Case Management Expectations

The following Case Management Expectations apply to all case managers on the approved case manager (Lifetime Care) Prequalification List. These expectations apply when working with participants of the Lifetime Care & Support Scheme (Lifetime Care) and/or workers in the Workers Care Program (Workers Care).

The term "participant" throughout this document includes both participants of Lifetime Care and workers of Workers Care.

All case managers are expected to be familiar with the case management taxonomy[1] and understand their own clinical responsibility if delivering services across all the interventions described.

Part 1: Case manager capabilities and behaviours mapped to the Case Management Taxonomy

1.	Engagement
1.1	**only accepts referrals for participants for whom they have the knowledge and expertise to deliver quality services**
	• only accepts referrals for participants within the categories the case manager is approved for (e.g. children, young people, adults and disability groups) • only accepts referrals for whom their hours of work can reasonably meet the participant's needs (i.e. case manager considers their availability and consequent responsiveness) • demonstrates knowledge of appropriate community services/supports available to participants • demonstrates the ability to develop knowledge on local services/supports when providing case management services for a participant in an unfamiliar locality.
1.2	**works with participants and their families in a way that builds trust, maximises engagement and develops self-efficacy**
	• demonstrates understanding of the needs of the participant in terms of their disability, personal goals and context • demonstrates understanding of the needs of the participant in terms of their progression along the Focus for Participation continuum, and adjusts their approach and performs the most appropriate case management interventions to best suit the participant's needs

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[1] Lukersmith, S (2017), A Taxonomy of Case Management: Development, Dissemination, and Impact. The Sydney eScholarship Repository, Post graduate theses/Sydney Digital Theses (Open Access) http://hdl.handle.net/2123/17000

- is sensitive to the social and cultural context of the participant

- uses clinical reasoning including knowledge of best practice, research evidence, the participant's circumstances, social and service context to make the most appropriate decisions and recommendations

- responds to participant needs and concerns in a timely manner

- actively engages the participant and where appropriate, their family in all decision-making

- demonstrates recognition that the participant is the expert in their own circumstances and respects their choices and priorities.

2.	Holistic Assessment

2.1   completes holistic assessment of the participant's circumstances and needs

- ascertains the participant's capacity for decision-making across a range of decision-making contexts, and applies the appropriate level of decision-making support for the circumstances

- identifies and utilises the participant's strengths – using narrative and self-reflection as tools to enable participants to build strengths-based self-efficacy

- completes holistic assessment of performance and needs across health and well-being domains, including participation in key life areas (e.g. education, work, social, cultural and civic life)

- completes comprehensive identification of barriers and facilitators to rehabilitation, self-efficacy and achievement of goals

- identifies the participant's progress along the Focus for Participation continuum – and anticipates the types of goals, level of engagement and what case management actions the participant needs

- elicits the participant's story – hears and is able to utilise their narrative to enhance their own understanding of their context and thereby maximise outcomes from services and supports

- observes the participant within their home – gathering information regarding all potential barriers & facilitators that might have an impact on activity/participation, and on rehabilitation progress

- uses quality of life outcome measures to monitor the participant's progress and inform rehabilitation priorities, goals and strategies

- gathers, understands and utilises the information in reports from other people involved

| | – e.g. doctors, allied health practitioners |
| | • assesses (formally or informally) the participant's (and their family's) health literacy |

3.	Planning
3.1	**plans are developed using a person-centred approach**
	• utilises and builds the participant's strengths to achieve rehabilitation/plan goals
	• includes the participant's perspective regarding progress, outcomes, and future needs in all planning
	• facilitates the participant to make informed choices regarding goals and strategies in plans. Provides the right support to the participant to enable them to exercise choice around supports which meet their needs.
	• works with participants and their families in a culturally sensitive way, managing any socially or culturally sensitive issues or concerns
	• Plan preparation strategies are used appropriately to enable participants to maximise their involvement in planning through self-assessment and reflection on progress, self-reflection and self-identification of strengths, priorities and goals
3.2	**plans include participant-generated as well as provider-generated goals as needed**
	• incorporates participant-generated and where appropriate to the circumstances case manager-generated goals
	• facilitates appropriate incorporation of treating practitioners' feedback and therapist-generated goals into next plans
3.3	**plans include strategies supported by objective progress reporting from past service providers and objective outcome measures**
	• plans contain information regarding objective measures of outcomes from the previous plan period. This information directly relates to what is included or proposed for the next plan period.
3.4	**plans promote independence across all phases of the Focus for Participation continuum and in all aspects of goal achievement and service delivery**
	• plans include details of what the participant is going to do to achieve their goals and self-manage as appropriate in the circumstances
	• descriptions of case manager role in plan implementation demonstrate commitment to reducing the participant's dependence on the case manager by facilitating the participant's health literacy, self-efficacy and sense of responsibility

