WESTERN REGION HEALTH CENTRE LTD

POSITION DESCRIPTION

Position:	Care Coordinator – Panorama
Location:	86 Paisley St, Footscray (However the position may be required to work from any of the Centre's sites)
Job Status:	Full time, ongoing, 38 hours per week (1.0 EFT)
Conditions of employment:	Social and Community Services - Victoria - Award 2000 and the Community Health Centre (Stand Alone Services) Multi Employer Certified Agreement 2005 - As Varied 24 May 2011, Social Worker Classification Class 2, Year commensurate with experience
Authority re Appointment:	General Manager Support Services
Reports To:	Team Leader Panorama

WESTERN REGION HEALTH CENTRE LTD.

The Western Region Health Centre Ltd. is committed to improving the health and well being of the people who live and work in the Western Region by providing an accessible range of comprehensive, high quality and integrated health and welfare services.

The Centre is an organisation providing a range of health services to the community, predominantly in the City of Maribyrnong with some programs extending to neighbouring municipalities and state-wide. Services include:

- general practice
- community health
- allied health services
- refugee health
- dentistry
- services for people who inject drugs
- general, family violence and victims of violent crime counselling and support
- mental health, homelessness and outreach services
- services for people with complex needs

PROGRAM INFORMATION

Panorama is funded by the Department of Health (Victoria) and aims to work with people affected by complex, and often severe, mental health problems.

There are two key focuses to the program:

1. *Intensive Home Based Outreach Support (IHBOS):*

   IHBOS aims to provide client focused, intensive home based support to two main groups of mental health clients:

   - Mental health clients who are in forensic and bed based clinical rehabilitations services, such as Secure Extended Care Units (SECU) and Community Care Units (CCU), with the aim of facilitating a successful transit to the community, and
   - Mental health clients who are living in the community and have, in addition to their mental health issues, complex, multiple needs (including co-occurring disability and substance use problems, poor life skills, recurrent homelessness, repeated unplanned hospital admissions, and/or involvement in the corrections system).

   This target group requires significant daily living support around activities such as shopping, medication management, budgeting, making appointments and accessing community based services. Clients are expected to have difficulties across multiple domains, limited capacity to self manage in the short term and minimal community and family connections.

   To be eligible for IHBOS clients must be assessed as being able to living in the community (with high level support), have the potential to achieve a level of daily living skills and social function, not pose an unmanageable risk to themselves or the community and, be willing to participate in the program. It is expected that IHBOS will improve outcomes for participants, including an improvement in stability of symptoms and improved health outcomes, a reduction in hospital admissions and involvement with corrections, improved long term housing security, improved life skills and community engagement, and improved continuity of care.

2. *Care Coordination for People with a Severe Mental Illness & Multiple Needs:*

   The aim of the Care Coordination Program is to target clients, registered with the specialist adult mental health service system (aged 16 – 64 years) who have a severe, enduring mental illness and psychiatric disability and multiple services needs, as well as a history of accessing a range of services in an ad hoc and often chaotic manner. Clients will most commonly have multiple problems, including mental illness and an intellectual disability or borderline intellectual functioning, acquired brain injury, Autism Spectrum Disorder, physical health and substance use problems.

Eligible clients will receive care coordination; a process aimed at improving coordination across different service providers. The role of the care coordinator includes:

- Development and monitoring of the care plan
- Taking a lead role in the coordination of services by promoting effective communication strategies
- Coordinating regular meetings of the relevant service providers
- Monitoring any brokerage provided for the client's care, and
- Developing or recommending flexible, creative and sustainable service options for the client

POSITION OBJECTIVE

The Care Coordinator – Panorama is responsible for coordinating the care of people with severe mental illness and complex needs by devising a care plan, arranging care team meetings and negotiating with service providers to ensure consistency of approach.

