South East Healthy Communities Partnership

Interagency Care Planning Project Report

October 2007
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1. Introduction

1.1 Background

As part of the continuous improvement of Service Coordination, South East Healthy Communities Partnership (SE HCP) identified the need to develop an Interagency Care Planning protocol. A project was funded to work with key stakeholders to build on Care Planning protocols developed elsewhere and to review them and to develop a protocol to meet the needs of consumers and the local service system.

At project commencement in October 2006, mapping of Interagency Care Planning practice identified that only four of the nine agencies/programs who completed the mapping survey had been involved in Interagency Care Planning. The agencies acknowledged current practice was informal and generally involved knowing that another agency was providing service to a consumer and coordinating visits to avoid services arriving at the same time. If an agency changed or ceased their service provision to a consumer this was not always communicated to other agencies involved.

The SCTT Service Coordination Plan had not been used by any of the agencies for Interagency Care Planning. Two programs had received a GP Team Care Arrangement from a consumer’s doctor but this was used as a referral and the process did not actively engage with them.

This report provides information about the various stages of the project and feedback from the workshop held in October 2007 following the trial period and ideas to further progress Interagency Care Planning in the South East.
2. Interagency Care Planning Protocol

2.1 Introduction

A workshop of reference group members and others reviewed protocols developed elsewhere and used those protocols as the basis for developing a protocol related to the local service system. Following the workshop in February 2007, the draft protocol and guidelines were further modified by the project reference group and feedback was sort from the SE HCP Chronic Care Alliance and Committee of Management (COM). Following endorsement by the COM the protocol below was trialled from May - October 2007.

The project acknowledges work done on Interagency Care Planning by:

- Central Victorian Health Alliance, Primary Care Partnership and
- North West Cross Alliance PCPs: Service Coordination Protocol Project

and used work from those projects in the development of the draft protocol.

During the project there has been considerable discussion about and increase in service providers awareness and knowledge of the Medicare items available to GP’s for Chronic Disease Management, including the GP Management Plan and Team Care Arrangement.

2.2 Aim of Protocol

An agreed process, for agencies/GPs providing care to a consumer with complex and or chronic needs to work together with the consumer to achieve better outcomes for the consumer and improved communication and service coordination between agencies/GPs.

Note: Agencies may choose to use this protocol for Intra-agency care planning when 3 or more services within an agency are working with complex clients.

2.3 Draft Protocol

STATEMENT OF OUTCOMES

Consumers with chronic and or complex conditions with services from 3 or more agencies experience greater involvement in planning their care needs, have a central point of contact and improved coordination of services to meet their needs. Participating service providers communicate and work as a team to meet the needs of these consumers.
PROCEDURES:

Step 1
Identify the need for an Interagency Care Plan during Initial Needs Identification/assessment/review. (see Guidelines: Target Group). nb The worker who identifies the need with the consumer does not automatically become the care coordinator/key worker.

Step 2
Check if an interagency care plan exists and seek consumer consent. Discuss with consumer whether an interagency care plan is in place and if so seek consent to contact service to become part of that process.
If no plan in place, discuss with consumer the purpose and benefits to them of an interagency care plan and seek agreement to commence process. Advise the consumer that they may have an advocate of their choice to assist them in the process.

Step 3
With consumer, identify participants (current and/or future) to be involved in developing the ICP using the Service Coordination Plan (SCP) in the SCTT and whether consumer has preference for Care Coordinator/key worker. (see Guidelines: Care Coordinator/Key Worker)
Ask consumer to complete SCTT consent form for sharing of information and document consumer agreement to the ICP process in agency consumer management system.

Step 4
Worker who has identified need for ICP communicates with identified participating services including GP (who is invited to contribute to the ICP and or a case conference) by phone/fax/e-referral and arranges time for case conference/teleconference/exchange of written documentation (or combination) to develop plan and appoint Care Coordinator/key worker.

Step 5a
At case conference/teleconference all participating services and consumer/carer develop ICP using the SCTT SCP and Care Coordinator/key worker is appointed (see Guidelines: The Plan) With the consumer/carer, the Care Coordinator/key worker checks the plan to ensure it meets consumers needs and personal goals and distributes to other participants.

Step 5b
If written exchange of information, Care Coordinator/key worker appointed following phone discussion and they with consumer develop ICP on behalf of team members and document and distribute SCP to all participants.

