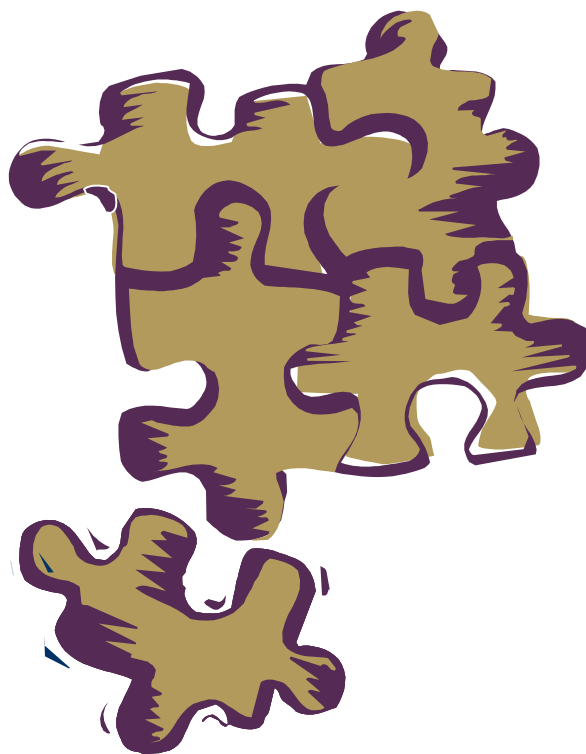


# Home and Community Care



## Care Co-ordination, Care Planning & Case Management Project Report Hume Region



*home and community care*

A JOINT COMMONWEALTH AND STATE/TERRITORY PROGRAM  
PROVIDING FUNDING AND ASSISTANCE FOR AUSTRALIANS IN NEED

Telos Consolidated  
June 2003

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## **Executive Summary**

This project set out to explore the use and understanding of the terms care co-ordination, care planning and case management, to determine the level of understanding of the terms and then work to develop consistent definitions.

The processes used primarily focussed on engaging workers in the field [mostly but not all Home and Community Care (HACC) funded], encouraging discussion and debate in relation to the terms. Initially a survey of key stakeholders and a literature search of the terms and their use in other States and countries informed the project. The forums across the Hume Region expanded on this with participants coming together to hear each other's views and develop a consistent definition and flow chart for each term. These were well attended with lively debate.

In some parts of the Hume Region this project and its activities occurred alongside the development by Primary Care Partnerships (PCPs) of Service Co-ordination tools. This provided some consistent language and understanding in the field, for example, Initial Needs Identification.

It was apparent that the usage of the term case management was fairly consistent and the tasks considered to be part of this role were similarly described by all groups.

There was some divergence in the view of care planning, in particular in relation to whether the plan was for one service, or across a range of programs that were all providing services to one client. Most participants acknowledged that plans being developed and reviewed by services working together reflected best practice but stated that this was not achievable in reality due to inadequate resources.

The issue was similar in relation to care co-ordination, where agencies recognised the advantages of having a lead agency, as a central contact and information feedback point. Agencies stated that this could become a defacto case management role.

Common understandings were drafted for the terms. Subsequently flow charts describing some of the activities involved, alongside principles that would apply in all situations were developed. The Steering Committee reviewed the input of each of the forums and developed a draft regional set of common understandings and flow charts. These were then presented back to the field at follow up forums which gave the Steering Committee feedback in relation to the draft terms and flow charts. The terms and charts that appear in the body of this report represent input from across the Hume Region, pulled together by the Steering Committee.

The project identified current practice in the Hume Region. The flow charts and principles underpin best practice in relation to the practical application of the terms in this project.

As continuous improvement is an element of all practice, to further the work of this project it will be essential that the necessary protocols are developed regionally and between individual agencies. These protocols would clarify the primary points of overlap and the roles and responsibilities of service provision. It was recognised at project inception that protocols would be the next step and that the Primary Care Partnerships were the most likely vehicles for developing these.

The project has achieved its goals, involved the field and has opened the terms care co-ordination, care planning and case management for debate and ongoing development. The recommendations inform the field of what is needed to work towards Best Practice in relation to the terms.

A secondary process has been to link the practice development to the DHS Better Access to Services strategy as currently all primary care agencies are working on this through their respective Primary Care Partnerships.

## Recommendations

The list of recommendations below was developed by the Steering Committee following the completion and collation of all forum material. Members of the Steering Committee had attended forums in their areas and received feedback from all other forums.

In the drive to continuously improve practice in order to best serve clients and their needs, the Steering Committee wished to draw the following recommendations to the attention of the HACC Best Practice Groups, the Department of Human Services, all agencies in the Hume Region and any others who are interested in developing quality practices. The recommendations are based on the practice issues raised in the forums attended by workers in the field.

Recommendations fell into several categories for implementation. Some were considered the responsibility of the HACC Best Practice Groups in the Region, others the responsibility of the Primary Care Partnerships and others the responsibility of the Department of Human Services.

**Recommendation 1:** That the Steering Committee, through this project and in conjunction with Telos Consolidated, arrange a forum to focus on the issue of lead agency, developing the role, responsibilities, expectations, principles behind nominating the lead agency and the relationships of other services with this agency.

**Recommendation 2:** That the Hume Strategic Advisory and Promotion Group reform, with 3 representatives from each of the sub-regional HACC Best Practice Groups

**Recommendation 3:** That the Hume Strategic Advisory and Promotion Group facilitate the development of protocols in relation to:

- ◆ Lead agency
- ◆ Facilitating client transition from care co-ordination to case management and case management to care co-ordination.

**Recommendation 4:** That the Primary Care Partnerships, with input from the four Hume sub-regional HACC Best Practice Groups, facilitate the development of protocols in relation to:

- ◆ Feedback of information
- ◆ Sharing information, for example in relation to care plans
- ◆ Service Co-ordination Plans.

**Recommendation 5:** That the Department of Human Services Regional Office, through the Home and Community Care training program, provide workshops in relation to protocols, processes and practices pertaining to information sharing.

**Recommendation 6:** That the Department of Human Services Regional Office provide opportunities for Privacy Act training with a focus on its application in actual practice.

**Recommendation 7:** That the Department of Human Services Regional Office, in conjunction with the Hume Strategic Advisory and Promotion Group, work with the field to develop consistent practices in relation to waiting lists, including the consequential implied risk management.

**Recommendation 8:** That the Department of Human Services Regional Office develop strategies to address the issue of potential defacto case management.

**Recommendation 9:** That the Department of Human Services Regional Office facilitate a workshop enabling HACC and other relevant service providers to clarify the roles of all agencies involved in monitoring the well-being of the client.

## Acknowledgements

This project was initiated through the four (4) HACC Best Practice Groups in the Hume Region with the Upper Hume Best Practice Group submitting for funds for a Hume Region Project. The Upper Hume Best Practice Group formed a Steering Committee inviting other Best Practice Groups to ensure their input and participation.

The Department of Human Services Regional Office has supported the project throughout through participation in the Steering Committee, the forums and the debate of the issues.

The greatest acknowledgement is to the workers and managers in the field – to all those who participated in the survey, the forums and the follow up forums. Some participated at all levels with staff attending various forums in different locations. The process and the outcomes of this project have only been possible due to the excellent input and the preparedness of all participants to openly and honestly debate practice issues.

Upon their request, some who could not attend forums contributed through phone consultations.

The project wishes to pay tribute to the following people and thank you for your time and energy.

First Name	Surname	First Name	Surname
Robyn	Adams	Martie	Juszkia
Abbie	Alcock	Karen	Keat
Bronwyn	Allen	Carmel	Kendall
Phillip	Allen	Melanie	Kennedy
Shirley	Bain	Fiona	Kirk
Judith	Barber	Jan	Kowarzik
Cynthia	Bird	Jenny	Lang
Martin	Blakemore	Catherine	Larkings
Helen	Boehm	Sharon	Laver
Jill	Boers	Marie	Lister
Rod	Brady	Greg	Loughnan
Penny	Bristow	Sue	MacFarlane
Helen	Brooks	Rhonda	McPherson
Craig	Chadwick	Heather	Maddock
Sally	Coates	Coral	Marks
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Katrina	Daniher		Annette	Nuck
Sandra	Davidson		Gail	O'Donnell
Helen	Davis		Sandra	O'Toole
Simon	Delahenty		Pam	Owen
Carmen	Denniss		Susan	Pack
Janis	Doyle		Maureen	Phillips
Letitia	Drummond		Joan	Pickford
Wendy	Dudley		Kaye	Pink
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Phillipa	Duggan		Carolyn	Prowse
Barb	Edwards		Debi	Randich
Pam	Ewert		Kerrie	Reardon
Sue	Fletcher		Karen	Richards
Jacinta	Flood		Julie	Riley
Sheryl	Follett		Cathy	Rogers
Susan	Forrest		Simon	Rose
Kerry	Foyster		Ann	Ryan
Laurel	Fry		Darren	Saunders
Rachel	Fry		Heather	Seiter
Chris	Gabriel		Linda	Sexton
Joy	Gadd		Wendy	Shanks
Pauline	Garvey		Denise	Simms
John	Gillman		Gwenyth	Smith
Judy	Glover		David	Taylor
Debra	Gook		Liz	Taylor
Yvonne	Gunton		Sally	Taylor
Shenna	Hammond		Rochele	Thomas
Nanette	Herry		Bobbie	Titcher
Sheridan	Hicks		Pam	Tobias
Heather	Hillas		Leanne	Torpy
Margaret	Holleran		Jan	Vincent
Margaretanne	Hook		Carly	Visscher
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Edna	Johnson		Lynette	Wilson
Helen	Johnson		Lee-Ann	Winiata
			Bernadette	Young
			Fiona	Zimmerman
			Jane	Zwar

## Steering Committee

The project was guided at all stages by a highly committed Steering Committee who worked both at the 'big picture' level and the micro level in drafting regional understandings of the terms and flow charts. Each member gave time, skill, energy and consistent involvement throughout the project. The Committee were excellent and responsive leaders of the project as well as participating in the many forums.

Member	Agency
Sheryl Follett, Chairperson	Upper Murray Family Care
Neil Duggan	Department of Human Services
Gary Foley	Community Interlink
Sharon Laver	District Nursing, Wodonga Regional Health Service
Sally McCarron	Mitchell Shire Council
Simon Rose Jan Consedine	City of Greater Shepparton
Ruth Tai	Shire of Indigo
Bobbie Titcher	CoNECT Support

The *Telos Consolidated* project team of Jill Nicholson and Sally Wright would like to express their gratitude to all members of the Steering Committee for their absolute commitment to 'making a difference' to the practice of care planning, care co-ordination and case management in the Hume Region in the here and now and the future. The members are already looking ahead to incorporate the learnings from this project into other areas.

*Jill Nicholson and Sally Wright*

## Project Background and Purpose

### Project Purpose

The aim of this Project was to engage with service providers to develop a consistent understanding of the work that they undertake when using the terms care co-ordination, care planning and case management; and identify the protocols and procedures that would support this work in the Hume Region. The further purpose was to achieve better services for clients and their carers/families, based on an improved understanding of the roles and responsibilities of services in the field.

### Context

The Home and Community Care (HACC) service sector, through the four (4) HACC Best Practice Groups in the Hume Region, had identified an increasing demand for 'care co-ordination, care planning and case management'. This had been experienced by providers who were either not funded to provide that service or believed they were providing it at levels not reflected in the funding.

Alongside this issue sits the lack of common understanding of what is involved in the roles of care co-ordination, care planning and case management and the practices and processes associated with these. This has the potential to create disharmony, service duplication and service gaps.

