



POSITION DESCRIPTION

POSITION TITLE:	HOME CARE HOSPITAL BASED CASE COORDINATOR
DEPARTMENT:	HOME CARE & ALLIED HEALTH
CLASSIFICATION:	HOME CARE CASE COORDINATOR/ DISCHARGE PLANNER
UNION:	MGEU – TECHNICAL PROFESSIONAL

REPORTING RELATIONSHIPS

POSITION REPORTS TO:	CLINICAL TEAM MANAGER – HOME CARE & ALLIED HEALTH
POSITIONS SUPERVISED:	NOT APPLICABLE

POSITION SUMMARY

The Home Care Hospital Based Case Coordinator [HBCC] is responsible for the coordination and delivery of a broad range of professional and non-professional services. The HBCC receives referrals and conducts assessments to determine Home Care support eligibility. The HBCC in collaboration with the client, family/caregiver and relevant interdisciplinary team members, develops, coordinates and evaluates the plan of care to support discharge from an acute care setting. In addition, through the collaborative process, the HBCC assists in the determination and planning if the client's needs are best supported in a personal care home or alternate care environment. The HBCC provides professional intervention where appropriate. Additionally, the HBCC establishes and maintains liaison with local health care services, hospital, community partners, and their families/ caregiver involved with the client.

The position of HBCC functions in a manner consistent with, and supports the mission, vision and values of the Interlake-Eastern Regional Health Authority.

ESSENTIAL FUNCTIONS AND DUTIES

Function and duties include but are not limited to the following:

The HBCC functions in a complex and dynamic acute care environment. Within a health services team of diverse professionals, the HBCC acts as a member of the team to identify those clients

appropriate for home care services and provides the following principal functions but not limited to:

Intake and Assessment

- Receives referral information.
- Reviews information, prioritizes, and determines the need for a Home Care assessment or redirects the referral appropriately.
- Ensures the case is registered on EHCR.
- Conducts a comprehensive assessment of client/family situation to determine eligibility and care needs related to home care and/or institutional placement.

Care Planning and Case Coordination

- Analyzes data received from assessment, identifies patterns/needs and prioritizes same.
- Develops a plan of care for the Home Care Program, including statements of client need, objectives, service provision, and evaluation criteria.
- Takes responsibility for implementation and coordination of the plan of care. May include initiating medical, rehabilitative, or consultative services as necessary to meet client need.
- Provides professional intervention where appropriate through professional counseling, teaching, guidance, crisis intervention etc.
- Develops individualized plan of care (including discharge plan), incorporating data from a variety of sources, in collaboration with other members of the healthcare team. Focuses on day-to-day, medium and long-range plans of care. Plan of care includes statements of client need, objectives, service provision and evaluation criteria.
- Documents assessments and client care plan in client's health care record.
- Works with clients, families/caregivers and other members of the healthcare team to re-evaluate and modify the plan of care according to changes in the client's health status.

Caseload Management

- Plans and organizes work schedule.
- Manages caseload demands effectively.
- Carries out activities necessary to meet program guidelines.
- Maintains current case count; ensures proper submission of statistics.

Program/Resource Planning

- Gathers data regarding resources and resource needs related to caseload/community.
- Ability to evaluate medical stability for safe discharge planning.
- Ability to respond to a variety of simultaneous demands and adapt to quickly changing situations.
- Participates with other program staff in interpreting the program 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 services and the informal community resource network.
- Incorporates IERHA guidelines and service limits when creating sustainable care plans with clients/families/caregivers.
- Advocates for clients while respecting their right to self-determination.

Team Participation

- Attends and participates at team meetings as appropriate and contributes to case management meetings.
- Participates with team in identifying community needs and gaps in service.
- Represents program at team level.
- Works within regional and departmental policy.
- Works with the Home Care and multidisciplinary team in the care planning process, including discharge planning from the hospital.
- Participates in educational development when required of new staff, students and related to the program.

Professional Development

- Participates in the education of related care professionals.
- Participates in studies and research related to the program.
- Keeps current of developments within own discipline as these relate to the Home Care Program.
- Pursuant to the Regional Health Authority Act, Interlake- Eastern RHA is designated bilingual (English/ French). Accordingly, all employees accept the responsibility to support clients in their official language of choice.

