



Summary Flowchart of Interagency Care Planning (ICP) Process

Step 1: Identify the Need

Practitioner identifies need for interagency care planning

Step 2: Check if ICP exists, If no ICP Seek consumer agreement to commence process

Practitioner discusses with consumer & seeks consumer consent to proceed

Consent not given

Consent given

Practitioner

- documents reasons
- offers again within 3 months

If plan in place contact agency with plan and ask to be involved

If no plan Practitioner explains purpose/benefit of plan to consumer

Step 3: Identify participants and seek consent to share information

Practitioner with consumer

- Identifies participants and consumers preferred care coordinator/key wk
- Consumer completes SCTT Consent Form
- Agreement to proceed documented

Step 4: Communicate with identified agencies and set time for case conference

Practitioner:

- Communicates need for an interagency SCP with all the relevant service providers (including GP) via phone or secure fax/e-referral. Time set for case conference/teleconference/ written information exchange or combination within 2-4 weeks

Step 5: Care Coord/Key Wk appointed and SCP developed. With consumer, check SCP and distribute to team

5A If case conference or telephone conference

5B If written exchange of information

Case conference meeting or telephone conference with consumer present if possible

- Care Coord/Key Worker appointed and leads development of the SCP
- Identifies goals and actions for Plan
- Care Coord/Key worker checks plan with consumer/carer to ensure it meets their needs

Written exchange of information following phone discussions to appoint key worker

- Care Coord/Key Worker develops SCP with the consumer/carer on behalf of team members

Within 5 days Care Coordinator/Key Worker

- Document the Service Coordination Plan
- Includes the Consent Form and a plan for updating and review
- Distributes to all participants

All Care Planning team members place SCP on agency client record

Step 6: Review SCP as per plan or other changes to consumer situation

Care Coordinator/Key Worker to:

- Convene Review as documented in Care Plan or within 2 to 4 weeks of request by other participants (including consumer/carer)
- Document and distribute new Care Plan

All Care Planning Team members to

- Notify the CC/KW of any changes in consumer circumstances
- Update changes notified by CC/KW
- Monitor their particular agreed goals/actions as specified in the Plan
- Ensure new Plan is placed on file within 2 days of receipt