icare lifetime care

CASE MANAGEMENT EXPECTATIONS

1: BEST PRACTICE CASE MANAGEMENT & PLANNING	
CRITERIA	CASE MANAGEMENT EXPECTATIONS
Only accepts referrals for participants for whom they have the knowledge and expertise to deliver quality services	Demonstrates understanding of the needs of the participant in terms of their disability Demonstrates understanding of the needs of the participant in terms of their progression along the rehabilitation continuum(ref App A), and adjusts their style of case management to best suit the participants needs Demonstrates capacity to deliver injury management education and support to the participant and/or their family if working with Phase 1 participants Is sensitive to the cultural needs of the participant Makes clinically appropriate decisions and recommendations in line with latest best practice and evidence-based data Only accepts referrals for children if they have prior experience working with children and families Only accepts referrals for adults if they have prior experience working with adults Only accepts referrals for participants within phases of the rehabilitation continuum they have been approved for 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) Demonstrates knowledge of appropriate community services/supports available to the participant Demonstrates the ability to develop local service/support knowledge when providing case management services for a participant residing outside of their own local area
Plans are developed using a person-centred approach	Plans are strengths-based Plans include the Participant's perspective regarding progress, outcomes and future needs

	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. The case manager role as described in the plan demonstrates their awareness of their role in maximising participant autonomy, choice, control & responsibility 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
Plans include Provider-generated as well as participant-generated goals as needed	Demonstrates the ability to determine when provider-generated and/or participant-generated goals are appropriate Facilitates appropriate incorporation of therapy feedback and therapist-generated goals into next plans Goals generated by the case manager are based on specific, measurable, achievable, relevant & timed (SMART) principles
Incorporation of both formal and informal supports into participant plans	Identification & appropriate utilisation of both formal and informal supports is evident, including formal supports not funded by **icare lifetime care**, to enable participant goal achievement
Case manager role in plan coordination and synthesis	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 Promotes and actively monitors progress and step completion throughout the plan period Plans demonstrate integration of steps and supports across service providers (ie interdisciplinary approach) 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.
Facilitates participant reflection on progress and integrates this with objective measures of outcomes in guiding next plan development	It is evident in plans that the case manager has actively engaged the participant in reflecting on their own progress 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.

Risk and Safeguarding	**Safeguarding Practice** Provides the participant (and family if appropriate), with enough information to ensure participant choices are fully informed 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: • 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 behavior management or child protection issues – eg FACS, guardian Where risk has been identified and advice/actions taken, appropriate documentation is provided to **icare lifetime care** **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. **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.
Goal achievement	Plan goals and steps enable measurement of outcomes for each Plan period Outcome measures for both funded and non-funded supports are used appropriately in plans Feedback from service providers and relevant others regarding progress 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

Effectiveness of supports in achieving steps	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 Monitors outcomes across the entire plan, not just the aspects **icare lifetime care** has funded
Disengagement/case closure/case handover	Case manager role as described in plans demonstrates work towards case closure/disengagement or case transfer where appropriate Demonstrates an understanding of the Case Management Taxonomy[1] interventions which can be performed independently by participants and/or their informal supports, or by other service providers such as attendant care workers, attendant care coordinators, **icare lifetime care** Coordinators, others Enables other team members, participants and families to manage those Case Management Taxonomy interventions which can appropriately be handed over to them 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 Ensures participants understand who they can seek assistance from should their needs change once case manager has disengaged.

2: DOCUMENTATION & REQUESTS: Treatment, Rehabilitation & Care, Reasonable & Necessary criteria, Forms	
CRITERIA	CASE MANAGEMENT EXPECTATIONS
Consistently uses the correct **icare lifetime care** forms	Correct use of My Plan forms and modules, Care Needs Reports & Attendant Care Service Requests, Equipment Requests, Service Requests, Home Modifications Requests, Continence Requests Forms have not been modified
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

[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

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 **icare lifetime care** 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 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 reasonable & necessary criteria 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. 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 reasonable & necessary criteria, but the participant still wishes the request to be submitted, the case manager has 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**
Ability to work cooperatively with participants and their families	Responds to participant needs and concerns in a timely manner Explains the Scheme, the Guidelines and Reasonable & Necessary criteria to enhance participants understanding of their rights and responsibilities under the Scheme Participant and family are actively engaged in all decision-making and goal-setting Approach to work demonstrates recognition that the participant is the expert in their own circumstances – through respecting their choices and priorities.
Communication with	Maintains communication with Participants and their family as agreed in the plan and as needed should circumstances change throughout the

participants	plan period. Selects from a range of communication strategies appropriate to the participants needs – eg face to face visits, telephone, text, skype, letters
Ability to work 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 facilities 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 criteria, paperwork, timeframes and progress reporting Provider feedback is appropriately discussed with participants and integrated into plans
Ability to work cooperatively with **icare lifetime care**	Communications indicate an appreciation of the extent – and limit, of **icare lifetime care**'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 lifetime care** regarding requests, and is able to understand **icare lifetime care**'s perspective when a request is not approved or further information is requested A reasonable, written explanation is provided when requests and plans are going to be delayed, extensions are required or retrospective requests are being submitted
Fosters a positive relationship between participants and **icare lifetime care**	Case Manager presents **icare lifetime care** in a positive light and assists participants to understand what they can reasonably expect from **icare lifetime care**, to foster a life-long relationship that is built on trust
Recognises and is proactive when relationships have become unproductive for participant	Liaises with **icare lifetime care** Coordinator when difficult relationships have emerged Is proactive in facilitating handover to new provider when relationships are beyond salvage Manages appropriately when the relationship between the participant/family and another service provider has become unproductive

