



Terms of Approval

Schedules

Schedule 1 Services

Schedule 2 Fees

Schedule 3 Service Standards

Schedule 4 Service Provider Quality Assurance Framework

For case managers employed by the Department of Health

Schedule 1 - Services

Case Management Services for the purpose of this Agreement include any or all of the main actions and secondary actions as described in the Case Management Taxonomy¹; and as may be requested or identified and approved as required to meet the injury-related needs of a participant of the Lifetime Care & Support Scheme.

All Services will be within the scope of the *Motor Accidents (Lifetime Care and Support) Act 2006* and the Guidelines, as well as any policies published on the Lifetime Care website.

The services must be provided by only the approved case manager, signatory to this Agreement. No actions or services can be delivered by or invoiced from other, non approved members of the business or team, including administrative or business support staff.

¹ 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 & Health Journal 2015

Schedule 2 - Fees

You will invoice Lifetime Care upon completion of the services.

You will obtain Lifetime Care's prior written approval to incur or pay any costs, expenses, fees or charges. Lifetime Care will reimburse you for those costs, expenses, fees or charges, subject to receiving a correctly rendered Tax Invoice with appropriate supporting evidence.

Fees payable

Lifetime Care will pay fees in accordance with the current hourly rate as agreed in the *NSW Health Policy Directive - Lifetime Care & Support (LTCS) Scheme - Charging Policy and Rates for Designated Units*, and as approved for the relevant Service Request/Plan.

Invoice to:

Your service will invoice fees in a correctly rendered invoice. For the purpose of this Agreement, an invoice is not correctly rendered unless:

- the invoice is a Tax Invoice*;
- the amount claimed in the invoice is correctly calculated under this Agreement;
- the invoice includes the relevant Participant number , e.g. 12/B975
- the invoice includes the relevant Purchase Order (RP) Number, e.g. RP12-3456;
- the invoice includes correct use of service codes as approved on the relevant certificate and Purchase Order
- the invoice is emailed to ltcsap@icare.nsw.gov.au

*The invoice must clearly show:

- the words 'tax invoice' in the title (not just 'invoice')
- a unique invoice number
- the date the invoice is issued
- your ABN and registered business name (as registered with the Australian Tax Office)
- the cost (including GST where applicable), which must not exceed the pre-approved amount on the certificate(or purchase order).

Schedule 3 – Service Standards

CASE MANAGEMENT EXPECTATIONS

| 1: BEST PRACTICE CASE MANAGEMENT & PLANNING | |
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| CRITERIA | CASE MANAGEMENT EXPECTATIONS |
| 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 rehabilitation continuum, and adjusts their style of case management to best suit the participants needs (ref Figure 1)</p> <p>Demonstrates capacity to deliver injury management education and support to the participant and/or their family if working with Phase 1 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 children if they have prior experience working with children and families</p> <p>Only accepts referrals for adults if they have prior experience working with adults</p> <p>Only accepts referrals for participants within phases of the rehabilitation continuum they have been approved for</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 the participant</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. There is evidence that the CM has provided enough support to the Participant to enable them to exercise choice.</p> <p>The case manager role as described in the plan demonstrates</p> |

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| | <p>their awareness of their role in maximising participant autonomy, choice, control & responsibility</p> <p>Assess Phase modules of My Plan 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>Demonstrates the ability to determine when provider-generated and/or participant-generated goals are appropriate</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 & timed (SMART) principles</p> |
| Incorporation of both formal and informal supports into participant plans | <p>Identification & appropriate utilisation of both formal and informal supports is evident, including formal supports not funded by Lifetime Care, to enable participant goal achievement</p> |
| Case manager role in plan coordination and synthesis | <p>Ensures all supports involved in the plan have received the plan, understand the agreed & 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 (ie 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>Safeguarding Practice 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 behaviour, 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</p> |

