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| Care Plan Coordination |
| A guide for service providers on the Multiple and Complex Needs Initiative |
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| Care Plan Coordination  A guide for service providers on the Multiple and Complex Needs Initiative |
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# What is the Multiple and Complex Needs Initiative?

The Multiple and Complex Needs Initiative (MACNI) is a time-limited service response for people 16 years and older with multiple and complex needs.

People will have a combination of mental illness, substance use, intellectual impairment, and acquired brain injury, and will benefit from a coordinated service response to meet their needs and goals.

MACNI is funded by the Department of Families Fairness and Housing, the Department of Justice and Community Safety, and the Director of Housing.

MACNI involves the partnership of the two departments and numerous service providers who provide both specialist and generic services to clients, such as:

* Aboriginal community-controlled organisations
* mental health services
* housing services
* justice and correctional services
* drug and alcohol services
* disability and health services.

Focusing on a more effective and coordinated approach to support, MACNI aims to:

* stabilise housing, health, social connection and safety issues
* pursue planned and consistent therapeutic goals for each individual
* provide a platform for long-term engagement in the service system.

Participation in MACNI is voluntary. A person can decide to discontinue MACNI services at any time during the process.

## Key elements of MACNI

* *Human Services (Complex Needs) Act 2009*
* Information, consultation and referral
* Care plan development and coordination
* *Service provision framework: Complex needs*
* The Complex Needs team.

# The legislation

MACNI is underpinned by the *Human Services (Complex Needs) Act 2009*. This Act establishes the authority for a collaborative and coordinated approach to planning service delivery for people with multiple and complex needs.

# What is a MACNI care plan?

A Complex Needs Panel considers referrals received by the departmental Complex Needs Coordinator and determines if the person is eligible to receive services under MACNI. The eligibility criteria is detailed at Appendix 1.

If the person is determined as eligible, a care plan must be developed.

The care plan provides a coordinated response to the identified needs of the person aimed at promoting stabilisation in housing, health and wellbeing, safety and social connectedness.

The care plan outlines a plan of action aimed at responding to the specific needs of the person, as identified through strengths-based needs analysis, including the promotion of cultural identity and connectedness.

The plan specifies the care, treatment and support strategies recommended for the person, taking into account their best interests. A care plan must specify its duration (of not more than 12 months). After the first 12 months, a care plan can be extended, with a limit of 36 months in total.

The care plan is the primary tool used by a care plan coordinator to coordinate the care team and monitor the progress of the person’s goals.

## Care plan development

A MACNI care plan is developed after a person has been determined eligible by an Area Director, following endorsement from a Complex Needs Panel.

The care plan is developed in partnership with a range of service providers, the person, family members and significant others. The *Human Services (Complex Needs) Act 2009* permits services to release information related to an eligible person’s personal or health information, if it is in the best interests of that person.

Consideration is given by the Complex Needs Panel as to the person’s specific needs and any assessments required to assist with the development of a draft care plan. A care plan developer is approved by the Area Director to develop a care plan for consideration by the panel. Determining who is responsible for the development of a care plan is dependent on consultations and negotiations with local service providers about their capability and expertise in developing a care plan.

Following the development of the care plan, the Complex Needs Panel endorses the plan and recommends a care plan coordinator to ensure the effective implementation of the care plan by the services identified in the plan. The Area Director provides formal approval.

A copy of the care plan is provided to the person and the services identified in the care plan.

Client-attached brokerage funding is available for the purchase of supports and services identified in a care plan. Refer to Appendix 2 for more information.

# Care plan coordination

Care plan coordination is a critical component of MACNI.

The appointment of a care plan coordinator aims to address existing concerns that service responses to people with multiple and complex needs are often crisis-driven, unplanned and uncoordinated. The specific focus of the coordination role is on improving cross-sector coordination, planning and collaboration for the multiple and complex needs target group.

## The role of the care plan coordinator

The care plan developer may recommend to the Complex Needs Panel which service provider is best placed to provide care plan coordination. The Complex Needs Panel will consider and recommend to the department the appointment of a care plan coordinator, which is then approved by the Area Director.

The role of the care plan coordinator is defined in Section 16 of the *Human Services (Complex Needs) Act 2009* and is detailed in Appendix 3.

The care plan coordinator is a key point of contact for the department and other service providers throughout the life of the care plan.