Step 6
Undertake review as per date set or when consumer/carer situation, goals, change using identified method (case conference, teleconference, written documentation or combination)
2.4 Guidelines

The Target Group
- People with chronic or complex conditions (see definitions) who have or need to have services from 3 or more service providers/programs
- Consumers who already have a case manager or care coordinator/key worker are not excluded from the trial.

The Plan
1. Interagency Care Plan (ICP)
   If the consumer appears to be in the target group, agency/provider asks:
   - Is there an interagency care plan (ICP)? – if there is, with the consumer’s consent contact the agency that has done this to be included in the plan
   - If no ICP, what other services are in place? – if there are multiple services and the person meets the criteria and agrees to have an Interagency Care Plan commence process.

2. GP Team Care Arrangement (TCA)
   Eligibility criteria for MBS Chronic Disease Management - TCA items include:
   - Chronic medical condition present for at least 6 months or terminal condition; and
   - Complex care needs
   - A need to see other providers on a regular, frequent and ongoing basis

   This is a Medicare item number that can only be initiated by GPs that aims to encourage GPs to undertake a “shared care” approach to patients with chronic and complex health care needs. It is used for patients with chronic or terminal medical condition and who require ongoing care from a multidisciplinary team of at least 3 health or care providers (including their GP).

3. What to include when providing feedback for developing an ICP
   - Consumer Details including name, address, DOB, phone details
   - Assessment Summary Outcome
     - Assessed problem or issues, assessment goals, Target/Review/end dates,
     - Planned action or intervention, Services to be provided, Service or health information given to consumers
     - Other relevant info eg admission/discharge date, referrals
     - Consumer signature/consent (verbal) and date
   - Or Discharge Plans as per assessment summary +/- Referral Information
   - Or Investigation Reports eg Xray, pathology etc

4. What would you include in the Interagency Care Plan
   - The assessed problem/s or issue/s
   - Goal/s – clear, achievable and consumer focused (personal goals of the consumer)
   - Some or all of these goals may be used in the plan:
     - Safety and Protection of consumer and/or support systems
     - Management of the episode/acute event or post episode/post acute event (short time frame of days –weeks)
     - Functional gain to improve or optimize levels of independence, wellness, quality
of life (weeks to months)
  o **Maintenance and support interventions** maintain levels of independence, wellness quality of life (weeks to months)
  o **Prevention and early intervention** strategies

**Target dates** or anticipated review or end dates

**Actions or Interventions**
  o Type of intervention – can be crisis, restorative or maintenance in nature or provide preventative, or safety related information
  o Level of service intervention
  o Frequency of the interventions

**Responsible agency/service**
You may also include an emergency/crisis response plan.

5. **Process for developing and reviewing an Interagency Care Plan**

Involve the consumer/carer where possible and seek their consent to include relevant services in the development of the Service Coordination Plan and their agreement of the plan and for it to be distributed to the services involved.

Choose the most appropriate method or combination of methods that can be organized in a timely manner but *please note that the most comprehensive method to develop the plan is considered to be a face to face case conference.*

  o **Case conference:** prior to meeting, assessments and agency care plans provided to Care Coordinator for review with the consumer/carer. Check for unmet needs, duplication, lack of coordination. At the meeting use collaborative problem solving and planning to resolve issues and action. Care Coordinator to collate and distribute SCP to those involved following service and consumer/carer agreement.
  
  o **Teleconference** as for case conference
  
  o **Paper based by secure email, fax, post**, assessments and agency care plans provided to care coordinator for review with the consumer/carer. Check for unmet needs, duplication, lack of coordination. Problem solve and action plan through discussion with relevant services. Care Coordinator to collate and distribute SCP to those involved following service and consumer/carer agreement

**Timeframe for Trial**
Development: Complete ICP using SCP within 4 weeks of agreement by consumer to be involved.
Review: Aim for 6 weeks after commencement of SCP.

**Feedback**
Need for all services included in the SCP to provide and receive regular feedback through the care coordinator/key worker via e-referral if available, otherwise fax.