The HACC Care Co-ordination, Care Planning and Case Management Project has taken place at the same time as primary care agencies across Victoria have been required to implement the Primary Care Partnership Better Access To Services (BATS) Strategy aimed at improving service co-ordination.

The strategy sets out clear objectives for the enhancement of primary care service co-ordination. Each Primary Care Partnership (PCP) is required to develop service co-ordination models that delineate roles and responsibilities between service providers to promote a seamless continuum of care for consumers. One strategy to achieve this is the development of a '*common language and understanding*'<sup>1</sup>. The terms deemed to be in common use within the service system are defined in the *Better Access to Services – A Policy & Operational Framework*, June 2001. Such terms include:

- Care Co-ordination and Care Co-ordinator
- Care Planning
- Case Management and Case Manager.

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<sup>1</sup> *Better Access to Services – A Policy & Operational Framework*, June 2001

The definitions used in the Victorian Primary Care Partnership *Better Access to Services* model<sup>2</sup> provide a valuable contemporary example illustrating that there is no universally accepted professional standard for the use of the terms. It also highlights how each service development process creates its own set of different and often contradictory terms to those in current usage.<sup>3</sup>

The PCP Service Co-ordination framework is underpinned by six key elements:

- Initial Contact
- Initial Needs Identification
- Service Specific Assessment
- Specialist Assessment
- Comprehensive Assessment
- Care Planning.

Initial contact, initial needs identification and service co-ordination tools<sup>4</sup> have been developed at a statewide level. Each of the four Primary Care Partnerships within the Hume Region have been involved in developing the protocols, processes and practices to facilitate the implementation of the Service Co-ordination framework, particularly the introduction of the tools.

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<sup>2</sup> Op cit P7

<sup>3</sup> Refer to Appendix C: Literature Review

<sup>4</sup> Refer Appendix B: Service Co-ordination elements and Associated Tools

Activities at a local and regional level have included:

- The engagement or secondment of staff and /or consultants by each of the Primary Care Partnerships to develop local documentation, manuals and protocols to guide and facilitate the implementation of the Service Co-ordination Initiative
- Train the Trainer workshops to familiarise agency representatives with the usage of Service Co-ordination Tools and recommended service co-ordination pathways as per the *Service Co-ordination: Tool Templates* and the *Service Co-ordination Orientation – A program for service providers*<sup>5</sup>
- Consultation with individual agencies identifying issues/barriers that may impede the efficient and timely introduction of the Service Co-ordination Tools and processes
- Piloting of the tools, draft processes and practices
- To progress the statewide implementation of the *Better Access to Services* strategy, the Victorian Government has commissioned the Western Metropolitan Region to develop a number of resources for general usage that support practice development in respect to care pathways, interagency protocols and the role of the lead agency<sup>6</sup>.

The common themes of the HACC Care Co-ordination, Care Planning and Case Management Project and the Victorian Primary Care Partnership Better Access to Services strategy are a timely opportunity to advance complimentary service development but also have the potential to cause confusion and frustration for service providers.

The HACC Care Co-ordination, Care Planning and Case Management Project has therefore been cognisant of the need to integrate the principles and practices of Service Co-ordination, as directed by the field, into the outcomes of this project.

In particular service co-ordination terminology has been comprehensively built into the practice flowcharts in this project. The PCP Service Co-ordination Project Staff in the four Hume Region sub regions are seeking to incorporate the common understandings and practice flowcharts into their respective PCP Service Co-ordination Practice Manuals.

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<sup>5</sup> *Service Co-ordination: Tool Templates* DHS Primary Care Partnerships May 2002  
*Service Co-ordination Orientation – A program for service providers* DHS Primary Care Partnerships October 2002

<sup>6</sup> Key documents include:  
*The WMR Service Co-ordination Best Practice & Continuous Improvement Manual*, Western Metropolitan Region Primary Care Partnerships First Edition December 2002; The WMR Interagency Referral; The E Referral Protocol; The WMR 'DIY Privacy for Primary Care Agencies' kit.

## **Project Method Overview**

The project was undertaken in six (6) stages, as outlined below, to maximise the input of practitioners in the field and to encourage debate around the terms used and their understandings. At all times the Project was guided by the Steering Committee.

### **Stage 1: Establishment and Accountability of the Project**

This stage involved the establishment of clear tasks, timelines and reporting responsibilities. Key stakeholders were introduced to the project through a newsletter. An extensive regional email group was set up to facilitate timely and efficient communication.

### **Stage 2: Research of the Current Situation**

This involved the literature review and survey, informing the Steering Committee and project participants of current practice in relation to the terms care co-ordination, care planning and case management in the Hume Region and elsewhere.

### **Stage 3: Develop Practice Definitions through Practice Forums**

This involved the participants at the five (5) practice forums in describing and analysing their current practice, including developing definitions of the terms and a flow chart of the tasks involved and the inter-relationships of these. Working relationships were strengthened as the participants worked together at the forums, developing a greater shared understanding of the terms and their use in practice.

Forum reports which reflected the discussion, definitions and flow charts developed at each of the forums were forwarded to all stakeholders in each sub-region.

### **Stage 4: Drafting Regional Common Understandings**

During this stage, the Steering Committee met to develop draft common understandings of the terms and draft flow charts, based on the work undertaken by the forum participants in Stage 3.

Feedback was received during this period that agencies appreciated the reports of the forums which documented the decisions. Workers were able to consider these in their day to day practice, in some instances modifying their practice.

### **Stage 5: Consolidating Practice**

Workers were invited to join one or more of four (4) follow up forums held across the Hume Region. These forums focussed on gaining feedback from participants in relation to the draft common understandings and flow charts developed by the Steering Committee in Stage 4. The workers involved then had a common and clear understanding of the practice terms.

Each forum also noted protocols required for the implementation of the draft terms and flow charts, and, listed practice issues still to be addressed.

## **Stage 6: Project Report and Recommendations**

The work of the project was documented into a report, documenting the process and outcomes of the project, both for those involved and others interested in the process and/or outcomes. This includes recommendations from the Steering Committee based on the feedback from the follow up forums. The underlying purpose of reporting and documenting is for ongoing practice development in the field which will hopefully continue to improve services to clients in the Hume Region, and to provide a resource for practice development in other areas.

## Project Outcomes

### Survey Process and Outcome

A key task of the Project has been to conduct a practice survey with practitioners and organisations that have a role in the continuum of care for HACC clients and their carers with the objective of:

- Facilitating reflection of what the above terms mean in practice and how application and expectations of such terms effect service delivery and continuity of care
- Creating worker interest and commitment in the project
- Providing Telos Consolidated and the Steering Committee with the background and contextual information to sensitively progress with the project.

### Survey Outcome

130 surveys<sup>7</sup> were emailed and 1 posted to service providers. Of these, 33 (25%) were returned.

### Survey Analysis

The analysis of the four (4) questions provides valuable qualitative data that demonstrates the following:

- That there is clear disparity in how the key terms are understood and applied
- As a result of the above, there is a level of tension between services in respect to the practitioner roles and responsibilities
- That there is a lack of understanding of the terms on the part of individual practitioners as demonstrated by the responses to questions 1 and 3
- That certain professional groups, for example District Nursing and Allied Health, hold a much more service specific view in relation to care co-ordination, care planning and case management
- The strongest uniformity in understanding/perception related to the view that Case Managers have responsibility to, using a holistic approach, take the lead role in assessment, care planning and care co-ordination
- That agencies who have a more generic assessment and care management role<sup>8</sup>, feel that they are being required to fulfil a defacto case management role for high needs clients
- The two most important issues to practitioners are the uncertainty in relation to professional boundaries and the resultant gaps and duplication of services for clients.

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<sup>7</sup> Refer to Appendices D & E for survey form and full survey results

<sup>8</sup> As per Victorian HACC Program Manual 1998

The analysis of survey responses which demonstrates the absence of a shared understanding in relation to the key terms, together with the practitioner's definitions of terms and practice examples, confirms the value and timeliness of the HACC Care co-ordination, Care Planning and Case Management Project.

Full details of the survey process, responses and analysis are included in Appendix E: Survey Analysis.

## Literature Review Summary

The Literature Review has been undertaken to:

- Analyse the terminology care co-ordination, care planning and case management
- Identify existing research and/or practice development initiatives that seek to establish a common usage and understanding of the terms care co-ordination, care planning and case management.

## Key Findings

- It is evident from the literature review that the terms care co-ordination, care planning and case management are used extensively and interchangeably across the human services sector
- The term care planning was found to be the most clearly identified term in relation to it being the process or action that actually develops the Care Plan. However this term was also used in some sources to describe the much broader process of assessment; identification of needs; development of a care plan; implementation and co-ordination of services; monitoring and review
- Different types of case management were identified, most commonly the differentiation between case management and managed care, with managed care having cost containment as a key principle and objective
- The literature has multiple references to the evolvement and professional qualities of 'true' case management, being a service type that assists those clients perceived to have the most complex needs and in most need of assistance to navigate a complex service system
- The Literature Review has not been able to locate any research or project documentation that specifically examines, or aims to establish a common usage and understanding of, the key terms
- The service system is seen to be complex both for the client and the practitioner and this complexity is exacerbated by the absence of agreed definitions for key practice terminology.

The literature review, undertaken in October 2002, establishes that a lack of standardization exists internationally in the usage of the terms care co-ordination, care planning and case management. Given the complexity that exists, it seems appropriate that a local response to standardisation, as in the aims of the HACC Care Co-ordination, Care Planning and Case Management Project, is a worthwhile service enhancement objective.

The full documentation of the Literature Review is included in this report in Appendix C: Literature Review.

## Principles

During the many discussions in relation to case practice and the use of the terms in this project, participants in the forums identified some key principles that are recorded below. This list is not exhaustive and could well be added to.

The principles reflected below apply to all case practice situations and it is assumed that these principles will underpin the practice of anyone who embraces and implements the common understandings developed in this project and the processes depicted in the flow charts.

It is a principle in any of the definitions and charts in this document that the client/carer is involved in all stages of the service delivery and flow charts, with a choice to exit at any point in time. Work undertaken with clients will keep their needs foremost as well as those of their carer/family.

When the word 'client' is used, it means 'the person who was referred for service and their carer and family'.

Client consent will always be obtained for any referrals, consultations or work undertaken that involves inter-agency co-operation. Agencies will adhere to the legislation that is relevant to their practice. The goal is to achieve service co-ordination for the client and to share necessary information in order to achieve this, whilst keeping private information that does not improve service co-ordination.

The agencies and their staff involved in service delivery will promote client autonomy and independence. Client's have a right to services and advocacy for services.

The flow charts that were developed are a guide to the processes involved and are **not** intended to be prescriptive of practice. The order of activities drawn is the usual practice as described by the workers present; however this may vary from client to client. Some activities will not be relevant or necessary for some clients and others may require activities that are not listed.

## Common Understandings

The purpose of this project was to develop common definitions and understandings of the terms care co-ordination, care planning and case management. It was also decided to develop flow charts of the activities involved in undertaking these tasks. (refer to next section)

The forums developed definitions and flow charts for each of the terms. There were five (5) forums, therefore we had 5 definitions of each of the terms and corresponding flow charts, although most groups decided to place care co-ordination and care planning on the one flow chart.

This initial process, of developing definitions, was followed by the Steering Committee developing a picture of what was common in the definitions and flow charts. This was developed into a document called 'Draft Common Understandings and Flow Charts' that was circulated to participants for their feedback at the follow up forums. Refer to Appendix F: Draft Common Understandings and Flow Charts.

This section of the report outlines the feedback given to the Steering Committee by the participants at each of the four (4) Follow Up Forums. The comments below demonstrated to the Steering Committee that there was a gap between current practice and the best practice that workers strive for. The comments are included in this report as they indicate why there is a variance between acknowledged best practice and the reality in which workers deliver services to clients.

