NEPCP Partnership For Healthy Communities

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
Determine the need for Care Coordination Plan Best practice would mean that your agency has a clear and documented process that ensures:	
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:	
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
Developing the Care Coordination Plan Best practice would mean the agency has:	
Guidelines for practitioner initiator in organizing a case conference (face to face, by telephone or written exchange of information)	
An agreed template for use to develop the Care Coordination Plan	
Guidelines for how agency individual treatment plans will articulate with the Care Coordination Plan	
Selection of Care Plan Coordinator Best practice would mean the agency has a clear and documented process to ensure:	
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)	
Staff are able to agree to a Care Plan Coordinator role if nominated at the case conference	
There is a position description and a recognised time allocation to undertake the Care Plan Coordinator role	
Document and distribute Care Coordination Plan Best practice would mean the agency has a clear and documented process to ensure:	
The Care Coordination Plan Is documented and distributed to all participants within 5 working days of the case conference.	
The Care Coordination Plan is placed prominently on the relevant consumer record or database within 2 working days of receipt	
Monitoring, updating and formally reviewing the Care Coordination Plan Best practice would mean the agency has a clear and documented process to ensure:	
Staff monitor their particular agreed goals and actions as specified in the Care Coordination Plan	
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	
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	
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	
Additional Considerations	
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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