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| | <p>are taken to minimise risk of harm. Some actions may include, but are not limited to:</p> <ul style="list-style-type: none"> • Guides participants in finding ways to mitigate or manage risk within their choices • Liaises with other stakeholders (such as icare lifetime care, other service providers, family, FACS,) to ensure a coordinated and appropriate approach by all • Knows when to refer to appropriate bodies for high risk behaviour management or child protection issues – eg FACS, guardian <p>Where risk has been identified and advice/actions taken, appropriate documentation is provided to icare lifetime care</p> <p>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, icare lifetime care is informed immediately by telephone and follow up email/other written correspondence.</p> <p>Adverse Change in Situation Advises icare lifetime care in writing, attaching any relevant documents (eg My Plan Assess Phase 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> |
| 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 Lifetime Care has funded</p> |
| Disengagement/case closure/case handover | <p>Case manager role as described in plans demonstrates work towards case closure/disengagement or case transfer where appropriate</p> <p>Demonstrates an understanding of the Case Management Taxonomy² interventions which can be performed independently by participants and/or their informal supports,</p> |

² 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 & Health Journal 2015

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| | <p>or by other service providers such as attendant care workers, attendant care coordinators, Lifetime Care Coordinators, others</p> <p>Enables other team members, participants and families to manage those Case Management Taxonomy interventions which can appropriately be handed over to them</p> <p>Recognizes 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> |
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2: DOCUMENTATION & REQUESTS: Treatment, Rehabilitation & Care, Reasonable & Necessary criteria, Forms

| CRITERIA | CASE MANAGEMENT EXPECTATIONS |
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| Consistently uses the correct Lifetime Care forms | <p>Correct use of My Plan forms and modules, Care Needs Reports & Attendant Care Service Requests, Equipment Requests, Service Requests, Home Modifications Requests, Contingency Requests</p> <p>Forms have not been modified</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 before 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 participants family/advocate |
| Forms are completed correctly and comprehensively provide the necessary information for Lifetime Care to make decisions about funding | <p>Plans and request forms are revised and up-dated prior to submission to ensure all participant information is current and correct</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 reasonable & necessary criteria</p> <p>Consideration of all five potential sources of knowledge (ref Figure 2) 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 & necessary criteria, but the participant still wishes the request to be submitted, the case manager has</p> |

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| | explained these circumstances in the request |
| Cost effectiveness considerations | Guides the selection of providers based on ability to deliver the most cost effective service - includes consideration of skills & experience as well as associated travel costs, hourly rates, availability to deliver services in own rooms |

3: WORKING RELATIONSHIPS

| CRITERIA | CASE MANAGEMENT EXPECTATIONS |
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| Ability to work cooperatively with participants and their families | <p>Responds to participant needs and concerns in a timely manner</p> <p>Explains the Scheme, the Guidelines and Reasonable & Necessary criteria to enhance participants understanding of their rights and responsibilities under the Scheme</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 participants needs - eg face to face visits, telephone, text, skype, letters</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"> • private/public • community-based/in-patient • allied health/disability/care/medical • formal/informal supports <p>Ensures service providers understand Scheme requirements - Treatment, Rehabilitation & Care guidelines, Reasonable & 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 Lifetime Care | <p>Communications indicate an appreciation of the extent - and limit, of Lifetime Care'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 Lifetime Care</p> |

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| | <p>regarding requests, and is able to understand Lifetime Care'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 required or retrospective requests are being submitted</p> |
| Fosters a positive relationship between Participants and Lifetime Care | Case Manager presents Lifetime Care in a positive light and assists Participants to understand what they can reasonably expect from Lifetime Care, to foster a life-long relationship that is built on trust |
| Recognises and is proactive when relationships have become unproductive for participant | <p>Liaises with Lifetime Care 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

| CRITERIA | CASE MANAGEMENT EXPECTATIONS |
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| Adheres to professional boundaries with regard to 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 managers 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 & disability sector best practice & initiatives. |
| Attends training run by Lifetime Care as appropriate | <p>Has attended relevant training opportunities offered including:</p> <ul style="list-style-type: none"> -completing modules relevant to CM service delivery as they become available on Lifetime Learning -My Plan modules completed on Lifetime Learning and using the tool kit appropriately |
| Adheres to privacy requirements | <p>Demonstrates adherence to privacy principles as defined by the Privacy & Personal Information Protection Act (PPIPA) and the Health Records& 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 & Personal Information Protection Act (PPIPA) and the Health Records& Information Privacy Act (HRIPA)</p> |

