

1: Best practice case management and planning	
Expectation	Evidence case manager meets the expectation
Only accepts referrals for participants for whom they have the knowledge and expertise to deliver quality services	<p>Demonstrates understanding of the needs of the participant in terms of their disability.</p> <p>Demonstrates understanding of the needs of the participant in terms of their progression along the focus for participation continuum (ref app a), and adjusts their style of case management to best suit the participants needs.</p> <p>Coordinates complex, multi-disciplinary rehabilitation programs and provides injury management education and support to the participant and/or their family if working with newly injured participants.</p> <p>Is sensitive to the cultural needs of the participant.</p> <p>Makes clinically appropriate decisions and recommendations in line with latest best practice and evidence-based data.</p> <p>Only accepts referrals for groups approved for (eg children, adults, phases on continuum, disability groups, specific skills).</p> <p>Only accepts referrals for participants for whom their hours of work can reasonably meet the needs (ie considers responsiveness and availability of part-time case management).</p> <p>Demonstrates knowledge of appropriate community services/supports available to participants.</p> <p>Demonstrates the ability to develop local service/support knowledge when providing case management services for a participant residing outside of their own local area.</p>
Plans are developed using a person-centred approach	<p>Plans are strengths-based.</p> <p>Plans include the participant’s perspective regarding progress, outcomes and future needs.</p> <p>Plans include informed choices made by the participant. Enough support is provided to the participant to enable them to exercise choice.</p> <p>Planning Conversations are used appropriately to enable participants to maximise their involvement in planning through self-assessment, self-reflection and self-identification of strengths, priorities and goals.</p>
Plans include provider-generated as well as participant-generated goals as needed	<p>Uses provider-generated and participant-generated goals appropriately in the circumstances.</p> <p>Facilitates appropriate incorporation of therapy feedback and therapist-generated goals into next plans.</p> <p>Goals generated by the case manager are based on specific, measurable, achievable, relevant and timed (SMART) principles.</p>
Incorporation of both formal and informal supports into participant plans	<p>Identification and appropriate utilisation of both formal and informal supports is evident, including formal supports not funded by icare, to enable participant goal achievement.</p>

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Case manager role in plan coordination and synthesis	<p>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.</p> <p>Promotes and actively monitors progress and step completion throughout the plan period.</p> <p>Plans demonstrate integration of steps and supports across service providers (i.e. interdisciplinary approach).</p> <p>There is no 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.</p>
Facilitates participant reflection on progress and integrates this with objective measures of outcomes in guiding next plan development	<p>It is evident in plans that the case manager has actively engaged the participant in reflecting on their own progress.</p> <p>Plans contain information regarding objective measures of outcomes from the previous plan period. This information relates directly to what is then proposed for the next plan period.</p>
Risk and safeguarding	<p><b>Safeguarding practice</b></p> <p>Provides the participant (and family if appropriate) with enough information to ensure participant choices are fully informed.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Guiding participants in finding ways to mitigate or manage risk within their choices;</li> <li>• Liaising with other stakeholders (such as Lifetime Care, other service providers, family, FACS) to ensure a consistent approach by all; and</li> <li>• Referring to appropriate bodies for high risk behavior management or child protection issues – e.g. FACS, guardian.</li> </ul> <p>Where risk has been identified and advice/actions taken, appropriate documentation is provided to icare.</p> <p><b>Serious Incident Response</b></p> <p>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, icare is informed immediately by telephone and follow up email/other written correspondence.</p> <p><b>Adverse Change in Situation</b></p> <p>Advises icare in writing, attaching any relevant documents (e.g. My Plan modules) 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.</p>

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Goal achievement	<p>Plan goals and steps enable measurement of outcomes for each plan period.</p> <p>Outcome measures for both funded and non-funded supports are used appropriately in plans.</p> <p>Feedback from service providers and relevant others regarding progress is meaningfully incorporated into successive plans.</p> <p>Where goals are not achieved, or not achieved within the anticipated time frame, clear explanation is given as to why.</p>
Effectiveness of supports in achieving steps	<p>Assesses the effectiveness of selected strategies and supports in meeting goals and steps – to ensure appropriate selection of supports in subsequent plans and to ensure the participant is making future decisions based on comprehensive information about effectiveness of past choices.</p> <p>Monitors outcomes across the entire plan; not just the aspects icare has funded.</p>
Disengagement/case closure/case handover	<p>Case manager role as described in plans demonstrates promoting participant independence and working towards case closure/disengagement or case transfer where appropriate.</p> <p>Appropriate use of other supports (for example attendant care workers, attendant care coordinators, icare coordinators, other team members) to perform actions in the Case Management Taxonomy<sup>1</sup> when indicated.</p> <p>Recognises when the participant no longer requires a case management service, OR that they may not be the appropriate case manager to continue providing this service.</p> <p>Ensures participants understand who they can seek assistance from should their needs change once case manager has disengaged.</p>

<sup>1</sup> Lukersmith, S et al *The brain injury case management taxonomy (BICM-T); a classification of community-based case management interventions for a common language* Disability and Health Journal 2015.