4.	Education

4.1 provides structured, plain language information to participants and their families to maximise their health literacy, self-efficacy, confidence and trust

- provides injury management education and support to the participant and/or their family if working with newly injured participants

- actively builds participants' health literacy by promoting their understanding of their health and health needs, appropriate service and service provider selection, and appraisal of outcomes

- provides information about the role of the case manager to participants and families and reinforces the participant's own role and abilities in maximising self-management

- Ensures understanding of educational information through appropriate use of language supports, interpreters, plain English/plain language material and systematic checking for understanding (such as "teach-back" techniques)

4.2 provides information, advice and support to community groups and service providers working with the participant as needed

- educates other health and service providers about working with Lifetime Schemes and working with the participant. Utilises the booklets "Working with Lifetime Care" and "Working with Workers Care" to achieve coordinated and mutually beneficial working relationships across the team.

- educates selected community services and community groups in understanding injury/disability sequalae to enhance a positive participant experience and maximise potential for achieving participation goals

5.	Training and Skills Development

5.1 provides training and reinforcement of specific strategies designed to maximise achievement of independence and participation goals

- helps participants and families understand what can be funded by Lifetime Schemes and how to request services when needed. Promotes the development of self-management capabilities over time.

- facilitates participants' engagement with person-centred planning by training in plan preparation, goal identification, reflection on progress and evaluation of services received and strategies tried.

- assists participants and families develop competency in self-managing aspects of disability, risk identification and safeguarding, including developing "who to call" risk-

		management plans and crisis management plans.
5.2		**understands, reinforces and monitors consistent application (across rehabilitation and care teams) of strategies developed and training provided by other team members. For example, positive behavior support programs, memory strategies, exercise and fitness home programs, dietary programs.**
		• ensures own (i.e. the case manager's) understanding of intervention plans and strategies developed by team members and promotes dissemination of these across the whole team to ensure a consistent approach and adherence to strategies
		• checks in with team members that they are using strategies such as "teach back" to ensure participant and family understand and can apply the techniques and knowledge they are being trained in

6.		**Emotional and Motivational Support**
6.1		**encourages and reinforces participants and their family to build independence, make decisions, exercise choice and responsibility and take action. Supports the participant's and family's adjustment to changed circumstances.**
		• proactively observes for any emerging adjustment issues
		• engages professional support if/when indicated
		• demonstrates understanding of the needs of families around grief and adjustment, and facilitates their access to appropriate supports as needed
		• uses motivational interviewing techniques to maximise engagement and responsiveness of participants

7.		**Advising**
7.1		**Identifies risks and applies appropriate safeguarding measures to promote participant safety**
		safeguarding practice • provides the participant (and family if appropriate), with enough information to ensure participant makes fully informed choices
		• demonstrates understanding of the difference between an active, well informed choice regarding high risk behavior, and inherent vulnerability when the participant lacks insight, has compromised judgement, is a child or other factors which might influence their capacity to be the decision-maker in a particular instance
		• where risk to a participant is identified, appropriate actions are taken to minimise risk

of harm. Some actions may include, but are not limited to:

- o guiding participants in finding ways to mitigate or manage risk within their choices
- o liaising with other stakeholders (such as Lifetime Schemes, other service providers, guardian, family) to ensure a consistent approach by all
- o referring to appropriate bodies for high risk behavior management or child protection issues – e.g. Dept Communities & Justice (FACS), guardian

- where risk has been identified and advice/actions taken, appropriate documentation is provided to icare

Serious Incident Response

in the event of the case manager becoming aware of a serious incident, one that has caused or poses an immediate or serious risk of harm (to the participant or to others), icare is informed immediately by telephone and follow up email/other written correspondence

Adverse Change in Situation

advises icare in writing, attaching any relevant documents, as soon as case manager becomes aware of an adverse change in situation for a participant where their safety or wellbeing will or may be significantly affected

7.2	**Assists participants to identify realistic goals and select appropriate strategies to achieve their goals**

- using a strengths-based, person-centred approach, guides the participant's identification of both realistic and aspirational goals

- provides information about options for strategies, services and service providers to assist participants make informed choices about the steps they will take to achieve their goals

8.	**Coordination**

8.1	**incorporates both formal and informal supports into participant plans**

- identifies a range of local supports for the participant to choose from to facilitate goal achievement

- identifies and appropriately utilises both formal and informal supports, including formal supports not funded by icare, to enable participant goal achievement