The primary role of the care plan coordinator is to coordinate the group of service providers identified in the care plan – the `care team’. In contrast, these service providers provide the direct care and support to the person. The coordination of services requires particular skill and effort by the care plan coordinator to ensure established goals stay in focus and progress is monitored.

The care plan coordinator plays a crucial role in monitoring the progress of the care plan and directing service providers to best meet the changing needs of the person. The care plan coordinator negotiates with nominated service providers in the care plan to effectively provide the services, conduct the activities and fulfil their respective roles and responsibilities. To do this, the care plan coordinator must have knowledge about the person’s experience of the care plan and whether it continues to meet their needs.

The role of the care plan coordinator is not the same as a case manager. In the delivery of MACNI over the last 14 years, experience indicates that care plan coordination is most effective when it is detached from the direct work with the person. This allows the care plan coordinator to maintain an independent overview of the progress of the care plan, enabling critical analysis. The purpose of this approach is to enable the coordinator to develop a meta-perspective of the care plan and the service providers engaged. This can be achieved by nominating:

* an experienced and influential senior person from a service as the care plan coordinator when that service is also providing direct care to the person, or
* the care plan coordinator from an agency that has no direct care of the person.

## Three critical role functions

1. **Steering the direction of the care plan with a future-oriented approach**

The care plan coordinator has a strong leadership role throughout the life of the MACNI care plan. Significant strategic and negotiation skills are required to actively direct the work of service providers, to ensure the sharing of information, enable reflection, joint problem-solving, risk-sharing and agreement on the care plan direction and appropriate strategies. A future-oriented approach that aims to pre-empt situations and establish contingencies is required. It is important that care plan coordinators have the skills to establish themselves as the central point of contact and facilitate effective communication.

1. **Coordinating the services provided in accordance with the care plan**

Care plan coordination requires a responsive, flexible and creative response to working with service providers. A solution-focused framework that embraces respectful negotiation practices, a partnership approach and forward planning is an important component of this approach. There are times when, despite positive attempts, the service provider is unable to adequately meet the needs of the person. The challenge for the care plan coordinator in these circumstances is to be alert to these issues, negotiate a new direction and engage a new provider (where appropriate).

1. **Monitoring and reporting to the department on the care plan’s progress**

The department has the task of approving and reviewing care plans. Therefore, a good relationship between the care plan coordinator and the Complex Needs Coordinator facilitates open communication and collaboration. Complex Needs panels require care plan coordinators to provide written or verbal reports (or both) on the progress of the care plan and outcomes for the person.

In addition, reporting on brokerage expenditure and its effectiveness is in many circumstances part of the role of the care plan coordinator. Therefore it is vital that the care plan coordinator maintains a close relationship with the care team and is able to provide up-to-date information about the person and service provider engagement as required by the department.

It is important to note that a care plan coordinator is chosen because they are considered to be the best party at a specified time to take on the role. Over the life of the care plan consideration should be given to reviewing the suitability of the care plan coordination agency, with a view to ensuring ongoing, sustainable support is in the person’s best interests.

# Responsibilities of the care plan coordinator

* The responsibilities of the care plan coordinator are to:
* ensure the person and, where relevant, their family or other supports are actively engaged
* be a point of contact for the person and their families, carers or guardians
* maintain a current and future focus on the person’s needs and goals
* support the care team by promoting effective communication between services and other relevant stakeholders
* coordinate regular meetings between service providers to develop and monitor the care plan
* liaise with the Complex Needs Coordinator throughout the life of the care plan
* encourage protocols between services to formalise partnerships and accountability mechanisms
* develop or recommend flexible, creative and sustainable service options for the person in collaboration with the department and care team
* coordinate a shared risk management response, including ensuring an appropriate and effective crisis plan is in place
* prepare brokerage requests and care plan reports (updates, reviews and closures) to Complex Needs Panels for consideration and recommendation
* administer and monitor brokerage where appropriate
* participate in monitoring and evaluation processes, including data collection and reporting
* plan the care plan closure and the transition of supports to the existing service system.

# Who can be a care plan coordinator?

Any service provider with an understanding, capacity and willingness to assume the role of care plan coordinator may be nominated by an Complex Needs Panel. Due to the complexity of service negotiation and strategic planning, it is recommended that any person nominated for the role is an experienced worker with clear authority within their organisation.