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| 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 |
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5: BUSINESS MANAGEMENT SYSTEMS

| CRITERIA | CASE MANAGEMENT EXPECTATIONS |
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| 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 Lifetime Care 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 Lifetime Care:</p> <ul style="list-style-type: none"> • ABN • Invoice number • Participant Number • RP number/s • Service codes • GST as appropriate <p>Only services pre-approved by Lifetime Care are invoiced</p> |
| Leave cover | <p>Appropriate arrangements are made to ensure participant receives all necessary services when case manager is on leave</p> <p>Includes:</p> <ul style="list-style-type: none"> • Informing Lifetime Care of up-coming leave (or of unplanned leave as soon as is practicable) and start/end dates of leave • Utilizing identified leave cover colleagues and providing Lifetime Care Coordinator (as well as Participant & their family and all involved provider services) their contact details • In instances where Lifetime Care Coordinator will be managing the file in your absence – discussing this with, and getting agreement from, the coordinator – well in advance • Ensuring 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 |

Figure 1: Phases of the Rehabilitation Continuum

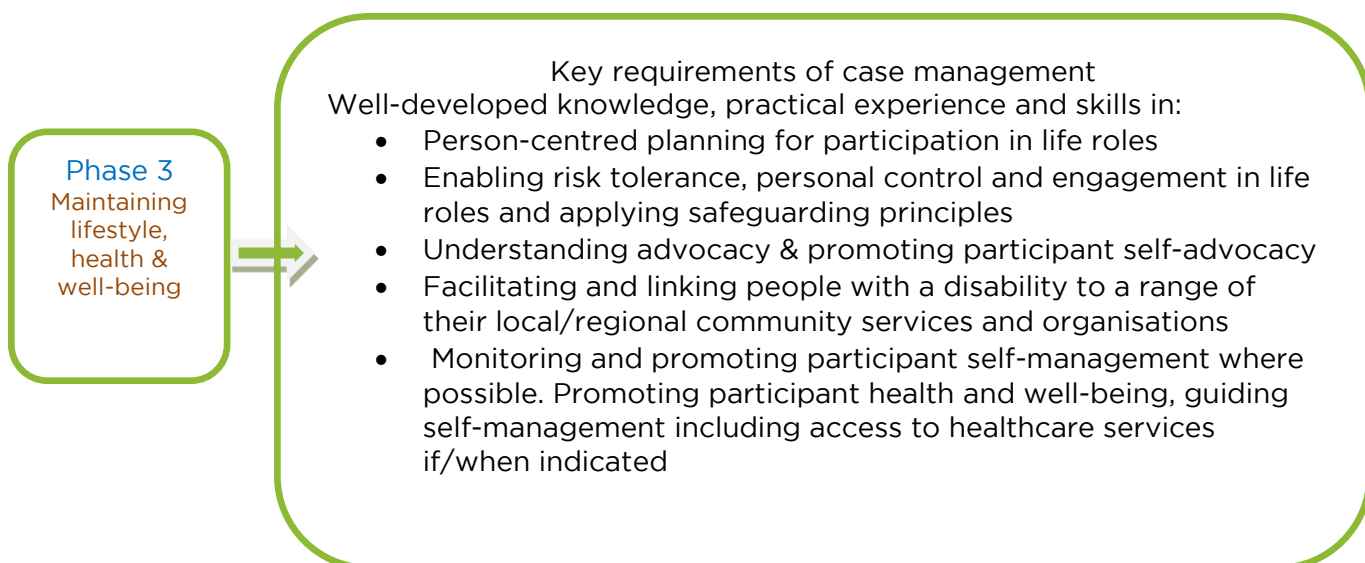
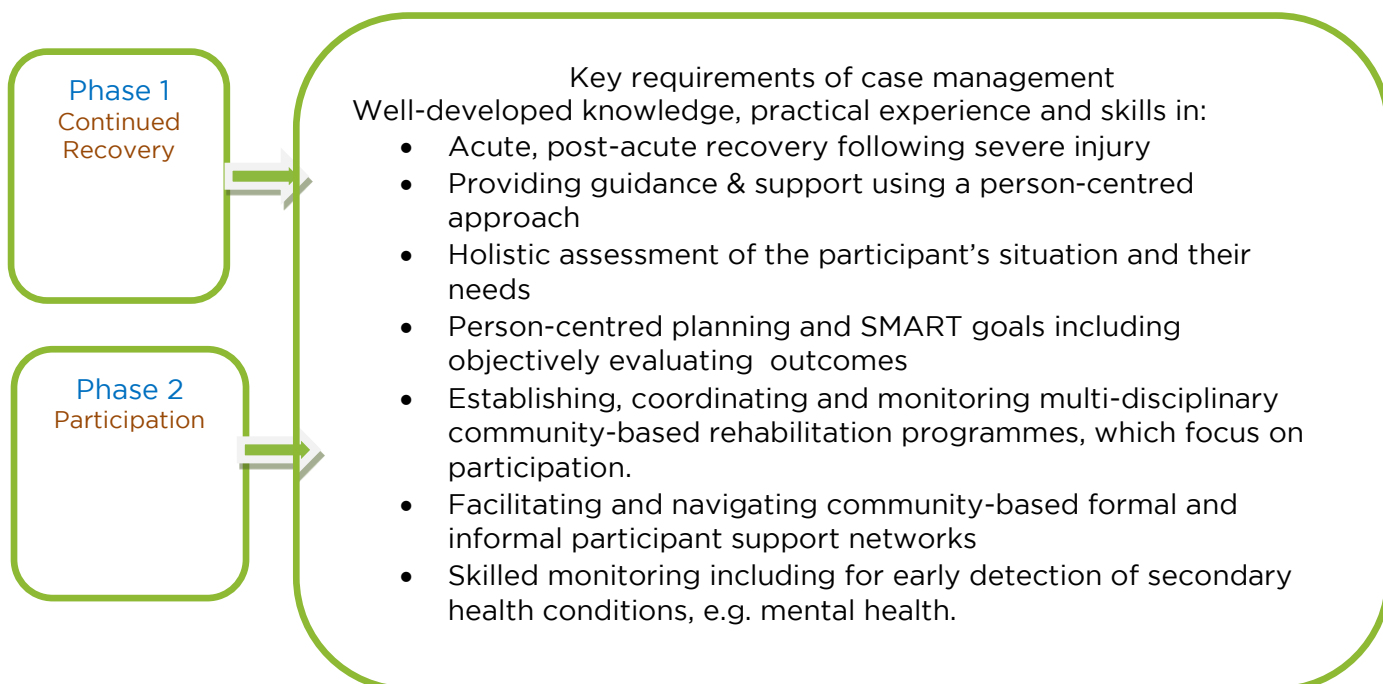
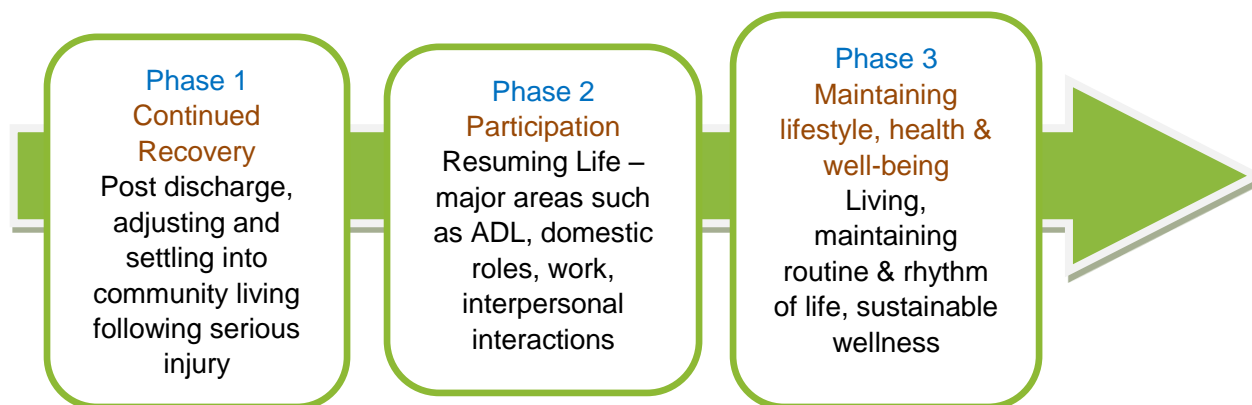