- coordinates complex, multi-disciplinary rehabilitation programs

8.2	**facilitates access to services**

- navigates and facilitates the access, management, and cohesion of services and supports for the participant

		• ensures selected service providers understand the participant, their needs and how to effectively work with the relevant Lifetime Scheme
		• advocates for the participant's inclusion in community groups and services where necessary
8.3	**ensures effective implementation of plans, including effective team collaboration, consultation, and participant engagement**	
		• ensures all supports involved in the plan have received the plan, understand the agreed and approved support they will deliver throughout the plan, and understand where they may need to liaise/work together with other supports
		• promotes and actively monitors progress and step completion throughout the plan period
		• ensures integration of steps and supports across service providers (i.e. interdisciplinary approach)
		• avoids unnecessary or inappropriate duplication of goals, steps or supports by service providers involved. Where two service providers are working towards the same goal/s, their specific role is clear.
		• arranges and coordinates team meetings as needed
		• facilitates timely receipt of therapy progress reports to ensure momentum of plan and goal achievement. (Provides sample progress report template/s developed by Lifetime Schemes to therapy providers if required).
		• identifies and reinforces where the participant can independently coordinate aspects of their services themselves

9.	**Monitoring**
9.1	**actively seeks feedback and evaluates progress to monitor goal achievement**
	• ensures plans and/or therapy intervention plans include measurable goals and steps to track outcomes and benefit
	• outcome measures for both funded and non-funded supports are used appropriately
	• feedback from service providers and relevant others regarding progress is discussed with participants and is meaningfully incorporated into successive plans
	• where goals are not achieved, or not achieved within the anticipated time frame, clear explanation is given as to why
	• monitors outcomes across the entire plan, not just the aspects icare has funded and not just at the end of the plan period

9.2	**effectively promotes and manages disengagement/case closure/case handover**
	• case manager role as described in plans demonstrates promoting participant independence and working towards case closure/disengagement or case transfer where appropriate
	• appropriately uses other supports (for example attendant care workers, attendant care coordinators, Lifetime Schemes staff, other team members) to perform actions in the Case Management Taxonomy when indicated
	• recognizes when the participant no longer requires a case management service and facilitates disengagement
	• recognizes when the participant's needs might be better served by an alternate case manager/service type and initiatives appropriate hand-over
	• ensures participants understand who they can seek assistance from should their needs change once case manager has disengaged.

Part 2:   Professional Behaviour expectations

1.	**Working Relationships**
1.1	**communicates effectively with participants**
	• maintains communication with participants and their family as agreed in the plan and as needed should circumstances change throughout the plan period
	• selects from a range of communication strategies appropriate to the participants' needs
1.2	**uses telehealth options appropriately**
	• understands the potential benefits and barriers to using telehealth with individuals
	• appropriately selects when telehealth is a reasonable and cost-effective option
1.3	**works cooperatively with a range of service providers**
	• makes referrals to a range of service providers. May include providers working within their own team, or providers working elsewhere – either in public or private organisations.

	• respects the position of providers from other sectors in the team and works cooperatively across all sectors:
	   ○ private/public
	   ○ community-based/in-patient
	   ○ allied health/disability/care/medical
	   ○ formal/informal supports

	• ensures service providers understand Scheme requirements – Treatment,

		Rehabilitation & Care guidelines, Reasonable & Necessary/Reasonably Necessary criteria, paperwork, timeframes and progress reporting
		• provider feedback is appropriately discussed with participants and integrated into plans
1.4	**works cooperatively with Lifetime Schemes**	
		• demonstrates an appreciation of the extent – and limit, of the Lifetime Scheme's role in meeting the range of participant needs which might be identified through planning and general case management activity
		• responds constructively to feedback from icare, and appreciates Lifetime Scheme's perspective when a request is not approved, or further information is requested
		• provides a reasonable, written explanation when requests and plans are going to be delayed, extensions are needed, or retrospective requests are being submitted
1.5	**fosters a positive relationship between participants and the Lifetime Scheme**	
		• presents the Lifetime Scheme in a positive light and assists participants to understand what they can reasonably expect from the Lifetime Scheme, to foster a life-long relationship that is built on trust
1.6	**recognises and is proactive when relationships have become unproductive for the participant**	
		• liaises with Lifetime Schemes staff when difficult relationships have emerged
		• is proactive in facilitating handover to new provider when their own relationship with the participant is compromising outcomes for the participant
		• manages appropriately when the relationship between the participant/family and another service provider has become unproductive

