Job Description

Keeping Well and Independent Program (KWIP) Care Coordinator

The Keeping Well and Independent Program is a quality improvement program designed for GPs to engage with patients that are older than 75 years old in the Northern Sydney Region. The goal of this program is to provide a framework for preventative and proactive care for patients who are at risk of ED presentations or unplanned admissions.

Job Title: KWIP Care Coordinator

Summary of Position:

This Practice Care Coordination is available to practices registered in the Keeping Well and Independent Program. The role supports the implementation of the Keeping Well and Independent Program by working in collaboration with the GP, their practice staff and patients. This will be achieved by:

- Being co-located at GP practices.
- Assisting GP practice staff to identify, enroll and manage patients at risk of an unplanned hospital admission.
- Connecting enrolled patients to relevant community and acute services and ensuring timely follow up post referral.
- Promoting timely access to patients that require urgent appointments
- Promoting the NSLHD's Geriatric Rapid Response Service and Geriatrician Outreach to GP service and other services if patients are experiencing acute decline.
- Promoting the use of care plans among GPs for medium to high-risk patients.

Essential Duties and Responsibilities:

- Work with the SNHN to troubleshoot where a practice is not receiving hospital letters or discharge summaries from public hospitals in Northern Sydney.
- Support the GP with patient risk stratification to identify high risk patients. This will include the use of risk scores calculated by the Ministry of Health's Risk of Hospitalisation (RoH) algorithm, Primary Sense's John Hopkins algorithm and any frail scale assessments the practice uses.
- Work with the GP to call the patient into the practice for their appointment and enroll identified high risk patients into the Keeping Well and Independent Program. The enrolment process entails:
    - Calling identified patients and asking them to attend the practice for a GP consultation
    - At the consultation discuss the program with the patient
    - If patient agrees to participate, the patient provides consent through a Patient Consent Form
    - Complete a quality-of-life survey, called the EQ-5D-5L as well as Frail Scale assessment with the patient.
    - Complete any suggested next steps or referrals from the frail scale assessment.

- Facilitate access to appropriate local health and social care services, both preventative and acute.
- Ensure all enrolled patients are contacted within five business days post hospital discharge.
- Work with the GP to determine key priorities for enrolled patients, such as; tracking test results, follow up on patient appointments and any documents required, implement steps to improve frail score.
- Undertake home visits to patients that are enrolled in the Program as required and appropriate.
- Facilitate multidisciplinary case conferencing opportunities between the GP, Geriatrician, and an appropriate additional external support person/service representative, where possible and needed for patients that are medium- very high risk and enrolled in the program.
- Serve as a point of contact, advocate and care navigation resource for patients, carers, care team, SNHN and NSLHD.
- Carry out the EQ-5D-5L and Frailty Screening survey with enrolled patient at enrollment and at the 12 months point after patient enrolment.
- Participate in quarterly support meetings with the Keeping Well and Independent Program Coordinator or SNHN Coordinator.
- Health coaching and education for patients.

Knowledge/ Skills and Abilities:

- Knowledge of primary, community and hospital avoidance services.
- Core values consistent with a patient-and family-centered approach to care.
- Demonstrates professional, appropriate, effective, and tactful communication skills, including written, verbal and nonverbal.
- Demonstrates a positive attitude and respectful, professional customer service.
- Acknowledges patient's rights on confidentiality issues, maintains patient confidentiality at all times, and follows HIPAA guidelines and regulations.
- Proactively continues to educate self on providing quality care and improving professional skills.
- Proficiency in communication technologies (email, cell phone, etc.).
- Highly organised with ability to keep accurate notes and records.
- Experience with health IT systems and reports.

Qualifications:

- Qualified Registered Nurse.
- Experience with navigation of local health and social support systems.
- Experience in clinical or community resource settings; care coordination and/or case management experience is desirable.
- Experience of working with older people or aged care clients and networks is desirable.

Further Information

Primary Sense:

Primary Sense extracts de-identified general practice data and uses evidence-based algorithms to provide GPs with real time medication alerts, reports and patient care prompts. It also provides general practices and Primary Health Networks (PHNs) with on-demand reporting to help with population health management.

Primary Sense run John Hopkins Risk of Hospitalisation Score:

The complexity levels of patients in Primary Sense reports are calculated with the Adjusted Clinical Groups (ACG)® Johns Hopkins tool. The ACG tool is underpinned by a robust evidence base of >30 years of practical application. The tool is used in 20 countries and has been validated in different healthcare settings, including general practice. It presents GPs with a score or likelihood of their patients presenting to hospital or at risk of hospital.

Risk of Hospitalisation algorithm ((ROH):

Risk of Hospitalisation (ROH) algorithm presents a meaningful prediction of a patient's unplanned hospitalisation in the next 12 months in the form of a numerical value. It is based on an extensive list of demographic and socioeconomic factors as well as hospitalisation and medical history. The score assists GPs to understand the likelihood of their patients risk in presenting to hospital to help inform or priorities care.