## **Care Planning**

### **Care Planning: Field Feedback**

The primary consistent feedback was that the draft common understanding presented to the follow up forums represented the 'ideal' care planning situation which included the appointment of a lead agency, feedback to the referring agency and a care plan that reflected the input and delivery of a range of services.

Agencies reported that they did not routinely appoint a lead agency or key worker.<sup>9</sup> Although in situations of complex care, agencies would agree that one agency assumes a lead role, they stated that this was not realistic as there were not the resources to fund the work of the lead agency. For example, the part time nature of some services, which do not have reception services, makes it difficult for them to be the lead agency. It was noted that the lead agency will only work if the network of agencies fulfil their responsibilities and keep the lead agency informed.

In general, the field uses the term care plan to refer to an agency specific plan of the services that they will provide to meet the client needs following their assessment. As such the care plan would not usually be circulated.<sup>10</sup> The care plan would be on file for the staff to refer to. As such one client could have more than one care plan.

Information from the plan would be given (as appropriate) to other service providers and a copy sent on request with client's consent. The plans usually note the other agencies that are involved (those known). Some agencies spoke of the client having a copy of the care plan.

The care plan reflects what is actually being delivered which may not totally reflect the client's desired outcomes. Clients' needs may be identified but not met due to wait list(s). Client desired goals would in some agencies be documented in the assessment rather than the care plan.

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<sup>9</sup> Exceptions to this are Mungabareena with Koori clients and CRIS where there is carer stress and appointing a lead agency may reduce the level of stress.

<sup>10</sup> Exceptions to this are the Department of Veteran's Affairs, CRIS, Discharge Planning, Palliative Care and services providing case management.

Some agencies, such as Post Acute Care and Aged Care Assessment Service (ACAS) would only be involved in monitoring and review for a very short period whilst they were involved in developing a care plan. Care planning is a dynamic and responsive process and this was not reflected in the draft.

Assessment of short and long term needs varies between client groups.

Exit was omitted from the draft common understanding.

### **Care Planning: Common Understanding**

The wording that follows incorporates the feedback from the four (4) follow up forums held in the Hume Region, specifically the general comments listed above. The current practice, relating to each term will be noted first, followed by the Best Practice.

### **Care Planning: Current Practice**

Care Planning is a dynamic, consultative process that includes the client, the family and appropriate service providers in the identification and assessment of client needs, from which a care plan is developed, that includes goals and actions aimed at achieving desired/optimal outcomes.

Key tasks include:

- Assessment of short term and long term client needs
- Prioritising of client needs and goal setting to meet such needs
- Exploring the most appropriate and cost effective way of meeting client needs
- Developing a Care Plan specific to the services of the agency, noting other agencies involved. The circulation of this Plan will depend on current individual agency practices
- Implementing the Care Plan
- Ongoing assessment and review of client needs and appropriate revision of the Care Plan.

### **Care Planning: Best Practice**

The best practice tasks include all those listed above, as well as the following:

- Developing a Service Co-ordination Plan to co-ordinate the client's care across all involved services, i.e. a Service Co-ordination Plan as described in the Service Co-ordination Tools
- Documenting and circulating the Service Co-ordination Plan, which may identify a lead agency and who is responsible for what components of the Plan

- Formalizing the Service Co-ordination Plan through actions such as: appointment of a lead agency<sup>11</sup>, documenting the list of agencies involved, allocation of responsibilities, setting a review date, providing the client with a copy of the Service Co-ordination Plan, distributing a copy of the Service Co-ordination Plan to participating agencies as per confidentiality and privacy guidelines.

## **Care Co-ordination**

### **Care Co-ordination: Field Feedback**

The same comments as those listed for Care Planning were reiterated by the participants at the follow up forums in relation to the draft common understanding reflecting the ideal, in particular in relation to the lead agency and feedback to agencies. It reflects what would be best practice but is not yet the current reality. Care Co-ordination was described as ad hoc, sometimes being undertaken more formally and across agencies due to the specific needs of clients.

One group commented that if there is a lead agency, it needs not to be referred to as 'the first point of call' as agencies will then receive calls about all manner of client issues that could be managed by other means, including family. Where there are multiple agencies, it is important that each understands the role of the other agencies.

Processes for client exit or closure were not clear, for example appointing a 'new' lead agency if the lead agency was no longer involved. The transition from care co-ordination and entry into case management was not clear.

Liaising and communicating with other service providers does not routinely happen for many reasons. Referrals may not contain enough information, particularly at the referral point so that the agency receiving the referral can best match the client with their service. It was acknowledged that some clients have services provided informally by family, neighbours or volunteer organisations.

### **Care Co-ordination: Common Understanding**

As with care planning, the wording below incorporates the feedback from the four (4) follow up forums held in the Hume Region.

### **Care Co-ordination: Current Practice**

Care Co-ordination is a process that implements the care plan to ensure that the specific service(s) in the plan are implemented in a client focused, flexible and timely manner. It is acknowledged that some clients will choose to co-ordinate their own care. The care plan is dynamic in response to the client's needs and may alter during the work with the client.

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<sup>11</sup> The tasks and duties of the lead agency need to be listed and clarified (refer to section on protocols and practice issues). Participants wanted clarification that this was not a case management role. Some described the role as a pivotal point for communication.

Care Co-ordination includes:

- Implementation of the Agency's Care Plan, particularly through each agency involved co-ordinating their own service(s)/program(s)
- Agencies ensuring that the care is meeting client needs through effective monitoring and review of the Care Plan
- Liaising and communicating with other service providers and client/carer
- Planned exit to other services/systems, eg. ACAS, case management or residential services.

### **Care Co-ordination: Best Practice**

The best practice tasks include all those listed above, as well as the following:

- Formalizing a Service Co-ordination plan with all involved services
- Ensuring that a lead agency is nominated
- If a lead agency is appointed, they are the communication link for the client/family, they receive feedback from other agencies, and, they lead the review of care and ensuing adaptations to the Service Co-ordination Plan.

## **Case Management**

### **Case Management: Field Feedback**

Again it was considered by participants at the follow up forums that the draft common understanding reflected the ideal instead of current practice, as other agencies do not routinely 'hear and get feedback from case management agencies'.

The word 'monitoring' in this common understanding gave rise to much debate about the meaning of the term, whether it had to be 'face to face' and what was considered 'regular'. Many considered that case managers do not 'monitor' and that service providers undertook this task. It appeared that agencies expected case managers to have regular contact with their clients. One suggestion was not to use the word monitoring and replace it with 'managing client care and responding to needs'.

The draft did not reflect a clear separation of case management and brokerage and the responsibility to purchase within the care plan.

Participants noted that clients do at various times 'exit' from care co-ordination, care planning and case management, for example, into case management or into a residential service or for any other reason. Groups also commented on the need for planned case management closure.

### **Case Management: Common Understanding**

As with care planning and care co-ordination, this wording incorporates the feedback from the four (4) follow up forums held in the Hume Region.

## **Case Management: Current Practice**

Case management encompasses the tasks and roles of Care Planning and Care Co-ordination and as such is based on a comprehensive assessment of the client's complex needs. The Case Manager, as a central point of contact and identified key worker, liaises with the client and services to provide holistic care, problem solving and advocacy on behalf of the client. This process will proactively respond to and plan for client needs, activate appropriate resources in consultation with the client, carers and other service providers, and, ensure that the client is aware of all options and is able to make informed choices.

Key tasks include:

- Being the lead agency
- Assessing client and carer/family needs using the social model of health framework
- Developing/updating the Care Plan and developing future goals
- Problem solving, trouble shooting, responding to crises
- Negotiating and facilitating service provision
- Liaising with service providers
- Monitoring the client's well-being, needs, care and the effectiveness of services
- Advocacy and mediation
- Planning of care within available resources, sourcing additional funds
- Empowering clients and/or their families to make informed choices
- Referrals to other agencies
- Identify the need for specialised training that may arise due to a client's specific needs
- Develop a Client Exit Plan.

## **Case Management: Best Practice**

The best practice tasks include all those listed above, as well as the following:

- Hear and give feedback from / to other agencies
- Identify the need for and co-ordinate case conference(s) <sup>12</sup>
- Clarify which agency will undertake what level of monitoring.

## **Flow Charts**

The feedback given at the follow up forums in relation to the draft flow charts has been incorporated in the final flow charts (see below). Feedback given was that the flow charts represented ideal/best practice, which was not necessarily the current practice at all times and in all agencies.

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<sup>12</sup> It was acknowledged that both the feedback and the case conferences are sometimes activities undertaken by case managers. They are listed with the 'Best Practice' as many workers felt these tasks were not routinely undertaken by case managers, just as appointing a lead agency is not routinely undertaken in care co-ordination.

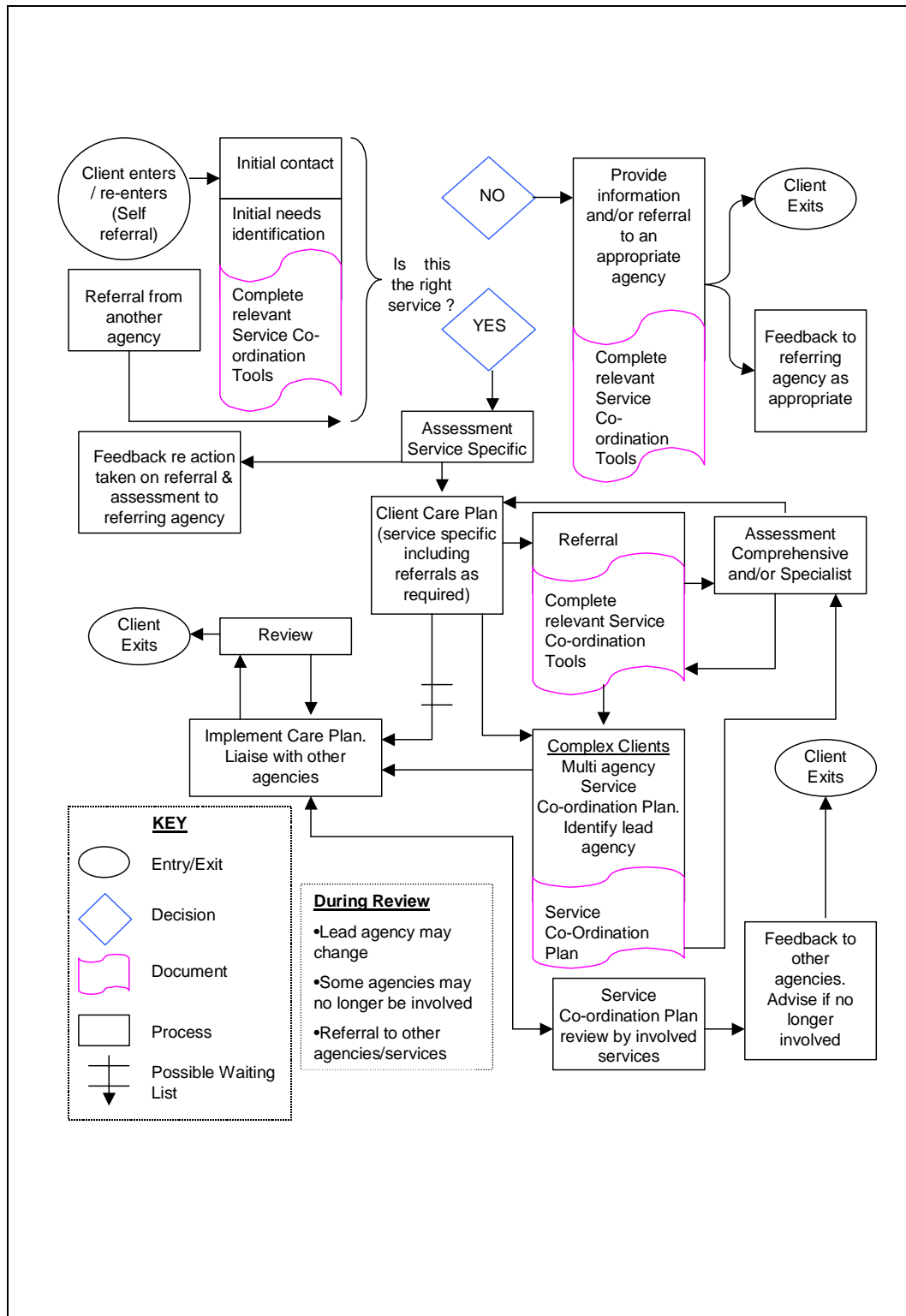
One group commented that the Care Planning and Co-ordination Flow Chart does not reflect the acute-sub acute flow and their previous involvement.