Figure 2: Sources of Knowledge

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.

Schedule 4 - Service Provider Quality Assurance Procedures

icare lifetime care is committed to ensuring quality service provision for our participants. We engage a wide range of Service Providers under different arrangements to deliver a broad range of services to meet participant needs. To ensure best possible management of the interactions between Service Providers and participants, and to maximise quality outcomes for our participants, **icare lifetime care** has developed a framework for provider management. The three-part framework formalises relationships with higher risk provider groups, defines communications and action pathways for when issues in provider performance arise, and establishes an annual risk-based provider monitoring program to ensure approved providers are meeting minimum benchmark standards.

The following principles guide our practice:

- **Social responsibility:** Services must be person-centred, addressing the needs of and implications for the participant.
- **Business value:** Quality service provision for participants allows us to achieve the best outcomes possible.
- **Shared accountability:** Everyone in the organisation is involved and has responsibility to identify and address Concerns and Issues as relevant to the provider engagement arrangements.
- **Stakeholder relationships:** Positive, collaborative relationships with approved Service Provider groups should be maintained and strengthened.
- **Being Proactive:** Timely intervention allows us to achieve service improvement
- **Risk management:** Identifying issues allows us to mitigate risk for participants, family, service providers, the community and **icare lifetime care** including reputational risk associated with poor provider performance and poor management of Service Providers.
- **Cost effectiveness:** Quality services provide value for money.

- **Business integrity:** We apply procedural fairness and confidentiality in all provider engagement, issues management and monitoring activities.

Definitions

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| Concerns | are matters that emerge in the process of working with a Service Provider that highlight a potential gap in the Service Provider’s knowledge or experience that prevents them from properly meeting icare lifetime care’s requirements. Concerns are a less serious failure to meet the standards of service provision than Issues. |
| Issues | arise when Service Provider performance has or may have a negative impact on participants and requires clarification and resolution. Issues are more serious than Concerns, and are assessed as being level 1, 2 or 3 based upon their seriousness. |
| Service provider | anyone we pay to provide services to a participant in the Lifetime Care and Support Scheme. icare lifetime care has two classifications of Service Provider: |
| Approved Provider | providers selected via a procurement or approval process. Approved Provider groups are managed by the Provider Quality Team (PQT). |
| Provider not subject to approval | providers who have no formal relationship with icare lifetime care and are not managed by the PQT. |
| Secure Provider File | a record file with access restricted to key staff and Executive only - separate to participant records. |

1. Provider Management Procedure

The Provider Management Procedure aims to achieve best quality service provision and positive outcomes for participants. Our approach to provider management seeks to ensure issues are managed consistently and fairly to achieve the best outcome for our participants, to support positive partner relationships with Service Providers and to minimise any financial or reputational risk to **icare lifetime care** or Service Providers.

The Provider Management Procedure outlines the roles, responsibilities and procedures for managing concerns and issues arising through direct service provision or business operations.

This Procedure applies to the Concerns and Issues identified by **icare lifetime care** in relation to services delivered to our participants and as a result of interactions between Service Providers and staff at **icare lifetime care**.

