

# MULTIPLE AND COMPLEX NEEDS INITIATIVE (MACNI)

## CARE PLAN COORDINATION

### Background

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Care plan coordination is a critical component of the Multiple and Complex Needs Initiative (MACNI).<sup>1</sup> The appointment of a Care Plan Coordinator aims to address existing concerns that service responses to individuals with multiple and complex needs are often crises-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.

### What is a MACNI care plan?

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A MACNI care plan is developed after a person has been determined eligible by the MACNI Central Eligibility and Review Group (CERG). The CERG receives and considers referrals from the DHS regional office and determines if the person is eligible to receive services under MACNI.<sup>2</sup> Consideration is then given by the region and relevant service providers as to the individual's specific needs and any assessments required, including analysis of previous assessments undertaken. A draft care plan is then developed for consideration by the relevant DHS Regional Panel.<sup>3</sup>

A MACNI care plan outlines a plan of action aimed at responding to the specific needs of the individual as identified through the assessment process. The plan should specify the care, treatment and support strategies, and accommodation options recommended for the person, taking into account his or her best interests. A care plan must specify a duration for the plan of not more than 12 months, although can be extended or varied for a period of up to 36 months post-CERG determination of eligibility.

The MACNI care plan is developed in partnership with a range of service providers, the individual, family members and significant others. Determining who is responsible for the development of a care plan is dependent on regional consultations and negotiations with Indigo (the state-wide MACNI service) and local service providers.

### The role of the Care Plan Coordinator

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A Care Plan Coordinator is appointed when a care plan for an individual is approved. This occurs at the DHS regional level by the Regional Panel. The Care Plan Coordinator is a key point of contact for the region and other service providers throughout the life of the care plan.

The role of the Care Plan Coordinator is defined in Section 16 of the *Human Services (Complex Needs) Act 2009*.<sup>4</sup>

The Care Plan Coordinator role involves:

- skilfully coordinating the services provided to the person in accordance with the care plan, including negotiating changes to the service provision as required
- actively steering the direction of the care plan with a future-oriented approach
- monitoring and providing written and verbal reports to the region on the implementation and progress of the care plan and the person to whom it relates.

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<sup>1</sup> The MACNI model is diagrammatically described in Appendix 1

<sup>2</sup> Appendix 2 details the eligibility criteria.

<sup>3</sup> There are 8 DHS regional offices in Victoria. See Appendix 3 for details.

<sup>4</sup> Appendix 4 details the role of the Care Plan Coordinator as outlined in the 2009 Act.

It is important to note that the role of the Care Plan Coordinator is not the same as a case manager or the provision of psychosocial support. Experience suggests that care plan coordination is most effective when it is detached from the direct work with the individual to whom the care plan relates. This enables the Care Plan Coordinator to maintain an independent overview of the progress of the care plan, holding multiple perspectives and enabling critical analysis. The purpose of this approach is to enable the coordinator to develop a 'meta' perspective of the care plan and the services 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 MACNI client, providing a separation between direct care/case management and care plan coordination, or by nominating as the Care Plan Coordinator from an agency that has no direct care of the MACNI client.

## **Critical features of the care plan coordination role**

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The Care Plan Coordinator plays a crucial role in coordinating and monitoring the progress of the MACNI care plan and in steering and directing services to best meet the changing needs of the individual to whom the care plan relates. The Care Plan Coordinator negotiates with service providers nominated in the care plan to effectively provide the services, conduct the activities and fulfil their respective roles and responsibilities as identified in the care plan. In addition, the Care Plan Coordinator must have knowledge about the individual's experience of the care plan and whether it continues to meet the needs of the individual.

There are three fundamental functions critical to the role.

### **1. Actively steering the direction of the care plan with a future-oriented approach.**

In this capacity, the Care Plan Coordinator has a strong leadership role throughout the life of the MACNI care plan. Significant strategic and negotiating 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. Establishing oneself as the central point of contact and facilitating effective communication are important skills of the Care Plan Coordinator.

### **2. Skilfully coordinating the services provided to the person in accordance with the care plan including negotiating changes to the service provision as required.**

Care plan coordination requires a responsive, flexible and creative response to working with service providers. A solution focussed 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 client. The challenge for the Care Plan Coordinator in these circumstances is to be alert to these issues, negotiate a changed direction and where appropriate and required, engage a new provider or change of the service provision.

### **3. Monitoring and providing written and verbal reports to the region on the implementation and progress of the care plan and the person to whom it relates.**

Each region has the task of approving and reviewing care plans. Therefore, a close relationship between the Care Plan Coordinator and the Regional Coordinator facilitates open communication and collaboration. Regional Panels require Care Plan Coordinators to provide written and verbal reports on the progress of the care plan and outcomes for the individual client.