OTHER

- Performs other duties as assigned.
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QUALIFICATIONS**EDUCATION/CERTIFICATION:**

- B.S.W., LPN, or RN, with current appropriate registration and a member in good standing. Suitable combinations of education and experience may be considered.

REQUIRED KNOWLEDGE:

- Excellent knowledge of pertinent community resources, supports, and services typically used/required by home care clients.
- Experience and knowledge within the Electronic Home Care Record and assessment tool interRAI-HC© required.
- Experience and knowledge of the following electronic databases required:
 - SaluVision
 - eChart
 - EDIS
 - EPR
- Familiarity with evidence-based practice and continuous quality improvement environments.
- Knowledge of and understanding of cultural and spiritual sensitivity.

EXPERIENCE REQUIRED:

- Two years experience as a Home Care Case Coordinator required.

- Experience with discharge planning from an acute care facility required.
- Experience working with the elderly an asset.

SKILLS/COMPETENCIES:

- Must have the ability to communicate effectively both verbally and in writing with professional and non-professional staff, patients and their families.
 - Must have excellent organizational and professional skills.
 - Must be committed to continuing professional development.
 - Valid Manitoba Class "5" driver license and access to a reliable vehicle.
 - Ability to work independently with a minimum of supervision.
 - Mental and physical ability to meet the demands of the position.
 - Given the cultural diversity of our region, the ability to communicate in more than one language would be considered an asset.
 - Proficiency of both official languages is essential for target and designated bilingual positions.
 - Completes and maintains a satisfactory pre-employment security check.
 - Satisfactory employment record.
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WORK CONDITIONS

- The incumbent functions autonomously on a day-to-day basis and manages assigned duties accordingly.
 - Will be required to travel throughout the region as duties may require.
 - No hazardous or significantly unpleasant conditions.
 - All health care workers are required to be immunized as a condition of employment in accordance with the Interlake-Eastern RHA Policy GA-13-P-110 Required Immunizations for Health Care Workers.
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WORKPLACE SAFETY AND HEALTH

The incumbent contributes to making the organization safe for clients and staff and recognizes the importance of reporting unsafe situations and participating in follow up reviews as a learning opportunity.

- Provides a safe environment by ensuring the adherence to Workplace Safety and Health Regulations and Policies and Infection Control Guidelines. Obeys all safety and health rules and follows recommended Safe Work Procedures. Informs supervisor of any unsafe acts, work conditions, incidents, near misses, injuries or illnesses immediately.
- Demonstrates a working knowledge of Workplace Hazardous Materials Information Systems (WHMIS) and adheres to procedures for handling and storing controlled substances as described in the Material Safety Data Sheets (MSDS). Uses personal protective equipment as required.
- Demonstrates understanding of role and responsibilities in fire prevention and disaster preparedness and participates in safety and health training programs including the health facility's Fire, Disaster and Evacuation Plan.

PATIENT SAFETY

- Participates in and demonstrates an understanding of patient safety principles and practices into all day to day activities. Follow all safe work practices and procedures and immediately communicates any activity or action which may constitute a risk to patient safety.

Created: January, 2022
Date

Revised: April, 2023
Date

Approved by: _____
Regional Manager/ Supervisor Date

Approved by: _____
Regional Lead/ CEO Date

Reviewed by: _____
Regional Lead, Human Resources Date

Position descriptions assist organizations in ensuring that the hiring process is fairly administered and that qualified employees are selected. They are also essential to an effective appraisal system and related promotion, transfer, layoff, and termination decisions. Well constructed position descriptions are an integral part of any effective compensation system.

All descriptions have been reviewed to ensure that only essential functions and basic duties have been included. Peripheral tasks, only incidentally related to each position, have been excluded. Requirements, skills and abilities included have been determined to be the minimal standards required to successfully perform the position. In no instance, however, should the duties, responsibilities, and requirements delineated be interpreted as all inclusive. Additional functions and requirements may be assigned by supervisors as deemed appropriate.