**2: Documentation and requests: Treatment, rehabilitation and care, reasonable and necessary criteria forms**

Expectation	Evidence case manager meets the expectation
Consistently uses the correct icare forms	<p>Correct use of My Plan, Care Needs Reports and Attendant Care Service Requests, Service Requests.</p> <p>Forms have not been modified.</p> <p>Provides the necessary information in emails for fast track requests/ service amendment requests.</p>
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.
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.
Forms are completed correctly and provide the necessary information for icare to make decisions about funding	<p>Plans and request forms are revised and updated prior to submission to ensure all participant information is current and correct.</p> <p>Enough information is provided about the participant and their circumstances for icare to make an ‘in the circumstances’ decision about funding.</p> <p>Request forms include details of how the request relates to Treatment Rehabilitation and Care.</p> <p>Request forms include enough information to enable an assessment against the Guidelines, including the reasonable and necessary criteria.</p> <p>Consideration of all five potential sources of knowledge (ref App B) is given, to determine the most effective and efficient means of achieving the desired outcomes.</p> <p>Hours and costs for services included in plans and requests are reasonable in the circumstances and recorded accurately.</p> <p>Where the case manager identifies that a request may not meet reasonable and necessary criteria, but the participant still wishes the request to be submitted, the case manager has explained these circumstances in the request.</p>
Cost effectiveness considerations	Guides the selection of providers based on ability to deliver the most cost effective service - includes consideration of skills and experience as well as associated travel costs, hourly rates, availability to deliver services in own rooms.

