

North East Primary Care Partnership READINESS CHECKLIST FOR INTERAGENCY CARE PLANNING

21 July 2011

This checklist assumes that agencies have policies, procedures and practices in place for assessment and individual care plans that meet Service Coordination best practice principles.

| Key Element | Comment |
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Determine the need for Care Coordination Plan

Best practice would mean that your agency has a clear and documented process that ensures:

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| Consumers who would benefit from a Care Coordination Plan are Identified at any stage of the care continuum (consumers with complex care needs, needing or receiving multiple forms of assistance and would benefit from a coordinated approach to care arrangements) | |
| The existence of other care plans, treatment plans, team care arrangements, are noted | |
| Consumers can initiate the process to obtain a care coordination plan | |
| Staff understand and are able to take on the role of Practitioner Initiator | |

Obtain Consumer Agreement / Consent & Identify Participants

Best practice would mean that your agency has a clear and documented process that ensures:

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| The need and processes of a Care Coordination Plan are discussed and agreed to by the consumer (written information about Interagency Care Planning may assist here) | |
| The consent process relating to a Care Coordination Plan is explained to the consumer and outcome of consent discussion, whether consent is given or if it is refused is recorded | |
| Practitioners can undertake Practitioner Initiator role that will involve Identifying and inviting the services to participate in the development of the Care Coordination Plan | |
| Practitioners can respond to a request to participate in the development of a Care Coordination Plan initiated from another agency | |

| Key Element | Comment |
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Developing the Care Coordination Plan

Best practice would mean the agency has:

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| Guidelines for practitioner initiator in organizing a case conference (face to face, by telephone or written exchange of information) | |
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| An agreed template for use to develop the Care Coordination Plan | |
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| Guidelines for how agency individual treatment plans will articulate with the Care Coordination Plan | |
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Selection of Care Plan Coordinator

Best practice would mean the agency has a clear and documented process to ensure:

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| Both the service providers and consumer and/or carer are involved with the nomination of a Care Plan Coordinator (see additional considerations for nomination in Protocol) | |
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| Staff are able to agree to a Care Plan Coordinator role if nominated at the case conference | |
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| There is a position description and a recognised time allocation to undertake the Care Plan Coordinator role | |
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Document and distribute Care Coordination Plan

Best practice would mean the agency has a clear and documented process to ensure:

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| The Care Coordination Plan Is documented and distributed to all participants within 5 working days of the case conference. | |
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| The Care Coordination Plan is placed prominently on the relevant consumer record or database within 2 working days of receipt | |
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Monitoring, updating and formally reviewing the Care Coordination Plan

Best practice would mean the agency has a clear and documented process to ensure:

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| Staff monitor their particular agreed goals and actions as specified in the Care Coordination Plan | |
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| Staff notify the Care Plan Coordinator if they become aware of any relevant changes in the consumer’s situation, or changes in their own contact details | |
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| The Care Plan Coordinator notifies all other parties if they become aware of any relevant changes in the consumer’s situation, or changes in participant details that require modifications to the plan | |
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| The Care Plan Coordinator undertakes a review at no less than 6 month intervals or an earlier review within 2 to 4 weeks of a request by any of the participants including the consumer or carer | |
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Additional Considerations

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| Are all professionals competent to undertake care planning? For example skills in effective communication, developing consumer directed goals, motivational interviewing and discussion of risk. | |
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