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 client and service provider engagement as required by the region.

It is important to note that a Care Plan Coordinator is chosen because they are considered the best party at a specified time to take on the role. Over the life of the care plan, reviewing the suitability of the care plan coordination agency with a view to ensuring ongoing, sustainable support for the client should be considered.

## **Specific responsibilities of the Care Plan Coordinator**

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The responsibilities of the Care Plan Coordinator are:

- supporting services by taking a lead role in the coordination of services and by promoting effective communication between services, and relevant others.
- coordinating regular meetings between all service providers to develop and monitor the care plan.
- liaising with the Regional Coordinator throughout the life of the care plan.
- joint problem solving and planning in collaboration with the region and care team. As the individual's circumstances change over time, ensuring that the care plan and service provider responses adjust to these changes is a key role of the Care Plan Coordinator. In addition the ability to appropriately use authority to direct the work of service providers including managing conflict between providers if required is essential.
- developing/recommending flexible and creative service options for the client in collaboration with the region and care team.
- maintaining a current and future focus on the client's needs and goals.
- coordinating a shared risk management response including ensuring that an appropriate and effective crisis plan is in place.
- administrating and monitoring brokerage where appropriate<sup>5</sup>
- transition planning to mainstream services.

Transition planning is critical and involves planning for the provision of the services and activities to meet the needs of the individual beyond the life of the MACNI care plan. Transition planning should remain a focus throughout the life of the care plan. This planning will require liaison and negotiation with the region that will remain the primary region for the client as well as with those services likely to remain involved beyond the life of the MACNI care plan.

## **Who can be a Care Plan Coordinator?**

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Any service provider with an understanding of the role, and capacity and willingness to assume the role of Care Plan Coordinator may be nominated for this role. Due to the complexity of service negotiation and strategic planning, it is recommended that any person nominated for the role of Care Plan Coordinator be an experienced worker with clear authority in their organisation.

In circumstances where there is no service provider able to take on the Care Plan Coordinator role and where it is deemed an appropriate recommendation, Indigo Assessment and Care Plan

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<sup>5</sup> Appendix 5 outlines the broad principles guiding brokerage decisions

Coordination Service may be nominated as the Care Plan Coordinator. This will be particularly useful in circumstances where the individual to whom the care plan relates is highly transient, crossing regional boundaries and whose complex needs necessitate the involvement of multiple services across multiple sectors. Indigo is a state-wide service specifically funded by MACNI to provide assessment, care plan coordination, secondary consultation and mentoring for MACNI clients and services working with these individuals.

The final decision as to who is nominated as the Care Plan Coordinator is based on the outcome of negotiations between the region, the care plan developer and relevant service providers.

## **Skills required of Care Plan Coordinator**

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Individuals considering nominating themselves for the role of Care Plan Coordinator would benefit from having the following mix of competence, demonstrated experience of, and confidence, in:

- communicating, managing and negotiating with a range of service providers and regional staff
- managing conflicting views and opinions between service providers
- analysing and formulating assessments, care plans, risk plans and transition plans while maintaining a stance of curiosity

A broad understanding of the health and welfare field will help provide for lateral problem solving and planning. In addition, an ability to strategically use consultation and confidence in the appropriate use of legislative authority (with clients and with service providers) aids the work of the Care Plan Coordinator.

Other personal qualities include: humane concern, empathy with client issues and service providers experience, imagination, hope and optimism.

The agencies from which a Care Plan Coordinator is nominated will need to:

- acknowledge the specific skill set (above) required to undertake the Care Plan Coordinator role effectively
- have a desire to integrate complex clients into existing service provision framework(s)
- provide appropriate supervision and support for the Care Plan Coordinator
- and where the agency is assuming brokerage allocation responsibility, have adequate accounting practices that allow for recording of expenditure and resource allocation in parallel with service activity.

## **The appointment of a Care Plan Coordinator**

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In considering the appointment of a Care Plan Coordinator, the region deliberates over the roles and responsibilities of the Care Plan Coordinator as described in the draft care plan and considers the rationale for the specific nomination as recommended by care plan developer. In circumstances where the region disagrees with the recommended Care Plan Coordinator, further discussions occur with the care plan developer, the region and relevant service providers as required, until resolution is reached.

Within fourteen days of approving a care plan, a copy of the care plan or a summary of the main goals must be forwarded to the person for whom it relates. All or part of the care plan may be forwarded to service providers dependent on the best interests of the person and the needs of the service provider.

