Position Description
CDMPP Quality Improvement and Support Co-ordinator
Period: 2017/2018

Title:	CDMPP Quality Improvement and Support Co-ordinator	**Organisation:**	NSW Outback Division of General Practice
Responsible to:	Executive Manager of Clinical Services	**Directly Responsible for:**	Supporting enrolled general practices to implement the CDMPP including the Practice Nurse/AHW strategy and QI program to improve chronic disease prevention and management at the practice level.
Status:	Full Time	**Hours per fortnight:**	76
Organisation Tier	Tier 4		
Classification Definition:	Modern Nurses Award 2010		
Remuneration Package:	A salary based on an hourly rate of $40.00 to $48.00 per hour will be negotiated and will be in line with the Modern Nurses Award 2010. The total salary package includes the hourly rate, 9.5% superannuation, 17.5% leave loading and a salary packaging benefit up to the amount of $16,050 per annum.		

About our organisation

NSW Outback Division of General Practice (NSW ODGP) is a health service provider that works to improve the health of people living in Western New South Wales. The NSW ODGP manages a variety of health contracts focusing on early intervention and prevention of chronic diseases, chronic disease management, lifestyle modification and health promotion programs.

Our main priority is the development and delivery of effective primary health care services to some of the most-high need and disadvantaged communities of NSW. We work to capitalise on the underlying collective healthcare capacity of General Practice services and strengthen health partnerships with prominent Aboriginal Health Services, Local Health Districts and other health organisations in our region.

Taking in a relatively large geographical area of Western NSW, we lead the Commonwealth's commitment to delivering better access and improved health outcomes for our communities

Background and Purpose of the Role

The new 'Chronic Disease Management and Prevention Program (CDMPP)' is funded by the Western NSW Primary Health Network (WPHN) and managed by the NSW Outback Division of General Practice (ODGP). The focus of the new CDMPP is to provide services where there is no alternative funding or services available for chronic disease prevention and management.

The program targets people with two or more preventable lifestyle chronic diseases (or at high risk of developing) and includes conditions such as Diabetes, Cardiovascular Disease, Respiratory Disease, Renal Disease and some Cancers.

The CDMPP Quality Improvement and Support Co-ordinator is responsible for supporting enrolled general practices to implement the CDMPP including the Practice Nurse/AHW strategy and QI program. The position is based in Dubbo and will work with the CDMPP enrolled general practices and Aboriginal Community Controlled Health Organisations (ACCHOs) within the Central West.

Working Relationships:

- The position is employed by ODGP and works as part of the CDMPP support team.
- The team is made up of four positions, strategically located in Bourke, Dubbo and Broken Hill, with each position responsible for supporting a group of enrolled practices.
- The team and work is led by an ODGP Team Leader and comes together via teleconference and face to face meeting for the purpose of training, planning and performance monitoring.
- On a day to day basis the position is primarily responsible for working closely with enrolled practices to improve chronic disease prevention and management at the practice level.

Scope of Practice & Key Responsibilities

The scope of practice of a profession is distinct to the definition of a particular workforce. However, the basic definition of scope of practice is – an overarching "range of activities and tasks a health professional is educated, competent and authorised to perform." (Queensland Nursing Council, 2005). Each health professional and clinical staff member at NSW ODGP performs their role with a full understanding of their scope of practice to ensure competency, quality and safety in delivery of our services and in alignment with NSW ODGP Strategic plan.

Functions and Objectives of the Co-ordinator CDMPP Quality Improvement and Support include but are not limited to:

- Provide practical support and guidance to enable enrolled practices to implement the agreed CDMPP QI program.
- Provide support to enrolled practices to review QI data and agree on improvements going forward to promote understanding of the practice population.
- Engage with GP teams to embed the CDMPP model of care (targeting Diabetes and Cardiovascular Disease) within the enrolled general practices.
- Improve access within the enrolled general practices for people with chronic disease to evidence based, coordinated GP led multidisciplinary care

