JOB DESCRIPTION

Telemedicine IMPACT PLUS (TIP) RN Facilitator - (1 Year Contract Position)

Position Profile

The Facilitator for the Telemedicine IMPACT PLUS model (TIP), a Registered Nurse, uses in-depth nursing knowledge, educator skills, research and clinical expertise with patients with complex co-morbid conditions who constitute the 1 and 5% who use the majority of health care resources, with the goal of supporting coordinated care of these patients in partnership with primary care practitioners in each designated Health Link, in order to prevent avoidable emergency department (ED) visits and hospitalizations. The RN works collaboratively with patients and their caregivers, primary care providers, inter-professional (IP) teams and specifically with CCAC coordinators to ensure that care plans are documented, shared, implemented and monitored.

This role, funded as a one (1) year contract with potential for expansion, will be focused on establishing the provision of timely access by solo primary care providers to inter-professional team consultations for those patients who have 3 or more ongoing complex conditions, are taking 5 or more medications and are burdened by psychosocial factors.

Accountability

- The Telemedicine IMPACT PLUS (TIP) RN Facilitator reports to, and is responsible to, the SETFHT Executive Director and Physician Lead, South East Toronto Family Health Team. All clinical decision being made outside the scope of the Telemedicine IMPACT PLUS (TIP) RN Facilitator must be done in consultation of the SETFHT Lead Physician and/or physicians of SETFHT.

Authority

- Does not direct the activities of staff or a function without direction of FHT decision makers. The Telemedicine IMPACT PLUS (TIP) RN Facilitator must comply with the nursing practice standards used by the College of Nurses of Ontario.

Roles and Responsibilities

The RN will:

- Assist in the identification of patients and providers to participate in this consultation
- Gather and organize health information to share across transitions in care
- Use templates to ensure care plan is documented in patient’s chart and shared within the circle of care, including the patient and his/her family
- Coordinate case conferences using OTN technology assisting with case presentation, facilitating that patients and their families as well as Primary care Providers (PCP) are “on board” for integrated care planning, and determining with the CCAC coordinator and PCP who will be stewarding the care plan
- Participate in an orientation and training process in this model of care
- Collaborate and liaise with IP teams, local Family Doctors and/or Specialists in the specific Health Link, and with CCAC case coordinators, using state-of-the-art telemedicine mobile laptop equipment
Role model clinical excellence, by working with physicians, IP teams and personal support workers within patient homes, family practice offices, FHTS, CHCs and hospitals, as well as CCAC, to develop protocols and a culture of collaborative patient centered care, ensuring continuity of care and effective transitions for clients and families to address ongoing needs.

Provide collaborative leadership, formal education sessions, coaching and mentoring to enhance the development of and lessons learned from this model

Facilitate the scaling of this model to engage other IP teams and solo providers

Participate in evaluation and measure of outcomes for this initiative.

Primary Responsibilities

Clinical RN roles:
1. Facilitates clinical assessments and health information gathering for complex patients of solo primary care providers
2. Consults physicians (family physicians or specialists) IP teams and the CCAC via telemedicine to support the assessment and management of patients requiring team based consultation with the goal of avoiding unnecessary transfers to the emergency room and developing anticipatory care plans.
3. Establishes documentation tools and protocols for direct telemedicine access to team-based assessments for participating family physicians.
4. Supports patients and families to identify their treatment goals and participates in the development of a care plan.
5. Supports primary care providers to identify the key issues in managing a complex patient, the resources needed to maintain the patient and family in the community, and the follow-up necessary to implement a coordinated care plan.
6. Collaborates with members of the interprofessional teams, acute care facilities and the CCAC regarding care planning and follow-up for individuals at high risk for hospitalization or readmissions.
7. Establishes collaborative relationships with EDs, rehabilitation hospitals, acute care, FHT and CHC, and CCAC teams and others to enhance smooth transitions along the continuum of care for identified complex patients.
8. Collaborates with community agencies and diagnostic service providers to support the timely provision of comprehensive services to these patients.
9. Engages frontline staff at the office practice site in the implementation and evaluation of strategies to enhance patient care plans.
10. Utilizes highly developed communication and conflict management skills to assist members of the inter-professional team with the understanding and resolution of ethical and/or difficult situations.
11. Participates in the evaluation of the initiative, measurement of outcomes and iterative change management.

