JULY 2021

EVIDENCE REVIEW 298

ISCRR
Institute for Safety, Compensation and Recovery Research

Best Practices for Person-Centred Case Management

A literature review

A literature review on the implementation of a contemporary case management model with a focus on person-centred processes and outcomes.

Amanda Moo, Dr Petra Bywood, Belinda Clark, Dr Janine McMillan

A joint initiative of WorkSafe VICTORIA MONASH University

CONTENTS

LIST OF TABLES

LIST OF FIGURES

Acknowledgements

This report has been prepared for WorkSafe Victoria by the Institute for Safety, Compensation and Recovery Research (ISCRR). ISCRR would like to thank Dr Ross Iles, Deputy Director of Insurance Work and Health Group, Monash University, for his expert advice and contribution to this literature review. ISCRR would also like to thank Tamie Fitzgerald and Leigh Siemienowicz at WSV for their assistance and collaboration throughout the development of this project; and Samantha Barker and Dr Jimmy Twin at ISCRR who supported the production of the report.

Disclaimer

Please note: This Literature Review has been produced by the Institute for Safety, Compensation and Recovery Research (ISCRR) in response to specific questions from WorkSafe Victoria. The content of this report does not involve an exhaustive analysis of all existing evidence in the relevant field, nor does it provide definitive answers to the issues it addresses. The review findings were current at the time of publication, June 2021. Significant new research evidence may become available at any time. ISCRR is a joint initiative of WorkSafe Victoria and Monash University. The opinions, findings and conclusions expressed in this publication are those of the authors and not necessarily those of WorkSafe Victoria or ISCRR.

EXECUTIVE SUMMARY

The primary aim of this review was to examine the best practice guidelines for implementation of a needs-based, person-centred case management model to assist WorkSafe Victoria (WSV) develop a new service model that helps manage the recovery of injured workers. A literature review of more than 90 peer-reviewed articles and grey literature related to person-centred case management was undertaken in July 2021. As the timeframe for this review was six weeks, searches were not exhaustive and no quality assessment of articles was undertaken.

Best practices for person-centred case management

Person-centred case management requires a flexible and responsive approach to meet a client's needs and changing circumstances at the system, organisational, professional and individual level. Eight best practices there were consistent across different cohorts and settings were identified:

- Value individual strengths and capabilities
- Collaboration - family/friends/support network/employer
- Respect diversity and equity
- Maintain transparency and privacy
- Match appropriate service and support
- Adaptable to change
- Focus on individual outcomes
- Promote continuous improvement and evaluation

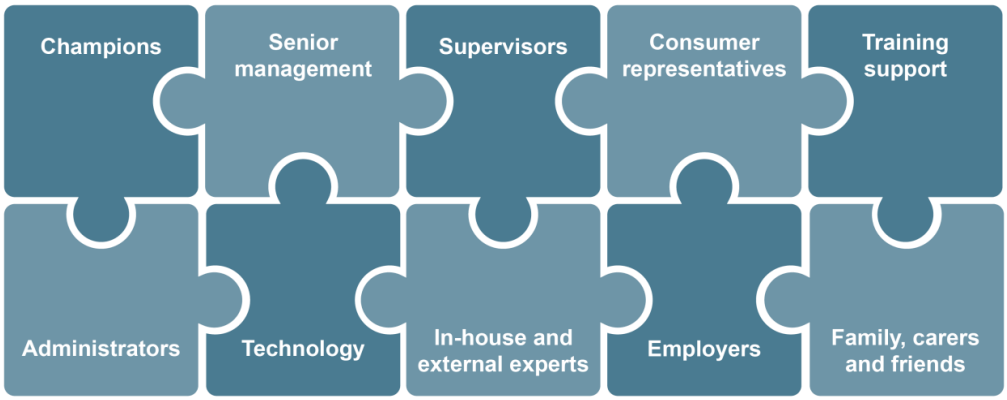
Capabilities and personal attributes of case managers

The essential capabilities and attributes of case managers to support their role in frontline delivery of person-centred practices to clients are:

- Formal professional qualifications
- Person-centred philosophy
- Reflective practice
- Flexible and responsive
- Communication and problem-solving skills
- Inclusive of a range of relationships.

The COLLABORATE© model, which is a universal, competency-based case management model, was developed to support a paradigm shift across all roles within organisations that aim to deliver person-centred case management.

In addition, several roles and functions need to work together to create a supportive working environment for case managers to practice person-centred case management effectively:



Role of the organisation in meeting client needs

Organisations deliver best practice case management and meet client needs by identifying the appropriate level of support required. Compensation claims are classified according to a range of different risk criteria related to the individual, injury and job/workplace characteristics.