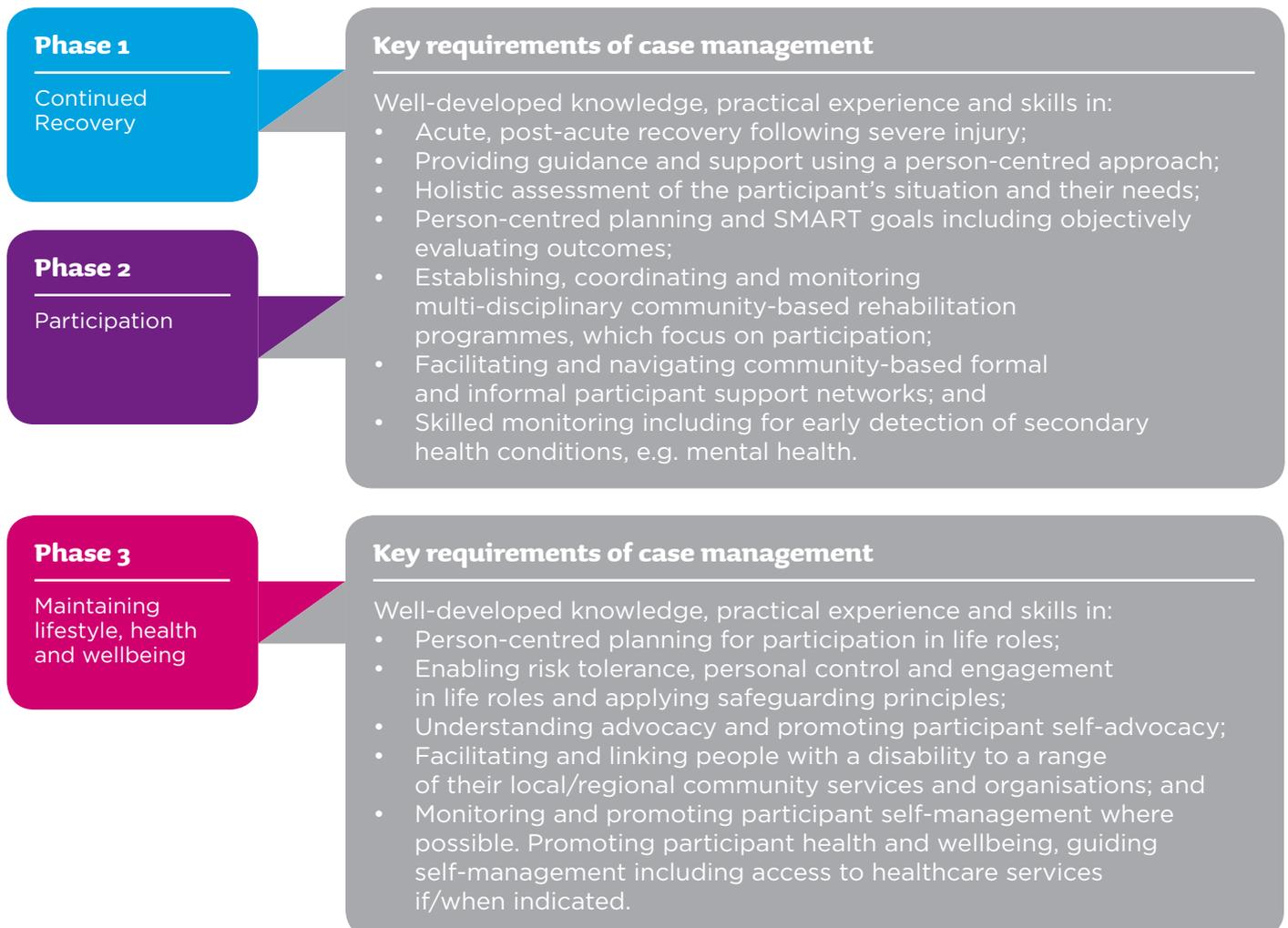
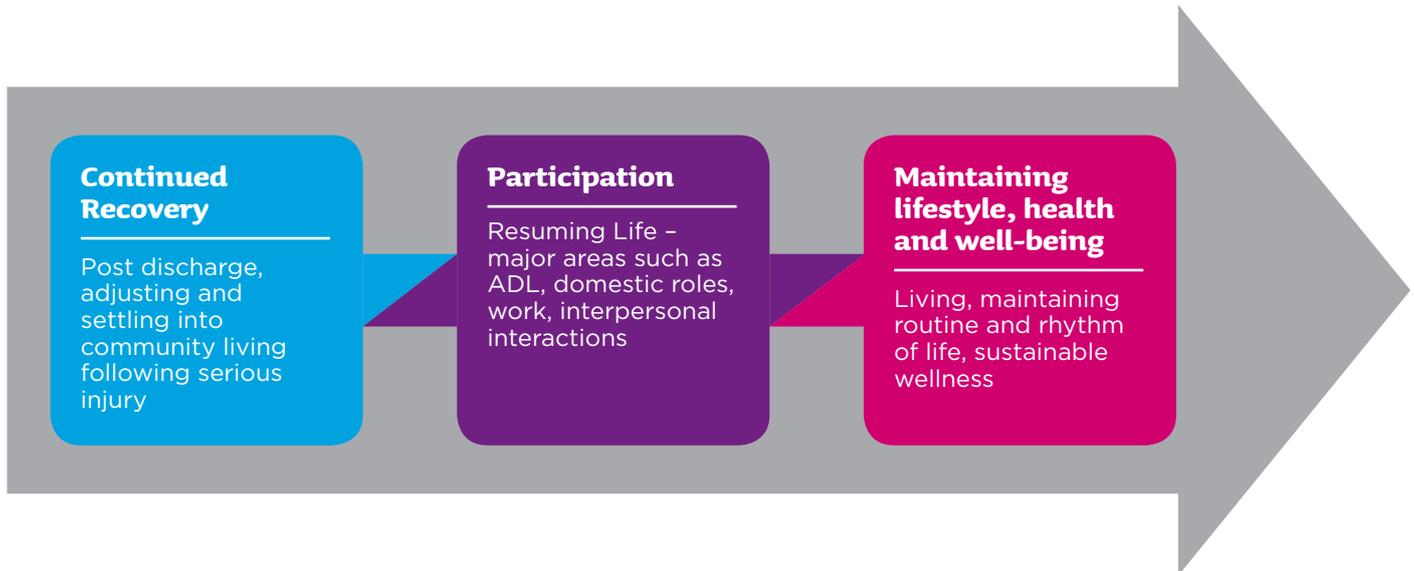
3: Working relationships	
Expectation	Evidence case manager meets the expectation
Ability to work cooperatively with participants and their families	<p>Responds to participant needs and concerns in a timely manner.</p> <p>Participant and family are actively engaged in all decision making and goal-setting.</p> <p>Approach to work demonstrates recognition that the participant is the expert in their own circumstances – through respecting their choices and priorities.</p>
Communication with participants	<p>Maintains communication with participants and their family as agreed in the plan and as needed should circumstances change throughout the plan period.</p> <p>Selects from a range of communication strategies appropriate to the participant’s needs.</p>
Ability to work cooperatively with a range of service providers	<p>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 facilities.</p> <p>Respects the position of providers from other sectors in the team and works cooperatively across all sectors:</p> <ul style="list-style-type: none"> <li>• Private/public;</li> <li>• Community-based/in-patient;</li> <li>• Allied health/disability/care/medical; and/or</li> <li>• Formal/informal supports.</li> </ul> <p>Ensures service providers understand Scheme requirements – Treatment, Rehabilitation and Care guidelines, Reasonable and Necessary criteria, paperwork, timeframes and progress reporting.</p> <p>Provider feedback is appropriately discussed with participants and integrated into plans.</p>
Ability to work cooperatively with icare	<p>Communications indicate an appreciation of the extent – and limit of icare’s role in meeting the range of participant needs which might be identified through planning and general case management activity.</p> <p>Responds constructively to feedback from icare regarding requests, and is able to understand icare’s perspective when a request is not approved or further information is requested.</p> <p>A reasonable, written explanation is provided when requests and plans are going to be delayed, extensions are needed or retrospective requests are being submitted.</p>
Fosters a positive relationship between participants and icare	<p>Presents icare in a positive light and assists participants to understand what they can reasonably expect from icare, to foster a life-long relationship that is built on trust.</p>
Recognises and is proactive when relationships have become unproductive for participant	<p>Liaises with icare coordinator when difficult relationships have emerged.</p> <p>Is proactive in facilitating handover to new provider when relationships are beyond salvage.</p> <p>Manages appropriately when the relationship between the participant/family and another service provider has become unproductive.</p>