Any Concerns or Issues that are identified by others (e.g. participants, family members, other Service Providers) relating to the operations of **icare lifetime care**, service provision to a participant or a Service Provider's business operations are managed under the complaint management process which forms part of the **icare lifetime care** customer feedback framework.

The Provider Management Procedure applies to all Service Providers. It is designed to empower staff at all levels to resolve service provision Concerns or Issues as soon as they arise, while also ensuring Service Providers are actively involved in the process and resolution.

Identification and Management of Concerns

Concerns are matters that emerge in the process of working with the Service Provider that indicate a possible gap in the Service Provider's knowledge or experience that prevents them from properly meeting our requirements.

Learning needs such as these can be addressed by providing direct feedback, additional guidance and/or other information on our expectations and procedures.

Identifying and addressing Concerns is an important part of the day to day collaborative relationship between Service Providers and frontline staff at **icare lifetime care**.

Concern management is based on a commitment across **icare lifetime care** to provide timely and objective feedback. Providing open, honest and constructive feedback to Service Providers about their performance is helpful in enabling Service Providers to adjust and improve their current and future operations and interactions with participants and us. This feedback should always focus on improving quality in service provision.

Engaging in open and objective feedback communications also provides an opportunity for the Service Provider to better explain their actions or reasoning. Effective Concern management results in a better understanding across all

parties involved and should ultimately result in better outcomes for the participant.

Concerns are managed by **icare lifetime care** coordinators. Coordinators are best placed to manage Concerns given their knowledge of the participant, their front-line communication role with Service Providers and their role in collaborative decision-making with key Service Providers. They also have a role in guiding, advising and coaching Service Providers to meet **icare lifetime care's** expectations, utilising their comprehensive knowledge of the operational responsibilities of all team members involved in a participant's experience with **icare lifetime care**.

Coordinators may seek support and information from their colleagues and seniors in fulfilling their role in the management of Concerns.

Concerns, actions and outcomes, including responses from the Service Provider that relate to services for a participant will be recorded in the participant file.

A Concern which is not resolved following direct feedback, instruction or guidance from the coordinator becomes an Issue.

Concerns that are repeated across participants by the same provider or business are escalated to be managed as an Issue.

Issue Management - Level 1

An Issue arises when Service Provider performance has or may have a negative impact on participant outcomes and requires clarification and resolution. An Issue may relate to:

- direct service provision to an individual participant
- a trend in service provision across a number of participants by the same Service Provider
- a breach of any formal terms of agreement where these are in place
- poor compliance with provider performance expectations.

All Issues are assessed by the coordinator in the first instance as they have the front-line relationship with the Service Provider and are in a position to identify the nature of the Issue and formulate an appropriate response. Coordinators will seek support and information from their senior and may seek support or guidance from the PQT.

Coordinator/Senior Coordinator management of all Level 1 Issues will include the following actions:

- a) Establish the facts regarding the Issue through review of relevant documentation and consideration of **icare lifetime care's** expectations and procedural requirements.
- b) Discuss the Issue with the Service Provider and clarify the facts from their perspective. Attempt to resolve the Issue and/or agree to next steps towards resolution. This discussion may include the relevant Service

Provider manager (for example, BIRP managers would like to be involved in all Issue management). Meetings can occur by telephone or face to face. The PQT may be asked to attend to assist in clarification of expectations where necessary.

- c) Document the Issue/s and the agreed actions and send to the Service Provider.
- d) Review and record in the file any written response/s from the Service Provider.
- e) Assess the outcomes as per the agreed actions.
- f) Monitor that outcomes are maintained.

Issues, actions and outcomes that relate to services for a participant will be recorded in the participant's file, along with any responses received from the Service Provider.

When coordinators/senior coordinators have attempted to resolve an Issue and have not received a satisfactory response from the Service Provider, the Issue may be escalated to Level 2.

When several Issues relating to the performance of one Service Provider are identified, this will also be escalated to Level 2.

