Alzheimer Society of Niagara Region (ASNR)

Mission, Vision and Values

The Alzheimer Society of Niagara Region's mission is to advocate for and with people with dementia and their care partners and provide access to a diverse range of appropriate resources and supports. Particularly, to alleviate the personal and social consequences of Alzheimer's disease and other dementias and to promote research.

Our vision is to create a community where individuals with dementia and their care partners are fully supported to maximize their quality of life and well- being. Ultimately, a world without Alzheimer's disease and other dementias.

Our Values

Collaboration**, A**ccountability**, R**espect**, E**xcellence

The Alzheimer Society of Niagara Region (ASNR) is a community support service organization that provides programs and services to people living with dementia and their care partners in the Niagara Region. We work closely with other service providers to ensure quality care and support for our clients.

We employ administrative and fund development staff, educators, social workers, nurses, therapeutic rec staff, personal support workers and volunteers who work together as a team to meet the needs of people living with dementia and their care partners.

We recognize the value and dignity of each individual and ensure everyone has genuine, open, and unhindered access to employment opportunities, free from any barriers, systemic or otherwise. We are dedicated to building a diverse and inclusive work environment, where the rights of all individuals and groups are protected and all members feel safe, respected, empowered, and valued for their contributions.

We value **justice** and **connection** and these are the guideposts we use for decision-making of all kinds. We believe that this will guide the organization toward a place of inclusion for all - where equity and access to essential supports and services becomes the reality

The First Link Care Navigator (FLN) will coordinate and integrate supports and services around the person living with dementia and their care partner who are referred to ASNR and not receiving services from the Family Support or Intensive Programs. 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 ASNR programs, other providers and across sectors along the continuum of care. The First Link Care Navigator will work collaboratively with the First Link Coordinator to ensure that people 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

Position Description

Title: First Link Care Navigator
Reporting To: Director of Education, Community Engagement and Quality
Salary: $56,000 - $62,000 – One-Year Renewable Contract
Hours of Work: 40 hours- Monday –Friday (includes .5 hour paid lunch break per day)
Some Evening and Weekend work may be required
Benefits: Extended health and dental benefits, RRSP matching program
Vacation: 3 Weeks paid vacation (Pro-rated to calendar year)

Duties and Responsibilities

Assessment and Care Planning:

- Pro-actively oversee incoming FLN 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
- Triage and coordinate FLN intake referrals based on level of risk, link clients to appropriate education, support services and resources and assign if necessary to family support counselling department.
- As required, 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 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 linkages, communication, information exchange and coordination between clients and service providers along the continuum of care
- Facilitate care conferences between clients/care partners and members of client/care partner care team, as necessary.
- 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, memory clinics, 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 MINT primary care based Memory Clinics as requested
- Participate in internal/external committees on an ad hoc basis

Pro-active Follow-Up:

- Monitor and provide proactive follow-up for clients that have not directly been assigned a Counsellor 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 people living with dementia 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:

- In collaboration with the First Link Coordinator, 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

Other Duties

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

Qualifications

- Regulated Healthcare Professional with current registration with a relevant college

- Minimum Bachelor degree in social work, gerontology or related health science discipline.
- Minimum of three years full-time experience working directly with people living with dementia and their caregivers
- Knowledge of available community services/supports and clinical, social and residential care options
- Police Vulnerable Sector Check
- Must have a valid driver's license and access to a reliable vehicle
- As ASNR clients include the most vulnerable persons, it is strongly recommended that all staff be immunized to help prevent the transmission of infections.

Other Skills and Experience:

- Experience and knowledge in the management of chronic and complex health conditions
- 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 (e.g.: P.I.E.C.E.S. and U-First!)
- Experience in assessment and care planning/coordination
- Experience working in settings requiring inter-professional collaboration
- Excellent verbal and written communication skills
- 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
- Commitment to continuing professional development
- Ability to speak French or other languages an asset

Physical Demands and Working Environment:

- No special physical demands are required beyond the performance of general office duties.
- Everyday risks or discomforts may require safety precautions typical of an office environment, i.e. use of safe work practices with office equipment, proper ergonomics, etc.
- Extended periods of visual concentration; extended periods of sitting in a stationary position.
- Equipment is utilized which is common to the office work environment (i.e. computer, printer, photocopier, multi-line telephone, fax machine, etc).

- Required presentations and consults outside the office can vary in environment settings to include but not limited to residential homes; long term care facilities; community organizations and hospitals
- We adhere to a scent free environment.

Commitment to Equity, Diversity, and Inclusion

The Alzheimer Society Niagara Region welcomes those who have demonstrated a commitment to upholding the values of equity and social justice and we encourage applications from First Nations, Inuit and Métis, Indigenous Peoples of North America, Black and persons of colour, persons with disabilities, people living with dementia, care partners and those who identify as LGBTQ2S+.

Commitment to Accessibility

In accordance with the Accessibility for Ontarians with Disabilities Act, 2005 and the Ontario Human Rights Code, The Alzheimer Society Niagara Region will provide accommodations through the recruitment process to applicants with disabilities. If selected to participate in the recruitment and selection process, please inform the Hiring Manager of the nature of any accommodation(s) that you may require in respect of any materials or processes used to ensure your equal participation.