4: Professional conduct and continuous improvement	
Expectation	Evidence case manager meets the expectation
Adheres to professional boundaries regarding role as case manager	<p>Interactions with participants, family and other service providers demonstrate knowledge of case management role, definition and boundaries (ref case management taxonomy).</p> <p>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.</p>
Terms of Approval	Adheres to all sections of the approved case manager (Lifetime Care) Terms of Approval.
Continuous improvement	Remains up-to-date in knowledge of current national health and disability sector best practice and initiatives.
Attends training run by icare as appropriate	<p>Has attended relevant training opportunities offered including:</p> <ul style="list-style-type: none"> <li>• completing modules relevant to case management service delivery as they become available on Lifetime Learning.</li> </ul>
Adheres to privacy requirements	<p>Demonstrates adherence to privacy principles as defined by the Privacy and Personal Information Protection Act (PPIPA) and the Health Records and Information Privacy Act (HRIPA).</p> <p>Breaches in privacy (by the case manager or by others) are reported and managed in accordance with the Privacy and Personal Information Protection Act (PPIPA) and the Health Records and Information Privacy Act (HRIPA).</p>
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.

5: Business management systems	
Expectation	Evidence case manager meets the expectation
Has efficient range of communication systems	<p>Has a business telephone – including for use in teleconferencing with other team members.</p> <p>Has email capability.</p> <p>Has Internet capability – including access to icare website, Yammer, Skype and Pulse (Lifetime Learning).</p> <p>Has scanning capability.</p> <p>Able to use the My Plan forms – interactive PDFS, Word, Excel.</p>
Ability to provide services efficiently	<p>Only accepts referrals for participants for whom they can deliver efficient home visiting/local community visits as needed.</p> <p>Acceptance of referrals demonstrates consideration of whether their own work days/arrangements can support the needs of the participant.</p>
Efficient invoicing systems	<p>Invoices are sent in a timely manner and include all information required by icare.</p> <p>Only services pre-approved by icare are invoiced.</p>
Leave cover	<p>Appropriate arrangements are made to ensure participant receives all necessary services when case manager is on leave.</p> <ul style="list-style-type: none"> <li>• Informs coordinator of upcoming leave (or of unplanned leave as soon as is practicable) and start/end dates of leave.</li> <li>• Utilises identified leave cover colleagues and provides coordinator (as well as participant and their family and all involved provider services) their contact details.</li> <li>• In instances where coordinator will be managing the file in your absence – discusses this with, and gets agreement from, the coordinator – well in advance.</li> <li>• 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 appropriate.</li> </ul>

## Appendix A - Phases of the focus for participation continuum

Lifetime Care recognises that different case management actions and skills are required at different times across the focus for participation continuum.



## Appendix B

### Sources of knowledge

#### FIVE SOURCES OF KNOWLEDGE FOR BEST PRACTICE IN CLINICAL DECISION-MAKING

1. The participants own descriptions, preferences and point of view - so that the individual context can be understood and considered (**NARRATIVE**).
2. Current best research evidence, scientific knowledge or established facts (including objective measures of the person's ability) (**EVIDENCE**).
3. Knowledge derived by the prescribing clinician from professional experiences (**GENERAL REASONING**).
4. Knowledge from thinking and reasoning when the participant's immediate and broader circumstances are considered (**A SHARED VIEW**).
5. Practical considerations on the limitations and factors which affect circumstances and potential outcomes (**PRAGMATIC REASONING**).

Best practice is using as many of these sources of knowledge as are available – and working out the best recommendation for the individual in their circumstances.