In the Case Management Flow Chart, the services commented that they do not regularly call meetings with the client and other service providers to develop or review the Service Co-ordination Plan.

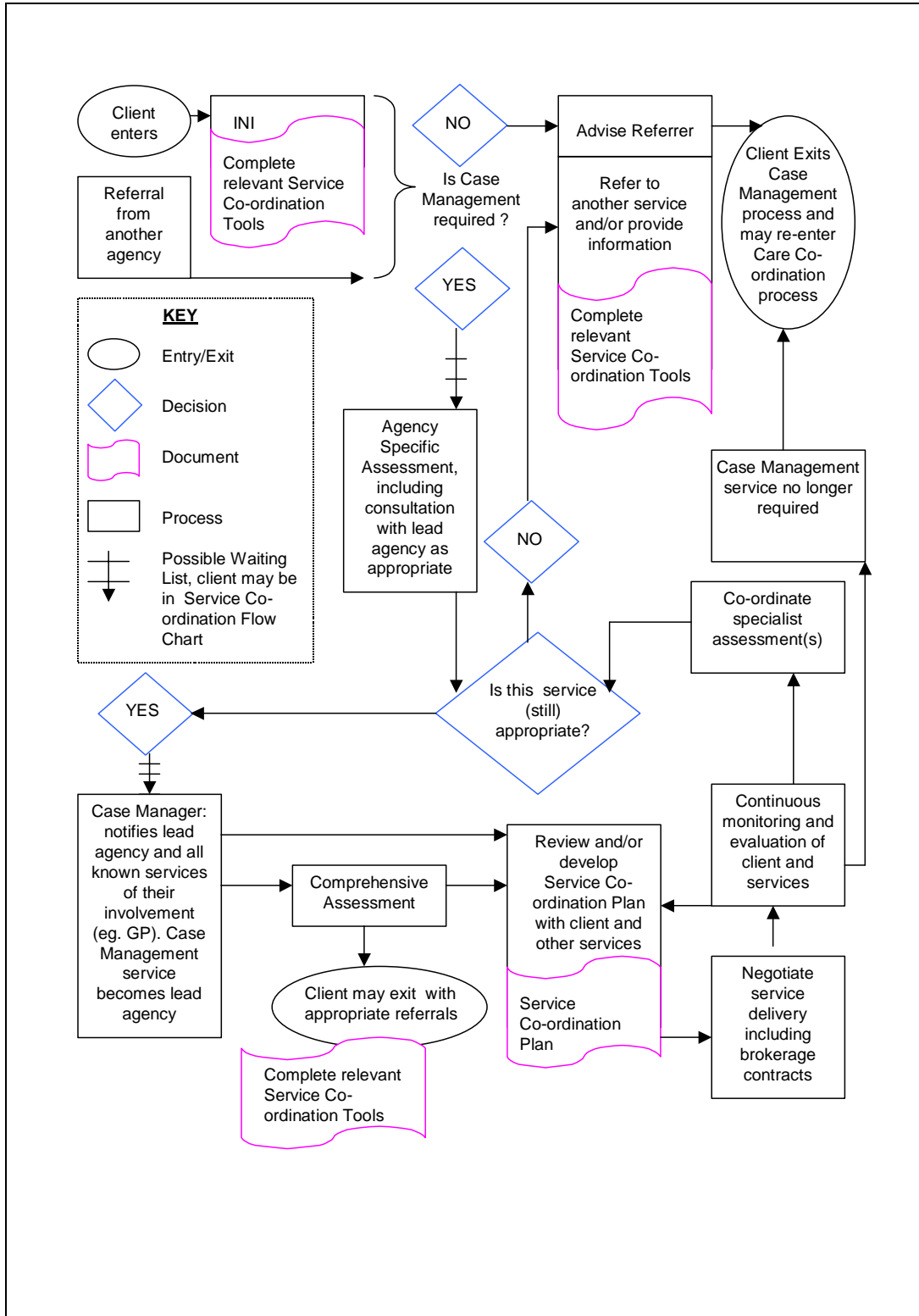
In the flow charts on the next two pages, the documents referred to are those that are part of the Service Co-ordination Tools.

The principles outlined earlier in the report apply to the flow charts below, therefore for example, where 'referral' or any communication with other agencies is shown, it is understood that this is with the consent of the client/carer.

## Care Planning and Co-ordination Flow Chart: Towards Best Practice



### Case Management Flow Chart: Towards Best Practice



## Protocols Required

At the follow up forums, participants were asked to list the protocols required for the effective implementation of the common understandings and flow charts. Much of the discussion revolved around the lead agency (see below). Other protocols that are required are listed below:

- Lead agency; includes definition of the role, responsibilities, expectations, identifying/nominating the lead agency, how services relate to the lead agency, consulting the client re which service is the lead agency, and, what to do in the event of a change in lead agency
- Development of Service Co-ordination Plan; responsibility, practicalities and protocols between agencies involved in the Plan
- Information / feedback to relevant agencies in many circumstances; for example:
  - following a comprehensive or specialist assessment
  - feedback from case managers to care providers
  - cessation/completion of services
  - client withdrawal or refusal of services
  - agency withdrawal of services
- Referral protocols; including feedback re status of the referral to the referring agency, what do agencies mean by a minimum level of information for referral practices, and, which Service Co-ordination Tools (templates) are required for a referral to each agency
- Protocols re intake, including responsibility for completing the Service Co-ordination Tools and which tools will be completed by which services
- Timeframes for Service Co-ordination intake processes to be completed
- Guidelines re who receives a copy of the Care Plan
- Protocol in relation to the transition between Acute and/or Post Acute Care and community based services
- For Aboriginal and Torres Strait Islander (ATSI) clients, choice given in relation to inclusion of an ATSI advocate
- Protocols for feedback to other agencies where the client has made the decision to exit
- Guidelines to facilitate client transition from care co-ordination to case management or vice versa
- Status of consent, communicating consent, use of consent forms
- Sharing information, eg guidelines re who receives a copy of the Care Plan.

## Practice Issues Raised: Steering Committee Suggestions

The table below records the practice issues that forum participants were asked to list at the end of the project, in order to identify the next steps in practice development in the Hume Region.

Participants were asked to list the practice issues that still require addressing, particularly in relation to defining the practices involved in the Project. Those issues considered to be of greatest priority by the participants are listed at the top of the table. Many of the Steering Committee suggestions refer to the recommendations contained in this report.

<b>Current Practice vs Best Practice</b>	<b>Suggestions for Issue Resolution</b>
Common Understandings as drafted reflect the ideal and not current practice; how do we move towards 'ideal' best practice? What impedes this now? Funding was considered to be the current impediment	Acknowledge current practice and promote Best Practice as done in this Project through discussions and in this Report
<b>Service Co-ordination in Practice</b>	
Service agreements imply service co-ordination; this is said to be built into unit costs but participants do not feel this is at all adequate	In accepting HACC funding, agencies agree to comply with all HACC funding policies, guidelines, standards and requirements. This includes co-ordinating services around consumer needs and with other services in the local area
Care co-ordination funds should be a major component of care (not a small add on)	The HACC program provides specific funding for care co-ordination ie. HACC Assessment & Care Management. The Hume Region has made this a priority activity for funding over the next three years
Clarify terminology in relation to care plan; service specific care plan and multi-agency care plan/Service Co-ordination Plan	The process of this project and this report has begun this. Further development would be achieved through Recommendation 4
Defacto case management occurs in the care Co-ordination process whilst the client is waiting for a case management service	Refer to Recommendation 8
Lead agency and the need to clarify who is responsible, roles, referrals (see protocols section of this report)	Refer to Recommendations 1 and 3
Identify triggers for reviewing the Service Co-ordination Plan	Refer to Recommendation 4

<b>Future of the Project / Agencies not involved to date</b>	
What do we do re the agencies who did not attend these forums and this debate?	There will be further opportunities for agencies to participate through forums and protocol development (refer Recommendations) and this report will be circulated to all agencies on the e-mail list. HACC Project Summary Report to be sent to project mailing list. Summary Report will include: Executive Summary, Recommendations, Common Understandings and Flowcharts.
How does the Project Steering Committee achieve Regional agreement in relation to the terms and the implementation of the flow charts	This project has sown the seeds, has continued a process of examining and debating practice, provided information that there are other ways of practising and encouraged best practice. Refer to Recommendations 2 & 3
<b>Case Management</b>	
Monitoring; definition of the term and the need to develop a service wide agreement re how this will happen	Refer to Recommendation 9
Need to explain case management waiting lists and how these operate, how to find out status of client on the list	Refer to Recommendation 7
The field holds high expectations of case managers and need to know what is realistic	Refer to Recommendation 9
Difficulties of case management services achieving closure and referral to a lead agency	Refer to Recommendations 3 & 7
Wait list stage may differ from agency to agency, may sit within ACAS prior to moving to case management package/place	Refer to Recommendation 7
<b>Feedback / Information</b>	
Lack of information provided to the service provider that is appropriate to the care the client needs; referrals from other services need to include the necessary information	Refer to Recommendations 4 & 6
Gap in communication/service between Hospital and community based services.	Generally beyond the scope of this project. May be partly addressed through Recommendations 3 & 4
Gaps in feedback noted to referrer and ongoing agencies, acute to sub acute and community based services	Refer to Recommendations 4 & 6

<b>Other Issues</b>	
Client refusing to give consent to information being shared	Refer to Recommendation 6
Consent: Status of implied consent, absence of signed consent, interpretation and application of Privacy Act/ Health Records Act, conflict between client and carer	Refer to Recommendation 6
Where does the INI originate? (particularly out of acute sector, GPs)	Refer to PCP Guidelines
Interpretation/application of Privacy legislation	Refer to Recommendation 6
So many different programs funded in so many ways – very complicated service system and difficult to know who is funded for what	Beyond the scope of this project

## **Appendices**

### **Appendix A: Glossary of Terms**

ATSI	Aboriginal and Torres Strait Islander
ACAS	Aged Care Assessment Service
BATS	Better Access to Services
CRIS	Carers Respite and Information Service
COGS	City of Greater Shepparton
CACP	Community Aged Care Package
DHS	Department of Human Services
DVA	Department of Veteran's Affairs
HACC	Home and Community Care
PCP	Primary Care Partnerships
PGAT	Psycho Geriatric Assessment Team

## Appendix B: Service Co-ordination Elements and Associated Tools

The following table was developed for the *Goulburn Valley Primary Care Partnership Draft Service Co-ordination Manual, November 2002, page 5*

Service Co-ordination Element	Brief Description of Element	Relevant Tool Templates / Supporting Information
<b>Initial Contact (IC)</b>	The <b>first point of contact</b> with the service system	<ul style="list-style-type: none"> <li>• Consumer information</li> <li>• Consumer Information Brochure</li> <li>• "Your information, It's Private"</li> </ul>
<b>Initial Needs Identification (INI)</b>	INI is an <b>Initial screening process</b> where the underlying issues as well as presenting issues are identified	<ul style="list-style-type: none"> <li>• Consumer Information</li> <li>• Summary and Referral</li> <li>• Consent Form</li> <li>• Supplementary Profiles</li> <li>• Living Arrangements / Functional / Health Conditions / Psychosocial / Health Behaviours</li> </ul>
<b>Assessment</b>	The INI process will have identified the need for specialist, service specific or comprehensive assessment	Assessment will build on the information collected through the use of the appropriate forms as part of the INI process
<b>Care Planning</b>	A <b>process of deliberation</b> that incorporates a range of existing activities such as care co-ordination, case management, referral, feedback, review, reassessment and monitoring	<ul style="list-style-type: none"> <li>• Service Co-ordination Plan</li> </ul>
<b>Information Management</b>	Sharing of health and care information:  The practice, process, protocols and systems to support the collection, use, disclosure, storage and disposal of consumer health and care information	<ul style="list-style-type: none"> <li>• Consumer Information</li> <li>• Summary and Referral</li> <li>• Consent Form</li> <li>• Profiles</li> <li>• Service Co-ordination Plan.</li> </ul>

## Appendix C: Literature Review

### Introduction

The Literature Review has been undertaken to:

- Analyse the terminology care co-ordination, care planning and case management
- Identify existing research and/or practice development initiatives that seek to establish a common usage and understanding of the terms care co-ordination, care planning and case management.

