JOB POSTING
LHIN 012/21

TEMPORARY FULL-TIME BSO/BSTU CLINICAL CARE COORDINATOR
Full-Time Unionized Position – ONA

Windsor Site – Windsor Alzheimer Society

Background:
The Erie St. Clair Local Health Integration Networks (LHIN) is responsible for overseeing the delivery of home care services in the region.

The Erie St. Clair LHIN has a need for a **Temporary Full-time BSO/BTSU Clinical Care Coordinator** as described below. The Erie St. Clair LHIN is committed to supporting healthcare in a manner that is consistent with patient and family centered care. Applicants are required to have a demonstrated understanding and commitment to this care philosophy. This position understands expectations around the quality and safety framework and participates in safety and quality initiatives, gathering and analyzing information as required. This position also requires a high degree of attention to detail and excellent time management skills. Preference will be given to candidates who are proficient in both official languages. The position is located at the Windsor Alzheimer Society and will be supporting home and community care deliverables. Travel is required within Essex County of the ESC LHIN.

LHIN 012/21 BSO/BSTU Clinical Care Coordinator

STARTING DATE:	As soon as possible
POSITION STATUS:	Temporary Full-Time (until approximately April 2022)
HOURS OF WORK:	37.5 hours per week (Occasional nights/weekends will be required on a flexible ongoing basis)
SALARY RANGE:	In accordance with the Collective Agreement

GENERAL ACCOUNTABILITY
Reporting to the Patient Services Manager and Regional Coordinator (ASWE), the Clinical Care Coordinator is responsible for providing a “hands-on” and an “in-home” support approach for patients. As an integral part of an interdisciplinary team, the Clinical Care Coordinator develops coordinated care plans to assist patients to live well with dementia. Expected outcome is reduced Emergency and hospital admissions and smooth transitions back to the patient’s home. The Clinical Care Coordinator provides an in-home nursing visit within 24 – 72 hours from hospital discharge for identified clientele. The Clinical Care Coordinator conducts a comprehensive nursing assessment, using a patient and Care Partner centered approach and works with the patient and their supports to develop a coordinated service plan inclusive of behaviour specific goal planning and connection with appropriate supports (i.e. First Link Care Navigator).

The Clinical Care Coordinator in collaboration with BSO partners, will provide patients with timely communication and linkage to primary care and other allied health professionals in order that these patients are able to live well throughout their disease progression with their dementia. The clinical care coordinator conducts assessments in various settings, including but not limited to home, hospital, primary care locations, Rest and Retirement Homes and LTCHs. The goal of the Clinical Care Coordinator is to assist, understand and collaborate with partners to assist with the stabilization of patients with responsive behaviours.

Additionally, this position is responsible for developing quality, timely and cost effective individual service plans for service provision utilizing a multi-disciplinary and multi agency approach to achieve optimal health outcomes. The purpose of this position is to provide clinical care as well as care coordination to meet the needs of their identified caseload. The Clinical Care Coordinator facilitates the health care team to provide the patient with seamless care transitions.

The Clinical Care Coordinator has dual accountabilities. The Clinical Care Coordinator is accountable to ESC LHIN (Home and Community Care) and the Alzheimer Society in the respective county. The Clinical Care Coordinator has several reporting metrics – accountable to the ESC LHIN and Provincial Coordinating Office for the MOHLTC.

Working within the Behaviour Support Ontario Regional Coordinator, the Clinical Care Coordinator is responsible to engage and communicate with other team members regarding the philosophy of Coordinated Care Plans (CCPs), through this engagement the Clinical Care Coordinator works with team members on the spread and scale of the philosophy of care. CCP's template to be vetted to ensure it applies to BSO Best Practices.

The Clinical Care Coordinator has 8 specific role Core Competencies, the expectation is that the Clinical Care Coordinator perform all competencies with other BSO team members,

- Assessment
- Care Planning
- Communication
- System Navigation
- Accountability
- Patient Safety and Quality
- Collaboration
- Patient Transitions

NATURE AND SCOPE:

- Conducts clinical nursing assessments and based on patients' level of need and discharge destination provides assessment, advice and recommendations to the appropriate receiving agency in order to assist patients
- Completes appropriate assessments to support care coordination and service planning
- Develops a Coordinated Care Plan (CCP), leads the plans and collaborates with all team members. Acts to update the CCP regularly, develops an action plan for the patient in collaboration with the health care team.
- Follows up with patient and/or provider to ensure uptake of recommendations
- Mobilizes an "upstream" thinking through recognition of symptoms which serve as a foundation for care planning. Engage patient/care partners in creating a holistic care

plan inclusive of the dimensions of well-being that focuses on their goals and priorities