Service Providers can appeal our management of a Concern or Level 1 Issue using the Complaints Handling procedure. Complaints can be made by verbal or written submission to the Coordinator, Senior Coordinator, Regional Manager or PQT, depending on the nature of the complaint.

Issue Management – Level 2

Level 2 Issues relating to the performance of an Approved Provider are referred to the PQT to take the lead responsibility in Issue resolution.

Level 2 Issues relating to the performance of a Provider not subject to approval are managed by the senior coordinator or Regional Manager. Where a participant has selected a specific Service Provider and an Issue regarding the service being delivered to that participant has reached Level 2, that participant will be informed of the nature of the Issue and action being taken. The participant will be reassured that the relevant actions are being taken to ensure they receive high quality service provision.

The management of all Level 2 Issues will include the following actions:

- a) Assess the Issue. This involves:
 - o consultation with Service Coordination
 - o consideration of the nature and seriousness of matters alleged
 - o review of actions taken and outcomes under Level 1 Issues procedures
 - o audit of relevant written records and files

- assessment of the alleged Issue against the contract KPIs/terms of approval/Service Provider expectations
 - assessment of the Issue against the National Code of Conduct for Health Care Workers
<http://www.coaghealthcouncil.gov.au/NationalCodeOfConductForHealthCareWorkers> (in NSW the details of this Code are provided in the Public Health Regulation 2012, Schedule 3; available at <http://www.legislation.nsw.gov.au/#/view/regulation/2012/311/sch3>)
- b) Discuss the nature of the Issue and potential options for resolution with the Service Provider. This may involve a meeting between the Service Provider, their manager, the coordinator, the senior coordinator, and/or the PQT.
 - c) Determine the appropriate action to resolve the Issue.
 - d) Communicate decision to the Service Provider, their manager and the coordinator/senior coordinator in writing and implement corrective/improvement action.
 - e) Record the Issue and agreed actions in a Secure Provider File, including any written feedback or communications from the Service Provider.
 - f) Assess the outcomes as per the agreed actions.
 - g) Record the outcomes in the Secure Provider File, including any written feedback or communications from the Service Provider.

A range of actions may be recommended and implemented as a result of a Level 2 Issue Management procedure. Options may include, but are not limited to:

- Specific feedback on the Service Provider's performance against the expectations and/or terms of approval and/or contract KPIs
- Recommendation of training or other learning/development strategies
- Involvement of the Service Provider's manager
- Removal of the Service Provider from the participant file to which the Issue relates
- Suspension or termination of a contract or approval rating

A decision to suspend or terminate an Approved Provider will first be raised with the executive leadership team.

Issue Management - Level 3

Issues that involve the media or the Minister or pose an immediate, serious threat to participants or **icare lifetime care** will be escalated directly to Level 3 and managed by the Integrated Care Leadership Team.

If a Provider not subject to approval lodges an appeal regarding a decision made at Level 2, this is deemed to be a complaint and is referred to the Complaints Management Procedure.

If an Approved Provider lodges an appeal regarding a decision to suspend or terminate service provision on a specific file, approval status or their contract, this will be managed by the Integrated Care Leadership Team at **icare lifetime care** as Level 3 Issue Management.

The Integrated Care Leadership Team will investigate Level 3 Issues and take appropriate action. Integrated Care Leadership Team decisions and outcomes will be recorded in the secure file.

Appeals Process

To appeal a decision made following Level 2 or 3 Issues Management, Approved Providers must use the following process:

1. The Approved Provider must submit, in writing, a request to appeal the decision of **icare lifetime care** addressed to:

Mr Don Ferguson
Group Executive, Integrated Care
icare
GPO Box 4052
SYDNEY NSW 2001

The appeal should outline clearly why the Approved Provider feels that the decision should be reconsidered, specifically addressing the reasons provided in **icare lifetime care's** Issue management determination.

The appeal must be received by **icare lifetime care** within 15 working days from the date of the letter advising outcome of the Issue management process.