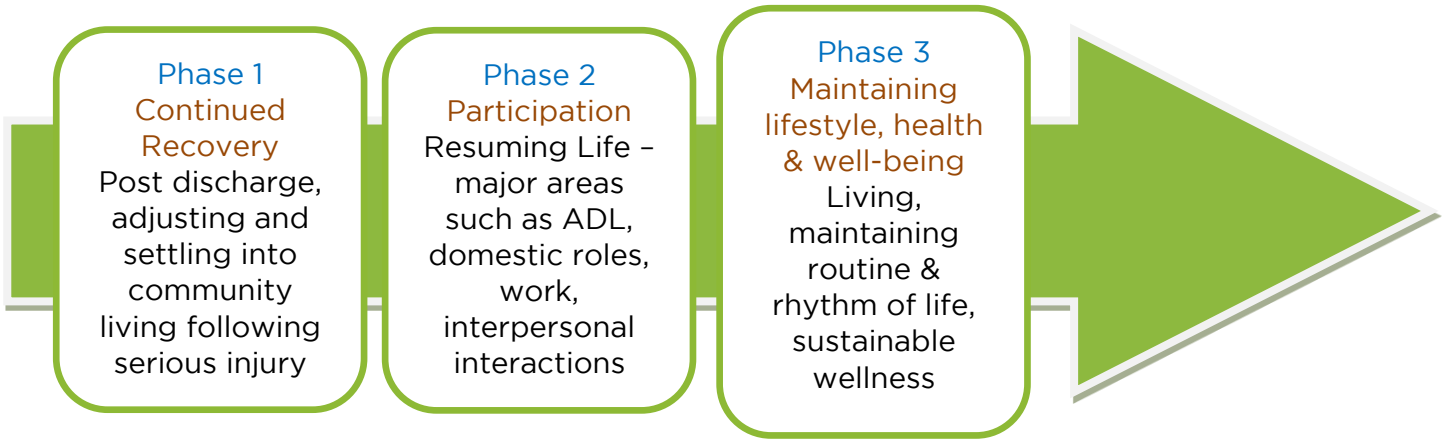
4: PROFESSIONAL CONDUCT AND CONTINUOUS IMPROVEMENT	
CRITERIA	**CASE MANAGEMENT EXPECTATIONS**
Adheres to professional boundaries with regard to role as case manager	Interactions with participants, family and other service providers demonstrate knowledge of case management role, definition and boundaries (ref case management taxonomy) 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
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 **icare lifetime care** as appropriate	Has attended relevant training opportunities offered including: -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	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)
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	
CRITERIA	**CASE MANAGEMENT EXPECTATIONS**
Has efficient range of communication systems	Has a business telephone – including for use in teleconferencing with other team members Has email capability Has Internet capability – including access to **icare lifetime care** website, Yammer, Skype and Pulse (Lifetime Learning) Has scanning capability Able to use the My Plan forms – interactive PDFs, word, excel

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.
Efficient invoicing systems	Invoices are sent in a timely manner and include all information required by **icare lifetime care**: • ABN • Invoice number • Participant Number • RP number/s • Service codes • GST as appropriate Only services pre-approved by **icare lifetime care** are invoiced
Leave cover	Appropriate arrangements are made to ensure participant receives all necessary services when case manager is on leave Includes: • Informing **icare 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 **icare lifetime care** Coordinator (as well as participant & their family and all involved provider services) their contact details • In instances where **icare 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

Appendix A Phases of the Rehabilitation – Life Continuum

Lifetime Care recognizes that different case management actions and skills are required at different times across the rehabilitation/life continuum.



Phase 1
Continued Recovery

Phase 2
Participation

Key requirements of case management

Well-developed knowledge, practical experience and skills in:

- Acute, post-acute recovery following severe injury
- Providing guidance & support using a person-centred approach
- Holistic assessment of the participant's situation and their needs
- Person-centred planning and SMART goals including objectively evaluating outcomes
- Establishing, coordinating and monitoring multi-disciplinary community-based rehabilitation programmes, which focus on participation
- Facilitating and navigating community-based formal and informal participant support networks
- Skilled monitoring including for early detection of secondary health conditions, e.g. mental health.

Phase 3
Maintaining lifestyle, health & well-being

Key requirements of case management

Well-developed knowledge, practical experience and skills in:

- Person-centred planning for participation in life roles
- Enabling risk tolerance, personal control and engagement in life roles and applying safeguarding principles
- Understanding advocacy & promoting participant self-advocacy
- Facilitating and linking people with a disability to a range of their local/regional community services and organisations
- Monitoring and promoting participant self-management where possible. Promoting participant health and well-being, guiding self-management including access to healthcare services if/when indicated

Appendix B

Sources of Knowledge

FIVE SOURCES OF KNOWLEDE 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.