Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

WINNIPEG REGIONAL HEALTH AUTHORITY
POSITION DESCRIPTION (Non-Management)

DATE: May 2, 2017
Revised June 14, 2017
Revised June 4, 2021

POSITION TITLE: Chronic Disease Management Clinician (Respiratory Focus) **JOB CODE:** 30002089

DEPARTMENT: Family Medicine/ Primary Care **UNION:** MAHCP

SUPERVISOR'S TITLE: My Health Team Manager

SUPERVISORY RESPONSIBILITIES:

EDUCATION:

- BSW, OT, PT, BSc PN, RPN, BN, RN, SLP, RD, or related health/human service degree required.

SPECIAL TRAINING:

- Certified Respiratory Educator preferred.
- Ability to attain the COPD and Spirometry course within 6 months required.
- Health Behavior Change counseling / Motivational Interviewing training an asset.
- Other training related to assessment and care of chronic disease (including physical and mental health related) an asset.
- Proficiency in computer software; experience with electronic medical records preferred.

EXPERIENCE:

- Minimum of two years within the last five years of directly related experience in a healthcare setting. Preference for experience in community-based services and/or primary health care, particularly primary care services.
- Demonstrated knowledge of current clinical practice guidelines.
- Experience working in inter-professional team; demonstrated ability to promote teamwork, collaboration and partnerships.
- Ability to plan, implement and deliver chronic disease management and self-management programming for individuals and groups.
- Comprehensive knowledge and practice skills required in mental health and its links with chronic disease.
- Ability to initiate and work independently.
- Demonstrated critical thinking and decision-making skills.

- Understanding of a population health approach, determinants of health, and equity, especially as it relates to chronic disease is an asset.
- Demonstrated flexibility required for working in a fast paced, changing environment.
- Understanding of fee for service family medicine work environment is an asset.
- Excellent interpersonal and verbal and written communication skills required.
- Demonstrates a professional approach in all situations.

PHYSICAL DEMANDS AND WORKING ENVIRONMENT:

LICENCES, REGISTRATIONS:
- Must be registered and a member in good standing with the relevant regulatory body.
- Requires a valid driver's license and vehicle to carry out job responsibilities.
- If successful applicant is a Registered Dietitian, must be a graduate of a recognized dietetic internship program accredited by Dietitians of Canada.

MAIN FUNCTION: (In Order of Importance):

The Chronic Disease Management Clinician will be responsible for the development and delivery of chronic disease management services, self-management and prevention programs to address health needs and priorities of the network's patient population in liaison with My Health Team partners and inter-professional teams. The Chronic Disease Management Clinician works in partnership with fee for service physicians, community organizations and regional health authorities to provide services and health education programs that maintain and promote the health of the Network's patient population residing in the community area.

The primary focus of the My Health Team is an enhanced primary care service through integration of healthcare services on health promotion, disease prevention, chronic disease management self-management and linkage with community-based resources.

POSITION DUTIES AND RESPONSIBILITIES:

PRIMARY CARE

Responsible for the assessment, planning, delivery and evaluation of primary health care for patients within the My Health Team partners primary care Clinics, which may include:

- Conducting comprehensive, multidimensional health assessments.
- Identifying actual/potential health issues.
- Working with patients to set goals, plan and implement guideline based, evidence informed interventions with a focus on health promotion and prevention of illness, chronic disease management and self-management
- Working with patients to monitor and evaluate desired health outcomes.
- Collaborates with the other My Health Team members and healthcare professionals (i.e. family physicians, WRHA chronic disease programs, WRHA community facilitators, WRHA HART Teams, Home Care Program and Winnipeg Integrated Services partners) to ensure optimal care for the patient.

- Initiates specialty treatment or other supports to manage chronic diseases based on specialty (e.g. titrating insulin, dietary education, supporting chronic disease self-management, home self-management assessments, carb matching, vascular and arterial assessments/screening, wound care management, outreach to vulnerable populations as required).
- Adheres to all client/patient care standards as outlined by the profession and the regulatory professional body.

COLLABORATION:

- Establishes and maintains an excellent, collaborative team relationship with the other My Health Team members and the inter-professional teams in practice.
- Develops and maintains excellent working relationships with the primary care practices, community-based organizations and regional health authority services.
- Functions as a member of the My Health Team:
- Collaborates with other members of the My Health Team to ensure integrated, quality care.
- Consults and refers to relevant My Health Team health care provider or community-based provider as appropriate.

NETWORK DEVELOPMENT:

- Contributes knowledge and expertise in community development, service integration and program development with community-based resources and members in the My Health Team
- Provides expertise in population health issues and community development to intersectoral groups and agencies within the My Health Team.
- Meets and collaborates with My Health Team members and community-based services in the development and implementation of the My Health Team to ensure service integration and avoid duplication.
- Collaborates with community programs to address and identify potential sharing of service delivery
- Enables local capacity building through:
    - encouraging patient participation in community activities
    - promoting and identifying community activities amongst My Health Team partners

PATIENT HEALTH AND WELLNESS:

- Implements the chronic disease management and prevention program in the designated area in partnership with primary care providers including: meets with primary care providers regarding the needs of patients, roles and responsibilities, and service expectations.
- Meets with primary care providers to identify interests and health issues and tailor clinics/programming based on identified needs.
- Utilizes existing community resources.

- Plans, develops, implements and evaluates programs within the My Health Team which promote health, prevent chronic disease and decrease and delay complications.
- Plans, develops, implements and evaluates programs within the clinic settings which promote health, prevent illness and postpone disability.
- Works with the team to ensure service coordination on behalf of the patients and providers, identifying their needs and supporting access to appropriate community, volunteer and professional services and programs.

PUBLIC RELATIONS/COMMUNICATION AND OTHER DUTIES:

- Supports and fosters an atmosphere of excellent customer relations throughout the organization and in all relations with patients, families, My Health Team partners and external agencies.
- Acts as a preceptor for students in health-related education programs.
- Adheres to all safety and health regulations and safe work practices.
- May be required to perform other duties and functions related to this job description not exceeding above stated skills and capabilities.