At this time, the opinion of the Care Plan Coordinator is sought regarding the most effective way to inform the individual of the care plan approval by the region. The region is keen that the individual has the information provided by someone who is best placed to explain the decision, the next steps in the process and is able to support the person to engage in the implementation of the care plan.

## Care Plan Reviews

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The care plan review is the key mechanism for the region and Regional Panels to monitor the progress and effectiveness of the care plan. Reviews take place at minimum six monthly intervals. Regions or Care Plan Coordinators can request a review to take place outside this time frame as required.

Preparation for 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. Care plan reviews are opportunities to change the care plan to better meet the needs of the individual. A review is likely to consider the continuing relevance of the involved services, new services to involve, and re-consider who the continuing Care Plan Coordinator is for the individual.

At times, the CERG may seek to review care plans for quality assurance purposes. In addition, should the region or 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 CERG for a review. Where possible this should be initiated in collaboration with the region. If this is not possible, a Care Plan Coordinator can contact the manager, MACNI central team directly to arrange a CERG review<sup>6</sup>.

## Information provision

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The *Human Services (Complex Needs) Act 2009* specifically allows service providers to disclose personal and health information about a person to the Secretary or delegate, the Care Plan Coordinator, and those services implementing the care plan, when the exchange of information is in the best interests of that person. The Act clearly specifies the limited purposes for which information can be exchanged, including the consideration of any report given to the Secretary 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 individual.

## Care plan review report

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Under the Act 2009, the Secretary can request the Care Plan Coordinator to provide a report on the progress of the person to whom the care plan relates.

For the region to review the care plan, a written report from the Care Plan Coordinator is required.

The care plan review report should outline concisely the status and progress of the care plan. The report should provide a level of detail that will enable the Regional Panel to have a description of the situation and effectiveness of the care plan to date and be informed of any issues and suggestions for change.<sup>7</sup>

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<sup>6</sup> Refer to MACNI website for contact details of manager MACNI central team

<sup>7</sup> Appendix 6 provides an example review report outline.

## Individual refusal

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An eligible person may refuse to participate in MACNI at any time.

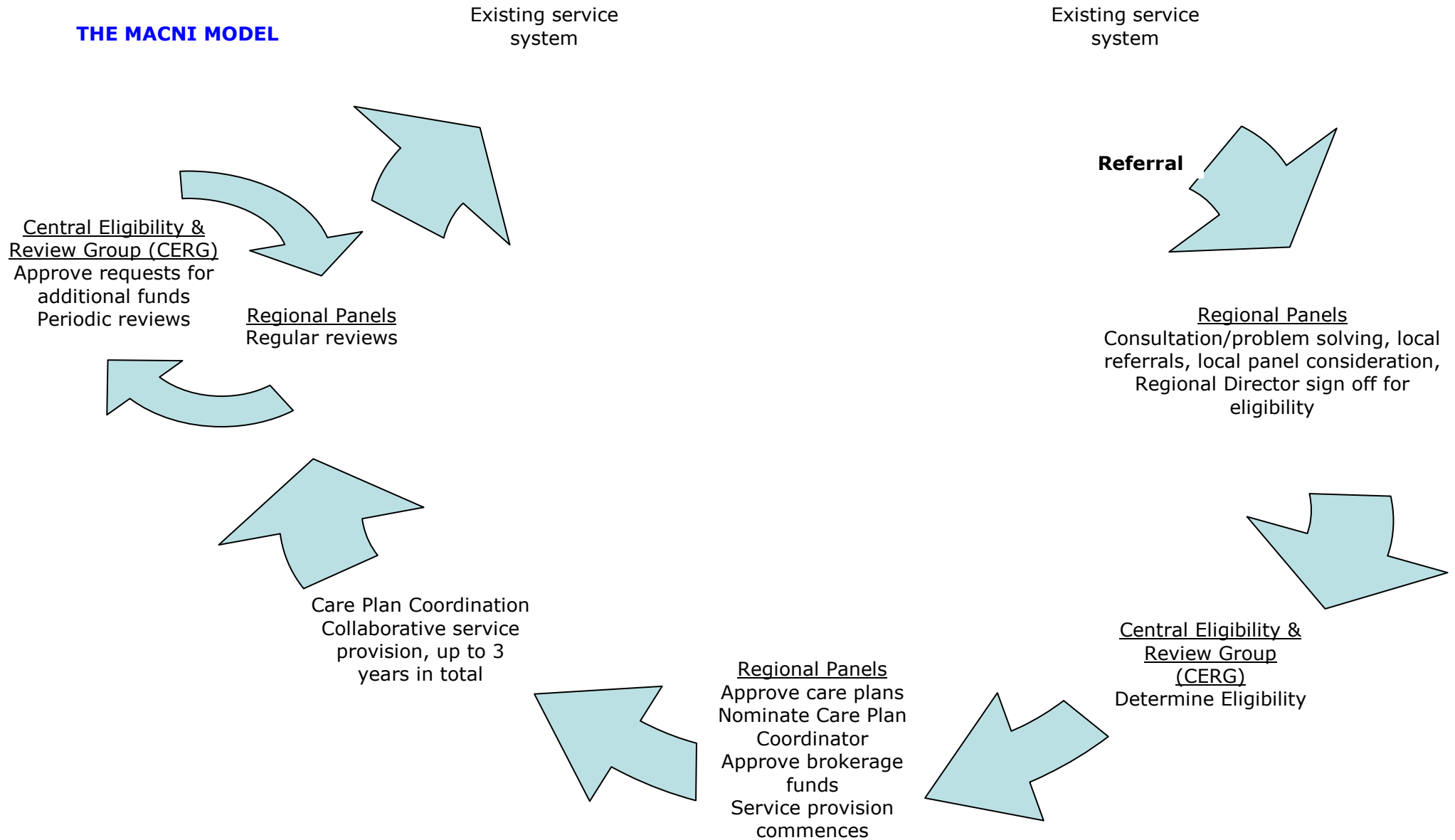
A Care Plan Coordinator, in conjunction with the relevant direct service provider, must determine if the individual's statements of refusal are a true reflection of their wishes. The level of impairment and behavioural profile of many within the eligible population suggest that willingness to participate may vary from day to day. Hence, the worker receiving the refusal must form a professional judgement about the intention of the person.