The services from which a care plan coordinator is nominated need to:

* acknowledge the specific skill set, including communication and negotiation skills, required to undertake the care plan coordinator role effectively
* have a desire to integrate people with complex needs into existing service provision frameworks
* provide appropriate supervision and support for the care plan coordinator
* have accounting practices that allow for recording of brokerage expenditure and resource allocation in parallel with service activity.

# Appointment of care plan coordinator

In considering the appointment of a care plan coordinator, the department takes into account the roles and responsibilities as described in the draft care plan and considers the rationale for the specific nomination recommended by the care plan developer.

Within fourteen days of approving a care plan, a copy of the care plan or summary of the main goals must be forwarded to the person that the care plan relates to. All or part of the care plan may be forwarded to services identified in the care plan.

The department will seek the view of the care plan coordinator about the best way to inform a person when their care plan is approved. The department prefers the provider inform the person as they have an existing relationship and are best placed to explain the decision, the next steps in the process, and are able to support them to engage in the implementation of the care plan.

# Care plan review

Under the *Human Services (Complex Needs) Act 2009*, the Area Director (of the department) can request a report from the care plan coordinator on the progress of the care plan in meeting the person’s needs.

The care plan review is the key mechanism for the department and Complex Needs Panel to monitor the progress and effectiveness of the care plan. Reviews take place at a minimum of six-monthly intervals. The person, department, involved services or care plan coordinator can request a review to take place outside this time frame as required.

Care plan reviews are opportunities to change the care plan to better meet the needs of the person. A review is likely to consider the continuing relevance of the involved services, new services to engage, and the care plan coordinator appointed for the person. Preparation for the commencement of the care plan review enables the care plan coordinator to reflect on their role, the role of the other service providers, and to consider any issues that may be affecting the implementation of the plan.

For the department to review the care plan, a verbal or written report (or both) from the care plan coordinator is required. The care plan review report should provide the Complex Needs Panel with:

* a concise update of the status and progress of the care plan
* a description of the situation
* effectiveness of the care plan to date
* any issues and suggestions for change.

Should the care plan coordinator require additional practice advice or support, or where conflict about the direction of a care plan emerges that cannot be resolved, a request can be made to the Complex Needs Panel for a review. Where possible this should be initiated in collaboration with the department.

# Care plan closure

Throughout the life of the care plan, and particularly in its last six-months, the care plan coordinator ensures transition planning for the provision of services and activities to meet the needs of the person beyond the life of the MACNI care plan.

This planning will require liaison and negotiation with the relevant departmental area and with those services likely to remain involved beyond the life of the MACNI care plan.

The Complex Needs Panel considers and endorses the closure of a care plan.

The care plan will be closed:

* at any point in time if requested by the person to whom the care plan relates
* when all relevant stakeholders, in consultation with the person, agree that the person’s needs or goals have been realised through the care plan
* when the care plan has reached the maximum duration of 3 years.

A Complex Needs Panel may request the care plan coordinator to prepare a written closure report to assist with the final review of the care plan for closure. The report is provided to the panel at the time the care plan coordinator is recommending that MACNI cease or when the maximum three-year involvement in MACNI has been reached.

The report should reflect on:

* the progress of the person throughout the time with MACNI, including their perspectives on achievements
* the role MACNI has played in improving the person’s outcomes and enhancing service integration and collaboration
* the learnings gathered by the care team, informed by the person’s perspective, about improved service responses
* confirmation of continuing support arrangements (as relevant)
* other future planning considerations.

# Information sharing

The *Human Services (Complex Needs) Act 2009* specifically allows service providers and the department to disclose personal and health information about an eligible person to the Area Director (or delegate), the care plan coordinator and those services implementing the care plan, where the exchange of information is in the best interests of the person.

The Act clearly specifies the limited purposes for which information can be exchanged, including the consideration of any report given to the Area Director for the purpose of monitoring the implementation of the care plan.

The Act does not compel service providers to exchange information, rather it allows them to make a professional judgement based on what they believe will be in the best interests of the person.

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|  | Where the request to share or release information with a third party is declined, the Care Plan Coordinator or Complex Needs Coordinator is required to escalate the issue through the relevant service provider (e.g. Hospital, Justice Health, etc). |

# Refusal to participate

An person may refuse to participate in MACNI at any time – before eligibility consideration and any time thereafter.

