

This package is designed to provide the candidate with sufficient information to submit an application for this position within the Sunshine Coast Division of General Practice Ltd (SCDGP). A generous and flexible package will be negotiated with the successful candidate.

This information package contains:

- General Information on SCDGP;
- Position Description;
- Selection Criteria
- Organisational Chart;
- Information on how to submit an application.

Please read the following information which includes details on how to apply.

If you require further information, please contact Marg Windsor at the Division on (07) 5456 8817 or email [mwindsor@scdgp.org.au](mailto:mwindsor@scdgp.org.au).

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## **Organisational Environment**

### **Sunshine Coast Division of General Practice Ltd**

The Sunshine Coast Division of General Practice Ltd (SCDGP) is a membership-based organisation representing the professional interests of general practice and allied health professionals on the Sunshine and Cooloola Coasts established in 1994. There are currently 460 General Practitioners (GPs) working within the Divisional boundaries from 114 general practices. Population demographics of the region indicate a current population approaching 400,000 with an annual visitor population in excess of 4.1 million. The Sunshine Coast is the fastest growing area in Queensland.

SCDGP maintains administrative offices in Maroochydore and operates clinical services from a further five locations throughout the region. SCDGP employs 58 members of staff (full and part time) and utilises contracted services for information management, payroll, accounting, clinical service delivery and network administration.

Divisions of General Practice in Australia are going through a transition into Medicare Locals; the third and last waive will commence on 1 July 2012. Some Divisions have elected to remain outside of the Medicare Locals, seeking to establish themselves as organisations offering similar existing services and benefits to General Practice and Allied.

The National peak body for Medicare Locals is yet to be defined and the State peak body is transitioning in the post Medicare Local environment into a different network. At this time it is expected that at least twenty Divisions of General Practice will remain in place as key suppliers of services to the Medicare Local and self-funding organisations in their own right.

The funding for Divisions beyond June 2012 will reflect the loss of Commonwealth funding for infrastructure and the need to be commercially sustainable from the range of services offered in the marketplace. It will also reflect a new funding partner in the yet to be established Medicare Local.

## VALUES STATEMENT

### Our Values

We are an organisation that strives to provide service to others. We aim to be a valuable contributor to the continuous improvement of positive health outcomes for our community achieved through a partnership with General Practice. As a partner to our staff and stakeholders, we respect and honour diversity of opinion, passion of thought and achievement through ethical and reliable service delivery, recognising these as integral contributions to our ability to achieve success as part of a caring and friendly team.

Achievement	Reliable
Honesty	Loyalty
Integrity	Fun
Good communication	Professionalism
Family	Responsible
Fulfilment of self and others	

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## POSITION DESCRIPTION

**Position:** Care Coordinator - Care Coordination and Supplementary Services (CCSS)

**Reporting Relationships:** Team Leader, General Practice Support (GPS)

**Level of delegation:** Financial - requires authority of Team Leader to commit to expenditure over \$100

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## PURPOSE OF THE POSITION

The Care Coordination and Supplementary Services (CCSS) Program is one of the measures included in the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

Under this Program, a qualified health care worker will be appointed to provide:

1. Care coordination for Aboriginal and Torres Strait Islander patients with a chronic disease. Patients must be referred by a GP in general practices or Indigenous Health Services participating in the Practice Incentives Program (PIP) Indigenous Health Incentive (IHI); and
2. Access to supplementary services. There is a flexible pool of funds that can be used to assist patients receiving care coordination under the CCSS Program. The funds can be used to access medical specialists and allied health services that are in accordance with the patient's care plan. The funds may also be used to assist with the cost of local transport to health care appointments.

## PRIMARY RESPONSIBILITIES

The Care Coordinator will be responsible for working collaboratively with patients, General Practitioners, general practice/Community-Controlled Health Service staff and a broad range of other relevant government/non-government services to facilitate provision of appropriate multidisciplinary care for Aboriginal and Torres Strait Islander People with target chronic diseases, to help them manage their health in a way that meets their individual needs and will result in optimal health outcomes.

