WINNIPEG REGIONAL HEALTH AUTHORITY
POSITION DESCRIPTION (Non-Management)

DATE: May 31, 2017
Revised October 10, 2017
Revised: January 18, 2019

POSITION TITLE: Priority Home Services Case Coordinator **SAP JOB CODE:** 30002301

DEPARTMENT: Home Care **UNION**: **MAHCP**

SUPERVISOR'S TITLE: Team Manager

SUPERVISORY RESPONSIBILITIES: none

EDUCATION:

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

EXPERIENCE:

- Recent, relevant experience and demonstrated competency in community health, home care, and/or primary care / primary health care is required.
- Experience as a Case Coordinator in Community Health Services is an asset.
- Understanding of basic rehabilitation practice, principles and philosophy, and strong assessment skills of client function in the context of client home and community preferred.
- Recent and relevant continuing professional education in relevant/related clinical area preferred.

OTHER:

- Computer based knowledge and experience required.
- Excellent interpersonal, oral and written communication skills, including conflict resolution.
- Ability to work independently and collaboratively with others in an interprofessional team.
- Demonstrated ability to prioritize, remain organized, take initiative and work under pressure with strict timelines in high-volume environments.
- Demonstrated leadership abilities.
- Excellent professional judgment, critical thinking, clinical reasoning and decision-making skills.
- Knowledge of *The Freedom of Information and Protection of Privacy Act (FIPPA).*
- Knowledge of *The Personal Health Information Act (PHIA).*

PHYSICAL DEMANDS AND WORKING CONDITIONS:

- Must be in good physical and mental health.
- May be exposed to infectious diseases, blood and body fluids, toxic materials, noise, allergens, physical and emotional stress.
- May encounter aggressive and/or agitated clients/visitors/staff.

- Available to work days and weekends. may be required to work evenings.

LICENCES, REGISTRATIONS:

- Valid driver's license and a vehicle required.
- Current registration in good standing with relevant college or licensing body in Manitoba.
- If successful applicant is a Registered Dietitian, must be a graduate of a recognized dietetic internship program accredited by Dietitians of Canada.

MAIN FUNCTION:

The Priority Home Service is a centralized Home Care service team that provides short term, intensive and restorative services to eligible clients for up to 90 days. This transitional home care service will be provided to clients being discharged from hospital that are eligible and/or waiting for Long Term Care (LTC) placement. The service will also provide short term support to clients classified as community urgent or those needing urgent placement directly from Emergency Departments. The objectives of this team will be to enable clients to remain in their home for as long as possible and when required, transition to LTC from the community as opposed to waiting for this placement while in hospital. The model will also help family caregivers continue in their caregiving role for as long as safely possible. Once a person no longer requires Priority Home Services, they may be able to return to regular home care services that will facilitate their activities of daily living and support their health needs. This team will facilitate seamless and timely transition of clients from hospital to home in partnership with the regular home care program and where indicated to LTC according to client need(s).

As a team member of the Priority Home Service, the Case Coordinator will collaborate with the interprofessional hospital team, the primary care home and community team to plan the client's service plan and to ensure the client receives coordinated, efficient and timely access to client and family centered services. The Case Coordinator will initiate the referral(s) and the service request for delivery of professional and non-professional services and will continue to coordinate and ensure delivery of services until the client is ready to transition to the regular home care program, or transitions to LTC.