- Engage primary care, providers, and community partners as needed to create a coordinated care plan (CCP) based on patient priorities and goals. The plan can include traditional and cultural activities. Share the plan with patient/care partners and health care partners/care team.
- Participates in Community of Practice (CoP) development for the sub region and continue to contribute to CoP in the development of innovative practices
- Develops collaborative working relationships with community partners and enhances existing work relationships with a broad range of community agencies, to ensure that care partners are linked seamlessly to community agencies that can support the patient who will transition from various acute and sub-acute environments to home destination. Collaborates with the patient/care partner and care team, including primary care team, contracted service providers and community support agencies, to develop and deliver care plans that are patient centered, meeting the patient's identified needs and goals, so that the patient's need to access the emergency room and hospital is reduced and to avoid duplication of services.
- Support transitions to and discharges from the Behaviour Support Transitional Unit
- Able to Navigate patients to multiple community resources with expert knowledge regarding available community resources in the sub region in a collaborative manner, including follow up.
- Determines eligibility for Placement (long stay, short stay and Behaviour Support Transitional Unit (BSTU).
- Coordinates transitional support upon admission to LTCHs, BSTU, Rest and Retirement homes, attends rounds at BSTU and discharge planning from BSTU as it relates to the geography served
- Authorizes all services, medical supplies and equipment necessary to achieve the established program goal; obtains special authorization as required
- Provides for IHH (Intensive Hospital to Home) service planning as appropriate. Conducts transitional assessments and contacts care providers, from hospital to provide seamless care
- Ensures the fiscally responsible use of appropriate resources to achieve the desired outcomes by mobilizing and integrating formal and informal patient support networks
- Assesses and promotes a safe environment for patients, care partners, and staff.
- Adheres to policies and practices developed and implemented by the ESC LHIN.
- Adheres to policies and practices developed and implemented by the Alzheimer Society.
- Shares information according to privacy guidelines
- Participates in establishing, maintaining, and monitoring standards for case management. This includes committee work and active participation and contribution to quality and educational initiatives.

Community Engagement

- Acts as a spokesperson as required, and interprets the role of the LHIN to patients, health care professionals and to the public.
- Demonstrates behaviours, actions and attitudes that are professional and consistent with the Erie St. Clair LHIN's vision, mission and values
- Demonstrates political sensitivity in all interactions

- Engages with Health Care team members to support the scale and spread of the Care Coordination philosophy
- Ensures the Health Care Team feels part of the team and decision making process

Team Building

- Develops professional working relationships with all interdisciplinary team members
- Works respectfully, positively and collaboratively within a team environment, sharing experiences and lessons learned
- Supports the team and work with team members to ensure departmental needs are met and client/care-partner have the best experience

Other Related Activities

- Strives to achieve continuous quality improvement and excellence in all activities and outcomes
- Implements new procedures and controls deemed necessary by management. Communicates each with the team for transparency
- Assists in the training and orientation of peers
- Travels throughout the Erie St. Clair as required
- Other duties as assigned

QUALIFICATIONS:

- A Baccalaureate degree from a recognized university in the field of Nursing (and/or a combination of nursing education, training and experience) holding current registration with a regulated college in Ontario
- Minimum 2 years of relevant experience in a clinical setting as a Registered Nurse working in the acute care setting
- Registered Nurse working in a clinical setting such as hospital, physician office setting. Sound knowledge of the Ontario health care system and working knowledge of community resources and roles of health care professionals
- Preference will be given to an individual who is strongly affiliated with Indigenous culture and traditions and has worked in a First Nations community
- Working knowledge of the nursing process, the consultation process, program planning and crisis management
- Emergency/critical care and community nursing experience
- Canadian Nurses Association (CNA) certification in an area of specialty: Certificate in Geriatric Nursing (GNC) or Certified Nurse in Critical Care Pediatrics (CNCCP) an asset
- Superior clinical assessment skills
- Solid knowledge of health care related legislation and practices
- Knowledge of direct care/case management models used in community health care Organizations to support system navigation and hospital avoidance
- Must have a valid Driver’s License and access to a reliable motor vehicle with appropriate business class liability insurance
- Geriatric experience is an asset

- French Language is an asset

To Apply:

Please submit your cover letter and resume no later than **4:30PM, FEBRUARY 14, 2021 TO:**

Resume@lhins.on.ca

*Please include the reference **"LHIN 012/21 BSO/BSTU Clinical Care Coordinator"** in your e-mail subject line.*

By submitting an application, applicants are consenting to the sharing of their personal information with individuals from the ESC LHIN who are participating in the selection process.

The Erie St. Clair LHIN is an equal opportunity employer. Individuals with a disability requiring accommodation during the application and/or the interview process should advise the recruitment contact so arrangements can be made.

We thank all applicants for their interest, but advise that only those selected for an interview will be contacted.