A care plan coordinator, along with the relevant direct service provider, must determine if the person’s statements of refusal are a true reflection of their wishes. The level of impairment and behavioural profile of MACNI eligible people suggests that willingness to participate may vary from day to day. Hence, the worker receiving the refusal must form a professional judgement about the intention of the person.

A refusal can be made to the care plan coordinator or the Area Director (of the department). It can be made at any stage of involvement in MACNI, including during the care plan development process or its implementation.

# Enquiries

Contact the Complex Needs Coordinator in your area for MACNI enquiries. If you are unsure who to contact email [Central.ComplexNeeds@dffh.vic.gov.au](mailto:Central.ComplexNeeds@dffh.vic.gov.au) .

### North Division

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| Area | Office | Contact |
| North East Melbourne | Preston | [NEMAComplexClients@dffh.vic.gov.au](mailto:NEMAComplexClients@dffh.vic.gov.au) |
| Hume Merri-bek | Broadmeadows | [HumeMoreland.ComplexNeeds@dffh.vic.gov.au](mailto:HumeMoreland.ComplexNeeds@dffh.vic.gov.au) |
| Loddon | Bendigo | [Loddon.ComplexNeeds@dffh.vic.gov.au](mailto:Loddon.ComplexNeeds@dffh.vic.gov.au) |
| Mallee | Mildura | [MalleeComplexNeeds@dffh.vic.gov.au](mailto:MalleeComplexNeeds@dffh.vic.gov.au) |

### East Division

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| Inner Eastern Melbourne | Box Hill | [IEMAComplexNeeds@dffh.vic.gov.au](mailto:IEMAComplexNeeds@dffh.vic.gov.au) |
| Outer Eastern Melbourne | Ringwood | [OEMA.ComplexNeeds@dffh.vic.gov.au](mailto:OEMA.ComplexNeeds@dffh.vic.gov.au) |
| Goulburn | Shepparton | [Goulburn.ComplexNeeds@dffh.vic.gov.au](mailto:Goulburn.ComplexNeeds@dffh.vic.gov.au) |
| Ovens Murray | Wangaratta | [OvensMurray.ComplexNeeds@dffh.vic.gov.au](mailto:OvensMurray.ComplexNeeds@dffh.vic.gov.au) |

### South Division

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| Area | Office | Contact |
| Southern Melbourne | Dandenong | [complex.clientsSM@dffh.vic.gov.au](mailto:complex.clientsSM@dffh.vic.gov.au) |
| Bayside Peninsula | Dandenong | [Complex.ClientsBP@dffh.vic.gov.au](mailto:Complex.ClientsBP@dffh.vic.gov.au) |
| Inner Gippsland | Morwell | [complex.clientsIG@dffh.vic.gov.au](mailto:complex.clientsIG@dffh.vic.gov.au) |
| Outer Gippsland | Bairnsdale | [complex.clients.oga@dffh.vic.gov.au](mailto:complex.clients.oga@dffh.vic.gov.au) |

### West Division

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| Area | Office | Contact |
| Western Melbourne & Brimbank Melton | Footscray | [WMBM.ComplexNeeds@dffh.vic.gov.au](mailto:WMBM.ComplexNeeds@dffh.vic.gov.au) |
| Sunshine |
| Central Highlands | Ballarat | [CHA.ComplexClientsReferrals@dffh.vic.gov.au](mailto:CHA.ComplexClientsReferrals@dffh.vic.gov.au) |
| Barwon | Geelong | [ComplexNeeds.Barwon@dffh.vic.gov.au](mailto:ComplexNeeds.Barwon@dffh.vic.gov.au) |
| Wimmera South West | Warrnambool | [WSWA.ComplexNeeds@dffh.vic.gov.au](mailto:WSWA.ComplexNeeds@dffh.vic.gov.au) |

# Appendix 1: *Human Services (Complex Needs) Act 2009* – Section 7: Eligibility Criteria

An eligible person is a person who—

1. has attained 16 years of age; and
2. appears to satisfy 2 or more of the following criteria—
   1. has a mental disorder within the meaning of the *Mental Health Act 2014*
   2. has an acquired brain injury
   3. has an intellectual impairment
   4. is an alcoholic or drug-dependent person within the meaning of section 5 of the *Severe Substance Dependence Treatment Act 2010*, and
3. has exhibited violent or dangerous behaviour that caused serious harm to himself or herself or some other person or is exhibiting behaviour which is reasonably likely to place himself or herself or some other person at risk of serious harm; and
4. is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with a care plan that may include welfare services, health services, mental health services, disability services, drug and alcohol treatment services or housing and support services.