POSITION RESPONSIBILITIES:

- Reviews consults/referrals and proceeds with comprehensive client and family assessment in hospital and/or community setting to determine appropriateness for enhanced home care services, and client's care needs.
- Ensures client is medically stable, does not require 24 hour in-hospital medical support and that the client can be maintained in the community with enhanced home care supports.
- Develops the client's service plan and then ensures implementation of the care plan and required home care/rehabilitation/restorative services where indicated.
- Collaborates and problem solves with home care service agencies and/or community offices to ensure appropriate delivery of Home Care Attendant/ Home Support Worker/other support services.
- Ensures client's service plan includes statement(s) of client need, objectives, implementations, service plan based on client /family assessment and the RAI-MDS tool

- Collaborates with the client, family, primary care home, and other members of the interprofessional team to develop and implement service plans as well as transition plans for the client to facilitate discharge within 90 days of admission to the Priority Home Care Service
- Documents assessments and client care plan in client's health record.
- Establishes collaborative partnerships with internal and external resources for the purpose of identifying service gaps and advocates for services to address gaps for persons and families.
- Understands the roles and responsibilities of each unique regulated and unregulated care provider staff of the client's team as well as other community agencies throughout the client's continuum of care to access the most appropriate service(s) available and in a timely manner.
- Understands and applies leadership principles that support a collaborative practice model including shared decision-making and accountability for one's own actions.
- Consistently communicates with other health providers in a respectful, collaborative, responsive and responsible manner.
- Engages self and others including the client and family in a positive manner and constructively addresses disagreements as they arise.
- Engages in relationships with care, dignity and respect regardless of race, ethnicity, culture, ability and/or language proficiency.
- Coordinates delivery of a broad range of home and health services based on Case Coordinator guidelines and the client's needs.
- Provides professional intervention where appropriate through professional education, counseling, assessment, advocacy, guidance and/or crisis intervention, etc.
- Works with clients, families and others in the healthcare team to complete reassessment(s) including RAI-MDS tool and modify the service plan according to changes in client's health and functional status.
- Plans and organizes work schedule to effectively manage caseload.
- Participates with or without other staff in accurately interpreting the program, related operational guidelines/directives and resources provided through the Home Care Program to the public and/or other agencies.
- Takes initiative to establish and maintain liaison with the local health care partners and any informal community resource networks.
- Participates in development and dissemination of education for new staff, students and others in the Home Care Program.

PROFESSIONAL RESPONSIBILITIES

- Provides care in a professional manner consistent with professional standards and code of ethics.
- Reports unsafe practice, professional incompetence, professional misconduct and incapacity or unfitness to practice of any healthcare team member through the appropriate channels.
- Provides constructive feedback to members of the healthcare team in a timely manner.

- Requests and accepts supervision and feedback on daily operations and performance where indicated.

EDUCATION AND RESEARCH

- Takes initiative for personal continuing education related to individual's professional scope, evidence-based and best practices that relate to the Home Care service delivery.
- Maintains and updates professional skills and knowledge base through self-examination and the integration of new and existing evidence through reading, continuing education and professional development opportunities.
- Recognizes limitations in knowledge and skills and takes appropriate action to compensate for any limitations identified.
- Attends and participates in professional development in-service opportunities.
- Participates in intra and interdisciplinary rounds, clinics, conferences and lectures appropriate to clinical practice area/home care.
- Demonstrates personal growth and development in the areas of clinical reasoning and use of evidence informed and evidence based practice.
- Responds to surveys and inquiries from researchers and other jurisdictions requesting information regarding community based care.
- Supports new professional knowledge by identifying possible research topics.
- Participates in approved service projects, research and program evaluation.
- Contributes to the knowledge base of the relevant professional body by sharing expertise, knowledge, and practical experience through presentations and publications.

SAFETY (Ongoing)

- Maintains responsibility for personal safety at all times.
- Contributes to a safe work environment and culture of safety.
- Reports hazardous conditions or equipment and takes action to address when appropriate.
- Adheres to all workplace health and safety regulations, policies, emergency procedures and safe work practices.
- Completes all mandatory safety education sessions and re-certifications, e.g. Workplace Hazardous Materials Information System (WHMIS), and Routine Practices.
- Reports any untoward incident to the Director or designate.

OTHER

- Participates in program, service and/or regional committees as assigned.

- Performs other duties and functions related to this job description not exceeding above stated skills and capabilities.