



IDENTIFICATION

Department	Position Title	
Northwest Territories Health and Social Services Authority	Referral / Care Coordinator	
Position Number(s)	Community	Division/Region(s)
57-12358	Yellowknife	Home Care Services/Yellowknife

PURPOSE OF THE POSITION

To provide a comprehensive, single point of access entry system for all Home Care referrals to residents of Yellowknife, Dettah and N'Dilo. The aim of this position is to ensure timely referrals, consistency and continuity in service providers, efficiency in service provisions, increased collaboration between service providers and increased public satisfaction with health care outcomes.

SCOPE

The Northwest Territories Health and Social Services Authority (NTHSSA) administers all public health, home care and general physician services throughout Yellowknife, Dettah and N'Dilo, as well as all regional health and social services delivered in Fort Resolution and Lutsel K'e. The NTHSSA provides and supports the delivery of community based health care services to adults and children in order to enhance the health and well-being of communities through excellence, accountability and respect for regional diversity.

Under the direction of the Manager, Home Care Services, the incumbent assesses clients' needs and determines urgency and eligibility for services. Home Care Services receives approximately 240 referrals a year and operates with a budget of \$1.4 million (including salaries). The Referral/Care Coordinator (RCC) ensures that each client receives the right service at the right time, by the right providers, in the most appropriate setting. The RCC provides information on a broad range of community based resources, and refers to both internal and external resources.

The RCC is an integral member of the Home Care team. The RCC initiates, monitors and coordinates an interdisciplinary plan of care in collaboration with community, hospitals,

institutions, schools and the region. The incumbent assists clients in accessing placement services and, where appropriate, plans for alternate care (i.e. Long Term Care, Extended Care Unit, southern placement), when clients are not eligible for home care services.

The RCC provides ongoing home care program development and education (i.e. policies and procedures), and performs program evaluation. The incumbent also coordinates the Palliative Care Program, providing leadership and collaborating with interdisciplinary teams to facilitate best practices in palliative care service delivery.

RESPONSIBILITIES

1. Care Coordination

As the single point of access to Home Care programs and services, the incumbent completes the initial screening, assessment, and referral, in a timely manner to provide efficient service delivery and to prevent duplication of services. This involves establishing priority by identifying unmet needs and urgency, and determining the appropriate internal and external resources.

- Receives all home care referrals and inquiries via person, phone, fax or email.
- Triage all referrals for need and urgency using the Priority Assessment (PAT) and Continuing Care Assessment and Placement (CCAP) tools, etc.
- Contacts the referral source, client and/or family to complete an intake and initial screening.
- Educates the client and/or family on home care services and community resources relevant to presenting issue/s to facilitate an understanding of how service providers, the client and family collaborate to meet identified goals.
- Coordinates all team and case conferencing to promote effective communication, collaboration and information sharing between inter-disciplinary team, client and/or family, health care providers and relevant community agencies.
- Educates and supports clients and families in efforts to be responsible in promoting, maintaining and enhancing health outcomes.

2. Discharge Planning

In collaboration with other stakeholders, client and/or family, identifies discharge-planning needs at the point of initial contact and addresses facility placement where applicable across the continuum of care.

- Meets weekly with Home Care service providers to proactively reassess present service delivery and future care outcomes for all Home Care clients.
- Coordinates and collaborates weekly with Stanton in establishing appropriate pre-discharge processes and referrals.
- Conducts on site visits with clients and families while in hospital prior to discharge where applicable.
- Facilitates client case conferences in collaboration with Stanton pre-discharge.
- Coordinates interdisciplinary team meetings.
- Provides ongoing documentation for all discharge planning, i.e. team/case conferencing, statistical information.

- Provides education and support for clients and families in self-care efforts that promote the maintenance and enhancement of health outcomes.

3. Monitoring , evaluation and program development

Under the direction of the Manager, Home Care, develops, monitors and evaluates Home Care services to ensure a cost effective and sustainable program.

- Monitors the ongoing provision of service delivery, ensuring that the necessary consultation occurs and/or the necessary assessments and actions are taken.
- Maintains ongoing records and monitors existing clients to ensure timely reassessment and discharge planning.
- Evaluates programs to ensure that services are delivered that best meet the guidelines of health promotion and rehabilitation.
- Provides advocacy on behalf of clients to ensure that clients receive appropriate and consistent services, resources and fair processes within the continuing care delivery system.
- Fosters external partnerships to identify and address gaps in the services and programs.
- Researches current trends, practices and ongoing educational opportunities.
- Maintains all pertinent statistical information to be used for program development.
- Participates in the ongoing assessment of program standards and guidelines.
- Prepares and presents information at local in-service programs.
- Maintains membership or liaison with professional organizations, social, health and other groups,

4. Palliative Care

Coordinates the palliative care program to ensure that clients and families gain access to timely and efficient services that support national, territorial and local standards.