## Specific Responsibilities

- To deliver services in accordance with the CCSS Program Guidelines to ensure that services provided through this position are consistent with the Guidelines;
- To understand and support appropriate administration of the Supplementary Services funding;
- To develop awareness of local services and maximise use of established resources, infrastructure and initiatives (including service directories and referral pathways);
- To inform GPs in the potential referring practices/services of criteria for accessing the service;
- To support identification of eligible patients;
- To assist patients to participate in regular reviews by their primary care provider;
- To contribute to implementation of patients' care plans including supporting adherence to treatment regimens;
- To support patient self-management;
- To assist patients to navigate the health system, accessing the range of specialist, allied health and other services they require;
- To ensure there are arrangements in place for patients to get to appointments;
- To assist patients to address social determinants impacting on their health such as accommodation, employment, etc;
- To transfer and update patients' medical records as appropriate (addressing consent and confidentiality);
- To collect reporting data as directed;
- To provide reporting as per contractual agreement;
- To work closely and effectively with members of the Closing the Gap workforce, including as an active member of the State-level network of CCSS Care Coordinators;
- To contribute to quality improvements in the practice/service including systems such as registers/recalls/reminders and communication between service providers;
- To conduct all activities in compliance with relevant legislation and organisational policies/procedures, reporting identified risks and opportunities;
- To participate in professional and performance development as required.

*Please note: this role is **not** intended to provide a screening service or independent care planning. The position is to support eligible patients only, in accordance with a care plan developed by the treating doctor.*

## KEY OUTCOMES

### Organisational Level:

- Completion of assigned Program deliverables and objectives within the required timeframes and Guidelines;
- Enhanced cultural awareness;
- Enhanced response to the needs of Aboriginal and Torres Strait Islander People;
- Improved communication and collaboration between key stakeholders to provide an integrated system of care.

## **Targeted Patient Population Level:**

- Patient-centred care;
- Improved care planning;
- Improved continuity of care across service boundaries;
- Improved efficiency of care;
- Proactive management maximising health promotion/prevention opportunities and early detection of chronic disease deterioration;
- Support for patients to access high quality services of their choice, whether mainstream or Community-Controlled;
- Improved health outcomes.