- Provide clear direction to implement systems and processes to embed the CDMPP model of care into the enrolled general practices, including identification of people with an undiagnosed chronic disease.
- Engage with GPs associated with clinical leadership within the enrolled general practices to embed a GP led multidisciplinary CDMP model of care within the general practice.
- Provide induction and ongoing support to CDMPP practice nurses to embed CDMPP processes within the enrolled general practices based on an agreed model of care.
- Provide training and ongoing support to CDMPP practice nurses to undertake data cleaning and maintain accurate data.
- Provide ongoing practical support to CDMPP practice nurses to develop and maintain Diabetes, Cardiac Heart Failure and other chronic disease registers.
- Demonstrate the CDMPP Model of Care risk stratification to assist the practice team to identify priority clients.
- Promote CDMPP eligibility amongst GPs and the practice team. This includes referral criteria and referral pathway.
- Provide training and ongoing support to the broader practice team to proactively manage the agreed Recall/Reminder system to improve scheduled care for chronic disease prevention and management.
- Where applicable, provide induction and direct support to the Aboriginal Health Worker/Practitioner in their role to support planned structured care for Aboriginal People with a chronic disease.
- Facilitate and participate in CDMPP network meetings with CDMPP practice staff (teleconference and face to face).
- Provide reports to the CDMPP Clinical Governance Subcommittee.
- Travel to attend CDMPP support team meetings as required.
- Travel to work with enrolled practices.

Core Competencies (all staff)

The core competencies expected of all NSW ODGP staff are:

1. Managing Change: The ability to demonstrate support for organisational changes needed to improve effectiveness; helping others to successfully manage organisational change.
2. Customer Orientation: demonstrating commitment to satisfying your external and/or internal customers.
3. Analytical thinking: identifying and seeking out information needed to clarify a situation, and to address problems by using a logical, systematic, sequential approach.
4. Verbal and Written Communication: expressing oneself clearly and appropriately in conversations and interactions with others and in business writing, including giving presentations and writing reports.
5. Teamwork: working cooperatively with others in a team.
6. Initiative: identifying what needs to be done and doing it before being asked or before the situation requires it.
7. Influencing others: gaining others' support for ideas, proposals, projects, and solutions.
8. Personal qualities including integrity, punctuality, reliability and a commitment to achieving results.

Selection Criteria:

Essential Criteria:

- Current nursing registration with the Australian Health Practitioner Regulation Agency (AHPRA).
- Current NSW Driver's Licence.
- Substantial post qualifying experience with a minimum of two years' experience working a general practice setting.
- Demonstrated experience in enabling effective coordinated care for patients with a chronic disease including using systems for data cleaning, risk stratification, disease coding, chronic disease registers, recalls/reminders and referrals to the multidisciplinary team.
- Demonstrated commitment to enabling and driving quality improvement (QI).
- Demonstrated ability to be flexible, respond to changing work priorities and self-manage personal professional development and workloads.
- Demonstrated ability to collaborate with and advise, support and direct other health professionals in providing chronic disease management.
- Demonstrate literacy in computers and medical software and proven extensive experience using practice data extraction and analysis tools such as PENCAT.
- Overall comprehensive knowledge of Medicare Benefits Scheme (MBS) items, including experience in the provision of Enhanced Primary Care (EPC) programs, GP Management Plans (GPMPs), Team Care Arrangements (TCAs) for multidisciplinary care of patients with complex needs and completing an "annual cycle of care" for patients with Diabetes.

Desirable Criteria:

- Post graduate qualification in a General Practice Nursing.
- Membership with the Australian Primary Health Care Nurse Association (ANPA).

Key Performance Indicators

- General Practice teams are engaged to embed a Chronic Disease Management model of care for Diabetes, Cardiac Heart Failure and other chronic diseases within the enrolled practices.
- Each enrolled Practice receives clear direction on how to implement systems and processes to embed a CDMP Model of care for Diabetes, Cardiac Heart Failure and other chronic disease into the practice
- 100% of Enrolled General Practices have Chronic Disease Registers in place for Diabetes, CHD and other chronic diseases
- GPs are engaged to provide clinical leadership for chronic disease management within the enrolled general practices.
- Ongoing support is provided to practice nurses to embed chronic disease management processes within the enrolled general practices based on an agreed CDMPP model of care.
- Ongoing practical support is provided to the CDMPP practice nurse to implement the agreed QI program.

- Ongoing practical support is provided to the CDMPP practice nurse to develop and maintain chronic disease registers and recall systems.
- Support is provided to enrolled practices to review QI data and agree on improvements going forward
- Participation in CDMPP Chronic Disease Support team meetings

(To be finalised in discussion with the position holder on commencement of role)

It is expected that this position description will change over time due to the nature of NSW ODGP activities and various program and compliance requirements.

Additional Information

Conditions of employment:	**National Employment Standards and relevant Modern Award** **Employment Contract** **NSWODGP policies and procedures**
Reports to:	Manager of Clinical Services

As the incumbent of this position, I confirm I have read the Position Description, understand its content and agree to work in accordance with the requirements of the position.

Employee Name: _____

Employee Signature _____ Date: _____

Manager's Name: _____

Manager's Signature _____ Date: _____