# Appendix 2: MACNI brokerage funding

People with multiple and complex needs often require service responses that are not available within the existing service system.

The complex needs service model includes discretionary client-attached brokerage funding for the purchase of specialist assessments, support and interventions to support the engagement and stabilisation of people through the delivery of the care plan. The brokerage funding is available for:

* people who appear to meet the eligibility criteria of the *Human Services (Complex Needs) Act 2009* and who are in receipt of Pre-MACNI service coordination (brokerage use is limited)
* people who have been determined as eligible under the Act for the purpose of giving effect to their care plan.

## Principles

The following principles guide brokerage allocation decisions:

* all formal MACNI services (MACNI assessment, care plan development and care plan coordination) must be delivered by providers who have a Service Agreement with the department and are registered under the *Disability Act 2006*
* client -attached brokerage is available as a last resort when supports or resources in the standard service system are unavailable or are unable to be provided within effective timelines
* the allocation of brokerage is derived from an analysis of the client’s needs and the prior effectiveness of other funding support and takes into account the sustainability of service delivery
* brokerage is strictly for direct purchase of services for the client. Only limited essential household items may be purchased
* brokerage is not an alternative to core funding and cannot be used to duplicate existing services or cover administrative costs
* brokerage is time-limited and non-recurrent and there must be significant effort to integrate the client back into mainstream service provision
* brokerage funds may be used to purchase secondary consultation, training, specialist clinical staff support or mentoring in accordance with the care plan and to build service capacity in the longer term. This training should be client-specific and not used as broad skill development. For example, conducting a general training session on Personality Disorder, trauma informed interventions, motivational interviewing – such sessions should be client-specific and reflect the individual’s behaviours and effective management strategies.

## Examples of use of brokerage funds

In implementing a care plan, brokerage funds can:

* enable new strategies to be used to engage the person
* support existing services to offer additional types of service
* purchase a new service type for a time-limited period.

## Limitations to use of brokerage funds

Brokerage is not to be used for:

* staff phones, fax or computer expenses
* purchasing vehicles, vehicle rental, petrol or vehicle maintenance
* staff-related travel expenses
* office rental, maintenance, utilities or insurance
* management/infrastructure fees
* standard supervision, training and attendance and conferences (it is the expectation that programs and organisations offer these provisions).
* client debts (including utility bills)
* landlord related items such as staff travel or associated costs
* rent arrears
* retrospective funding requests
* any items or service that can be funded by the existing service system (for example Housing Establishment Fund (HEF), etc).

# Appendix 3: *Human Services (Complex Needs) Act 2009* – Section 16: Care Plan Coordinator

1. If the Area Director approves a care plan that relates to an eligible person, the Area Director must appoint a care plan coordinator in relation to that care plan.
2. A care plan coordinator must—
   1. monitor the implementation of the care plan and the progress of the person to whom it relates; and
   2. coordinate the services provided to the person to whom the care plan relates in accordance with the care plan; and
   3. when requested by the Area Director, provide a report to the Area Director on the progress of the person to whom the care plan relates.
   4. The Area Director may seek to obtain personal information or health information about an eligible person to whom a care plan relates from the care plan coordinator and any person or organisation providing services to the eligible person in accordance with the care plan for the purposes of—
   5. considering any report given to the Area Director under subsection (2)(c);
   6. monitoring the implementation of the care plan.
   7. A care plan coordinator may seek to obtain personal or health information from the Area Director or any service provider identified in the care plan for the purposes of his or her functions under subsection (2).
3. The following are authorised to disclose personal or health information about the person in accordance with a request under subsection (4)—
   1. the Area Director;
   2. a service provider referred to in subsection (4).

# Appendix 4: The role of Care Plan Coordinators

The intended audience for this document is Care Plan Coordinators who are contracted by the Department of Families Fairness and Housing (the department) to provide Care Plan Coordination under section 16, *Human Services (Complex Needs) Act 2009* for the Multiple and Complex Needs Initiative (MACNI).

In a small number of cases the Complex Needs Coordinator may take on the role of Care Plan Coordinator. If the care plan coordinator requires support to complete the below tasks, the Complex Needs Coordinator is able to provide support, guidance an capacity building.

