs (AOD) challenges, and those with diverse genders and sexualities.

At AccessHC, our vision for reconciliation is an Australia where Aboriginal and Torres Strait Islander peoples experience equitable health and social outcomes. Our Reflect Reconciliation Action Plan (RAP) will contribute to achieving reconciliation. We will seek an understanding of and acknowledging histories and injustices, support the active expression of culture, build strong, trusting relationships, and apply culturally appropriate practices within our work.

We will work in partnership with Aboriginal and Torres Strait Islander peoples to create a welcoming and safe place for everyone at our services. AccessHC acknowledges the Wurundjeri Woi-wurrung people, who are the Traditional Owners of the land on which we work. We pay our respects to Wurundjeri Elders past, present, and future, and extend that respect to other Aboriginal and Torres Strait Islander people and we acknowledge that sovereignty was never ceded.

As a vaccine positive organisation, we encourage COVID-19 vaccinations and require successful applicants to undergo a NDIS Check, Working With Children Check, Police Check and potentially an International Check.

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