**Care Coordinator/key worker**
  o If consumer has a **Case Manager/HARP Care Coordinator/HARP Service Facilitator/key worker for EIiCD** they would act as the Care Coordinator/key worker
  
  o If consumer does **not have any of the above** discuss with the consumer who they would prefer to be their Care Coordinator/key worker.
  
  o **Which agency** is best suited to provide the Care Coordinator/key worker:
    - Is there a main service provider/support person
SEHCP Interagency Care Planning Project

- Funded to provide care coordination
- Preference of consumer if possible
- Capacity to facilitate process
- Area of specialization and knowledge meets consumer needs
  - **Consumer, Carer or family member as care coordinator/key worker**  eg Parents of children with special needs – need for agency to support carer/family member undertaking this role, include an agency “fall-back” person in the plan
  - **Changing the Care Coordinator/key worker** over time eg ACAS may only be involved in the initial development phase of the plan so the Care Coordinator/key worker would need to change to someone who has ongoing contact with the consumer/carer.

**Good Practice Guide for Workers: Role of Care Coordinator/Key Worker**

“If you are the key worker, coordinate

- The implementation of the Service Coordination Plan including review and, re-assessments
- Any monitoring activities
- Care
- The liaison and communication with key stakeholders such as the GP and organise case conferences etc if required
- The development of exit options and procedures
- Information management processes to meet the requirements of the Health Records Act and other privacy legislation
- Coordinate the development of a SCP for consumers with complex or multiple needs and multiple agency involvement
- Empower the consumer to participate in the development, implementation, monitoring and review of their Service Coordination Plan
- Obtain consent to share the Service Coordination Plan and other consumer information with other agencies if required
- Provide a copy of the Service Coordination Plan to other agencies, the consumer’s GP and the consumer”


**2.5 Definitions**

Use of common terminology is a repeating theme in discussion about interagency care planning. Frequently different terms are used to convey similar meanings which can lead to confusion for consumers and service providers. For the trial period it was agreed that the following definitions would be adopted.

**Care Planning** is a process of deliberation that incorporates a range of existing activities such as care coordination, case management, referral, feedback, review, re-assessment, monitoring and exiting. Care planning involves the judgement/determination of relative need as well as competing needs, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.

Care Planning also provides a means of synthesizing assessment information and agreed strategies and is particularly important in facilitating appropriate care for consumers with multiple or complex needs. Care Planning is dynamic and can occur
at a number of levels.


**Care Coordination** describes activities undertaken following a Living at Home Assessment for a subgroup of clients with complex needs and circumstances. Clients needing care coordination include clients receiving services from multiple organizations who are not receiving case management as part of a package of care.

Client care coordination for this client subgroup is an extension of the assessment, care planning and care plan implementation process where there is multi-agency involvement.

Client care coordination may include a range of tasks such as facilitating interagency care planning due to multiple agency involvement in service delivery; facilitating development and reviews of the service coordination plan; more frequent monitoring and review of the service specific care plans; or assistance with accessing services from a range of program areas outside the HACC program.

Care coordination and case management are distinct activities on the same continuum. Client care coordination can be regarded as a less intensive form of case management.

Ref: Framework for Assessment in the Home and Community Care Program in Victoria June 2007

**Case Management** includes the roles and tasks described above for care coordination as well as arranging additional services needed by the consumer by means of sub-contracting, purchase of services or maintenance of effort agreements between organisations: organising case conferences and actively monitoring care plans for changes in client or carer circumstances.

Ref: Framework for Assessment in the Home and Community Care Program in Victoria June 2007

**Chronic condition** - A condition of at least six months duration that can have a significant impact on a person's life and requires ongoing supervision by a health professional. Amongst Australia's national health priorities are chronic conditions that are our greatest burdens of disease: asthma, cancer, cardiovascular disease, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.

Ref: HARP Chronic Disease Management Guidelines, p. 9.

**Key worker** - A key worker should be an appropriately qualified health professional whose role includes: coordinating a comprehensive assessment (if required); collecting clinical information at regular intervals; ensuring that a care plan is in place and that it is monitored and reviewed; identifying client and care capacity for self-management; communicating and liaising (including service outcome communication) with other health care providers (including GPs, AHPACC Partnership worker); coordinating a multidisciplinary case conference; being a contact for the client should their condition deteriorate or circumstances change that may impact on the course of their condition; supporting carers; referring to community-based activities; a flexible approach to ongoing follow up; and, following up clients dropping out of the program.
Complex Needs

- People with multiple disabilities (health, social, cognitive) needing assistance in a number of areas of their life
- People who are vulnerable and live alone and have no effective or immediate support from family or friends, particularly those with confusion and memory loss
- People with behaviours that others find difficult and don’t want assistance from services or don’t perceive the need for assistance when there is objectively a clear need for it
- People with frequently changing and fluctuating needs
- People who have a multiplicity of disabilities combined with communication and relationship difficulties or social isolation
- Situations where there are two ‘consumers’ – the person with the disability and the carer, both of whom have significant needs
- People who have considerable disabilities and lose their carer
- People from non-English speaking backgrounds, where language or culture or family expectations mean that traditional service responses are not appropriate, or at least need modification or, where they cannot identify services as they have no understanding of the role of these services
- People who have an acute decline in ability to self manage.


