

## Service Navigator – Care Coordination Service

### Position Details

This position is responsible for ensuring the Care Coordination Service for adults with chronic disease achieves its objectives in line with the program schedule and model of service deliver set out by Footprints in conjunction with Brisbane South Primary Health Network (PHN).

The Care Coordination Service aims to make a real difference to outcomes for adults who:

- Have one or two chronic conditions (where mental health is not the primary presenting condition)
- Experience bio-psychosocial risk factors
- Not frequently hospitalised
- Aged 40 years and over
- Live within the specified statistical area level (Beenleigh, Browns Plains, Loganlea-Carbrook and Springwood-Kingston).

<b>Employer</b>	Footprints in Brisbane Inc. (Footprints)	<b>Program Area</b>	Mental Health Services
<b>Location</b>	Kingston	<b>Salary Range</b>	As per Award rates
<b>Status</b>	Fixed Term Full Time	<b>Hours/FTE</b>	38 hours per week
<b>Industrial Instrument</b>	Social, Community, Home Care and Disability Services Industry Award 2010	<b>Classification Level</b>	Level 5
<b>Reporting relationships</b>	This role reports to the Team Leader - Care Coordination Service		

### Responsibilities

Key Responsibilities
<ul style="list-style-type: none"> <li>▪ Work with adults with chronic health conditions and bio-psychosocial risk factors to identify, link to and coordinate services and supports they need</li> <li>▪ Collaborate with a range of organisations and primary health care providers to coordinate and integrate services to deliver supports that address consumers' needs</li> <li>▪ Support consumers to access and prepare for applying to the National Disability Insurance Scheme (NDIS), Aged Care Services and or Mental Health Services</li> <li>▪ Work collaboratively with consumers' supports and services, to achieve outcomes in relation to the consumer's recovery plan</li> <li>▪ Provide information and facilitate connection between the consumer's services and supports relating to identified needs</li> <li>▪ Support information flow between health providers involved in the consumer's care and coordinate service delivery</li> <li>▪ Develop support plans within a collaborative, client-focused, strengths based model</li> <li>▪ Attend internal and external meetings, including committee meetings</li> <li>▪ Comply with reporting requirements by collecting, collating and communicating all relevant data to the appropriate internal and external stakeholders as required</li> <li>▪ Ensure its quality practice function and participates actively in training, professional development and best practice activities</li> </ul> <p><b>General</b></p> <ul style="list-style-type: none"> <li>▪ Follow all organisational policies and procedures</li> <li>▪ Participate in monthly professional supervision sessions, and ongoing learning and development activities</li> <li>▪ Promote and maintain a safe and healthy work place, ensuring adherence to WHS policies and procedures</li> <li>▪ Work within the vision, mission and values of Footprints</li> </ul>

## Knowledge and Skills

### Essential

- A Bachelor level or higher degree in health services, social sciences or other related discipline
- Extensive experience in a human services environment, particularly experience in understanding service delivery and how it can best deliver for consumers with complex chronic health conditions
- Ability to oversee and adopt a recovery-focused approach with consumers with chronic conditions and biopsychosocial factors
- Well-developed written and verbal communication skills, together with the ability to develop and maintain relationships with key external and internal stakeholders
- Computer literacy and the demonstrated ability to manage a client database and associated reports
- Current class C driver license, Yellow Card, and satisfactory national police check

### Desirable

- Current First Aid Certificate