## **SELECTION CRITERIA**

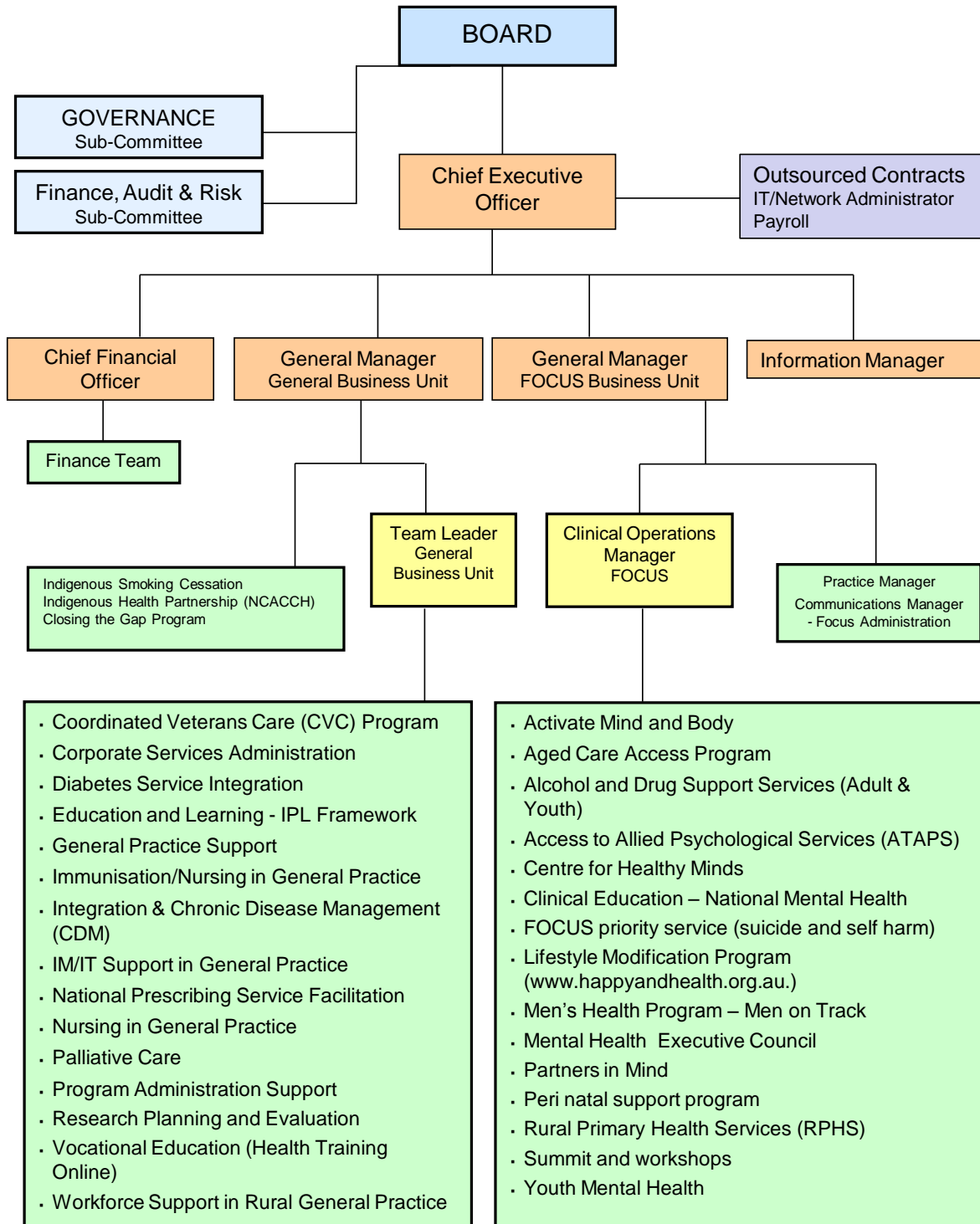
### **Essential Skills/Attributes**

1. Qualified health care professional/worker;
2. Clinical understanding of chronic disease;
3. Strong organisational skills (prioritisation, realistic goal setting, adherence to time frames, reliability);
4. Ability to capture and share clinical information with appropriate health care providers (including in electronic formats);
5. Highly developed interpersonal skills, including demonstrated liaison and negotiation skills;
6. Ability to develop rapport with Aboriginal and Torres Strait Islander patients/communities and provide support in a culturally sensitive way;
7. Ability to advocate on behalf of Aboriginal and Torres Strait Islander patients;
8. Ability to work effectively with/engage a range of health professionals and services;
9. Sound understanding of general practice/primary health care.

### **Desirable Skills/Attributes**

1. High level of self-motivation/initiative;
2. Ability to operate/rapidly acquire the skills necessary to operate technological applications (e.g. relating to practice/service software, secure messaging etc);
3. Demonstrated capacity to cope with complex and demanding situations in a professional manner;
4. Understanding of the current health reform context to appreciate the direction of health care;
5. Ability to be flexible and adapt to a changing environment.

# Organisational Chart



KEY: Sub Committee Senior Management Operational Leader Operational Teams

**APPLICANTS ARE TO SUBMIT THE FOLLOWING  
IN ELECTRONIC FORM:**

1. Cover sheet with your name, address and contact details
2. Curriculum Vitae or Résumé
3. Application addressing each of the Selection Criteria

Applications are to be emailed to: [mwindsor@scdgp.org.au](mailto:mwindsor@scdgp.org.au)