national AGED CARE alliance

National Aged Care Alliance

Continuum of Care Working Party Discussion Paper

The Health Care Coordinator (Residential Aged Care) in the Continuum of Care

3 July 2003

Introduction

This discussion paper follows on from the Alliance Issues Paper No. 1: "The Aged Care Health Care Interface", in which the establishment of the role of a dedicated Health Care Coordinator (Residential Aged Care) was first put forward and a broad framework of relationships described for a regionally based health service for older people (see figure 3 p.5).

This Discussion Paper aims to conceptualise and operationalise the Health Care Coordinator (RAC) role in the evolving continuum of care. Details of the professional objectives, skills and responsibilities of the Health Care Coordinator (RAC) are described in the accompanying Position Description.

Australian Health Care Agreements

Since the development of the Alliance Issues Paper, the Australian Health Care Agreements (AHCA) Reference Group has reported on the Interface Between Aged and Acute Care (November 2002). The report recommended (page 68) inter-alia, that there should be an AHCA Schedule to:

> "Introduce a common assessment process to be used regardless of where care is being provided" and "Sponsor the introduction of Australian Care Pathways to guide the care of older people across the acute/aged interface".

The Reference Group report did not define "Australian Care Pathways". The term implies the development of contemporary guidelines for the health care of older people that would be applicable across acute, residential, and community settings. There is no uniform definition of "care pathways" and the Alliance considers that the term "care pathways and guidelines" is a more useful and inclusive description.

Development and implementation of these initiatives

The recommendations by the AHCA Reference Group indicate that governments would sponsor the development and implementation of these initiatives. Such sponsorship would be needed for:

- an appropriately constituted expert writing group, supported by collaboration among professional and academic bodies, and
- the enabling of an integrative information technology and management system.

Subjects and conditions to be covered by the care pathways and guidelines

The Reference Group report also failed to specify the subjects and conditions to be covered by the care pathways and guidelines, but the following common issues would be appropriate priority topics and targets for the care pathways and guidelines across acute, residential and community aged care settings:

- non-acute, restorative care, and rehabilitation, including "interim" and "transitional" care (these terms will need agreed definitions),
- palliative care,
- advance care directives,
- hospital discharge planning,
- after hours primary medical care,
- intravenous and subcutaneous infusions,
- altered mental states (including behavioural symptoms),
- falls and fracture prevention,
- pain management,
- continence management, and
- wound management.

Core organisational structure for a health service for older people

This paper describes a core organisational structure for a health service for older people. It is a structure that:

- would constitute a platform for effective delivery of common assessment and care pathways and guidelines at the regional level,
- is based largely on the augmentation of, and collaboration between, health and aged care structures that are already in place in each region, and
- would obviate any need for a new bureaucracy or the establishment of any new service entities.

Existing organisations and their roles

Existing organisations and their roles in the implementation of care pathways and guidelines for older people are outlined as follows:

Acute Hospital-Based Health Service

- Integration of care pathways and guidelines with relevant inpatient and ambulatory services.
- IT support and expertise.
- Health records development and management.
- University and professional affiliations – medical, nursing, allied health.
- Utilisation of established communication networks for information management and dissemination.

Regional Division of General Practice

- Organisation of the relationship of general medical practitioners with residential aged care (and hospital) services within the region. GP participation (and leadership when appropriate) in the systematic implementation of care pathways and guidelines in all residential and community settings.
- Inter-relationship of the Enhanced Primary Care initiatives with the care pathways and guidelines for older people.
- The function of the Divisions in care pathway and guideline implementation in aged care homes could be through the establishment of the role of one or more salaried or sessional GP aged care advisors in each Division.

Regional Geriatric Service and Specialist Ambulatory Clinics

- Multidisciplinary, medical, allied health and nursing specialist expertise and education to support the care pathways and guidelines.
- An additional operational clinical specialist function across the interface could be developed in the role of gerontic specialist nurses supported within the regional geriatric service.

Residential Aged Care Services

- A dedicated and trained Health Care Coordinator (RAC) in each aged care home.
- The internal and external functions of the Health Care Coordinator (RAC), in support of the care pathways and guidelines, are outlined in the accompanying position description.

Community Aged Care Services

- Integration of links with the community based care providers including community nursing, other community services and consumer organisations.

Prevention of health breakdown in residential aged care

Health care related activities in residential aged care services are currently dominated by RCS management and accreditation imperatives, rather than integrated outcome focused health pathways. Prevention of health breakdown in residential care and consequent inappropriate (and often undesired) hospital admissions from residential care will produce financial efficiencies as well as better outcomes for older people.