This is consistent with accepted good practice in those parts of the human services sector where repeated attempts to engage individuals with complex needs may continue over an extended period of time, particularly where there is a high risk of harm to the person or the community.

A refusal can be made to the Care Plan Coordinator or the Secretary. It can be made at any stage of involvement in MACNI including during the care plan development process or its implementation.

**APPENDIX ONE**

**THE MACNI MODEL**



## APPENDIX TWO

### **HUMAN SERVICES (COMPLEX NEEDS) ACT 2009** **SECTION 7: ELIGIBILITY CRITERIA**

An eligible person is a person who:

- has attained 16 years of age: and
- appears to satisfy two or more of the following criteria -
  - i. has a mental disorder within the meaning of the *Mental Health Act 1986*;
  - ii. has an acquired brain injury;
  - iii. has an intellectual impairment;
  - iv. is an alcoholic or drug-dependent person within the meaning of the *Alcoholics and Drug-dependent Persons Act 1986*; and
- has exhibited violent or dangerous behaviour that has 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
- is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with a care plan under the Act that may include welfare services, health services, mental health services, disability services, drug and alcohol treatment services or housing and support services.

## APPENDIX THREE

### DHS Regions and Regional Delegations

There are eight DHS regions. Each region has a MACNI Regional Coordinator who is the first point of contact for MACNI matters.

Region	Contact Telephone	Location
Barwon South West	<b>5226 4540</b>	State Govt Offices 2 <sup>nd</sup> Floor, Cnr Fenwick & Little Malop St GEELONG 3220
Grampians	<b>5333 6530</b>	State Govt Offices Cnr Mair & Doveton Streets BALLARAT 3350
Loddon Mallee	<b>5434 5555</b>	74-78 Queen Street BENDIGO 3552
Hume	<b>5722 0555</b>	43-47 Rowan Street WANGARATTA 3677
Gippsland	<b>5136 2400</b>	11 Hazelwood Road MORWELL 3840
North and West Metropolitan	<b>9412 5333</b>	145 Smith Street FITZROY 3065
Eastern Metropolitan	<b>9843 6000</b>	883 Whitehorse Road BOX HILL 3125
Southern Metropolitan	<b>9213 2111</b>	Level 2, 26 McCrae Street DANDENONG 3175

Regions have established Regional Panels whose membership comprises of senior DHS managers and managers from local community services.

Under the delegated authority of the Regional Director, Regional Panels advise on:

- care plan approval
- Care Plan Coordinator nomination
- regional brokerage allocation approval
- care plan monitoring and review
- care plan variation or termination

## **APPENDIX FOUR**

### **HUMAN SERVICES (COMPLEX NEEDS) ACT 2009 – SECTION 16: CARE PLAN COORDINATOR**

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

## APPENDIX FIVE

### Principles for the Multiple and Complex Needs Initiative (MACNI) brokerage funding

Individuals with multiple and complex needs often require service responses that are not available within the existing service system. The MACNI service model includes provision of a discretionary pool of brokerage funding available at two different stages in the model. Each region has brokerage funding for expenditure on MACNI eligible clients. In addition, brokerage funding is accessed via the statewide Central Eligibility and Review Group (CERG).