Interagency Care Plan (ICP) An agreed process, for agencies/GPs providing care to a consumer with complex and or chronic needs to work together with the consumer to achieve better outcomes for the consumer and improved communication and service coordination between agencies/GPs.

Service Coordination Plan (SCP) The actual forms from the SCTT on which the Interagency Care Plan is documented.

2.6 Resources

Information for consumers and General Practitioners (Attachment 1 and 2) were developed to support the trial of the protocol. The information for consumers was to assist consumers and their families understand interagency care planning and the benefits for them of being involved in the trial.

Division of General Practice members of the reference group advised that information about the project was best provided via the GP Division Newsletters and then when clients were identified and agreed to take part in the trial talking with the General Practitioner and or their Practice Nurse about their involvement in the development of an interagency care plan.
2.7 Trial Process

The project planned to undertake 20 interagency care plans during the trial period from May to August 2007. As approval processes took longer than anticipated the trial was extended to October 2007.

Reference group members (Attachment 4) from Local Government, Community Health, an NGO, Linkages and CACPs, RDNS, Early Intervention in Chronic Disease, Better Living Better Health (HARP), Divisions of General Practice, Mental Health Continuing Care and a Regional Health Service had the role of supporting take up of the draft protocol by speaking with co workers about the protocol and trial process.

The aim of the trial was to:

- Test the practices and processes developed in the draft protocol
- Identify benefits, barriers, challenges for service providers to ICP
- Identify future work to be undertaken to support interagency care planning.

Prior to the trial commencement Casey Council stated that due to restructuring of their assessment team they would not be able to take on the Care Coordinator role but would contribute to any care plans initiated by other services involving shared clients. RDNS Better Living Better Health (HARP) Care Coordinators were unable to act as Care Coordinators as they were involved concurrently in a pilot for the HARP program.
3. Outcomes of the Protocol Trial

3.1 Overview

During the trial period the assessment services at both Casey Council and Mecwa Cardinia Care underwent restructure which impacted on these agencies capacity to be involved in the trial especially as Care Coordinators/Key Workers and directly impacted on the number of Interagency Care Plans (ICP) developed.

City of Gt Dandenong (CGD) initiated a meeting with Bunurong Community Care and another with RDNS to identify shared clients who would benefit from an ICP. This resulted in 3 ICP being developed between CGD and RDNS and other agencies.

City of Casey was involved in the development of one ICP with a number of other agencies.

Nine agencies participated in ICP developed during the trial. These included City of Gt Dandenong, City of Casey, RDNS, Mecwa Cardinia Care. Post Acute Care, South East Palliative Care, Very Special Kids, Brotherhood of St Laurence Nexus program and the Carer Respite Service. One General Practitioner participated via phone and was kept informed of changes to the consumers ICP.

The number of agencies providing support to clients who had an ICP developed ranged from three plus the GP to five plus the GP.

The Care Coordinator/Key Worker role was taken by City of Gt Dandenong staff on two occasions and by RDNS and the Carer Respite Service once each. Care planning meetings were held at the consumer's home with some agencies involved by phone.

3.2 Learnings from the Trial

Although the draft protocol was not tested extensively staff who used it found it met their needs. The suggested time frame of producing the ICP within 5 days of the case conference proved difficult to meet, however it was decided to keep this timeframe as the goal. It was also suggested that the protocol include comment about the use of Advocates by the consumer.

Benefits

Outlined below are the benefits that agencies reported from their own perspective and that of the consumers involved:

- Family knowledge that all services are working from the one plan and the feeling that they were really supported
- Consistency of message to consumer
- All service providers together at one time which resulted in improved understanding of what other agencies could provide and how the services could work together to meet the clients needs
- The opportunity to meet face to face and establish relationships with other workers
- SCTT Service Coordination Plan useful, met needs
- GP involvement - on phone, kept informed of changes
- Eliminated duplication of services
- Joint discussion about review timeframe.

