VHA Health & Home Support

Job Description

Position: **Navigator** (*affiliated with the RITE© program)*
Immediate Supervisor/accountability: Manager of Community Gateway© or delegate

VHA's Mission & Values

Our Mission -
Advancing compassionate, safe community-based health care - people live with independence and dignity

We Value -
Client-centred care *– respect needs and preferences*
Safety *– manage risks effectively so people enjoy their best possible health*
Accessibility – *respond to diversity*
Quality *– improve outcomes and the quality of the care experience for clients and caregivers*
Collaboration *– work together to achieve positive change*
Learning and growing *– continually improve services through client engagement and professional growth*
Innovation *– develop and promote new ideas and evidence-based practices*
Accountability *– strategic and responsible use of resources*

Job Summary:
Using an Integrated Care approach (also known as co-ordinated care), the Navigator is responsible for assessing each client. Use of the interRAI Community Health Assessment (CHA), as well as other standardized interRAI tools is critical to this role. The Navigator develops, in consultation with the client and caregiver, a comprehensive care plan to meet the client's goals and for supporting the client and caregiver to live as independently in the community as possible. This is accomplished by identifying and connecting the client with appropriate health and social services with the goal of building individual resilience while maintaining independence.

The Navigator also assists in the development of skills which promote meaningful participation in the typical and valued life of the community life. The Navigator works collaboratively with health care professionals, health and social service organizations and directly with the client and their support network. Each Navigator brings a unique skill set that is enhanced when combined with other health professionals in a multidisciplinary team.

Responsibilities

Organizational Responsibilities:

1. Work positively, according to our Values, to help the organization fulfill our Mission.
2. Implement safe practices at all times and report health and safety concerns.
3. Active participation in regular supervisory meetings.
4. Initiate continual updating of skills, attend mandatory and other training as required.
5. Maintain a high standard of attendance and punctuality.
6. Responsible for maintaining professional relationships with clients, referral sources, employers, families, care providers and appropriate others; and for maintaining confidentiality.
7. Participate in relevant meetings.
8. Adhere to VHA policies and procedures, and the professional code of ethics.

Service Responsibilities: By building a respectful relationship with each individual and their family, the Navigator promotes dignity, well-being and independence. Specifically, the Navigator works as part of a multi-disciplinary team to fulfill the following functions while ensuring respect for each client's choice(s) and level of involvement:

Client Support Functions.

1. Assessment:
    a. Develop therapeutic rapport with each client and caregiver/family;
    b. Access, review and interpret previous assessments via the Integrated Assessment Record (IAR);
    c. Complete client assessments using conversation-based methodology;
    d. Assess the health care and social service needs of clients using standardized interRAI-CHA tools;
    e. Complete other assessments as appropriate to each client's unique level of support.

2. Care Co-ordination and System Navigation:
    a. Provide in-home assessment to identify client care needs, goals, interests and abilities through a person-centred planning process; identify and liaise with the client's natural supports, building on these relationships to optimize client independence;
    b. Develop a written Coordinated Care Plan (CCP) in partnership with each client;
    c. Facilitate access to identified services ensuring health and social service navigation to appropriate resources so that they support the care plan and the client's goals;
    d. Optimize each client's involvement in their community by:
        i. making referrals to community and other resources as required;
        ii. advocating for access to appropriate services and supports as needed by the client; and
        iii. ensuring collaboration and effective communication between care team members.
    e. With client consent, consult and liaise with service providers, etc to ensure
        i. A shared understanding of client needs;

ii. Appropriate interventions/services to meet those needs; and
iii. Ensure quality of care and service.

f. Participate in/initiate care conferences that encourage problem-solving and innovative solutions;
g. Monitor client progress and adjust care plans as needed;
h. Review care plan expenditures and support each client to manage within the care plan budget, advocating for additional financial resources when needed and appropriate;
i. Engage the client and support network in discharge planning.

3. Education:
    a. Positively and professionally represent all services providers, external stakeholders, community agencies and service providers to clients while maintaining a depth of knowledge of community-based resources;
    b. Improve each client's self-management skills through health education and information;
    c. Support individuals to develop decision-making skills that support positive self-care, personal responsibilities, and management of reasonable risks;
    d. Support, educate and connect clients in all areas of daily living including but not limited to meal preparation, homemaking/home support, shopping, hygiene, personal care, budgeting, safety awareness, leisure/social activities, and generally maintaining a healthy living environment.