### Key Findings

- It is evident from this literature review that the terms care co-ordination, care planning and case management are used extensively and interchangeably across the human services sector
- The term care planning was found to be the most clearly identified term in relation to it being the process or action that actually develops the care plan. However, this term was also used in some sources to describe the much broader process of assessment; identification of needs; development of a care plan; implementation and co-ordination of services; monitoring and review
- Different types of case management were identified, most commonly the differentiation between case management and managed care, with managed care having cost containment as a key principle and objective
- The literature has multiple references to the evolvement and professional qualities of 'true' case management, being a service type that assists those clients perceived to have the most complex needs, and in most need of assistance to navigate a complex service system
- The Literature Review has not been able to locate any research or project documentation that specifically examines, or aims to establish a common usage and understanding of, the key terms
- The service system is seen to be complex both for the client and the practitioner and this complexity is exacerbated by the absence of agreed definitions for key practice terminology.

## Methodology

The research is based on five main activities:

### Journal and broad key word searches

- Utilising the RMIT University Library Data Base, Catalogues and E Journal facility, a limited response was obtained when conducting a key word search – *care co-ordination and care planning and case management* - primarily using the Proquest, Medline and API catalogues

### Broad Internet key word searches

- The Internet key word searches were undertaken using the meta search engine Dogpile and search engine Google. Google provided the best resources yielding 1000+ entries. Of the 200 examined, the majority related to organisations providing services for the elderly and people with disabilities in the United States and Canada. In these sources there was extensive interchangeability and multiple uses of the key terms.

### Targeted Internet searches

- Relevant information has been sourced from the Victorian Department of Human Services web site primarily identifying the terminology and definitions utilised by the HACC Program and Primary Care Partnerships. The Better Access to Services Service Co-ordination Model terminology is a key reference for consideration. The *Projects in the HACC Program in Victoria 2002 –2003*<sup>13</sup> report indicates that there are no similar projects funded by HACC at this point in time. The Royal Australian College of General Practitioners web site<sup>14</sup> yielded information in relation to the terminology used with the Enhanced Primary Care items relevant to this project.

### Examination of available documents, conference papers and publications

- A number of local documents were examined. The Australian Journal of Social Work Vol 54 No 4 Dec 2001 examines case management and its relationship to the human services workforce. The terminology of this project is explored in relation to case mix in Vol 55 No 1 March 2002. Various conference and workshop papers explore the inter relationship of assessment, care co-ordination, care management and case management.

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<sup>13</sup> Department of Human Services *Projects in the HACC Program in Victoria 2002-2003* Department of Human Services Melbourne June 2002

<sup>14</sup> The Royal Australian College of General Practitioners web site [www.racgp.org.au](http://www.racgp.org.au)

#### Direct liaison with individuals involved in the field

- Contact was made with Darnelle Eckersall, currently Manager of Community Services at Banyule City Council. Darnelle has extensive involvement with local government service development in relation to assessment and care management. She was not aware of any work that had been done in the field relevant to this project and commented that all the developmental work in relation to this area is under the umbrella of the PCP Service Co-ordination model implementation. Discussions with various case managers yielded the same response.

### Literature Review Findings

As stated in the key findings the terms care co-ordination, care planning and case management are used extensively and interchangeably across the human services sector. A sample of definitions and usage of terms will be presented to highlight this inconsistent application both internationally and within Australia.

### Care Co-ordination

Care Co-ordination is presented in the literature as having the greatest diversity of distinct meanings. It is presented as:

- An **alternative term** for case management, care management (Connecticut Partnership website 2002<sup>15</sup>, Australian Coordinated Care Trials website<sup>16</sup>)
- As a **substitute** for case management where this term is considered to be disempowering and unacceptable. The American Academy of Paediatrics Policy Statement 1999 notes the preferred use of the term care co-ordination as families are a partner in planning their child's care rather than subordinates in an authoritarian system. Care co-ordination in this context includes care planning<sup>17</sup>
- **The function** of case management, that is care co-ordination is what case managers do. It involves holistic assessment, development of a care plan, ensures that appropriate services are delivered and monitors such care delivery (Multnomah County Oregon Ageing and Disability Services website 2002)<sup>18</sup>
- **One component of the process** of care management/case management. Care co-ordination is the implementation and monitoring of the care plan (Senior Info site 2002<sup>19</sup>, California Care Network website 2002<sup>20</sup>)
- An **activity** that takes place at **regular interdisciplinary meetings** (Warren 1998<sup>21</sup>).

Challis (2002)<sup>22</sup> highlights diversity when he identifies four levels of (care) co-ordination:

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<sup>15</sup> Connecticut Partnership website [www.opm.state.ct.us](http://www.opm.state.ct.us)

<sup>16</sup> Coordinated Care Trials website [www.health.gov.au/hsdd/cocare/trials.htm](http://www.health.gov.au/hsdd/cocare/trials.htm)

<sup>17</sup> American Academy of Pediatrics website [www.aap.org/policy/re9902.html](http://www.aap.org/policy/re9902.html)

<sup>18</sup> Multnomah County Oregon Ageing and Disability Services website [www.co.multnomah.or.us/ads/about/case.html](http://www.co.multnomah.or.us/ads/about/case.html)

<sup>19</sup> Senior Info site 2002 [www.senior-infosite.com/senior/articles](http://www.senior-infosite.com/senior/articles)

<sup>20</sup> California Care Network website 2002 [www.calcarenet.ca.gov/home\\_community\\_services.asp](http://www.calcarenet.ca.gov/home_community_services.asp)

<sup>21</sup> Warren, D Bass Coast & South Gippsland Aged & Disability Services Policy and Procedure Project Final Report December 1998

- At the strategic planning, interagency co-ordination level
- Inter-professional collaboration in multi-disciplinary teams
- Co-ordination of services by a key worker
- Multiskilling of workers to reduce the number of personnel involved in the care of an individual client.

The use of the term care co-ordination is further confused by the use of the term *co-ordinated care* in service development literature (Prideux 1998)<sup>23</sup> where the term is used to describe broader service system integration.

## Care Planning

Although there was extensive reference in the literature to the term care planning, and the implied process of developing a care plan, there were limited references to its relationship to case management and care co-ordination. The term care planning was used in the most consistent manner in the literature in that it was generally considered to be an **activity** of case management, care management and care co-ordination. The most valuable definitions were located in the Australian literature.

The following table presents a number of care planning definitions.

Source	Care Planning Definitions
McVicar and Reynolds <i>People with Complex Needs: Effective Support at Home</i> , page 72 Australian Government Printing Service Canberra 1995	'Care Planning is the bridge from assessment to actual delivery of services. Care planning is the part of the process where the consumer's views about their needs and priorities and worker's professional judgements need to be blended together through discussion and negotiation.'
Standards and Guidelines for the Enhanced Primary Care Medicare Benefits Schedule items, page 51 The Royal Australian College of General Practitioners web site <a href="http://www.racgp.org.au">www.racgp.org.au</a>	'What is Care Planning? Care Plans are comprehensive, longitudinal plans for the care of the individual patient. ....the usual GP works with other health and care providers to develop, review or contribute to care plans for people with one or more chronic conditions and multidisciplinary care needs.'
Area Agency on Ageing of South Texas website <a href="http://www.stdc.cog.tx.us">www.stdc.cog.tx.us</a>	'Care planning refers to the determination of appropriate and available formal or informal services within the client's community, and when appropriate, recommending modifications to the physical environment to suit client needs'

<sup>22</sup> Challis, D *Case Management: problems and possibilities* Policy Studies Institute London 1989

<sup>23</sup> Prideux, J *Targeting Best Practice* Municipal Association of Victoria 1998

<p>Final Draft Victorian HACC Program Manual May 1998 Aged Care Branch May 1998</p>	<p>'Care planning is a process that translates the information collected about clients into a plan of service delivery. This plan involves putting together packages of services in a manner that supports informal care arrangement. Therefore the Care Plan encompasses HACC services, non-HACC services, family support, and the support of friends, neighbours and the community.</p> <p>The overall goal of the care plan is to maximise and enhance the consumer's independence and quality of life. The care plan recognises and supports the consumer's abilities, as well as addressing their needs. Care plans are always developed in consultation with Carers and other relevant service providers.</p>
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In the context of this project, relevant literature in relation to whose responsibility it is to develop a care plan and who has 'key worker' responsibility is to be found in the documentation as per individual program areas, i.e. Final Draft Victorian HACC Program Manual, Coordinated Care Trials, the Victorian Primary Care Partnerships Better Access to Services model documentation<sup>24</sup> and the Enhanced Primary Care literature. The latter defines the care planning items 720 to 728 under which a General Practitioner may claim remuneration for their role in care planning and reviewing of care plans.<sup>25</sup>

## Case Management

Extensive literature exists in relation to the definition and practice of case management and the critical analysis of current practice (Burns and Perkins 2000<sup>26</sup>, Challis 2002<sup>27</sup>, Hall et al 2000<sup>28</sup>, O'Connell et al 2000<sup>29</sup>, Yarmo Roberts 2002,<sup>30</sup> DHS SAAP Case Management Resource Kit<sup>31</sup>). Common reference is made to the fact that there is confusion amongst practitioners in relation to the use of terms, and that the role boundaries and responsibilities are unclear.

On the Connecticut Partnership Plans website,<sup>32</sup> information is prefaced by the title - *Case Management (also known as Care Co-ordination, Care Management or Care Advisory Services)*. In these sites the term **care management** is commonly used.

Kennedy et al (2001)<sup>33</sup> go further and state that case management has become so much the prevailing approach to service delivery that it has almost become the euphemism for human services delivery.