2. The Group Executive, Integrated Care will review the decision made and consider the information provided in the appeal. The review may include:
 - discussion with the Approved Provider
 - discussion with the Approved Provider's manager
 - discussion with **icare lifetime care** staff involved at Level 2 Issue Management
 - review of all written documentation related to the specific Issue and appeal
 - further assessment of the Approved Provider's work against the Terms of Approval and/or provider expectations as appropriate

It is anticipated that **icare lifetime care** will complete the appeal review within 30 working days of lodgement. During this time, the Approved Provider may continue delivering services to the participants they are already involved with, but may not accept any new referrals.

3. **icare lifetime care** may:

- Uphold their original decision
- Change their decision
- Offer an alternative strategy for Issue resolution

4. The outcome of the Appeal process will be communicated in writing.

2. Provider Monitoring Procedure

To ensure on-going compliance with the expectations for quality service provision **icare lifetime care** completes a range of monitoring activities.

This ensures:

- Approved Providers are meeting the quality assurance criteria set out by **icare lifetime care**
- Approved Providers comply with the Terms of Approval or contract KPIs

Approved Providers will be subject to a regular scheduled risk-based audit. The nature and process of the audit is dependent on the KPIs for that group under the relevant terms of approval or contract.

Monitoring occurs for the following Approved Provider groups:

- Case managers
- Attendant care providers
- Building modifications occupational therapists (BMOTs)
- Building modifications project managers (BMPMs)
- Disputes Assessors

Annual monitoring procedures including audit indicators, audit methodology and audit actions for each of the Approved Provider groups are determined and managed by the PQT in consultation with icare Risk team....

The following areas of risk are considered for inclusion in monitoring audits:

- Safety – serious incident reports, breaches in contract requirements regarding risk
- Exposure – number of participants using the service
- Quality – impact on participant experience if quality is poor
- Cost – average cost per participant or total earnings (from **icare lifetime care**) of the provider service

- Participant experience – customer satisfaction/dissatisfaction rates
- Responsiveness – meeting KPIs around timeframes

Monitoring methodology includes:

- Audits of Participant files & Level 2 Issues files
- Review of performance/monitoring reports
- Auditing attendance at forums, training, completion of on-line learning required for the performance of the role

The outcome of the annual monitoring review will be communicated to the audited Approved Providers in writing. Any adverse outcomes will also be discussed with the Approved Provider, and presented with clear supporting information.

Approved providers will have the opportunity to respond to the audit report and have any adverse findings reconsidered by the PQT.

PQT will finalise and record its recommendations in a Secure Provider File. Any recommendation to commence the process of removing a Service Provider's approved status will be communicated in writing to the provider and the executive leadership team at **icare lifetime care**, with information about the appeals procedure.

Appeals will be managed through the Integrated Care Leadership Team.

Appeals Process

To appeal a decision to suspend/terminate the services of an Approved Provider, the following procedure applies:

1. The Approved Provider must submit, in writing, a request to appeal the decision of **icare lifetime care** addressed to:

Mr Don Ferguson
Group Executive, Integrated Care
icare
GPO Box 4052
SYDNEY NSW 2001

The appeal should outline clearly why the Approved Provider feels that their approval status should be reconsidered, specifically addressing the reasons provided in **icare lifetime care's** audit determination.

The appeal must be received by **icare lifetime care** within 15 working days from the date of the letter advising outcome of the Issue Management process.

2. The Group Executive, Integrated care will review the decision made and consider the information provided in the appeal. The review may include:
 - discussion with the Approved Provider
 - discussion with the Approved Provider
 - discussion with the PQT
 - perusal of all written documentation related to the audit
 - further assessment of the Approved Provider's work against the contract KPIs, Terms of Approval and/or provider expectations as appropriate

It is anticipated that **icare lifetime care** will complete the Appeal review within 30 working days of lodgement. During this time, the Approved Provider may continue delivering services to the participants they are already involved with, but may not accept any new referrals.

3. **icare lifetime care** may:
 - Uphold their original decision
 - Change their decision
4. The outcome of the Appeal process will be communicated in writing