## What is the role of the contracted service provider?

While a care plan coordinator can be nominated from any service or program, the service provider needs to demonstrate the following:

* a commitment and expertise integrating clients with complex needs into existing service provision
* an ability to nominate or recruit an experienced, influential and highly capable person/s to undertake the care plan coordination role
* the capacity to provide appropriate supervision and support to the care plan coordinator
* professional values of open communication, effective networking and the capacity to provide independent and objective care team governance
* skill sets in establishing and implementing rigorous accountability frameworks, including financial acquittal of brokerage funding.

## Key roles and responsibilities of a Care Plan Coordinator

#### Upon appointment

* review the recommended MACNI assessment and care plan, including the key focus areas and goals of the client
* review recommendations made by the Complex Needs Panel (the panel) and / or existing assessments
* access, gather and review relevant assessment reports and documentation
* meet with the Complex Needs Coordinator to discuss the current circumstances / key relationships and any anticipated challenges
* identify key members of the care team
* identify all existing and potential funding sources. For example income, benefits, state trustees, NDIS or other packaged funding, etc.

#### Care team and care plan implementation

* schedule and facilitate regular case meetings (monthly at minimum) in agreement with the Complex Needs Coordinator
* monitor the care plans implementation and progress of the client
* coordinate the services provided to the client consistent with the care plan
* develop, maintain and distribute key stakeholder contact details to the care team
* promote collaboration integrated service delivery
* ensure appropriate follow up of agreed tasks
* assist in negotiations and provide advocacy, ensuring the client’s voice / goals / perspective is acknowledged
* encourage protocols between services to formalise partnerships and accountability mechanisms
* consider, explore and engage service providers, facilitating referrals as appropriate
* during periods of high risk and/or crisis, the Care Plan Coordinator is to provide oversight and coordination of actions and tasks required to manage immediate risks and concerns.

#### Complex Needs Coordinator

* meet or correspond regularly with Complex Needs Coordinator regarding case direction, planning, issues and panel recommendations
* ensure the Complex Needs Coordinator is made aware of information regarding case direction, care team functionality and processes currently being implemented
* ensure the Complex Needs Coordinator is briefed prior to care team meetings and panel presentations – there should not be any new information presented in the meetings from the Care Plan Coordinator
* seek support / guidance from the Complex Needs Coordinator as appropriate.

#### Client

* ensure the client and, where relevant, their family or other supports are actively engaged
* be a point of contact for the client and their families, carers or guardians
* maintain a current and future focus on the client’s needs and goals.

#### Communication

* develop and document an agreed communication strategy or plan, including the roles and responsibilities of each care team member
* seek information and provide correspondence with service providers, professionals and emergency services as appropriate
* maintain and promote active communication amongst care team members
* share and collate information consistent with provisions under the *Human Services (Complex Needs) Act 2009*, noting this provides safeguards for the sharing of information, it does not compel third parties to share information.

#### Documentation

* prepare and circulate meeting agendas to care team members at least two business days prior to a scheduled meeting to enable members to make comment, suggest additional agenda items and prepare appropriately
* prepare and circulate meeting minutes to care team Members within one-week post meeting to assist actions to be implemented as quickly as possible
* regularly review and maintain the care plan including tasks and progress against recommendations
* regularly review and maintain behaviour / risk management plans, seeking professional secondary consultation as appropriate
* plan the care plan closure and the transition of supports to the existing service system
* prepare brokerage requests and care plan reports (updates, reviews and closures) to Complex Needs Panels for consideration and recommendation
* prepare reports and/or supporting documentation for the Complex Needs Panel and provide these to the Complex Needs Coordinator at least 7-10 business days prior (to be negotiated with the Complex Needs Coordinator)
* administer and monitor brokerage where appropriate, including providing an acquittal of the brokerage funds at scheduled panel meetings
* provide a transition / exit plan six months prior to closure
* provide a closure report at the point of closure.

## The Complex Needs Panel

Each formal MACNI client will be presented to the Complex Needs Panel regularly as part of a formal review process consistent with the *Human Services (Complex Needs) Act 2009*. Each presentation will require specific documentation to be prepared, including:

* MACNI care plan review report (six-monthly at minimum)
* MACNI care plan (six-monthly at minimum)
* MACNI progress updates (documented)
* MACNI transition / exit plan (six months prior to closure)
* MACNI closure report
* Copies of recent assessments (if relevant)
* brokerage requests

A suite of standardised templates for Care Plan Coordinators to prepare and complete the required documentation will be provided by the Complex Needs Coordinator. These templates have been developed to ensure state-wide consistency.

