Case Conferences:

The purpose of case conferences is to:

- Determine the adequacy of the plan of care and appropriateness of continuation of care

- Assure the provision of all services the patient may require, including referrals to other community programs the patient may need

- Assure coordination of services in patient-goal directed activity on the part of each home care staff member

- Evaluate patient progress and plans for future care

- Provide assistance to team members having difficulty planning care for specific problem cases

- Refer cases which require further study to the clinical record review committee

- Identify patient, family or caregiver's educational needs

- Review/generate interventions and goals for the plan of care for initial certifications, and for recertifications

Case conferences are multi-disciplinary, and are to be held on each patient receiving ongoing services by the Agency, regardless of the number of disciplines involved in the care.

Case conferences shall be held regularly to review problem cases and to review the plan of care for appropriateness and feasibility of continued services. Such conferences shall be documented in the clinical record and should be held on each patient upon admission, at the time the plan of care is due for review (every 60 days or more often) and prior to discharge, if necessary. If a problem arises, the patient is not meeting goals, or has a significant change in status, a conference should be held. The conference at time of discharge need not involve the entire multi disciplinary group, but may be between the case manager, Director, and/or other disciplines providing care to the patient.

All professional disciplines participating in the patient's care should have input at the conference. For personnel participating in the patient's care but unable to attend the conference, a telephone conference could be established. Documentation of the conference shall be the responsibility of the primary nurse or supervisor, or other professional as instructed by the supervisor. The documentation shall include a summary of progress, assessment of the need for continued care, plans, and discharge goals.
Inter-Disciplinary Communication:

When more than one discipline is involved in the care of a patient, those disciplines are to have frequent and ongoing communications to assure their efforts are coordinated effectively and support the objectives outlined in the plan of care. All care coordination between disciplines, phone or one-on-one conversations, written notes left in the home, faxed information, etc. will be documented in the clinical record.

All staff delivering patient care services are encouraged to have at least weekly contact with their supervisor. This contact can be in the form of individual conferences held within the office, telephone conferences or group case conferences. Any conference related to an individual patient may be documented as a case conference.

Cross Reference: __________________________________________