UNION JOB DESCRIPTION

JD912

JOB TITLE:	Occupational Therapist- Community Care Coordinator	**JOB DESCRIPTION NO.:**	60246
CLASSIFICATION:	Occupational Therapist P1	**GRID/PAY LEVEL:**	H-J-P1
COLLECTIVE AGREEMENT:	Health Science Professionals	**HSCIS NO.:**	38901
UNION:	CUPE	**JOB/CLASS CODE:**	38901
PROGRAM/DEPARTMENT:	Home & Community Care	**BENCHMARKS (If Applicable):**	
REPORTING TO:	Manager or designate		
FACILITY/SITE:	Various VIHA SI Sites		

JOB SUMMARY:

In accordance with the Vision, Purpose, and Values, and strategic direction of the Vancouver Island Health Authority, patient safety is a priority and a responsibility shared by everyone at VIHA; as such, the requirement to continuously improve quality and safety is inherent in all aspects of this position.

As a member of a multidisciplinary/interdisciplinary health care team, the Community Care Coordinator -OT (CCCOT) provides care within the context of a client-centred care approach, the vision/values of the Vancouver Island Health Authority (VIHA) and in accordance with the College of Health and Care Professionals of BC Standards of Practice. The CCCOT assesses, plans, delivers, organizes, reviews, and evaluates the care needs of clients and their caregivers/families requiring community-based services. The CCCOT fosters and promotes continuity of care and cooperative partnerships by collaborating with appropriate physicians and liaising with other programs/organizations involved in the provision of services. The CCCOT provides education, counseling and guidance to clients/families and other caregivers. The position functions autonomously, while recognizing the importance of using an inter-disciplinary, collaborative approach to achieve excellence in health services and education.

TYPICAL DUTIES AND RESPONSIBILITIES:

1. Assesses the client's physical/emotional/psychosocial/spiritual/cognitive care needs. Develops a holistic care plan based on the client's short and long term goals, emphasizing self-management strategies. Administers direct interventions and evaluates the client's progress towards health care goals. Evaluates effect of implementing plan of care and revises plan as needed. Typical practice areas include: assessing occupational performance in Activities in Daily Living (ADLs), work and leisure activities and prescribing strategies and interventions; complex seating; complex power mobility prescription and training; ADL devices and other assistive technology; access for augmentative communication; cognitive assessment and retraining, delegation of tasks to Community Health Workers and Health Services for Community Living.

2. Provides a variety of functions related to Care Coordination including:

- Arranging home support and other care services.
- Coordinating access to Assisted Living and facility placement, day programs, respite and other community programs, linking with other health sectors as appropriate.

3. Acts as an advocate for the individual by respecting client choice and provides support for the caregiver as required. Identifies clients at risk and provides appropriate intervention as required. Promotes and facilitates client independence by exploring all care options.

4. Works collaboratively with appropriate physicians, clients/families/caregivers, health care professionals and other community resources to identify and resolve care issues for family/client/caregivers and addresses cultural/language barriers and ethical dilemmas. Coordinates the integration of care and makes referrals to other service providers as appropriate.

5. Provides guidance, education and counseling to clients, families and other caregivers by providing health care information relevant to the client's health concerns, performance of self-care activities, coping skills and lifestyle adaptation.

6. Maintains records in accordance with established procedures and policies and prepares/maintains statistical data, correspondence reports and other documentation as required.

7. Plans, participates in and facilitates client care conferences. Participates in interdisciplinary team meetings; collegially shares information; demonstrates and/or provides guidance on clinical/health related tasks.

8. Exercises standards of occupational therapy practice and professional competence as per COTBC guidelines.

9. Integrates and applies best practice by accessing available educational resources, and advocates for continuous improvement to promote excellence in client services.

10. Acts as a field-guide and mentor to new staff and occupational therapy students.

11. Performs other related roles and responsibilities as required.

QUALIFICATIONS:

Education, Training And Experience

Graduation from a recognized university program in Occupational Therapy. Current licensure in a practicing category with the College of Health and Care Professionals of BC as an Occupational Therapist. Eligible for membership in the Canadian Association of Occupational Therapists (CAOT). Three (3) years' recent related experience in working with clients with complex disabilities, including two (2) years' community health experience with a home care component; or an equivalent combination of education, training and experience. Valid BC Driver's License.

Skills And Abilities

- Ability to integrate and apply COTBC Standards for Occupational Therapy Practice in the context of community practice.
- Working knowledge of community health, Expanded Chronic Care Model, health promotion, illness prevention, and the challenges facing young adults with complex disabilities within a client/family-centred care approach.
- Working knowledge of life span development, family theory, multicultural health practices, principles of health education/promotion and determinants of health.
- Demonstrated ability to apply the occupational performance model, i.e., assess (physical, mental/psychological/functional and environmental) analyze, plan, make decisions; organize, prioritize, evaluate, and communicate as required.
- Demonstrated abilities in written/verbal communication, facilitation, mediation, and conflict resolution techniques, and demonstrated critical thinking and problem solving skills.
- Ability to establish and maintain effective working relationships with clients and their families and with colleagues, both on a one-to-one basis and with an interdisciplinary team/group context.
- Ability to relate well with people from a wide variety of socio-economic/cultural environments.
- Demonstrated ability to prepare/maintain a variety of charts, records/reports related to work.
- Demonstrated discharge planning and case coordination.
- Demonstrated ability to plan, organize and prioritize a dynamic workload, both independently and in consultation with other team members.
- Working knowledge of community resources.

- Demonstrated ability to effectively participate in purposeful change.
- Ability to carry out the physical demands of the job.
- Basic computer literacy, including the use of email, Internet and Continuing Care Information Management Systems.
- Demonstrated ability in chronic disease management.
- Comprehensive knowledge of other health disciplines (including primary care physicians) and their role in client care.
- Demonstrated ability to communicate, negotiate and deal effectively with co-workers, physicians, and other health care staff.