4. Support Effective Risk Management:
    a. Promote an enhanced living environment for individuals, which supports their emotional well-being and physical safety while minimizing risk;
    b. Support and optimize care transitions as needed;
    c. Recognize unusual or threatening conditions and resolve issues as necessary;
    d. Mediate and problem-solve with multiple parties in a variety of contexts.

5. Strategic Directions:
    - Network and collaborate with all regional partners, health care and non-traditional providers and agencies;
    - actively participate in furthering VHA's strategic initiatives.

Administrative Functions

1. Document client progress in electronic database(s);
2. Collect data and report to Manager on program outcomes.
3. Responsible for completing all required documentation, including case notes and additional case records;
4. Create and maintain a work schedule based on client need and authorized hours; manage client caseload to meet expected targets;
5. Develop & maintain cooperative, effective contacts.
6. Provide required program support and administration.
7. Complete associated forms & reports to program and VHA standards.
8. Other related duties as required.

Qualifications

Mandatory:

1. Current registration with a professional college in Ontario (ie CNO, COTO, OASWSSW).
2. Experience working with people with complex health and social conditions, preferably in a community-based setting or other relevant professional experience.
3. Demonstrated ability in the creation and promotion of opportunities for inclusion through person-centered practices and person-centered planning
4. Initiative, integrity, reliability and ability to work flexible hours (including occasional evenings and weekends).
5. Ability to work with the general public and as a team member.
6. Computer literacy; proficient in Microsoft Office Suite and an electronic database (ie CHRIS, Goldcare).
7. Demonstrated ability to use sound judgment and effective organizational skills.
8. Proof of up-to-date immunizations, including all COVID 19 vaccines for which the incumbent is eligible.
9. Current Level C First Aid/CPR certification
10. Clear criminal record check – vulnerable sector.
11. Use of a vehicle and a valid driver's license.

Preferred

1. Bilingual (English/French).
2. Mental health and/or addictions training and/or experience.
3. Experience with case management and coordinating care.
4. Training in:
    a. Mental Health First Aid
    b. ASIST (Applied Suicide Intervention Skills Training**).**

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<u>Disclaimer</u>
This Position Description indicates the general nature and level of work expected. It is not designed to cover or contain a comprehensive listing of activities, duties or responsibilities required by the incumbent. Because of the changing nature of the work and the work to be done, the position specifications may be adjusted as necessary.

Working Conditions

Key for Degree of Physical Activity Required or Working Conditions - % of Time Involved

a) Limited, up to 25% of time
b) Moderate, 26% - 50% of time
c) Considerable, 51% - 75%
d) Constant, 76% - 100%

Work Environment

Type	Explanation	Degree
Adverse Conditions *(noise, heat, cold, fumes or unpleasant environments)*	Most work is performed inside client's homes or an office environment where exposure is negligible. Use of Personal Protective Equipment (PPE) may be required.	A
Isolation *(physically removed from other staff &/or resources)*	Not applicable	N/A
Exposure to Potential for Accident or Health Hazards	Most work is performed indoors where exposure is limited. Home environments may be challenging.	A
Hours of work *(variable shifts, irregular hours, very early or late shifts)*	Variable shifts, irregular hours and weekend work may be needed in order to accommodate meetings with clients and caregivers. Requirement to rotate evening shift work.	A
Travel	Considerable travel by personal vehicle.	C
Time away from home	Not applicable	N/A

Physical Effort

Type	Explanation	Degree
Audio Attention	Meetings: telephone, videoconference, in-person, conference/workshop format.	C
Visual Attention	Keen observation skills. Personal computer/laptop for documentation	C
Manual Dexterity	Keyboarding	B
Lifting or bending or climbing	N/A	A
Remain in a seated or standing position	Frequent opportunity to alter position.	A

Mental Effort

Type	Explanation	Degree
Overview	Ability to establish rapport to assist clients/caregivers to navigate health & social service systems, identify and access the services/supports needed to remain independent in the community. Able to cope with emotional and/or traumatic situations. Poor decision-making may have a profoundly negative impact on the client, caregiver(s), VHA and/or the community.	C
Level of responsibility	Flexibility, patience, strong analytical and problem-solving skills are all needed.	C
Pace of work / workload	Periods of work that are predictable and routine punctuated by periods of work with competing pressures and priorities.	B
Role conflict *(conflicting job demands, extent of work fragmentation, interruptions)*	Most work can be pre-scheduled; occasional interruptions.	A