Clients expect that their unique circumstances, views and preferences will be considered in any decisions that impact them. Client needs are met when there is:

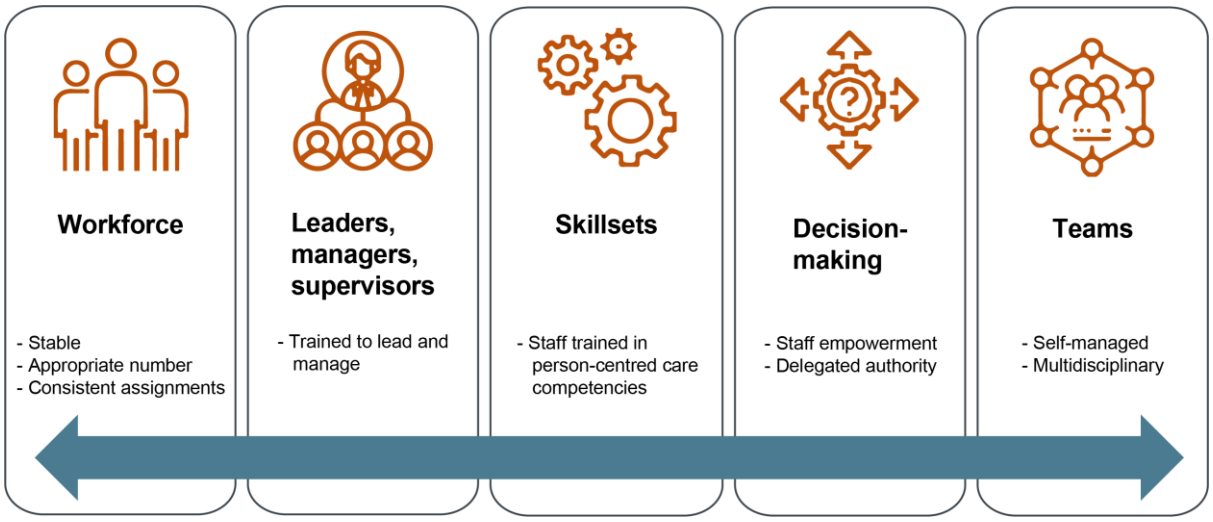
- The right to choose
- Effective communication
- Shared decision-making.

Transitioning to a person-centred organisation

No specific examples of successful transition from a traditional to a person-centred case management model were identified in the literature. However, generic models such as Lewin's or Kotter's change management models and Bridge's transition model may be applied to a broad range of settings.

Developing a workforce culture that embraces the subtle shift from a task-driven to a person-centred culture needs to precede any changes in the processes or services.

Key elements of a person-centred care work culture



Evaluation

No specific benchmarks for best practice person-centred case management in the workers' compensation sector were identified in the literature. However, there are several health care organisations that are recognised as leaders in delivering high-quality, effective person-centred care such as Kaiser Permanente (US), Southcentral Foundation Nuka system of care (Alaska) and Jönkoping County (Sweden).

Three main approaches used to assess person-centred care are:

- Surveys or interviews with those experiencing the care services
- Surveys or interviews with those delivering the services
- Observations of encounters between the case manager and client.

The quality of person-centred care is typically measured by determining:

Preferences: Type of care that clients wanted; attitudes and values of health care professionals

Experiences: Extent to which clients perceived that they received patient-centred care

Outcomes: Impact of person-centred care (e.g. effective communication and effect on client experience).

Seven key attributes of high-performing person-centred health care organisations are:

1. Comprehensive care delivery
2. Clear purpose, strategy and leadership
3. People, capability and culture
4. Person-centred governance
5. Strong partnerships
6. Person-centred technology and built environments

Challenges

Inconsistent terminology and definitions

Wide variability in roles and functions of case managers

Competing interests among organisations that work together in the interests of the client

Lack of evaluations to determine which elements are essential to good case management

Implementation costs and expenses, e.g. system / process reform, time and training

Considerations

Integrate person-centred practices from the top, with the support of champions across the organisation

A person-centred framework tailored to the workers' compensation setting may be required

Performance indicators that measure 'what matters' and monitor workforce and clients

The impact of different stages of change on the workforce when transitioning towards a person-centred model

Standardised training modules that target core competencies in person-centred case management

While there are many published best practices on person-centred care across a variety of disciplines (especially disability and healthcare), there is a lack of publicly-available literature in person-centred case management for worker's compensation.

1. INTRODUCTION

1.1 Background

WorkSafe Victoria (WSV) is developing a new Service Model that aligns with the Victorian government's objective of designing and providing human-centred services. WSV intends to apply a biopsychosocial lens to case management and build a fully equipped case management workforce to improve the outcomes of injured workers. To do this, a change strategy is needed so that all stakeholders have a shared understanding of the new model's vision, goals and processes.

