JOB DESCRIPTION

POSTION TITLE	Care Coordinator – Comprehensive Primary Care Team
RESPONSIBLE TO	General Practice Teams
RESPONSIBLE FOR	The primary purpose of the role is to facilitate high quality coordination of care as part of the comprehensive primary and community team for people and whānau with the greatest complexity of care needs, who require their care to be frequently transferred between providers and across services, which includes hospitalisations. Facilitating care coordination improves quality of care and can increase appropriate community-based care, closer to home.
SCOPE:	The scope is limited to the Whanganui rohe, working in partnership with Kaiāwhina and general practice teams
HOURS:	**TBC -** hours per week

NATIONAL CPCT STRATEGY INTENT

Building a high quality healthcare system that works collectively and cohesively around a shared set of values and a culture, enables everyone to bring their best to work and feel proud when they go home to their whānau, friends and community. The reforms are expected to achieve six system shifts.

These are:

1. The health system will reinforce Te Tiriti principles and obligations to actively protect and enable Māori interests and aspirations to secure equitable outcomes for Māori, and take bold actions to address discrimination, bias, and systemic racism throughout the system
2. Enable Māori to excise their authority over Māori health in accordance with Māori philosophies, values, and Māori development. Enable and support whānau voice in the design and delivery of service that are culturally safe and produce equitable outcomes
3. 3. All people will be able to access a comprehensive range of support in their local communities to help them stay well
4. 4. Everyone will have equal access to high quality emergency and specialist care when they need it
5. Digital services will provide more people the care they need in their homes and communities.
6. Health and care workers will be valued and well-trained for the future health system.

The care coordinator, irrespective of their employer will work as an integral part of the Comprehensive Primary and Community Team (CPCT), interdisciplinary team (IDT). The care coordinator is a key member of the IDT and will be actively involved in interdisciplinary (IDT) structure and functions including meetings, and using the systems and processes that support IDT functioning and outcomes.

People and whānau identified at greatest need for high quality care coordination are those who are receiving care from multiple providers, in multiple settings (e.g., social, allied health, community medical, hospital medical, mental health, etc). Effective care coordination during transitions of care (e.g., hospitalisation), can reduce risks of deterioration of health. Therefore, effective care coordination can reduce unnecessary hospitalisations (e.g., ASH rates), re-hospitalisations, missed outpatient appointments (e.g., reduce DNA rates), and perpetuation of the health inequities this population contends with.

The care coordinator will have strong relationships across the health and well-being sector that involves 'diverse but dense' networks and relationships. This role, within the Whanganui Locality prototype, will require working within the primary, Iwi and community health services provider network, to establish priorities and processes based on the person and whānau goals and which activities of care coordination need to be prioritised.

In addition to the activities and services described above, there is an opportunity for the care coordination facilitator to role model in:

- Person / whānau centredness, including the use of a whānau ora approach

- Empowering people/ whānau to be partners in their own health
- Collaborative working across health and social services
- Using a population-based approach and risk stratification to reduce health inequities by focussing care on those with greatest need.

RESPONSIBILITIES AND FUNCTIONS

Care coordination activities a include identifying, facilitating and / or performing:

- Facilitate identification of individuals / whānau who receive care from multiple providers, in multiple settings (e.g., social, allied health, community medical, hospital medical, mental health, etc). Episodes of care transitions (e.g., hospitalisation) for people with complex needs benefit from effective care coordination. This enables resource alignment for those with the greatest need for high quality care coordination.
- Ensure timely and complete transmission of information and accountability for aspects of care, when a transition of care occurs such as acute community care, early supported discharge, attending outpatient treatment, and necessary hospitalization.
- Determine patient and whānau goals and assess or review health and wellbeing needs, to achieve the goals. This may include NASC (Needs Assessment Service Coordination) assessment for people/whānau with intensive needs.
- Identify all participants in a person's care (i.e., the 'circle-of-care') and negotiate who is responsibility for key care activities.
- Participate in communication so that all involved in the 'circle-of-care' have the information they need.
- Provide tailored support and education for self-management that considers patient and whānau preferences, and other factors impacting the person / whānau wider determinants of health.
- Facilitate and ensure proactive Plans of Care (PoC) exist and are refined and updated, to accommodate new information or circumstances, with input from people/whānau and their 'circle-of-care' (e.g., the CPCT and relevant agencies). The PoC covers the goals and needs of the person/whānau, including accountabilities and responsibilities for routine care tasks, and anticipates progression of medical needs.
- Proactively monitor identified needs, the impact of health or treatment on daily life, and review progress on goal achievement. Respond to gaps and change by facilitating appropriate follow-up.
- Provide tailored support and education to the person / whānau that supports self-management and considers patient and whānau preferences, and other factors impacting the person / whānau wider determinants of health.
- Assist connections to available community resources and refer as required.
  Case management and intensive support for people/whānau with highest and most complex needs. This may at times involve direct provision of care.
- Leading and supporting interdisciplinary team functioning and collaboration to deliver to the plan, including facilitation of meetings involving relevant health and social service providers.