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<sup>24</sup> *Better Access to Services – A Policy & Operational Framework* Primary Care Partnerships Department of Human Services Victoria June 2001

<sup>25</sup> The Royal Australian College of General Practitioners web site [www.racgp.org.au](http://www.racgp.org.au)

<sup>26</sup> Burns, T & Perkins, R *The Future of Case Management International Review of Psychiatry* August 2000

<sup>27</sup> Op cit P 4

<sup>28</sup> Hall, J et al *Iowa Case Management: Innovative social case work Social Work New York April 2002*

<sup>29</sup> O'Connell et al *Models of Integrated Cancer Care: A Critique of the Literature Australian Health Review* Vol 23 No1 2000

<sup>30</sup> Yarmo Roberts, D *Reconceptualizing Case Management in theory and practice: a frontline perspective Health Services Management Research* 15 P147-164

<sup>31</sup> *Case Management Resource Kit for SAAP Services* Department of Human Services Melbourne

<sup>32</sup> Connecticut Partnership Plans website op cit P3

<sup>33</sup> Kennedy et al, *The response by Australian Universities to Case Management Australian Social Work* Vol 54, No4 December 2001

The literature demonstrates the application of the term case management to diverse practice situations where the needs of clients vary from a short-term intervention to a long term, intensive therapeutic relationship. The term **care management** is used for both case management (for clients with complex needs) and service Co-ordination practice (for clients with less complex needs).

For the context of this literature review definitions of case management were sought that:

- Provide a comprehensive definition of the term and practice elements of case management, and,
- Identify the relationship of case management to care co-ordination and care planning.

Source	Case Management Definitions
Slack,M & McEwen , M(1999)  The impact of Interdisciplinary Case Management on Client Outcomes  Family & Community Health Gaithersburg Oct 1999	'Case Management is a complex concept for which diverse definitions exist. Case management is a <b>delivery model</b> for providing client focussed care. Key elements of case management program include conducting a holistic, comprehensive client assessment to determine needs and capacities, developing a culturally appropriate plan of care to promote or sustain health goals, using community resources, documenting client encounters/case management activities, monitoring /evaluating client outcomes, and participating in intra and inter disciplinary consultation and collaboration.'
Connecticut Partnerships  Op cit P3	'Case Management is a <b>service</b> for you and your family that identifies, links, co-ordinates and monitors assistance from formal service providers such as home health aides, and informal caregivers such as family and friends to help you remain at home safely and achieve the highest level of independence.'
Multnomah County Ageing and Disability Services  Op cit P3	'Case Managers provide <b>care co-ordination</b> to assist people to remain as independent as possible and to keep them out of institutional care. The case manager provides care co-ordination by assessing client needs and preferences, developing the plan of care, authorizing services, monitoring services, evaluating progress and revising the plan of care.'

Source	Case Management Definitions
<p>Geron, S &amp; Chassler, D</p> <p>Advancing the State of Art: Establishing Guidelines for Long Term Case Management, Journal of Case Management Vol 4 No5 1995</p> <p>Although developed in 1995 Geron &amp; Chassler's definition is widely cited in the recently published literature.</p>	<p>'(Long term) case management is a service that links and co-ordinates assistance from both paid service providers and unpaid help from family and friends to enable consumers with chronic functional and/or cognitive limitations to obtain the highest level of independence consistent with their capacity and preferences for care.</p> <p>Case management requires case managers with specialized skills and competencies to make the timely provision of at least the following core functions:</p> <p>Completion of a comprehensive, systematic, and standardized assessment of the consumer's functional and cognitive capacity and limitations, and other needs, strengths, abilities, and resources</p> <p>Development of a care plan based on the results of the assessment and meeting consumer needs and preferences within the constraints of payer requirements</p> <p>Implementation and co-ordination of the care plan</p> <p>Monitoring of consumers and provider services sufficient to ensure that services continue to be appropriate to the consumer, of high quality, and efficient use of public and private resources</p> <p>Completion of a comprehensive reassessment as needed</p> <p>Discharge from case management when appropriate.</p> <p>Case management is a consumer-centred, flexible, cost conscious and quality driven service.'</p>

Yarmo Roberts (2002)<sup>34</sup> notes that there is no comprehensive model of case management, and in fact multiple sub types of case management exist. (page 148). She states:

*'As the definition of case management is dependent on the specific model of case management being implemented, there is no uniform definition that encompasses all aspects of case management. Depending on the particular country's organisational framework of the health and social system, many models of case management have developed.'*

<sup>34</sup> Op cit P5

Subtypes identified in the literature include:

- Managed Care (O'Connell et al 2000, Hall et al 2002<sup>35</sup>)
- PACT (Program for Assertive Community Treatment) (Hall et al 2002, Burns & Perkins 2000<sup>36</sup>)
- Strengths Model (Hall et al 2002, Burns & Perkins 2000<sup>37</sup>)
- Iowa Case Management Model (Hall et al 2002<sup>38</sup>)
- Administrative Case Management (Challis 2002)
- Complete Case Management (Challis 2002)
- Psychosocial Rehabilitation (Burns & Perkins 2000).

Burns and Perkins (2000)<sup>39</sup> state that the term care management is being used in preference to case management in the UK due to the 'dehumanising inference that recipients **were cases to be managed**'.

There is vigorous debate in the literature in relation to such issues as the therapeutic role of case managers, advocacy and managed care. However, common elements are:

- Holistic assessment
- Single point of accountability for co-ordination, monitoring and review of care
- Desirability for clients with multiple /complex needs
- Small caseload
- Flexible, proactive approach
- Strong engagement/relationship development
- Advocacy.

### **Common Usage and Understanding of Terms**

Although an acknowledged issue in the human services sector, it was difficult to source literature/research/models of practice that sought to establish a common understanding of and use of the terms care co-ordination, care planning and case management. Luntz (1995)<sup>40</sup> documents a collaborative project conducted in the Western Metropolitan Region of Melbourne from September 1992 to April 1993 that aimed to improve access to services for children and adolescents requiring multi agency involvement to address behavioural and emotional issues.

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<sup>35</sup> Op cit P5

<sup>36</sup> Op cit P5

<sup>37</sup> Op cit P5

<sup>38</sup> Op cit P5

<sup>40</sup> Luntz, J *Collaboration in the Service of Co-ordination Children Australia* Vol 20 No 4

A major contributor to the access issues was the lack of clarity about the roles and responsibilities of Government Departments. Identified issues included the difficulties posed by the absence of an appointed key worker, inadequate understanding of individual roles and skills, and the lack of interagency protocols. Although a model for co-ordination was developed it was never trialled.

O'Connell et al (2000)<sup>41</sup> outline essential strategies for integrated cancer care such as the appointment of a liaison person and the development of effective communication strategies, but common definition of terms is not included.

Yarmo (2002)<sup>42</sup> comments on the lack of literature relating to the congruence of service delivery models with the actual practice delivered by front line professionals who have the direct contact with clients. She comments that certain value assumptions exist in relation to case management practice models that are not translated in practice. One of these is that there is clear delineation of client responsibilities between case managers and other professionals. Her study of three Victorian case management models – Linkages Programs, co-ordinated Care Trials and Mental Health Services Case Management – identified duplication of care co-ordination functions, and lack of professional recognition for a case manager's primary responsibility in co-ordinating client care.

### **The Current Context in Victoria**

The Victorian Primary Care Partnership Better Access to Services (BATS) initiative sets out clear objectives for the enhancement of Primary Care service Co-ordination. Each PCP is required to develop service co-ordination models that delineate roles and responsibilities between service providers for a seamless continuum of care for consumers. A strategy to achieve this is the development of a '*common language and understanding*'<sup>43</sup>. The Service Co-ordination framework is underpinned by six key elements:

- Initial Contact
- Initial Needs Identification
- Service Specific Assessment
- Specialist Assessment
- Comprehensive Assessment
- Care Planning.

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<sup>41</sup> Op cit P5

<sup>42</sup> Op cit P5

<sup>43</sup> *Better Access to Services – A Policy & Operational Framework* June 2001

To progress the adoption of this Service Co-ordination Model a **common language** is proposed. Of relevance to this project are the following terms.

Term	Definition
Care Co-ordination	'The range of services required by a consumer are co-ordinated so that they are delivered in the most efficient and effective way to meet individual consumer's needs. Care Co-ordination enables continuity of care, avoids duplication of services and ensures that meeting consumer needs is paramount over the needs of individual service providers and is not hampered by program boundaries.'
Care Planning	'A process of deliberation that incorporates a range of existing activities such as care co-ordination, case management, referral, feedback, review, reassessment and monitoring. Care planning involves the judgement/determination of relative need as well as competing needs and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.'
Case Management	'The activities undertaken by one central person who assumes overall responsibility for the care plan, in order to streamline the interface between the service system and the consumer and carer. Activities may include some or all of: <ul style="list-style-type: none"> <li>• Assessment</li> <li>• Care Plan Development</li> <li>• Referral and/or feedback</li> <li>• Implementation of Care Plan, including liaison with service providers</li> <li>• Monitoring</li> <li>• Review</li> <li>• Reassessment</li> </ul> Management of brokerage funds.'
Care Co-ordinator	A nominated person who has responsibility of ensuring that the care plan is implemented and that reviews and reassessments are undertaken at the appropriate times by the relevant service providers'.
Case Manager	See Care Co-ordinator

Of note is a lack of reference to the term Care Manager which was a key definition in the Final Draft of the Victorian HACC Program Manual May 1998.<sup>44</sup>

<sup>44</sup> Op cit P5

In relation to the objectives of the HACC Care Co-ordination, Care Planning and Case Management Project it can be said that the above terms lack clarity as tools to more clearly differentiate between the role and responsibilities of case managers and other practitioners who have a role in assessment, care planning, the implementation of care, monitoring and review.

### **Summary Remarks**

The definitions used in the Victorian Primary Care Partnership *Better Access to Services* model<sup>45</sup> provides a valuable contemporary example illustrating that there is no universally accepted professional standard for the use of terms. It also describes how each service development creates its own set of different and often contradictory terms to those in current usage.

The literature review establishes that a lack of standardisation exists internationally in the usage of the terms care co-ordination, care planning and case management. This situation is a barrier to optimal service delivery and continuity of care for clients and their carers. Given the complexity that exists it seems appropriate that a local response to standardisation, as per the aims of the HACC Care Co-ordination, Care Planning and Case Management Project, is an appropriate service enhancement objective. As Yarmo (2002)<sup>46</sup> comments:

*'Despite countries sharing common concerns of co-ordination and providing health care services, the local contexts are an important consideration when reviewing potential case management applications.'*

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<sup>45</sup> Op cit P7

<sup>46</sup> Op cit P5

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## Appendix D: Survey Form

### HACC Care Co-ordination, Care Planning and Case Management Project

Service Provider Survey  
October 2002

The Hume Region Department of Human Services has funded this project to promote enhanced practice in the service provision areas of Care Co-ordination, Care Planning and Case Management. The key aim is to engage those who provide such services to develop a consistent and agreed understanding of the work that they undertake when using these terms, and work towards clarifying any differing perceptions. The project will complement the PCP Service Co-ordination initiatives, sharing common objectives in improving continuity of care and maximising the use of existing resources

The purpose of this survey is to gain a picture of how you and your colleagues use these terms in practice and to guide the detail of the Practice forums (see newsletter). All responses will be kept strictly confidential, with the responses being generalised to highlight any current practice issues.

Please return this survey by Tuesday 5<sup>th</sup> November 2002 to Sally Wright [outsidep@mcmmedia.com.au](mailto:outsidep@mcmmedia.com.au) If you have any queries, please ring Sally on 5821 6959.

Name:

Agency:

Position:

E-mail Address:

Phone:

Question 1: Please indicate which of the following activities you undertake by ticking the appropriate box, including those for which you are funded and those which you also do in response to the needs of your clients.

Care Co-ordination				Care Planning				Case Management			
Yes		No		Yes		No		Yes		No	

Question 2: Briefly describe your understanding of the following terms. Please provide a typical example from your own practice where appropriate, to illustrate this understanding in a practice context.

