

# Position description Diabetes Connect Case Manager

Position title	Diabetes Connect Case Manager				
Position holder	Vacant				
Program	Healthy Communities				
Funded by	Department of Health				
Based at location	Stawell				
Responsible to	<ul> <li>Program Leader Healthy Communities</li> <li>Manager Community and Capacity</li> <li>General Manager Systems and Engagement</li> <li>Chief Executive Officer</li> </ul>				
Direct reports	• None				
Award	Community Health Centre (Stand Alone Services) Social and Community Service Employees Multi Enterprise Agreement 2022, or Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2020-2024				
Classification	SACS Level 3.1 to 4.1 Community Health Nurse				
Hourly rate	SACS \$36.00 to \$41.52 CHN \$51.76	Annual	\$56,909 to \$65,635 \$81,822		
Status	Part time fixed term to 30 June 2025				
Hours per week	30.4				
PD last updated and approved by CEO	March 2024				

#### **Position summary**

The Diabetes Connect Case Manager is an essential link to provide guidance to support local integrated pathways for people living with Type 2 diabetes as part of the Diabetes Connect pilot. People with type 2 diabetes are at high risk of poor health outcomes and this can be exacerbated by existing barriers, that are potentially avoided.

The Diabetes Connect Case Manager will target people who are newly diagnosed or require additional support to manage their type 2 diabetes, and who are at risk of avoidable hospitalisation due to clinical and/or social risk factors. This will include targeting those with the greatest risk of poor health outcomes and greatest economic and social need, and who may face barriers to accessing care through other services/settings.

The Diabetes Case Manager is one of the key points of contact for Diabetes Connect Clients and aims to improve the health, wellbeing, and quality of life for people with type 2 diabetes through the provision of coordinated, integrated and effective person-centred care. This role will focus on the non-clinical aspects of care including health coaching, linking to social activity and improving access to virtual check-ins.

## **Key responsibilities**

- Connect people who have Type 2 diabetes with the clinical and social services and supports they need to meet their health and wellbeing goals with a focus on social prescribing and improving self-management capacity.
- 2. Support clients to implement individual care plans which may include:



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- a. Support clients in attending appointments and managing appointment times, including prompts and reminders.
- Facilitate virtual care with clients who do not want to participate in face-to-face service, including improving health literacy and capabilities of accessing platforms such as telehealth.
- c. Provide information and education to support understanding and access to healthcare and their ability to make informed decisions about their own health care.
- d. Facilitate material supports where they meet the brokerage guidelines of Diabetes Connect funding model.
- e. Arrange transport for medical appointments or health activities.
- 3. Identify and implement risk adjusted interventions including health coaching, remote monitoring and virtual check-ins and following risk and escalation protocols to manage clinical and social deterioration.
- 4. Respond or facilitate response to monitoring and escalating care as required.
- 5. Contribute to assessments, action plans, reports, and reviews in collaboration with the Diabetes Connect Clinical Care Coordinator.
- 6. Maintain accurate data collection and reporting with strict adherence to all GCH and Department of Health requirements for data collection and reporting.
- 7. Provide supervision and support to students as required.
- 8. Other duties commensurate with current skills and experience as agreed with the Program Leader, Manager, General Manager or the Chief Executive Officer.

#### **Key selection criteria**

#### Qualifications

- Minimum Diploma of Community Services or relevant discipline, or
- Bachelor of Nursing.

#### Mandatory

Experience working in a healthcare related setting.

#### Desirable

- Experience working with people with a chronic disease.
- Experience in using health coaching models such as motivational interviewing, Ask Tell Ask, cognitive behaviour therapy, positive psychology, appreciative inquiry, stages of change.

# Demonstrated skills and experience

- Demonstrated attention to detail with well-developed administrative and organisational skills to effectively manage high volumes of work and determine priorities, meet targets and deadlines.
- Ability to maintain confidentiality at all times.
- Demonstrated knowledge and application of computer software, including Microsoft Office and the Internet.
- High level verbal and written communication skills that enable effective and appropriate communication with a broad range of people at all levels.
- Demonstrated ability to contribute to positive workplace culture and practices.

### Licences and registrations

- Current Victorian driver licence
- Current National police check (less than 3 months old)
- Current Employee Working with Children Check



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#### Personal attributes

- Empowering
- Professional
- Inclusive
- Courageous
- Compassionate

# **Conditions of employment**

This position is part time fixed term ceasing on or before 30 June 2025 and is subject to: Successful completion of a six-month probationary period.

And requires the following checks:

- Satisfactory police check
- Employee Working with Children Check

**Note:** Checks must be obtained and provided prior to commencement as a condition of employment at Grampians Community Health. Where check results are unsatisfactory in relation to the role to be carried out, the offer of employment will be withdrawn.

### **Required training**

- Health coaching.
- MARAM Identification and Screening.
- MARAM Collaborative Practice.
- Sentrient online learning management system courses as required.

Employee acceptance of p	osition:	
Employee signature Date	Vacant	