Leadership and Education
The TIP Facilitator enhances professional practice and evidence based clinical service provision through education and leadership. To this end, the RN will:
1. Engage staff, acute, IP teams, CCAC, primary care providers and other stakeholders in the development, implementation and evaluation of the Telemedicine Impact Plus Initiative.
2. Provide formal education sessions, mentorship, coaching and support to staff, students and other members of the clinical team to enhance clinical knowledge, critical thinking, problem solving and decision making regarding the provision of evidence based team-based care to complex patients.
3. Provides information on the Telemedicine IMPACT PLUS Initiative to individuals, groups and community, especially other Health Links within TCLHIN.
4. Within the various Health Links, participates in the growth and expansion of the initiative and provides feedback on knowledge and skills of program staff.
5. Helps to scale the initiative from an initial pilot to involve more primary care physicians and mentor additional IP teams.
6. Provide leadership/ collaborative support for the development of policies, procedures and guidelines to enhance evidence based primary care.
7. Work with members of the leadership team in the East Toronto Health Link to support and ensure a culture focused on safety, learning, professional development, innovation and clinical excellence.
8. Maintain links with educational institutions including cross appointment where appropriate.
9. Identify opportunities to influence health policies related to Urban Telemedicine.

Research and Evaluation
As a practice expert, the RN supports program evaluation and the development and sharing of research and knowledge by:

1. Participating in the development of the evaluation tools and data management strategies for the Telemedicine IMPACT PLUS Initiative.
2. Providing leadership for the analysis and reporting of data
3. Assisting with the development of program and service evaluations/ reports and the benchmarking of program indicators.
4. Critiquing, interpreting and applying research findings to enhance the development of clinical excellence with urban telemedicine.
5. Disseminating research and practice innovations through formal and informal channels to advance the practice of team-based consultations for a complex population.

Secondary Responsibilities
- Assist with process of obtaining feedback from community providers for service development and evaluation

Decision Making
- Assessment and treatment of care needs of complex patients referred to TIP as appropriate within the RN’s scope of practice
- Determination of client’s need for urgent/ emergent care
- Identification of service issues requiring management attention
- Identification of barriers to TIP Initiative success
- Recommendations to the program regarding services, gaps and changes to enhance patient and staff safety and/or quality of care
- Recommendations to the Health Link Steering Committee regarding the development of a culture that values patient centered care, interprofessional teamwork and clinical excellence.

Qualifications

Education
- Graduated as an RN from a recognized university program
- Member in good standing with the College of Nurses of Ontario
- Experience in geriatrics or primary care/ community health an asset
- Member of professional organization(s) in nursing such as RNAO
- Current BCLS certificate required
Experience and Skills

- Minimum 3-5 years of clinical experience in caring for elderly patients and/or providing outreach in the community an asset
- Experience working in primary care or emergency care setting preferred
- Demonstrated in-depth expertise regarding clinical assessment and primary care needs of vulnerable elderly, patients with complex co-morbidities and patients with chronic mental health challenges
- Evidence of sound knowledge and skill with adult education techniques
- Demonstrated ability to work in a self-directed manner using well developed leadership, critical thinking, organizational and problem solving skills
- Demonstrated sound interpersonal, team development and conflict management skills
- Advanced knowledge and skill with regard to patient safety, change leadership, project management and evaluation an asset
- Sound knowledge of legislation pertaining to acute care in the community
- Fluent in Information technology and computer skills (Microsoft office and electronic patient record), experience with developing data bases
- Experience with telemedicine use an asset
- Excellent work and attendance record required
- All employees agree to work within the legislated practices of the Occupational Health and Safety Act of Ontario
- All employees are required to contribute to a transparent culture of patient and staff safety by adhering to, and abiding by, patient and staff policies and procedures set by South East Toronto Family Health Team

Thank you for your interest in the South East Toronto Family Health Team. Only those candidates selected will be contacted for an interview. No telephone inquiries, please. SETFHT supports Employment Equity initiatives and encourages individuals from diverse backgrounds to apply for this position.

Applicants should quote Job: Telemedicine IMPACT PLUS (TIP) RN Facilitator

Contact by: e-mail only

Job Contact Information
Human Resources
South East Toronto Family Health Team
e-mail: humanresources@setfht.on.ca

Please forward cover letter and resume by May 24, 2013.