2.	**Documentation**
2.1	**consistently uses the correct Lifetime Schemes forms**
	• correct use of My Plan forms and Service Requests
	• provides the necessary information in emails for fast track requests/service amendment requests
2.2	**requests are made in a timely manner**
	• requests are submitted in time for the request to be reviewed and processed and the outcome communicated <u>before</u> the date that the plan/service/item needs to be available to the participant
2.3	**requests are completed by the appropriate person**

		• requests are appropriately completed by the case manager, a treating professional, an independent assessor, the participant or a member of the participant's family/advocate
		• care needs assessments are completed by an approved assessor and not the case manager (unless they are an approved care needs assessor or a care needs review has been requested)
2.4	**forms are completed correctly and provide the necessary information for the Lifetime Scheme to make decisions about funding**	
		• plans and request forms are revised and up-dated prior to submission to ensure all participant information is current and correct
		• enough information is provided about the participant and their circumstances for icare to make an "in the circumstances" decision about funding
		• request forms include details of how the request relates to Treatment Rehabilitation and Care
		• request forms include enough information to enable an assessment against the Guidelines, including the Reasonable & Necessary criteria for Lifetime Care or Reasonably Necessary criteria for Workers Care.
		• hours and costs for services included in plans and requests are reasonable in the circumstances and recorded accurately
		• where the case manager identifies that a request may not meet the reasonable & necessary (or reasonably necessary) criteria, but the participant still wishes the request to be submitted, the case manager has explained these circumstances in the request
2.5	**cost effectiveness considerations**	
		• the case manager guides the selection of providers based on ability to deliver the most cost-effective service. This includes consideration of skills and experience, travel costs, hourly rates, and availability to deliver services in own rooms.

3.	**Professional conduct**
3.1	**adheres to professional boundaries regarding role as case manager**
	• interactions with participants, family and other service providers demonstrate knowledge of case management role, definition and boundaries
	• engages services of appropriate professionals or community services to complete assessments, prescribe equipment or services, or deliver services which fall outside of the case manager's role
3.2	**Terms of Approval**
	• adheres to all sections of the approved case manager (Lifetime Care) Terms of

		Approval
3.3	**continuous improvement**	
	• remains up to date in knowledge of current national health and disability sector best practice and initiatives	
	• utilises support from within own business unit where available (i.e. senior staff and colleagues) to ensure high quality service provision to participants	
3.4	**attends training run by Lifetime Schemes as appropriate**	
	• has attended relevant training opportunities offered including completing modules relevant to case management service delivery as they become available on Lifetime Learning	
3.5	**adheres to privacy requirements**	
	• demonstrates adherence to privacy principles as defined by the *Privacy & Personal Information Protection Act* (PPIPA) and the *Health Records & Information Privacy Act* (HRIPA)	
	• breaches in privacy (by the case manager or by others) are reported and managed in accordance with the *Privacy & Personal Information Protection Act* (PPIPA) and the *Health Records & Information Privacy Act* (HRIPA)	
3.6	**conflict of interest**	
	• declares any potential conflict of interest, for example relationships with other service providers, other funding bodies or the participant and their family and takes appropriate action to avoid a conflict of interest	
3.7	**respect**	
	• in all formal and informal communications does not compromise the reputation of icare, its programs or its personnel	
	• when referencing work for icare on business web-pages, uses approved icare logos and honest claims regarding relationship	

4.	**Business Management Systems**
4.1	**Has efficient communication and business technology systems**
	• has a business telephone
	• has email capability
	• has Internet capability – including access to icare website, Yammer, and other systems as they become a part of usual business practice
	• has scanning or photo-sharing capability

		• able to use the My Plan forms – interactive PDFs, word, excel
		• has capability of offering telehealth options to appropriately selected/identified participants and/or team consultations using a secure platform
4.2	**ability to provide services efficiently**	
		• only accepts referrals for participants for whom they can deliver efficient home visiting/local community visits as needed
		• acceptance of referrals demonstrates consideration of whether their own work days/arrangements can support the needs of the participant
4.3	**efficient invoicing systems**	
		• invoices are sent in a timely manner and include all information required by icare
		• only services pre-approved by icare are invoiced
		• does not submit invoices for retrospective services
4.4	**leave cover**	
		• appropriate arrangements are made to ensure participant receives all necessary services when case manager is on leave
		• informs coordinator of planned leave with adequate notice for alternative arrangements to be actioned (or of unplanned leave as soon as is practicable)
		• utilises identified leave cover colleagues and provides coordinator (as well as participant and their family and all involved provider services) with their contact details
		• in instances where coordinator will be managing the file in case managers absence; discusses this with, and gets agreement from, the coordinator – well in advance
		• ensures no key plans or requests will need to be completed during the period of leave – plans should either be brought forward, or request an extension as is appropriate

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