Function Statement - Internal

Allied Health
Complex Care Coordinator

The Statement of Duties associated with this role is generic and is used for all Allied Health Complex Care Coordinator positions at HPO4 level vacancies in Hospitals & Primary Care North. The purpose of this Function Statement is to give more detail about the particular requirements of this role.

Please refer to the Statement of Duties for any Essential Requirements associated with the role.

Title	Allied Health Complex Care Coordinator- generic
Business Unit	Hospitals & Primary Care - North, Allied Health
Location	Launceston General Hospital
Business Unit Description	The Allied Health Complex Care Coordination (CCC) team is an integral, highly valued team of multi-disciplinary allied health professionals, applying a collaborative transdisciplinary approach to achieve innovative solutions to complex issues surrounding patients. Everyone has a different definition of complexity, but for our team, complexity is very much about *exceptional* circumstances that are above and beyond usual practice for the health care teams working directly with the patient. This means that multi-medical or psycho-social presentations are not routinely considered complex by CCC. Often our patients will have no clear hospital care pathways or sustainable discharge options back into the community, and many systems and services are involved that can lead to fragmentation of care and poor patient experience. The CCC team works with the patient, their supports, and the healthcare team to identify and coordinate care pathways, support patient flow, resolve barriers to discharge, avoid re-presentation to hospitals, reduce the burden of system navigation on health care teams, and promote partnerships with patients and successful working relationships with the healthcare team. **Client population:** inpatients aged over 18 in H&PC-N facilities.

	Governance: The Allied Health Leadership Committee (AHLC) have determined that CCCs will have dual reporting lines: 1. Service Manager - Full duties and scope of the position - Clinical services planning and quality improvement - Escalation processes - Operational supervision - Data analysis and reports - CPD requests related to the position scope 2. Professional Manager - Mandatory requirements, registration, accreditations - ABC stats - Profession specific orientation and commitments - Professional supervision - Employment documentation, including timesheets & leave forms - Funding for CPD The Service Manager and Professional Manager will carry joint responsibility for: - Planned leave - Vacancy cover - PDAs - Performance management - Reporting to AHLC
Specific Duties/Responsibilities	The incumbent will operate within the scope of the CCC role and within the AH representative framework, as differentiated from professional specific / background scope, to: *Oversee case management/service coordination for individual Patients/Clients:* • who are likely to have a lengthy hospital stay due to undefined discharge pathway including post discharge housing • who have complex psycho-social barriers impacting on planning and discharge • who are potential and/or current NDIS participants with high unmet needs

	• who display behaviours which impact on ability to access required care post discharge • who the team are unable to achieve mutual goals and discharge plans with the client and/or their Family, requiring a 'buffer' between clinicians and pathway facilitator • other complex issues impacting on length of stay, risk of readmission, patient care/safety *Coordinate the multi-disciplinary team for patients/clients with complexity to:* • identify appropriate service pathways • coordinate NDIS and other applications, including liaison, negotiation and advocacy with external agencies to provide best service to meet client needs • provide direction for team on information required and timelines to support discharge; support and assist team for issues with client/family/changes of plan for complex clients as relevant • facilitate and attending family meetings of identified complex clients when and where relevant • plan appropriate pathways and resources required to ensure discharge is sustainable **Professional Development:** • provide formal and informal MDT coaching and education and capacity building for understanding and applying processes and pathways for patients with complex needs to develop sustainable knowledge and skills • identify and address own knowledge and skill gaps in NDIS, housing, behavioural/ cognition/ psychosocial processes and pathways, including communication strategies with individuals and stakeholders. • identify and address own knowledge and skill gaps in Acute Services, Rehabilitation and Multi-disciplinary services, and community networks **Systems, Data and Analysis:** • prepare high level documentation or reports for escalation of issues

	• develop/refine systems & processes for appropriate planning for complex patients/clients • analyse trends, use data to make service development recommendations • liaise with Discipline Leads for other data sources such as ABC, HEART, AUSCAR and other service benchmarking data • implement measurements for the CCC service- patient experience/ patient outcomes/ service outcomes in collaboration with AHLC • analyse and evaluate CCC outcomes to ensure service and client needs are met including individual plans and longer- term outcomes. • make recommendations, develop and implement agreed service changes & pathways and follow up post discharge outcomes with the aim of establishing sustainable systems, processes and learning to support continuous quality process. • identify complex care issues or professional issues arising in care which need to be escalated to Supervisor, Clinical and Professional Leads • work and integrate with senior leadership groups within Allied Health, Nursing & Medicine • maintain routine ABC statistics for all client (IPA) activity, including NDIS intervention codes • maintain routine records of operational processes including measures of complexity, capacity and interventions consistent with other CCCs
Preferred Experience	• Extensive hospital experience at senior practitioner level working in multi-disciplinary roles and holistic patient centred care and management • Experience working with NDIS services and systems
Preferred Skills & Knowledge	• High level clinical reasoning for complex unique clients • Ability to work with ambiguity and uncertainty in client pathways to navigate, direct and drive optimal outcomes • Practical knowledge of multi-disciplinary roles and responsibilities in order to lead, promote and drive collaborative practice around complex patient caseload

	• Detailed knowledge of NDIS and other service systems including Aged Care, Compensable Third party, equipment schemes, Housing, Mental Health • Flexible innovative adaptable problem solving and planning • Ability to develop strong relationships and networking across internal and external services, care providers and other external providers • Ability to work within tight /set timeframes to provide efficient service; ability to prioritise and manage busy fluctuating workload; recognising and ensuring patient and family's needs are met in a balanced way; responsive and timely actions to progress patient care • Knowledge of contemporary models of care and adapting to local context and resourcing • Ability to develop strong relationships and networking across internal and external services, tailoring communication to target audience
Other Notes	•