ESSENTIAL CRITERIA

It is expected that the care coordinator connects seamlessly with the Kaiāwhina role and together identify whānau and patients that may need navigation support / additional literacy advice / budget and access support and information to prioritise their health needs and seek help so they can self-manage and restore their wellbeing post interface with the clinical and social services.

PERFORMANCE DEVELOPMENT

This will occur in accordance with the performance development process, with annual review against the agreed performance development plan.

Key Result Area	Performance Indicators / Expected Outcomes
Equity	• People / whānau with the greatest need and risk of inequitable health outcomes are prioritised for coordination of care. • Determinants of health are addressed by coordination of care extending across health and social service providers. • Remain focused on the pursuit of Māori and Pacific health gain as well as achieving equitable health outcomes for Māori and Pacific. • Support Māori-led and Pacific-led responses, including tāngata whenua- and mana whenua-led care coordination to deliver mana motuhake and Māori self-determination. • Pro equity health planning and co-ordinating care for individuals, whānau and communities. • Willing to personally take a stand for equity and commitment to helping all people achieve equitable health outcomes. • Demonstrate awareness of colonisation and power relationships. • Demonstrate critical consciousness and on-going self-reflection and self-awareness in terms of the impact of their own culture on interactions and service delivery.
Comprehensive Primary and Community Teams	• Work in accordance with Te Mauri o Rongo. • Identify skill sharing opportunities and delegation to other roles, in particular non-regulated roles such as navigators and kaiāwhina.

	• Demonstrate commitment and understanding of adjusting intensity of care to meet health need and risk. • Promote comprehensive primary care teams by being an active participant and advocate for collaboration. • Utilise as available IT enablers for interdisciplinary team functioning, including record sharing, tasking, messaging, assessment, care plans and risk stratification tools. • Active participation in CPCT interdisciplinary processes, including model of care development and cross-agency approaches.
Hospital avoidance/ supporting early discharge.	• Prioritises all requests to facilitate timely and complete transmission of information and accountability for aspects of care, when a transfer of care occurs such as acute community care, early supported discharge, attending outpatient treatment, and necessary hospitalisation. • Coordinates the interdisciplinary team to support people and whānau. • Act as a point of contact for CPCT/Hospital services. • Be responsive to acute needs.
Supporting those at greatest risk of poor health outcomes	• Identify people and whānau with complex health issues and inequitable health outcomes and who will benefit for the coordination of care. • Facilitate completion of a care plan capturing actions required by individuals and whānau, CPCT and other agencies as required to address identified needs. • Assess or review health and wellbeing needs, including ability to carry out NASC assessment. • Pro-actively plan and co-ordinate care for individuals and whānau.

Collaboration	• Support interdisciplinary team functioning and collaboration of the CPCT and other services by actively contributing to leading, facilitating, and supporting team development. • Develop and maintain relationships with key primary care, community, and Māori and Pacific providers. • Maintain a broad knowledge and key relationships with social service providers. • Demonstrate commitment to working collaboratively, ensuring team responsiveness to time-critical interventions such as hospital avoidance, establishing urgency, be visibly open, clear, and innovative whilst building mutually beneficial partnerships with various stakeholders both internally and externally. • Model behaviour that strengthens a team approach to delivery of healthcare.
Professional	• Accept responsibility for ensuring that care and conduct meet the standards of the professional, ethical, and relevant legislated requirements. • Utilise best practice and evidence-based approaches in all aspects of work. • Demonstrate an understanding of the principles of the Te Tiriti o Waitangi and be respectful of people and whānau personal beliefs, values, and goals. • Read and adhere to the organisation's vision, values, policies, and procedures while representing the organisation in a committed manner and projects a positive image. • Demonstrate an understanding of the Code of Health and Disability Services Consumer Rights and Health Information Privacy Code. • Undertake education and / or qualifications required for the service. • Maintain confidentiality and appropriate escalation of concerns. • Ensure infection control and health and safety measures are understood and followed. • Recognises and values the roles and skills of all members of the health care team in the delivery of care.

