WINNIPEG REGIONAL HEALTH AUTHORITY
POSITION DESCRIPTION

DATE: February 27, 2018

POSITION TITLE: Primary Care Wellness Integrator **JOB CODE: 30002553**
UNION: MAHCP

DEPARTMENT: Primary Care

SUPERVISOR'S TITLE: My Health Team Manager

SUPERVISORY RESPONSIBILITIES:

EDUCATION:

- Post-secondary degree required in one of the following disciplines: BN, RPN, OT, PT, BSW, RT, SLP, RD.
- A suitable combination of relevant education and experience may be considered.

SPECIAL TRAINING:

- Competent in Windows-based computer programs (Word, Excel, PowerPoint, Outlook).
- Previous experience with database software preferred

EXPERIENCE/SKILLS:

- Minimum of two years (within the last five years) of directly related experience in a healthcare setting.
- Experience working with people experiencing Mental Health concerns within a community setting preferred.
- Knowledge of existing Community Area resources and Mental Wellness Resources.
- Experience with case management including: initial assessments; Supportive counselling; performing assessment, planning, and service coordination within a Harm Reduction approach
- Knowledge of Aboriginal historical experience and Cultural Safety an asset.
- Experience with Trauma Informed Care delivery an asset.
- Experience working with individuals/families from diverse backgrounds (cultural, financially disadvantaged, persons with disabilities, socially disadvantaged, new comers, etc.).
- Experience with Poverty, Addictions, Harm Reduction, Mental Health / complex housing needs.
- Knowledge of Community Partners' Programs.

- Effective leadership, coordination, negotiation, problem solving and conflict resolution skills.
- Demonstrated effective verbal communication skills and demonstrated effective presentation skills
- Ability to plan, implement and deliver chronic disease management and self-management programming for individuals and groups.
- Ability to initiate and work independently while Demonstrating a professional approach in all situations
- 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 an asset.
- Demonstrated flexibility required for working in a fast paced, changing environment.
- Understanding of fee for service family medicine work environment an asset.
- 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.

OTHER:

- Demonstrates effective networking and agency-relations skills.
- Demonstrated ability to effectively build and maintain relationships, and function as a team member; working collaboratively across sectors as an active participant in multi-disciplinary teams.
- Excellent Organizational skills.

PHYSICAL DEMANDS AND WORKING ENVIRONMENT:

- May be exposed to physical and emotional stress.
- May encounter aggressive and/or agitated clients/visitors/staff.
- May be required to work in various community locations
- May be required to work evenings or weekends
- Access to a vehicle required

LICENCES, DEGREES, REGISTRATIONS:

- Responsible for maintaining and providing proof of registration with relevant regulatory body.
- Requires a valid driver's license and vehicle

MAIN FUNCTION:

My Health Team (Primary Care Network) is a collaborative partnership between independent primary care practices, community organizations and regional health authorities.

Partners work closely with one another to plan, develop and provide enhanced local primary care services to the patient populations within their geographic area. This will support the patient journey through the health system and across community and acute care. As part of the My Health Team network, the Primary Care Wellness Integrator will provide case management in the context of the Recovery Model of care for patients where services needed are not available through existing services/providers or where these are not accessible within the required timeframes throughout the healthcare system.

The Integrated Program Wellness Coordinator reports to the My Health Team Manager. The incumbent will work with My Health Team partner clinics who provide these types of services to align and support existing Mental Health strategies in the Community Area necessary to support and address wellness, health needs and priorities of the networks patient population in liaison with My Health Team partners and inter-professional teams.

MAJOR RESPONSIBILITIES:

- Completes assessments of client's needs with respect to wellness; determining client identified goals towards connecting to community resources, supports or services as it relates to wellness on a continuum of Mental Wellness approaches

- Develops an up to date and detailed knowledge of Community Based resources supporting connections to Mental Health and Addictions services offered by partner Programs within the Downtown / Point Douglas Community Area (Winnipeg Integrated Services and Non-Profit Community Agencies including Housing Supports and Service Integration) and integrating with existing Mental Health resources.

- Works collaboratively with the Community Facilitators in the Community Area to build relationships and networks linking the MyHT strategically to existing community area resources
- Connects patients to the most appropriate supports assisting individual patients and families with case management and recovery model wellness interventions.

- Conducts outreach in collaboration with My Health Team providers and community partners' programs to identify those at risk for disconnection from Community area or social support.

- Trains, coaches and mentors peer supporters in Income Security promotion and acts as resource to peer supporters in the community area post training.

- Develops the capacity of DT/PD My Health Team providers, partner clinic staff and CDM Clinicians to identify patients at risk for marginalization and or crisis.

- Partners with existing initiatives in Mental Health and Addictions , addressing Poverty and Indigenous Cultural Safety to augment existing resources, build partner capacity and develop peer support and leadership skill to avoid duplication in service delivery

- Assists all Network patients in navigating the service systems, provide education on risk management, and work collaboratively with My Health Team Clinicians supporting chronic disease prevention and management Provide on-going supportive and/or case management services in accordance with the challenges, needs, and the strategies identified within the service plan in order to help the clients to achieve the stated goals and objectives.
- Participates in interagency planning and service coordination activities as directed to improve and enhance service continuity and effectiveness for clients.

- Assists all Network patients in navigating the service systems, provide education on risk management, and work collaboratively with My Health Team Clinicians supporting chronic disease prevention and management.

COLLABORATION:

- Maintains knowledge and awareness of a range of services and resources with respect to Community Area services in Downtown / Point Douglas Works collaboratively with service providers in various programs and services to ensure effective continuity of services for individuals
- Facilitates meaningful attachment to appropriate community based Mental Wellness resources.
- Participates in multi system service planning as required

NETWORK DEVELOPMENT:

- Works to integrate Community Area partner services with Primary Health Care delivery and align existing programs to deliver a more comprehensive service supported by linkages to Community Area resources via Community Facilitator collaboration.

- Works with existing partner services such as existing Drop in Counseling to act as triage and support to identify client needs and link to most appropriate community or mental health resource.

- Provides case management and wellness promotion support to My Health Team partner clinics, community health agencies and non-profit community Mental Health programs to facilitate increased partner capacity to deliver align with Mental Health Services.

PATIENT HEALTH AND WELLNESS:

- Works with a trauma informed care approach aligning wellness initiatives and service in line with Mental Health strategies and community services with Primary Health Care as a key component of proactive, comprehensive patient care.

- Works to develop and implement peer support groups to deliver support services and acts as consultative support to peer support groups as they are created leveraging lived experience where possible.