POSITION REQUIREMENTS

Care Plan Development and Coordination

To ensure an appropriate service system response, the Care Coordinator will:

- Conduct a review of existing client information (such as psychiatric, psychological, occupation therapy reports) from mental health and other services
- Meet with clients to obtain relevant information to contribute to the development of a care plan
- Make recommendations for additional clinical assessments in consultation with the Team Leader and/or Program Manager
- Make contact with relevant services and advise them of the role of care coordinator
- Work with treating clinicians to develop appropriate support structures
- Consult with the current service providers and relevant key stakeholders to determine the most appropriate service/services to meet the needs of the individual client
- Construct a Care Plan for the individual that reflects their needs for support and provides a platform for their on-going involvement in the existing service system
- Negotiate with existing service providers for a collaborative, responsive and planned support system for the client
- Monitor the implementation of the Care Plan and the holistic progress of the person to whom it relates
- Coordinate the services provided to the person in accordance with the Care Plan
- Report on the progress of the care plan to relevant parties, in consultation with the Program Manager and Team Leader, as required
- Explain the role of care coordinator to clients and engage with them in relation to the care plan
- Ensure services are provided in a manner that is sensitive to the cultural background of clients

Community networking, liaison and advocacy
To ensure a comprehensive and consistent approach to client care, the Care Coordinator will:

- Develop and maintain excellent working relationships with all key service providers and other stakeholders
- Participate in community development, community education and similar activities, as required
- Identify service gaps and access barriers, then recognize and implement potential ways to address these problems

General Organisational Requirements (standard)
The Care Coordinator will abide by general organisational requirements by:

- Participating in strategic planning and development activities as required
- Participating in internal and external evaluations as required
- Implementing relevant administrative procedures and systems to ensure reporting requirements to the Department of Health, WRHC board and other relevant agencies are available as requested
- Participating in service and organisation development and quality improvement processes
- Participating in service and organisation planning and design
- Participating in regular supervision meetings and an annual Individual Development Review process with the Team Leader
- Maintaining and developing standards of practice and skills by pursuing internal and external professional development opportunities
- Promoting and representing the Centre as a caring, professional, and client-focused organisation, and its range of primary health and social support services
- Participating in the identification of risks to the program and organisation
- Adhering to Workplace Health Safety and Wellbeing standards within the organisation
- Adhering to all Centre policies and procedures

Commitment to the philosophy of Western Region Health Centre (standard)
The Care Coordinator will abide by the philosophy of the Western Region Health Centre program by:

- Demonstrating a commitment to the philosophy expressed in the Centre's vision, goals and values statements
- Demonstrating a commitment to working within a service which includes targeting of marginalised communities
- Demonstrating a commitment to providing services in a manner that is sensitive to the cultural background of clients

Other

- Participating in home-based outreach when required
- Other tasks and responsibilities relevant to the role as requested

KEY SELECTION REQUIREMENTS

Applications are invited from suitably qualified and experienced people addressing the following areas:

Mandatory

- A relevant tertiary qualification and experience working with people who have mental health issues and other complex needs
- A demonstrated understanding of the principles of care planning and care coordination
- A demonstrated understanding of the Victorian mental health sector, in particular how it relates to people with severe mental illness
- A proven track record in devising creative and multidisciplinary strategies for client care
- Highly developed written and verbal communication skills
- Computer literacy
- Current Victorian Driver's licence

OTHER RELEVANT INFORMATION

- WRHC is an equal opportunity employer
- **Pre-Existing Condition Declaration**
  - Prior to any person being appointed to this position it will be required that they disclose full details of any pre-existing injuries or disease that might be affected by employment in this position
- **Proof of Right to Work in Australia**
  - Documentation that proves the right to work in Australia will be required prior to appointment
- A pre-employment police check is mandatory for all new employees
- **Working with Children Check -** Appointment to the position will be subject to a satisfactory Working with Children Check
- Probation period of three (3) months
- Recipients of Voluntary Departure Package (VDP) are ineligible to apply
- Employees are requested to comply with the Centre's policy on staff immunisation

Employee signature: ____

Employee name: ____________________________ Date: _______________

Manager signature: ____

Manager name: ____________________________ Date: _______________