Care Co-ordination

Care Co-ordination Example

Care Planning

Care Planning Example

Case Management

Case Management Example

Question 3: For the 2-week period, 21<sup>st</sup> October 2002 to 3<sup>rd</sup> November 2002, could you please complete the table below, listing the number of clients where you have primary responsibility, and, the approximate number of hours spent (using your own definitions) in care Co-ordination/care planning/case management. You may wish to use the attached sheet to assist you.

	Care Co-ordination	Care Planning	Case Management
No. Clients			
Estimated No. Hours			

Question 4: From your perspective, what is the **single most important** practice issue in relation to Care Co-ordination, Care Planning and Case Management?

Thank you for taking the time to complete this survey.  
Your input is most appreciated.

Please return surveys to Sally Wright by 5<sup>th</sup> November 2002:  
Email to [outsidep@mcmedia.com.au](mailto:outsidep@mcmedia.com.au)  
Fax 58316009

Which Practice Forum you are able to attend?

You will be informed of the confirmed venue as soon as all venue bookings have been finalised.

Optional table to assist you to complete  
Practice Survey Question 3.

Estimated Number of Hours spent in the following

Date	Care Co-ordination	Care Planning	Case Management
Monday 21st October			
Tuesday 22nd October			
Wednesday 23rd October			
Thursday 24th October			
Friday 25th October			
Saturday 26th October			
Sunday 27th October			
Monday 28th October			
Tuesday 29th October			
Wednesday 30th October			
Thursday 31st October			
Friday 1 <sup>st</sup> November			
Saturday 2nd November			
Sunday 3 <sup>rd</sup> November			
Totals			

## Appendix E: Survey Analysis

### Introduction

A key task of the HACC Care Co-ordination, Care Planning and Case Management Project has been to conduct a practice survey with practitioners and organisations that have a role in the continuum of care for HACC clients and their carers with the objective of:

- Facilitating reflection of what the above terms mean in practice and how application and expectations of such terms effect service delivery and continuity of care
- Creating worker interest and commitment in the project
- Providing Telos Consolidated with the background and contextual information to sensitively progress the project.

### Methodology

130 surveys were emailed to service providers and 1 sent by mail. Of these 33 (25%) have been returned.

The following table demonstrates the sub regional distribution.

Sub Region	Number Distributed	Number Returned	Response Rate
Upper Hume	38	10	26.3%
Central Hume	26	8	30.8%
Lower Hume	29	3	10.3%
Goulburn	38	12	31.6%
<b>TOTAL</b>	131	33	25.2%

### Survey Response Analysis

The analysis of the 4 questions provides valuable qualitative data that demonstrates the following:

- That there is clear disparity in how the key terms are understood and applied
- As a result of the above, there is a level of tension between services in respect to the practitioner roles and responsibilities, particularly in relation to case management
- That there is lack of understanding of the terms on the part of individual practitioners as demonstrated by the responses to question 1 and question 3

- That certain professional groups, for example District Nursing and Allied Health, hold a much more service specific view in relation to care co-ordination, care planning and case management
- The strongest uniformity in understanding/perception relates to the view that Case Managers have responsibility to, using a holistic approach, take the lead role in assessment, care planning and care co-ordination
- That agencies who have a more generic assessment and care management role<sup>47</sup>, feel that they are being required to fulfil a defacto case management role for high needs clients
- The two most important issues for practitioners are the uncertainty in relation to professional boundaries and the resultant gaps and duplication for clients.

The analysis of survey responses tabulated in the following tables, together with the practitioner's definitions of terms and practice examples, confirms the value and timeliness of the HACC Care Co-ordination, Care Planning and Case Management Project.

### Survey Response Details

Please note that the analysis for the purposes of this report only details responses to Questions 2 and 4 of the survey. The responses received for Questions 1 and 3, whilst supporting the finding that there is a lack of understanding of the terms on the part of individual practitioners, were not appropriate for meaningful detailed analysis.

In the following tables, which provide the detailed responses to the practice survey, question 2 asked about each of the three terms care planning, care co-ordination and case management. Similar responses were grouped together and have been labelled 'Group 1' or 'Group 2'.

Question 2	Care Co-ordination	Key Words	No. of Responses
	Responses = 33 No Response = 3		
<b>Group 1</b>	Facilitate and ensure predictable and consistent support in a flexible and client centred manner Co-ordination of a number of different services for a client or carer Common role of all services where there is no funded case manager Process that follows care planning, liaison with other service providers to negotiate who will do whatever is needed for client Taking the lead role Making referrals	Facilitate Co-ordination of different services Common role  Follows care planning Liaison negotiate Lead role Making referrals	19
Group 2	Above plus intensive support for some clients, defacto case management	Defacto case management	1

<sup>47</sup> As per Victorian HACC Program Manual 1998

<b>Question 2</b>	<b>Care Co-ordination</b> Responses = 33 No Response = 3	<b>Key Words</b>	<b>No. of Responses</b>
Group 3	Purchase of service provision from external agencies, service provision monitored and recorded, budget managed in accordance with costs of above	Service purchase External agencies Monitor Budgeting	1
Group 4	Arrangement and allocation of resources within a particular service type i.e. District Nursing	Within a service type	3
Group 5	Co-ordinating workers involved in providing services for a client. Having a clear care plan to give to workers. Ensure that information received back from workers is responded to. Maintenance of care programs (delivery)	Co-ordinating workers Maintenance of care	4
Group 6	Assessment of client's home situation followed by appropriate treatment, carer education and referral to other discipline	Assessment and treatment	2

#### **Sample Definitions of Care Co-ordination**

'Role of all services where there is no funded case manager. Following on from care planning, liaison with other service providers to organize who will provide what for client'

'Liaison with and referral onto appropriate service providers for provision of services to best meet the client's needs. Also includes wait listing for appropriate services e.g. CACP. To be effective, there must be adequate feedback between the client/carer/family, service providers and General Practitioners (GP)'

'Initial assessment, reassessment'

'Preparation and allocation of resource (human, equipment, vehicles) to provide care to clients'.

#### **Care Co-ordination Practice Examples**

- I ensured that home care, augmenting existing service provided by the Shire, was provided on a different day of the week
- Worker attends to client's housework, finds that hot water service is not working properly. Care Coordinator contacts Case Manager who then resolves the problem Client assessed as needing Occupational Therapy and Physiotherapy assessments. Referrals made to other agency, consultation with family and GP. Contact other service providers to ensure all have similar care expectations/goals as our service
- 74 yr old female referred by local GP for dementia assessment. Following assessment, the clinician involved liaised with the GP who arranged Geriatrician review, referred onto to PGAT for depression screen, Alzheimer's Association for counselling, CRIS for home based respite and COGS for meals on wheels. In addition to this, eligibility was approved for residential respite care and a Community Aged Care Package. This clinician was the contact point for the family during this assessment and care co-ordination period.

<b>Question 2</b>	<b>Care Planning</b>	<b>Key Words</b>	<b>No. of Responses</b>
	Responses = 33 No Response = 4		
Group 1	Assessment of needs, collection of information, development of a care plan in response to the above	Assessment Collection of information	6
Group 2	Development of an individual package of care, based on clinical characteristics, psychosocial issues and environmental factors. Care plan should endeavour to maximize the client's independence and improve or maintain quality of life in own home environment  Appraisal of service provision after careful determination of needs and resources	Individual package of care Maximize independence Determination of needs Appraisal	7
Group 3	Follows assessment  Developing an actual plan of care to occur  Facilitates the awareness for all involved of who is doing what  Precedes care co-ordination	Follows assessment  Develop plan Precedes care co-ordination	6
Group 4	Outcome of liaison, joint planning between all stakeholders.  Involves care planning meetings  Goal setting and timelines	Joint planning Goal setting and timelines	2
Group 5	A plan of care based on a service specific/specialist assessment, ie. District/Community Nursing  Within own discipline	Within own discipline	8

<b>Sample Definitions of Care Planning</b>
<ul style="list-style-type: none"> <li>• Service specific planning but may include referrals to other services. Doesn't have overview of all services that may need to be involved.</li> <li>• The plan of action that involves identification of individual client needs. This includes: <ul style="list-style-type: none"> <li>• Initial assessment and discharge planning</li> <li>• Establishment of goals and objectives with client</li> <li>• Plan of action to achieve goals and objectives</li> <li>• Regular review and evaluation of care plan</li> <li>• Outcome.</li> </ul> </li> <li>• Development of a plan of care following initial assessment. Care planning leads to care co-ordination with referrals being made to other services as required.</li> </ul>

<b>Care Planning Practice Examples</b>
<ul style="list-style-type: none"> <li>• Can include client service meetings or more specifically planning care to address client needs. For example, a client with quadriplegia will need assistance with daily living activities and will have this outlined and scheduled in a care plan</li> <li>• Following initial assessment, a care plan was formulated with the client and her family.</li> <li>• As a result of visiting and completing an Assessment Review of an older person in a rural isolated area with a dilapidated house, goals for care planning would be identified to be achieved as an outcome of the assessment. It may be that the following care planning is required:             <ul style="list-style-type: none"> <li>• 2 weeks respite every six months in suitable hostel with a view to seeking an option for permanent placement that enables the client choice of venues</li> <li>• Review of current Aged Care Assessment to enable client to access hostel level care (assessment required if over twelve months old)</li> <li>• Increase showering assistance to daily</li> <li>• Assessment for home modifications by Occupational Therapist</li> <li>• Seek alternatives for transport to community luncheons and medical appointments. (Community Managed Transport)</li> <li>• Ongoing medical monitoring twice weekly by District Nurses</li> <li>• Application for Safety Alarm (Listed for free alarm with interim funding by CRIS).</li> </ul> </li> <li>• A time line would occur with the identified Care Planning requirements. A copy provided to the client and with the client's permission a copy to other services providers/GP.</li> </ul>

<b>Question 2</b>	<b>Case Management</b>	<b>Key Words</b>	<b>No. of Responses</b>
	Responses = 33 No Response = 6		
Group 1	Person with the skills to conduct comprehensive, skilled assessment, mandate to work across service boundaries, co-ordinate assistance, provide support and encouragement to the client as well as monitoring client needs and providing advocacy as required	Comprehensive assessment  Advocacy	4
Group 2	A more intense relationship with the client, face to face interaction. Contact sustained over an extended period of time and involves overseeing of contributions of other service providers, including organisation of case conferences.  Low client load.	Intense relationship  Extended contact  Overseeing service provision  Case conferences  Low client load	1

<b>Question 2</b>	<b>Case Management</b> Responses = 33 No Response = 6	<b>Key Words</b>	<b>No. of Responses</b>
Group 3	<p>Key (lead) person for client and all service providers to contact</p> <p>Regular contact with client and all service providers</p> <p>Responsibility to develop care plan which is disseminated to all service providers so that all service providers know exactly who is doing what, and ensure that all required assistance is obtained.</p> <p>Proactive, anticipates and responds to changing needs before they become a crisis for the client.</p> <p>Case Manager is notified of all changes/problems</p> <p>Brokerage a feature</p>	<p>Key person to contact</p> <p>Lead worker</p> <p>Regular contact</p> <p>Care plan disseminated</p> <p>Proactive</p> <p>Case Manager notified of changes</p> <p>Brokerage</p>	19
Group 4	<p>Elements of Group 3 as well as:</p> <p>Client empowerment and advocacy</p> <p>Basic support level counselling i.e. grief and loss</p> <p>Funding resources internally and externally</p> <p>Conflict resolution between providers and within family</p> <p>Management of changes in situation/care environment i.e. initiating specialist assessments</p> <p>Applying for Guardianship and Administration Orders.</p>	<p>Client empowerment and advocacy</p> <p>Supportive counselling</p> <p>Service funding</p> <p>Conflict resolution</p> <p>Management of changes</p> <p>Apply for Guardianship and Administration Orders</p>	2

#### **Sample Definitions of Case Management**

- 'Case management is the responsibility for ongoing monitoring, evaluation and management through regular face to face contact and the ability to anticipate changes in care needs and appropriately manage these
- Administration, in-service, pharmacy pickup, discharge planning
- Occurs on a more frequent basis and differs from care co-ordination in intensity and frequency and it is proactive, rather than reactive. It involves intake and assessment, identifying of needs and establishing of a care plan, then takes on the role of ensuring the care plan is enacted, by negotiating with service providers, continual contact with client, monitor efficacy of care plan, then review and keep going with the cycle. The case manager seeks out feedback from service providers and identifies as the single point of contact for that client, both to the client and to the other service providers. The case manager has a picture of all the services that the client receives, and a picture of their overall needs
- Ideally case management is carried out by persons employed to do that work, not as an aside to their other "real work" e.g. being employed as a District Nurse to do clinical work.'