As above, reports and/or supporting documentation are required to be provided to the Complex Needs Coordinator at least **7-10 business days prior** (to be negotiated with the Complex Needs Coordinator). This timeline is requested to enable documents to be reviewed by the Complex Needs Coordinator, allowing adequate time for queries, discussions and / or any changes to be applied prior to documents being sent to panel members.

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| --- | --- |
|  | Please ensure all drafted documents are sent to the Complex Needs Coordinator as Word Documents, they will be converted to PDF files when finalised. |

The Complex Needs Coordinator is required to ensure that brokerage requests can be supported by the available divisional budget and an initial in-principal approval from the relevant Area Director received to enable panel members to actively recommend/not recommend the request(s). If the allocated divisional budget cannot support the request, the Complex Needs Coordinator may seek Care Plan Coordinators to reduce costs wherever possible. Complex Needs Coordinators may also query requests for funding for items outside the brokerage guidelines (refer to Section 13 of the Service provision framework: complex needs for further information regarding brokerage).

All relevant panel documents (including reports, assessments, etc.) will be finalised and circulated to panel members at least two business days prior to the scheduled panel date. This provides panel members with the opportunity to review documentation and consider potential queries or recommendations to be raised at panel.

The Complex Needs Coordinator may also meet with the Area Director (the Complex Needs Panel Chair) to provide a briefing of presentations and an extended agenda.

## Panel – Care Plan Coordinator responsibilities

* prepare reports and/or supporting documentation for the Complex Needs Panel and provide these to the Complex Needs Coordinator at least 7-10 business days prior (to be negotiated with the Complex Needs Coordinator)
* ensure previous panel recommendations have been addressed
* prepare brokerage requests (including seeking quotes) and forward these to the Complex Needs Coordinator
* brief the care team on the expectation of panel and agree on their presentation / anticipated questions
* consider what discussion points or questions to raise at the panel
* request support / guidance from the Complex Needs Coordinator as required

## Client-attached brokerage

Each departmental division is allocated a budget every financial year to implement MACNI service responses. MACNI enables creative strategies to be implemented to deliver the best service model for a client to be able to engage and live safely in their community. However, there are budget limitations and it is the responsibility of the Area Director and Complex Needs Coordinator to ensure that brokerage requests do not exceed the allocated budget.

The Care Plan Coordinator and their agency/organisation are accountable for MACNI recommended brokerage funds paid to them to support the MACNI client – including funds to provide care plan coordination services and additional care plan coordination brokerage (to purchase additional services or assessments). The Care Plan Coordinator will be required to provide an acquittal of the brokerage funds at scheduled panel meetings or as requested by the Complex Needs Coordinator.

Consideration of the client’s ability to contribute or be responsible for funding items through their own income stream must be provided. This will foster the client’s sense of responsibility and independence within the community and limits reliance on MACNI brokerage funding. Sustainable options for funding should be continually explored throughout the client’s time as a formal MACNI client.

A Care Plan Coordinator cannot change an approved care plan or brokerage request without consulting the Complex Needs Coordinator. Panel recommendation and Area Director approval may also be required.

Additional brokerage funds will not be provided for a Care Plan Coordinator to increase care team meetings, direct support hours, therapeutic or allied health session, etc. without approval from the panel at a scheduled meeting or out of sessions.

For cases that require a change to the recommended plan/brokerage request, an out of session brokerage request can be arranged with your Complex Needs Coordinator if the next panel meeting scheduled is deemed too far away. This is not an ideal situation and makes it difficult to track funds when requests are being made at different times, therefore it is preferred, where possible, to have all requests completed within the scheduled panel meeting.

For more comprehensive information regarding brokerage and approval processes, refer to Section 13 of the service provision framework: complex needs.

## Brokerage – Care Plan Coordinator responsibilities

* consider, where reasonable, the client’s ability to contribute or be responsible for funding items
* prepare brokerage requests (including seeking quotes) and forward these to the Complex Needs Coordinator
* administer and monitor brokerage where appropriate, including providing an acquittal of the brokerage funds at scheduled panel meetings.
* consider how current supports can be sustained in the community / standard service system once MACNI closes