**Barriers**

- Capacity/time required to undertake the Care Coordinator/Key Worker role
- Working Group/staff changes/turnover resulted in diminished spread of information about the ICP Protocol and trial
- Staff suggested that development of Central Intake services has resulted in less contact between workers so personal relationships are not at the level they were previously and it is more difficult to set up joint meetings
- As the SCTT Service Coordination Plan was not available electronically one agency did not use it
- Restructuring of assessment services in two local government areas during trial period.

**Other Issues**

Other points which became obvious during the trial were:

- Some clients may wish to have an Advocate support them during the ICP process
- Not all clients can cope with a large groups of staff for joint assessments so it may be necessary to conduct the Case Conference away from the persons home or by a mix of phone/face to face.
## 4. Next Steps

Discussion at the post trial workshop identified possible areas for future work which are set out below.

<table>
<thead>
<tr>
<th>Focus</th>
<th>Action</th>
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<tbody>
<tr>
<td><strong>1. Staff Development</strong></td>
<td>Request HACC Training Committee investigate inclusion of Care Planning and running/organising a Case Conference on the training calendar.</td>
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</table>
| **2. Engage additional Referral Partners in service coordination and ICP** | To ensure referral partners are aware of the developments in ICP it was suggested that the following sectors and services are engaged in service coordination and ICP activities.  
- Children’s Services eg Windemere, Connections, WRESA Care  
- Disability Services eg Yooralla, MS Society, ARBIAS  
- Mental Health and Alcohol and Drug services eg Aged Mental Health Team, SEADS  
- Aged Services eg Do Care  
- Early Intervention and Chronic Disease Management programs  
- Better Living Better Health HARP  
It is also important for services currently involved in service coordination to extend their involvement in Interagency Care Planning. |
| **3. Further roll out of Interagency Care Planning (ICP) in the South East catchment** | Raise awareness of ICP by:  
- Inclusion in agency staff induction and protocols  
- Inclusion on agenda for agency team meetings  
- Suggestion at staff supervision to use ICP for clients with complex needs  
- Sharing of outcomes of pilot at local Service Coordination and Chronic Disease Management meetings  
- Providing information to relevant consumers on the purpose of ICP  
- Informing other service providers of the ICP protocol through SE HCP dissemination processes  
- Joint agency meetings to identify shared clients with complex needs who may benefit from ICP |
<p>| <strong>4. Further engagement with General Practitioners</strong> | Continue to encourage provision of feedback on shared clients to General Practitioners |
| <strong>5. Dissemination of</strong> | Share outcomes of pilot at statewide Service Coordination |</p>
<table>
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<tr>
<th>project findings</th>
<th>meetings</th>
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<td>• Provide report to DHS Care Planning Project Manager for inclusion on DHS Care Planning website</td>
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| 6. HACC Assessment Framework Implementation | Ensure any changes locally due to the implementation of the HACC Assessment Framework consider the need to provide ICP either as the Care Coordinator/Key Worker or as a participant in the process |

| 7. Information Technology | Further investigate Infoxchange Care Planning tool |
Attachment 1: Information for Consumers

To provide a more coordinated service for you, Service Providers (eg Council services, Community Health, your GP etc) want to trial careplans for people who may be using more than two services. This is known as an “Interagency Care Plan”. We need your help to do this. Your service provider thinks an Interagency Care Plan would be of benefit to you and would like you to be part of the trial.

WHAT HAPPENS NEXT

If you agree to be involved you will be asked to give consent for your information to be shared between your service providers.

Your service provider will arrange a meeting or phone link. At this meeting you and all your service providers will discuss support services that could assist you meet your needs and goals. We will develop a draft Interagency Care Plan.

After the meeting you can discuss the proposed plan with your service provider to make sure it meets your needs and that there are no gaps or overlaps of services.

After the trial period (May -September) we will ask you to tell us about your experience. This and the feedback from service providers will be used to revise the way service providers work before this process is used more widely in your area.

Thank you for your part in helping to improve service coordination and planning in the South East.
Attachment 2: Information for General Practitioners

BACKGROUND
Across Victoria many people who use a range of health and community services have said that there is no real coordination between the services.

To try to overcome this South East Healthy Communities Partnership has funded a project to develop and trial an Interagency Care Plan Protocol. A working group comprising community based service providers and GP Division staff in Greater Dandenong, Casey and Cardinia has drafted a protocol designed to support improved service coordination.