- Provides ongoing program development to ensure programming standards, policies and procedures meet standards and guidelines established by national, territorial and local standards
- Acts as Chairperson for the Home Care Palliative Working Group, responsible for promoting excellence in palliative care services.
- Coordinates ongoing educational opportunities to promote excellence in care provisions and service delivery and to remain current in practice standards.
- Participates in relevant committees, to provide continuity in care across the continuum (i.e. chemotherapy rounds, acute care.)
- Monitors and evaluates palliative care program.
- Promotes and maintains partnerships with palliative care stakeholders (i.e. PALLIUM, Cancer Board, Canadian Hospice Palliative Care Association (CHPCA)).

WORKING CONDITIONS

*(Working Conditions identify the **unusual and unavoidable**, externally imposed conditions under which the work must be performed and which create hardship for the incumbent.)*

Physical Demands

As typically associated with office positions.

Environmental Conditions

The incumbent will spend 25% of their day in client homes where the incumbent may be (and often is) exposed to unsanitary conditions, pets, cigarette smoke and loud noises which may make the incumbent sick (i.e. allergies).

In addition, the incumbent will be exposed to all weather conditions (ranging from -40 to +30) when driving to and from client's homes. The constant changes in temperature (office - vehicle - home - vehicle - etc.) may make the incumbent sick.

For 25% of their shift an incumbent may be exposed to communicable diseases, blood and body fluid that can result in potential health risk to the incumbent.

The rest of the day will be spent on administrative duties within an office setting.

Sensory Demands

This position requires a high degree of concentration and attention to detail but can also expect numerous and continues interruptions during the working day. The incumbent can be called upon at any given time to attend various situations and/or locations

Working within the client home may be extremely distracting and make normal assessment and diagnosis more difficult as these settings may be distracting for both the incumbent and the patient (noise level, family interruptions, visual commotion, etc.).

Focused attention to verbal and non-verbal communication of potentially volatile, difficult, intoxicated and verbally and/or physically abusive clients.

The remainder of the day will be spent on administrative duties within an office setting where the incumbent may be required to focus on a computer terminal.

Mental Demands

The RCC has the opportunity to develop relationships with the clients of the Home Care Program. The RCC is expected to remain calm, controlled and professional, regardless of the situation and demonstrate compassionate care to the client, family and other members of the health care team. The RCC is required to support a peaceful and dignified death of those residents that may cause significant emotional stress.

There is uncertainty in knowing what to expect while at work, especially in uncontrolled settings (i.e. home visits). There is legitimate concern about risk of verbal or physical assault and unknown and unpredictable situations (i.e. patients or family members under the influence of alcohol, demanding and confrontational family members).

Within the health care setting there can be significant lack of control over the work pace, with frequent interruptions that may lead to mental fatigue or stress. The incumbent must make decisions quickly that could have far reaching effects on the client's well-being. Conflicting priorities and very short deadlines place mental demands on the incumbent.

KNOWLEDGE, SKILLS AND ABILITIES

- Ability to research, develop and evaluate programs.
- Strong ability to envision continuous quality program improvement and methods for effective outcomes.
- Knowledge of northern cultures as they relate to the delivery of health and social programs.
- Demonstrated ability to work in a cross-cultural setting including sensitivity to gender, age and culture.
- Knowledge of current trends in health prevention, intervention and promotion.
- Strong interpersonal and interviewing skills.
- Excellent written and oral communication skills, public speaking and teaching skills
- Current working knowledge of the community and utilizing resources in the most effective and efficient manner for the client and services providers and to ensure culturally appropriate care.
- Ability to work in an interdisciplinary setting - requires a working knowledge of a variety of disciplines' roles and responsibilities to ensure a collaborative and resource effective interdisciplinary team approach.
- Sound decision-making, judgment, problem solving, and conflict resolution skills.
- Ability to deal effectively with people of all ages and backgrounds in stressful and emergency situations.
- Possesses a humanistic values system, belief in importance of the individual and demonstrates trust in people.
- Strong working knowledge and experience in the field of Hospice Palliative Care relating to current trends and service delivery.
- Proven computer literacy in Excel, Word, Publisher and Health Information Systems.
- Ability to interpret, analyze and apply statistical information.

Typically, the above qualifications would be attained by:

This level of knowledge is commonly acquired through a Baccalaureate degree in a health related discipline with five years recent experience in a community health/home care setting, or related environment. The incumbent must also possess 1 year of program development experience in a health care setting.

ADDITIONAL REQUIREMENTS

Yellowknife Regional Requirements

Active registration with a Northwest Territories and/or professional licensing body (e.g. RNANT/NU, CAOT, CASW) and basic CPR with annual certification is mandatory.

Must also possess a current Class 5 driver's license.

Position Security (check one)

- ☐ No criminal records check required
- ☐ Position of Trust – criminal records check required
- ☐ Highly sensitive position – requires verification of identity and a criminal records check

French language (check one)

- ☐ French required
- ☐ French preferred
- ☒ French not required