	• Communicates effectively in an appropriate and professional manner with people and whānau, and members of the health care team that reflects the cultural needs of whānau. • Develop and maintain appropriate professional networks to support current knowledge of leading practice.
Innovation and Improvement	• Be open to new ideas and contribute to a culture where individuals at all levels bring their ideas on how to 'do it better' to the table. • Model an agile approach –tries new approaches, learns quickly, adapts fast. • Develop and maintain appropriate external networks to support current knowledge of leading practice.
Health and Safety	• Take all reasonable practical steps to eliminate and mitigate risks and hazards in the workplace that could cause harm, placing employee, contractor and others' health, safety, and wellbeing centrally, alongside high-quality patient outcomes.
Compliance and Risk	• Model responsibility to ensure appropriate risk reporting, management and mitigation activities are in place. • Ensure compliance with all relevant statutory, safety and regulatory requirements applicable to WRHN and health system. • Understand, and operate within, the financial & operational delegations of the role.

RELATIONSHIPS

External	**Internal**
Strong trusted relationships with whānau to support coordination across a broad range of services and providers including: • CPCT members • Māori and Pacific Providers • Hospital and Specialist Services	• Comprehensive Primary and Community Team members

• Community health services • NGOs, social service agencies and other government agencies • Other community and volunteer agencies	

QUALIFICATIONS AND EXPERIENCE

To succeed in this role, you will have:

Essential

- A relevant health professional qualification.
- Experience in implementing Te Tiriti o Waitangi in action.
- Registration with relevant regulatory authority.
- Registered Nurse; Physiotherapist; Occupational Therapist; Social Worker.
- Current annual practising certificate with no restrictions.
- Primary or community healthcare experience.
- Comprehensive understanding of the inequities in access and health outcomes in Aotearoa New Zealand.
- Advanced written and verbal communication skills.
- Excellent time management and organisational skills.
- Excellent critical appraisal skills and being able to identify the best evidence-informed solutions to clinical and practice questions and issues.

Desirable

- A relevant post-graduate qualification e.g., Case Management Australia and New Zealand have resources including self-assessment frameworks.
- Experience in leading and advising other health professionals or providers of care.

To succeed in this role, you will be able to:

Essential

- Demonstrate an understanding of the significance of and obligations under Te Tiriti o Waitangi, including how to apply Te Tiriti principles in a meaningful way in your role.
- Take care of own physical and mental wellbeing, and have the stamina needed to support complex health and social situations.
- Maximise the quality and contributions of individuals and teams to achieve the organisation's vision, purpose, and goals.

- Establish and maintain positive working relationships with people at all levels within the public and private sectors, related industry, and community interest groups.
- Demonstrate a strong drive to deliver and take personal responsibility.
- Demonstrate self-awareness of your impact on people and invests in your own leadership practice to continuously grow and improve.
- Demonstrate the highest standards of personal, professional, and institutional behaviour through commitment, loyalty, and integrity.
- Work in an evolving role and health system and be adaptable and flexible.
- Demonstrate an understanding of the intent of comprehensive primary and community teams and model appropriate practice.
- Proactively build trust and whānau ngatanga with individuals and whānau so conversations and the sharing of information is effective for all, and enabling of self-determination and autonomy of people receiving care.
- Undertake clinical procedures within scope of practice, and in accordance with the needs of the practice team.
- Lead and facilitate development and delivery of quality improvement activities.
- Develop and maintain relationships within the practice team, wider community and secondary care providers, external agencies, and NGOs.
- Effectively gather necessary information clinical and care needs through interviewing and assessment.
- Formulate a clinical judgement and course of action following a clinical encounter.
- Advocate for an individual's health through identifying health literacy and health needs, identifying problems or concerns and their potential solutions, provides support to the individual to enable them to self-manage and self-determine their health.

Desired

- Demonstrate the ability to be independent, be able to prioritise work effectively, develop one's own ways of doing things able to guide oneself with little or no supervision.
- Demonstrate the ability to manage changing and unpredictable workloads and be innovative and proactive.

This position description is intended as an insight to the main tasks and responsibilities required in the role and is not intended to be exhaustive. It may be subject to change, in consultation with the job holder.