#### **Case Management Practice Examples**

- Our service had constant involvement with a client and her family for a period of four months. As the client had complex medical issues and needs and had a new diagnosis of dementia, the clinician spent a great deal of time working through the issues with the client and her family
- Assessment and Review meeting which included home visit to Client and Daughter
- Follow-up consultation with service providers involved with client. Identified needs which included:
  - Increasing frailty and falls
  - Recent hospital admissions identified by medical staff as non-acute
  - Cannot attend community functions or medical appointments because no longer has licence and lives on farm property
  - Family support not available as nearest family live in Melbourne
- All the actions were carried out by contact with appropriate service providers, case manager was involved in meeting with client carer, family and district nurse, with Office of the Public Advocate, client was accompanied to an audiology appointment, case manager then worked with client and administrator from State Trustees to set up financial plan. Application sent in to Victorian Eyecare Scheme to assist in funding new glasses, optician appointment was organised and attended
- New issue identified by District Nurse re client missing some pills. Doctor notified, strategies discussed with District Nurse and plan devised for different container.

Question 4 asked practitioners to list the single most important practice issue for them currently in their work in relation to the terms care co-ordination, care planning and case management. Similar responses are grouped together in the following table.

<b>Question 4</b>	<b>The Most Important Issue</b> Response = 33 No Response = 6	<b>Key Words</b>	<b>No. of Responses</b>
Group 1	Professional boundaries Clear roles and boundaries and recognition that there can be a shift in roles when clients are transferred into a case management / brokerage role There is confusion regarding which roles are retained to HACC providers and are purchased through brokerage and which are relinquished, ie care planning and case management What is funded Case Manager's role and responsibilities?	Professional boundaries Roles and responsibilities	8
Group 2	Gaps and overlaps in service provision, duplication Better co-ordination of services Better resource management to obtain most effective outcomes for client i.e. reduce duplication and work unilaterally to achieve goals; at a client level and wider systems level. Enable more effective targeting (to funding bodies) to increase funding Establishing the least complex system for clients	Gaps Duplication Better co-ordination Better resource management Decrease complexity for clients	9
Group 3	An understanding that we all are working towards the same goal – a client focused service	Client focused	2
Group 4	Case managers not being available to clients and service providers, not being proactive and accepting responsibility for holistic welfare of the client	Lack of availability of Case Managers	1
Group 5	Relevant client information not being provided between services. Using Privacy Act as a reason	Client information not provided	1
Group 6	Appropriately trained and experienced staff	Trained, experienced staff	1
Group 7	Knowledge of available services	Knowledge of Services	3
Group 8	Inadequate communication between case manager and service providers. Service provider should be aware that a case manager is involved	Inadequate communication	1
Group 9	Agencies have insufficient staffing resources to	Insufficient	1

Question 4	The Most Important Issue Response = 33 No Response = 6	Key Words	No. of Responses
	meet demands of care co-ordination /case management	staffing resources	

## Appendix F: Draft Common Understandings and Flow Charts

### Background

The following pages represent work undertaken by the Steering Committee for this project in February 2003. The aim of this process was to develop a picture of what was common across the Hume Region in the definitions and flow charts that were the result of the five (5) forums held in November and December 2002.

The Steering Committee chose to look for words most commonly used by the participants at the five forums, as recorded in the Reports that reflected each forum. Some members had also participated in forums. In developing the flow charts, the Steering Committee had the charts from each of the forums in front of them and looked at what was commonly represented.

Below are the principles that govern all work undertaken. Following the principles are Common Understandings of the terms that are the focus of this project, and, two (2) flow charts, one for care planning and co-ordination and the other for case management.

### Principles

It is a principle in any of the definitions and charts in this document that the client/carer is involved in all stages of the service delivery and flow charts below with a choice to exit at any point in time. Work undertaken with clients will keep their needs foremost and those of their carer/family.

Client consent will always be obtained for any referrals, consultations or work undertaken that involves inter-agency co-operation.

The flow charts that follow are a guide to the processes involved and are **not** intended to be prescriptive of practice. The order of activities drawn is the usual practice as described by the workers present; however this may vary from client to client. Some activities will not be relevant or necessary for some clients and others may require activities that are not listed.

### **Care Planning: Draft Common Understanding**

Care Planning is a consultative process that includes the client, the family and appropriate service providers in the identification and assessment of client needs, from which a care plan is developed, that includes goals and actions to achieve desired/optimal outcomes.

Key tasks include:

- Assessment of short term and long term client \* needs
- Prioritizing of client needs and goal setting to meet such needs
- Exploring most appropriate and cost effective way of meeting client needs
- Developing, documenting and circulating the care plan, which may identify a lead agency and who is responsible for what components of the plan
- Implementing the care plan
- Ongoing assessment and review of client needs and appropriate revision of the care plan
- Formalizing the care plan through actions such as appointment of lead agency, documenting list of agencies involved, allocation of responsibilities, setting a review date, providing the client with a copy of the care plan, distributing a copy of the care plan to participating agencies as per confidentiality and privacy guidelines.

\* Client means 'the person who was referred for service and their carer and family'

### **Care Co-ordination: Draft Common Understanding**

Care Co-ordination is a process that implements the care plan to ensure that the specific service(s) in the plan are implemented in a client focused, flexible and timely manner.

Care Co-ordination includes:

- Implementation of the care plan, particularly through each agency involved co-ordinating their own service(s)/program(s)
- Formalising the care plan and ensuring that a lead agency is nominated (this was a focus of some, but not all, forums). If a lead agency is appointed, they are the first point of call for client/family, other agencies feedback to the lead agency and they lead the review of care and adaptations to the care plan
- Provision of a communication link between client, service provider and care co-ordinator
- Liaising and communicating with other service providers
- Agencies ensure that the care is meeting client needs through effective monitoring and review of the care plan.

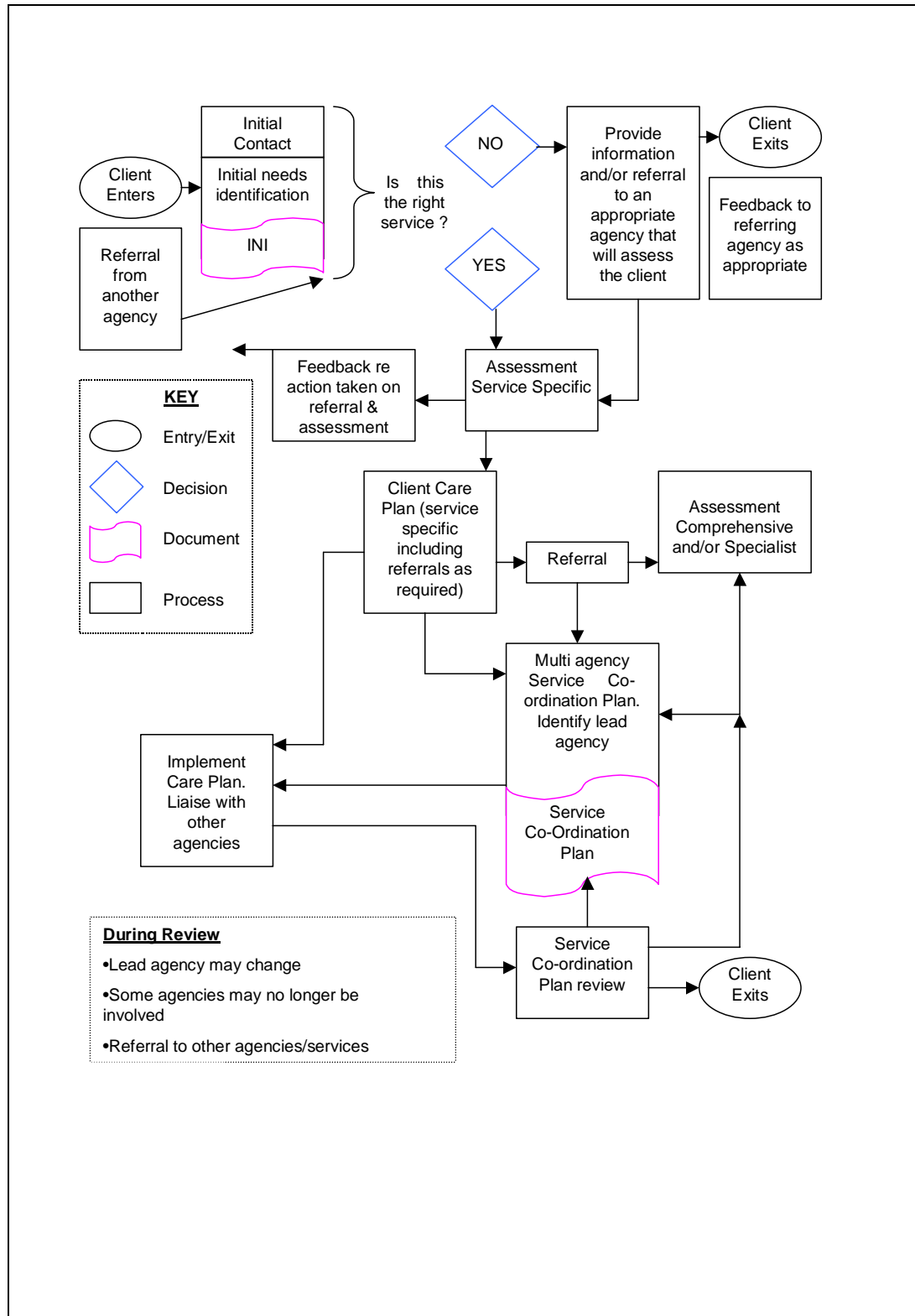
## **Case Management: Draft Common Understanding**

Case Management encompasses the tasks and roles of care planning and care co-ordination and as such is based on a comprehensive assessment of the client's complex needs. The Case Manager, as a central point of contact and identified key worker, liaises with the client and services to provide holistic care, problem solving and advocacy on behalf of the client. This process will proactively respond to and plan for client needs, activate appropriate resources in consultation with the client, carers and other service providers, ensure that the client is aware of all options and is able to make informed choices.

Key tasks include:

- Being the lead agency
- Assessing client and carer/family needs using the social model of health framework
- Developing/updating the care plan and developing future goals
- Problem solving, trouble shooting, responding to crises
- Negotiating/liaising with service providers
- Hear and give feedback from / to other agencies
- Continuing/ongoing involvement
- Monitoring the client
- Advocacy and mediation
- Resource management, planning of care within available resources, sourcing additional funds
- Identifying the need to hold case conference(s)
- Empowering clients and/or their families to make informed choices
- Referrals to other agencies
- Arranging training for those providing service(s).

**Draft Care Planning and Care Co-ordination Flow Chart**



**Draft Case Management Flow Chart**