Care in the right place at the right time

Older people will be far more likely to be cared for in the right place at the right time once there is adequate interim care provision and care pathways and guidelines are in place for advance care directives and palliative care. Waiting times for transfer out of the acute hospital will be reduced, and older people with terminal illness, according to their expressed wishes, will not spend their last days in inappropriately intrusive health care environments, or be caught up in disruptive, inappropriate or futile transfers between care settings.

Preconditions for implementation are in place

There is broad stakeholder consensus about the desirability of a care pathway and guideline based approach to underpin the continuum of care for older people. The professional expertise to write the care pathways and guidelines for the continuum of care for older people is readily available. The organisational infrastructure for their implementation and ongoing coordination appears relatively straightforward.

Where to from here?

Given that all of these elements are now in place, the onus is on Australia's health and aged care ministers to take this matter forward expeditiously.

Position Description
Health Care Coordinator (Residential Aged Care)

Reporting to:

Conditions of Employment:

Position Objectives

To coordinate health service organisation and provision in the residential aged care facility by:

- Ensuring the productive interaction of stakeholders and health services providers both within the aged care facility and across the continuum of care, thereby enriching the options for older people.
- Facilitating productive and effective health interventions and outcome-directed health care within the aged care facility and across the interface between residential aged care, acute care, and care in the community.

Skills and Experience

- A full understanding of the process of ageing and the continuum of care.
- Experience in caring for older people and the commensurate disabilities associated with ageing.
- Demonstrated experience in caring for older people in a residential aged care environment.
- Proven skills in inter-agency coordination.
- Ability to develop and implement processes and work practices.
- Demonstrated ability in interpretation, assessment and advice relating to the care management of older people.
- Highly developed written and verbal skills.
- Ability to motivate and support others.

Selection Criteria

- Post-graduate qualification in Gerontology or working towards.
- Extensive specialist experience in caring for older people with demonstrated ability in the assessment of their clinical care needs.
- Experience in working with and liaising with a multi disciplinary team.
- An understanding of the complex matrix of aged care provision across all disciplines, institutions and specialty services.
- Ability to manage time and set priorities to achieve a broad range of outcomes within defined parameters and with minimal direction.
- Demonstrated ability to develop implement and evaluate processes and services.

Key Responsibility Areas

1. Enhancement of primary care.
2. Multidisciplinary clinical practice guidelines.
3. Acute after hours response procedures.
4. Advance care directives.
5. Health information/data management.
6. Health education, training and research.
7. Triage for regional services.

Responsibilities

1. Enhancement of Primary Care

- To implement and oversee the integration of care pathways and guidelines within residential aged care, maintaining strong links with the community and acute care providers.
- Work closely with General Practitioners to link the Enhanced Primary Care initiative with agreed care pathways and multidisciplinary practice guidelines.
- Provide ongoing support to clinicians and care providers so that care pathways and guidelines continue to be used properly.
- Develop and ensure maintenance of a review process that continues to target client needs accurately within available resources.
- Provide assessment and identification of client needs.
- Facilitate liaison between health care providers.

2. Multidisciplinary Clinical Practice Guidelines

- Develop and promote multidisciplinary practice guidelines in conjunction with medical, allied health and nursing colleagues.
- Direct client care and intervention through utilisation of the care pathways and guidelines to enable prompt, appropriate and effective health outcomes.

3. Acute After Hours Response Procedures

- Develop and implement inter-agency protocols that facilitate efficient, outcome focused responses.

4. Advance Care Directives

- Develop and implement inter-agency protocols that facilitate the introduction and transfer of advance directives across all care agencies.

5. Health Information/Data Management

- Maintain appropriate records including advanced directive records.
- Administer a system where the needs of all clients are determined and recorded within identified procedures and timeframes as per care pathways and guidelines.
- Develop and maintain inter-agency protocols that ensure passage of information across all care agencies and providers.
- Maintain and regularly update relevant statistical data for planning and reporting purposes.

6. Health Education, Training and Research

- Identify employee training needs and arrange education and support.
- Develop and disseminate education and information packages for carers and families.
- Implement research activities.

7. Triage for Regional Services

- Cooperate with other Health Care Coordinators (RAC) to form a functional network for resource management, information sharing and coordination of activities.

- Along with other health care coordinators, establish formal relationships with:
  - divisions of general practice,
  - hospitals,
  - community health centres,
  - geriatric services,
  - psychogeriatric services,
  - palliative care services,
  - pharmacy services,
  - community nursing services,
  - allied health providers,
  - consumer groups, and
  - other clinical community services.