Sullivan County Department of Public Health

Title: Care Planning/ Coordinator of Services (COS) **Number**: CP-15 **Page Number:** 1 of 2	Original Approval: 6/19 Reviewed/ revised: 4/24

Statement/ Purpose:
To establish guidelines for providing individualized patient care that is multidisciplinary, consistent, coordinated, high quality, and cost effective.
To provide guidelines for initiating, customizing, and following a goal-directed plan of care based on best practice.
To facilitate communication among multidisciplinary team members providing patient and family-centered care.

Authority:
CoP 484.60(a), CoP 484.60(d)

Application:
All SCDPH clinicians

Terminology:

Responsible Party:
Training and Quality Improvement Coordinator

Cross-Reference:
Admission process

Procedure:
Each patient receives an individualized written plan of care specific to his or her needs. All members of the care team contribute to a multidisciplinary plan of care based on assessed patient/family needs and goals that is guided by evidence and best practice. Care is initiated as clinically-indicated and documented accordingly. The patient's plan of care includes the following components as applicable:

1. Individualized plan of care that identifies patient-specific, measurable outcomes and goals which includes:
    a. All pertinent diagnoses.
    b. The patient's mental, psychosocial, and cognitive status
    c. The types or services and duration of visits to be made
    d. Prognosis
    e. Rehabilitation potential
    f. Functional limitations
    g. Activities permitted
    h. Nutritional requirements
    i. All medications and treatments

j. Safety measures to protect against injury
k. A description of the patient's risk for emergency department visits and hospital readmission and all necessary interventions to address the underlying risk factors.
l. Patient and caregiver education and training to facilitate timely discharge
m. Patient specific interventions and education as well as measurable outcomes and goals identified by both the CHHA and the patient/ caregiver.
n. Information related to any advanced directives
o. Any additional items the CHHA or provider may choose to include.

2. Each CHHA clinician involved in a patient's case will assure communication related to their service area and interventions provided to the patient by writing a Coordination of Services (COS) note in the medical record every 14 days or less. Each clinician must notify the other clinicians involved in the patient's case to provide them with an update via the note. The COS note will include:
    a. Service type
    b. Progress made by the patient for this service.
    c. Education and training being provided to the patient/ caregiver/ family and their progress, as applicable.
    d. Communication with provider(s)
    e. If the patient has pain, how that is being addressed.
    f. Any other pertinent information.