Care Coordinator Role

The Care Coordinator will be responsible for working with NCACCH clients, specialists, GP's and the NCACCH Program Manager and NCACCH Chronic Disease Support Facilitator to provide multidisciplinary care and services for Aboriginal and/or Torres Strait Islander people with a chronic condition. All care coordination functions will be in accordance with the care plan developed by a GP with the Care Coordinators assisting the client in understanding and adhering to the care plan whilst utilising existing partnerships and to link the client into services required. The role will focus on the following aims of the program:

- Enhance the wholistic health of NCACCH Aboriginal and/or Torres Strait Islander clients with significant chronic conditions who are living in the Sunshine Coast and Gympie communities. The program assists in the facilitation of self-management of their chronic condition/s resulting in optimal health outcomes

- Support NCACCH Aboriginal and/or Torres Strait Islander clients with chronic condition complex care needs to access a range of culturally appropriate clinical and community support services available to meet individual needs

- Assist in breaking down the barriers in relation to medical terminology and facilitate the implementation of care plan requirement/s

- Assist in improving communication, collaboration, networks and referral pathways between NCACCH, Sunshine Coast Hospital & Health Service and other relevant services which aim to improve an integrated system of care

Key Responsibilities:

- Work closely with the NCACCH client and/or carer and to provide an active contribution to the implementation and continuation of the clients individualised care plan

- Ensure all information given eg. medical terminology, is provided in a way that the client and/or carer understand. Obtain feedback from the client and/or carer to check that the information and advice was correctly understood

- Increase client and/or carer knowledge and use of chronic disease self-management options including medication compliance

Performance Indicators:

1. Reduced avoidable admissions for clients receiving the service

2. Input contact information into the web based IHAS / MMex database within 72 hours of the contact

3. Collection of baseline and then 3 mthly observations as per the NCACCH CDMP GP Status Form

4. Improved access to appropriate services, in particular specialist services. Specialist referral requests to GPs are to be made at time of initial visit for all clients and then 6/12 monthly timeframes

5. Increased self-efficacy in relation to managing chronic conditions

6. Reduction in the burden of disease for a selected group of Aboriginal and/or Torres Strait Islander clients with chronic condition/s

7. Improved access by Aboriginal and/or Torres Strait Islander clients to community supports and specialist services

8. Improvements in self-management of chronic condition/s