Brokerage funding is available for the purchase of support and interventions to assist with the engagement and stabilisation of MACNI clients. Brokerage funding provides opportunities to trial innovative support and interventions to improve a client's health, safety, social connectedness and accommodation. The funding also supports the work of involved service providers with MACNI clients where brokerage is one funding option available for services responses that are 'over and above' their normal work. Many service providers require training, secondary consultation, mentoring and support to build their capacity to meet the needs of MACNI clients. These supports may be funded with brokerage dollars.

#### Principles

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The following principles should guide brokerage allocation decisions:

- MACNI brokerage is a 'last resort option' for its availability is based on the understanding that alternate sources of funding have been explored and exhausted. MACNI brokerage funding is not a long-term replacement for DHS program or divisional funding.
- The allocation of funds to clients is derived from an understanding of the client's needs and from consideration of the prior effectiveness (for the client) of other funds used for similar or related purposes.
- The use of funds should not duplicate existing services.
- Funds for new service types are for a time-limited period only.
- The allocation of brokerage funds should be mindful of the need for sustainability. There should be significant effort and focus on the integration and/or transition of the client into the mainstream service system as this better enables client's ongoing needs to be met.

#### Examples of use of brokerage funds

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In implementing a care plan, brokerage funds can:

- enable strategies to engage the individual to be used
- support existing providers to offer additional types of service
- purchase a new service type for a time-limited period
- purchase support to improve a client's participation or connections in the community as a sustainability strategy.

In building a service's capacity to work with a MACNI client, brokerage funds can enable the provision of:

- specialist secondary consultation
- specialist training, and/or
- additional supervision and mentoring.

### **Exceptions to use of brokerage funds**

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Brokerage is NOT available for:

- office rental
- administration charges if the Care Plan Coordinator is being directly funded
- staff mobile phones
- car rental
- petrol & car maintenance
- staff travel expenses
- office maintenance
- utilities
- phone/fax/internet
- computer expenses
- insurance
- management / infrastructure fees
- routine agency supervision

## **APPENDIX SIX**

### **CARE PLAN REVIEW REPORT**

#### **Context**

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The report should include a summary of the current status of the care plan from the perspective of all involved, including the:

- Care Plan Coordinator's perspective of how the individual's circumstances are progressing. What is going well so far, what is not, what has helped and what has not and what they would like to see happen in the coming months
- perspective of other service providers involved in the care team, noting any differing views or experiences of implementation
- perspective of individual of how their circumstances are progressing
- perspectives of family and significant others where they exist and are involved in the individual's life.

#### **Indicators of Progress**

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Following the context, the report should consider the individual's progress in terms of the recommendations outlined in the care plan and should describe incremental progress under the four platforms of the MACNI, namely:

- Stable Accommodation
- Health and Well being
- Safety
- Social Connectedness

In addition to the four platforms, the report should include commentary regarding:

- Service System Responsiveness

This section should consider how well services are able to work together, a reflection of the appropriateness of the varying roles and responsibilities as defined in the care plan and any recommendations for change. It also needs to include transition considerations and any additional service gaps that may have been identified. Longer range comment/forecasting regarding the roles to be assumed beyond the life of the care plan should be included as appropriate.

#### **Brokerage Funds**

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Where brokerage funds have been approved by the region or the CERG and are the responsibility of the Care Plan Coordinator to disperse, the report should outline the expenditure of these funds and in particular describe the benefit or 'value add' of these funds.

This section should provide details regarding:

- expenditure to date of the brokerage funds authorised in the care plan
- impact and effectiveness of the funded service or activity with regard to the progress of the individual
- comment on whether brokerage funds should continue at the current level. If so, for what period, for which purpose/services or tasks and how it will add benefit and
- any recommendations for change, including additional identified needs.

## Recommendations

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The report should describe any recommendations for change to the current care plan and include a brief rationale that will be informed by the description of progress to date in the earlier sections of the care plan review report.

A recommendation for the timing of the next care plan review should be noted in this section including an appropriate rationale.

Any further commitments or decisions about transitioning a client that the region should consider prior to a care plan ending should also be recommended.

Should the next care plan review be the final review, plans for the provision of services and activities beyond the life of the care plan should be discussed including agreements reached with relevant service providers.