HOW WILL IT WORK?
Service Providers will invite clients with complex needs using more than three services, and who may benefit from an interagency care plan, to be involved in the trial of the protocol. Once clients have agreed to be involved (and consented to their information being shared between providers) their GP will be invited by the client’s case manager or worker to take part in a case conference which may be in person, by phone or by providing written information to develop the interagency care plan.

At the case conference, the GP may choose to undertake a GP Management Plan (MBS Item 721) and/or Team Care Arrangement (MBS Item 723). If, as a consequence of the case conference, the GP undertakes a 723, then it is understood that they will liaise with the patient and provider to complete the “Team Care Arrangement.”

Alternatively, the GP may choose to contribute to the care plan developed by another provider (MBS Item 729). If the GP does not undertake either a GPMP or TCA, they may still claim the relevant “participation in a community-based case conference” item (Items 759, 762, or 765).

WHAT HAPPENS NEXT?
After the trial period (May-September) if you have been involved your feedback will be sought and used to improve the protocol before it is used more widely in the South East.

Contact:
Julie Sutherland Dandenong and District Division of General Practice ph 9706 7311
Diana Fayle Eastern Ranges GP Association ph 9739 6751
Heather Lawson for South East Healthy Communities Partnership ph 9645 1499
Attachment 3: Interagency Care Planning (ICP)

**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.
- 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 identifies key participants and consumers preferred care coordinator/key worker.
- Consumer completes SCTT Consent Form.
- Agreement to proceed documented within 5 days.

**Step 4: Communicate with identified agencies and set time for case conference**
- Practitioner: Communicates need for an ICP 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 ICP developed. With consumer, check ICP and distribute to team**
- Case conference meeting or telephone conference with consumer present if possible:
  - Care Coord/Key Worker appointed and leads development of the ICP.
  - 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 ICP with the consumer/carer on behalf of team members.

**Step 6: Review ICP as per plan or other changes to consumer situation**
- Practitioner: 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.

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**Consent given**
- Practitioner documents reasons and 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.

**Consent not given**
- Practitioner with consumer:
  - Identifies participants and consumers preferred care coordinator/key worker.
  - Consumer completes SCTT Consent Form.
  - Agreement to proceed documented.

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**Step 6A**
- Written exchange of information following phone discussions to appoint key worker:
  - Care Coord/Key Worker develops ICP with the consumer/carer on behalf of team members.

**Step 6B**
- Written exchange of information following phone discussions to appoint key worker:
  - Care Coord/Key Worker develops ICP with the consumer/carer on behalf of team members.

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**All Care Planning team members to**
- Document the ICP in SCTT Service Coordination Plan.
- Includes the Consent Form and a plan for updating and review.
- Distributes to all participants.

**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.
## Attachment 4: Reference Group Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency /Program</th>
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<tbody>
<tr>
<td>Alison Manning</td>
<td>HARP CDM CHF Clinical Nurse Consultant</td>
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<tr>
<td>Lisa Paulin</td>
<td>Eastern Ranges GP Association</td>
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<td>Diana Fayle</td>
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<tr>
<td>Bernadette Unmack</td>
<td>Care Consultant Care in Context - Dandenong</td>
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<tr>
<td>Ruth Johnson</td>
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<tr>
<td>Joel Hanafin</td>
<td>Mental Health Continuing Care Team</td>
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<tr>
<td>Jill Walsh</td>
<td>Project Manager EiCD, Cardinia Casey CHS</td>
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<td>Thea Payne</td>
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<tr>
<td>Julie Sutherland</td>
<td>Dandenong &amp; District Division of General Practice</td>
</tr>
<tr>
<td>Lucille Flanagan</td>
<td>City of Gt Dandenong, Community Care</td>
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<td>Meredith Bryant</td>
<td>Mecwa Cardinia Care</td>
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<td>Sussy Vasquez-lozano</td>
<td>City of Casey Coordinator Assessment Officers</td>
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<tr>
<td>Maree Eisma</td>
<td>Social Worker, Kooweerup Regional Health Service</td>
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<tr>
<td>Sue Conway</td>
<td>RDNS HARP Service Facilitator</td>
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<tr>
<td>Sue Chamberlain</td>
<td>Area Coordinator, Care Coordination Programs Bunurong</td>
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<td>Community Care</td>
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- **SEHCP Interagency Care Planning Project**