Alzheimer Society
SARNIA-LAMBTON

Job Posting:

First Link Care Navigator

The Alzheimer Society is an equal opportunity employer and we are dedicated to building a workforce that reflects the diversity of our communities in which we live and serve. We are also committee to inclusive, barrier-free recruitment and selection processes in accordance with the Human Rights Code and AODA and encourage applications from people with disabilities. Accommodations are available on request for candidates taking part in all aspects of the selection process.

Reports To

Manager of Clinical Services

Job Summary

The First Link Care Navigator is responsible to coordinate and integrate supports and services around the person living with dementia and their care partner. In this direct client service role, they will be the key "go-to" person for families after a dementia diagnosis, with responsibility for identifying needs, supporting self-management goals, and strengthening the communication and care planning linkages between providers and across sectors along the continuum of care. The First Link Care Navigator will strive to ensure that every person diagnosed with dementia and their care partners have timely access to information, learning opportunities and support when and where they need it in order to achieve the following outcomes:

- increase system capacity to provide families facing a dementia diagnosis with system navigation support
- improved client experience and health for the person living with dementia and their care partner(s)
- greater care partner capacity and competency to effectively manage their role and reduce incidence of crisis situations
- enhanced capacity for the person living with dementia to remain in their own home and community for as long as possible

Essential Duties and Responsibilities

Initial Contact, Assessment and Care Planning:

- Pro-actively manage incoming First Link referrals to facilitate early intervention and ensure that clients (people living with dementia and their care partners) have a named point of contact for care navigation support as early as possible before and/or after diagnosis
- Gather information, conduct or review relevant assessments, and meet with clients (people living with dementia and care partners) to identify current and future needs, goals and level of risk.
- Establish appropriate intervention plans with internal and external resource matching to meet bio/psycho/social needs using a person/family-centred approach
- Identify needs related to care coordination across service providers and outline responsibilities of all parties

Navigation and Care Coordination:

- Support clients in navigating the system to access appropriate learning opportunities, support services, care and resources as identified in their individualized plan of service

- Pro-actively facilitate and advocate for linkages, communication, information exchange and coordination between clients and service providers along the continuum of care
- Facilitate regular and ongoing care conferences between clients/care partners and all members of client/care partner care team. This may include in-person meetings and use of a range of technology options and/or accommodations, including language translation services, video conferencing, etc
- In collaboration with internal and external parties, engage in problem solving and develop strategies to address/overcome barriers in effective coordination/integration of supports and services
- Leverage and maintain positive working relationships with physicians, health care professionals, health and community support service providers (e.g. hospitals, primary care, mental health, BSO, long-term care, retirement homes, police/EMS, specialized geriatrics, community Health Links), and other relevant partners through proactive outreach activities
- Support awareness of First Link to health professionals, service providers and other relevant community stakeholders in collaboration with internal and external partners
- Participate in internal/external committees on an ad hoc basis

Pro-active Follow-Up:

- Monitor and provide proactive follow-up for clients and care partners to ensure ongoing collaboration across services/providers and to identify opportunities for new or emerging care options to meet changing needs and to address service/support gaps
- Provide supports to clients and care partners as they transition through use of different parts of the health, social and residential care systems

Monitoring/Evaluation:

- Collect, maintain and report required quantitative and qualitative data to support province-wide monitoring, evaluation and reporting
- In collaboration with the Alzheimer Society of Ontario and LHINs, participate in planning and implementation of evaluation to examine the overall effectiveness of First Link referral, intake, navigation, care coordination, and proactive follow-up functions, to ensure a timely response to emerging needs

Service Delivery Standards and Quality Improvement:

- Maintain confidential, accurate and current client records, including complete and thorough documentation for each client contact, in compliance with relevant privacy legislation and in accordance with professional standards and internal policies
- Ensure that client consents, privacy, and confidentiality are maintained in compliance with legislation, professional standards/regulations and internal policies
- Maintain an advanced level of knowledge of Alzheimer's disease and other dementias, including clinical manifestations, behaviours, current care practices, treatment options, placement options, available community resources, and all relevant legislation
- Assist with the development and maintenance of policies, procedures and resources to support First Link referrals, intake, system navigation, care coordination, and follow-up activities
- Participate in knowledge transfer and exchange and collaborate with Alzheimer Societies across Ontario to support the delivery of best practices and ongoing quality improvement

Group Program Facilitation:

- Lead therapeutic group programs for family care partners of persons living with dementia
- Contribute positively to patient care through the application of research-based practice
- Plan and implement program outreach and promotional events with local community dementia program service providers
- Contribute to creation, evaluation and publication of patient and/or program promotion materials
- Participate in program training, mentoring, and professional development activities

Other:

- Perform other duties consistent with the job classification, as required

Hours of Work

- The First Link Care Navigator generally completes all duties within normal business hours; however, flexibility in hours is required, with occasional evening and weekend work.
- Participation in the on call rotation is a requirement of this position.

Job Qualifications

Education:

- Post-secondary degree in Social Work from an accredited university with current registration with the Ontario College of Social Workers and Social Service Workers; a Registered Nurse with current registration with the College of Nurses of Ontario; or a post-secondary degree with a relevant professional registration (acceptable to the employer)
- Further study in the field of gerontology, dementia is an asset

Experience:

- 3 to 5 years client service experience in the health and/or social service sectors
- Experience working directly with people living with Alzheimer's disease or other dementias and their care partners
- Experience and knowledge in management of chronic and complex health conditions
- Knowledge of available community services/supports and clinical, social and residential care options
- Understanding of roles and linkages across primary care, community care and specialized geriatric services
- Strong knowledge of client-centred philosophy
- Knowledge of clinical practices and training models related to dementia (eg: P.I.E.C.E.S. and U-First!)
- Experience in assessment and care planning/coordination
- Experience working in settings requiring inter-professional collaboration

Other Knowledge, Skills, Abilities or Certifications:

- Excellent communication (verbal and written)
- Exceptional interpersonal skills, including shared decision-making and facilitation
- Ability to prioritize workload and manage competing tasks
- Ability to take initiative and be resourceful
- Excellent problem-solving and change management skills
- Proficiency in technology (e.g.: Microsoft office and case management and care coordination systems)
- Demonstrated ability to work independently and within a team
- Expertise and experience in cultural sensitivity and diversity
- Ability to speak French or other languages an asset

Travel Requirements:

- Frequent travel in and around Lambton County to carry out the functions of this position, and to attend relevant meetings. Occasional travel outside of Sarnia-Lambton may be required. Valid driver's license and access to a dependable vehicle are required

Physical Demands:

- Performance of general office duties

- Significant periods sitting at the computer, but with the opportunity to move away from the work station
- Sensory attention is required for the majority of the work day (looking at computer screen, reading documents, etc.)

Other:

- The Society requires that new employees be fully vaccinated for COVID-19, subject to any accommodation obligations it may have under human rights legislation.

The above statements are intended to describe the general nature and level of work being performed by most people assigned to this job. They are not intended to be an exhaustive list of all duties, responsibilities and requirements.

To Apply:
Please submit your resumé and cover letter to:

Human Resources Manager
hr@alzheimersarnia.ca

Please include the job title in the subject line.

Applications will be accepted by *email only*. We thank all those that apply, but only those selected for an interview will be contacted.

The Alzheimer Society welcomes those who have demonstrated a commitment to upholding the values of equity and social justice and we encourage applications from members of groups that have been historically disadvantaged and marginalized, including First Nations, Metis and Inuit peoples, Indigenous peoples of North America, Black and persons of colour, persons with disabilities, people living with dementia, care partners and those who identify as 2SLGBTQ+.