# Care Coordinator Position Description \*

\*Please note that this is an example position description and should be used as a **guide only.** Practices should review their current workforce, activities and processes, and document a position description that is relevant and appropriate to them.

### Title

Care Coordinator

### Location

<<location of practice>>

### Organisation Description

<<description of general practice>>

### Reports to

<<practice manager, practice principal>>

### Job Summary

The Care Coordinator is responsible for working with patients to identify their goals, support them with chronic disease self-management, and coordinate services and providers in order to meet those goals.

The Care Coordinator coordinates team-based healthcare services for patients. They work in partnership with patients, their caregivers/families, community services, and the clinical team. This role facilitates a “shared goal model” within and across settings to achieve coordinated high-quality care that is patient and family centred.

### Key Responsibilities:

Service provision

* Assess patient and family’s unmet health and social needs
* Develop a care plan based on mutually agreed goals with patient, family, and provider including emergency plan, medical summary, and ongoing action plan, as appropriate.
* Monitor patient’s engagement with their care plan and progress toward goals in a timely fashion, facilitate changes as needed
* Facilitate patient access to appropriate medical and specialty providers and community support organisations
* Provide effective communication to improve health literacy
* Ensure effective tracking of test results, medication management, and attendance at follow-up appointments
* Ability to maintain confidentiality of all medical, financial, and legal information

Leadership

* Provide mentoring/coaching of other team members and coach patients/families toward successful self-management of their chronic disease
* Serve as a point of contact, advocate, and informational resource for patient, family, care team, and community resources
* Facilitate and attend meetings between patient, families, care team, and community resources as needed

Safety & quality

* Develop systems to prevent errors (e.g. shared medical records, data recording)
* Participate in performance improvement and continuous quality improvement activities
* Recognise and respond to opportunities for improvement

Professional development

* Actively participates in care coordinator related training and meeting activities
* Maintain ongoing education, training competencies as appropriate, attends conferences and education, training and seminars related to relevant areas of practice

Selection Criteria:

Essential Criteria

* Healthcare provider eligible for registration with their professional body
* Understanding of care coordination
* Previous experience in working with patients who have chronic diseases
* Understanding of chronic disease self-management and behaviour change
* Demonstrated strong essential leadership, communication, education, collaboration and counselling skills
* Knowledge of, and experience with, navigating local medical and social support services
* Ability to manage multiple and simultaneous responsibilities and to prioritise scheduling of work
* Ability to determine appropriate course of action in complex situations
* Ability to identify and implement appropriate patient communication strategies and overcome accessibility barriers
* Highly developed verbal and written communication skills
* Ability to work independently, exercise creativity, and maintain a positive attitude
* Ability to critically appraise and utilise innovative models of care and new technologies
* High level administrative and computer skills with strong attention to detail
* Follows evidence-based practice
* Holds a current driver’s licence

Desirable Criteria

* Healthcare provider registered with their professional body
* Experience working in a primary care setting
* Experience in health coaching, behaviour change, motivational interviewing or change management
* Experience using general practice software
* Knowledge of the Medicare Benefits Schedule
* Knowledge of the Enhanced Primary Care items, Health Assessments, Team Care Arrangements and GP Management Plans