POSITION DESCRIPTION – Registered Nurse Care Coordinator Chronic Disease	
Part 1 – Expectations for Your Role	
Position	Registered Nurse Care Coordinator Chronic Disease
Service / Program	Primary Care / Clinical and Complex Care Services / My Care Partners
Industrial Instrument	Nurses - Nurses and Midwives (Victorian Public Health Sector)(Single Interest Employers) Enterprise Agreement 2024-2028
Instrument Classification	Registered Nurse – Grade CN4
Reports to	Clinical Lead
Effective Date	May 2025

Key Deliverables

As a Chronic Disease Registered Nurse Care Coordinator in the My Care Partners Program you will be instrumental in providing individualised, person centred care to patients with complex and chronic conditions. Your primary focus will be to support these patients in managing their health and maintaining their wellbeing at home. You will utilise your expertise to address complex psychosocial and environmental needs, ensuring that each patient receives comprehensive and holistic care.

- Conduct comprehensive assessments of patient's overall health, working closely with them to understand their specific conditions, recommend treatments, and ways to actively manage their health.
- Deliver chronic care interventions including care coordination and care navigation services to at risk patients within the My Care partners Program (MCP) in South Western Sydney (SWS)
- Deliver care enabling services to assist general practice in facilitating patient enrolments and program activities
- Enhance provider access to accurate and reliable patient information and improve communication among the patient care team through relationship building and usage of digital health tools
- Foster shared care models between general practice, primary and community health services and acute care for at risk patients enrolled in the program
- Improve patient reported experiences, patient activation and quality of life for those in the program
- Work to reduce potentially preventable hospitalisations, emergency department visits and hospital bed days through targeted chronic disease management and care coordination
- Enhance the quality of care for patients in SWS living with chronic and complex conditions
- Promote team based care and communication among the patient care team reducing fragmented care and enhancing patient centred coordination
- Provide inclusive care that meets the needs of diverse communities, including LGBTIQA+, Culturally and Linguistically Diverse Communities (CALD) and Aboriginal and Torres Strait Islander people

Patient Support and coordination

- Assist patients in identifying and bridge gaps in care, enabling access additional support for managing their chronic conditions and unmet needs.
- Maintain effective communication with General Practitioners (GP's), practice nurses, practice managers and other clinicians in the patients care team through online meetings, telephone conferencing and secure messaging.
- Participate in online clinical huddles with GP's for case conferencing and care coordination
- Provide timely follow up care for patients following unplanned hospitalisations.
- Ensure clinically appropriate escalation of care for patients experiencing clinical deterioration

- Manage the Supplementary Services Funding to advocate for affordable, sustainable healthcare options that reduce financial barriers to access timely healthcare.
- Support patients in setting goals and developing care plans to address health needs, making referrals to appropriate health professionals and services as outlined in the care plan.
- Empower patients with self-management strategies, encouraging positive health changes and self-advocacy.

Professional Development & Collaboration

- Participate in key stakeholder engagement activities
- Ensure services are customer focused, high quality and compliant with Quality and Compliance standards adhering to evidence based best practice
- Maintain accurate patient records ensuring completion of all documents in a timely and accurate manner in accordance with organisational standards.
- Practice within relevant professional and ethical standards.
- Foster a team culture aligned with Each values and behaviours.
- Contribute to the continuous development and quality improvement of the program
- Represent the service at internal and external forums, meetings and networking opportunities as required.

Skills

- Advanced clinical skills in managing a complex clinical caseload using a patient centred approach
- Excellent skills in a wide range of clinical assessments, treatments, interventions, and patient education in chronic disease management
- An understanding of and a commitment to the principles and practices of community health, primary health, and the social model of health
- Demonstrated capacity to work with people from diverse backgrounds including LGBTIQA+, Culturally and Linguistically Diverse Communities (CALD), and Aboriginal and Torres Strait Islander people
- Experience in working across a variety of clinical settings including general practice
- Demonstrated experience and skill in the provision of chronic disease management services
- Ability to develop and nurture positive and ongoing relationships with a range of stakeholders
- Excellent communication skills

Qualification/Registrations/Licences

- Bachelor of Applied Science (Nursing), or equivalent
- Registered Nurse, Division 1 with current registration to practice with AHPRA
- Drivers license.

Physical Requirements

- Ability to travel and conduct home visits.
- Ability to travel between Each locations and clients place of dwelling
- Ability to work from home when required
- Able to sit at a computer for 6-8 hours per days.
- Walk up stairs.
- Lift 3kgs

POSITION DESCRIPTION - Employee
Part 2 – Expectations for Our Team

At Each, we are committed to improving lives and strengthening communities through a range of health, disability, housing, counselling, and mental health services. With a dedicated team of over 1,500 employees and 250 volunteers, we aim to create a positive impact, empowering individuals to live healthier, happier lives.

Our vision is for everyone to live well, and we strive for a healthier, more equitable future through innovation, advocacy, and community engagement.

We care. We listen. We learn. We deliver. Altogether better care.

Expectation of Employees

Employees are expected to work collaboratively with team members and other Directorates, contributing to both individual and community outcomes. They must model Each's values, ensuring an inclusive, safe, and engaging culture.

Employee Responsibilities

- Ensure quality, safety, and risk management to protect staff, customers, and the community.
- Collaborate with team members and stakeholders to achieve positive outcomes.
- Create a safe, respectful environment that fosters growth, learning, and wellbeing.
- Track progress and outcomes to meet Each's goals and performance targets.
- Work within professional boundaries and program guidelines.
- Demonstrate leadership behaviours and serve as an ambassador of Each.

Quality

Employees must engage in continuous improvement, comply with legislation and accreditation standards, and maintain the necessary skills and knowledge for their role.

Safety & Wellbeing

All Each employees are responsible for their own health and safety, as well as that of others, in line with OH&S legislation and Each's policies.

Child Safe Commitment

Each is dedicated to creating a child-safe environment, with zero tolerance for child abuse. Everyone is responsible for protecting and reporting any suspected child abuse, ensuring the safety and well-being of children involved with Each.

Inclusion and Diversity Commitment

Each is dedicated to an inclusive and diverse workplace where everyone is valued and respected. All staff are expected to promote inclusivity, embrace diversity, and foster a collaborative environment, ensuring a safe and supportive workplace for all.

Key Selection Criteria

Skills & Behaviours

- Adhere to Each's Behavioural and Performance Standards.
- Strong communication and interpersonal skills for building relationships.
- Collaborative team player with a positive attitude.

Desirable Experience, Knowledge, and Qualifications

- Relevant tertiary qualifications.

- Proven collaborative teamwork skills.
- Understanding of the Not-For-Profit and Health sectors.

Mandatory Competencies/Licences

- Criminal History Check and Employee Working with Children Check (as required).
- National Worker Screening Check (if required for the role).
- Entitlement to work in Australia

Expected Behaviours for all Each Staff

- Act in accordance with Each's Code of Conduct, policies, and service principles.
- Respond to family violence risk in line with the MARAM Framework.
- Promote a safety-first culture and adhere to health and safety policies.
- Ensure Each Great Care is put through its PACES (Person-Centered, Accessible, Connected, Effective and Safe).
- Support a zero-tolerance stance on abuse, neglect, and discrimination.
- Foster an inclusive, collaborative work environment, prioritizing customer needs.
- Contribute to teamwork, innovation, and continuous improvement.
- Engage in continuous learning and complete all mandatory training on time.