The Victorian government defines "person-centred" or "human-centred design" as an iterative design process, which builds on the needs of the people who use a given service, and integrates their feedback into the design process.[1] In this case, the people for whom the person-centred case management system will be designed includes injured workers, employers, providers and delivery partners as well as the WSV and agents' case management workforce.

WSV requested the Institute for Safety, Compensation and Recovery Research (ISCRR) to examine the literature to identify best practice guidelines for implementing and evaluating person-centred case management.

1.2 Aims and methods

1.2.1 Aims and objectives

The main aim of this review was to examine the guidelines for best practice implementation of a needs-based, person-centred case management model. This included identifying the necessary supporting roles, benchmarking measures, and workforce strategies for cultural embedding of a person-centred case management model.

This research will inform a capability strategy that aligns to WSV's Service Model; and that meets the individual needs of injured workers and improves their recovery and return to work (RTW) outcomes. This work will also inform how WSV measure and support the workforce to transition to delivering effective person-centred case management.

1.2.2 Research questions

1. What are the best practice guidelines for person-centred case management?
2. What are the best practice guidelines for bench marking contemporary case management?
3. How do organisations delivering best practice case management meet the needs of their customers?
4. How do you successfully transition your organisation to deliver best practice case management (current state to future)?
5. What key performance indicators drive best practice case management?
6. What supporting functions / roles support the implementation and embedding of best practice case management?
7. What are the capabilities and personal attributes of case managers across varying case types (low/med/high)?

1.2.3 Methods

A literature review was undertaken in July 2021 and searches were conducted in academic databases (Medline, Embase, Scopus), Google Scholar, Google advanced and relevant journals (e.g. Professional case management).

More than 90 articles and documents were reviewed, including peer-reviewed journal articles and systematic reviews; and frameworks and policy documents from health institutes, health services and government agencies in Australia and overseas.

Given the short timeframe for this review (six weeks), searches were not exhaustive; therefore it is possible that relevant literature was not identified and reviewed. In addition, no quality assessment of articles was undertaken, so the strength of the available evidence has not been confirmed.

2. PERSON-CENTRED APPROACH TO CASE MANAGEMENT

This review is based on literature from multiple sources and a wide range of settings. There are many different terms used to describe similar concepts related to the person-centred approach, including 'patient-centred', 'client-centred', 'human-centred', 'individual-focused' and 'customer-focused'. Although there may be slight differences in these terms, fundamentally they reflect similar ideals. Therefore, for the purposes of this review, the term 'person-centred' is used to represent not only the specific circumstances of a worker's injuries, but also the broader context of their lives and interrelationships.[2] Similarly, the term 'client' is used to refer to a person, individual, patient or injured worker to cover a range of settings, unless there is a specific context. Where specific studies are referenced, other terms (e.g. patient-centred) may be used to accurately represent the literature.

Overall, while there was a large body of literature pertaining to case management and case manager attributes and practice, there was a lack of relevant literature regarding evidence-based evaluation of person-centred case management.

2.1 National standards of case management

Case management is practised and well-established in social work, health care and other sector services. It can be short-term, long-term or ongoing depending on need. Countries around the world such as the United Kingdom (UK), United States (US), Canada and Singapore have developed standards of practice in case management from a variety of disciplines. The Case Management Society of Australia and New Zealand (CMSA) also sets a minimum national level of practice (benchmark of excellence) to be attained by a practitioner throughout the case management process.

Case management has been defined by CMSA as "a collaborative process of assessment, planning, facilitation, and advocacy for options and services that aims to meet individuals' holistic care needs and ultimately promote quality cost-effective outcomes".[3] This provides a framework for service delivery in a variety of fields including mental health, child protection, education, disability, veterans' affairs and homelessness. Each discipline or field has different challenges, and brings its own approach to case management models along with specific supporting roles that are integral in the process.

2.2 Person-centred approach

The concept of person-centredness is embedded in the definition of case management and means allowing people's values, beliefs and circumstances to guide how services are designed and delivered.[4] In this way, people are enabled and supported to participate meaningfully in decisions that impact on them; and to form partnerships with their service providers.[4]

While it is not a new concept, it has taken on heightened prominence in recent years. Numerous studies have shown that person-centred practices can lead to improvements in client satisfaction, workforce attitudes, job satisfaction, emotional stress and overall workforce wellbeing.[5]

As the term implies, a person-centred approach to case management treats the client as an individual and puts the client at the centre of planning, care and support.[6-8] Originating in the disability sector, many health care organisations have since adopted person-centred approaches in care and support. It is embedded throughout the National Safety and Quality Health Service Standards (second edition), reflecting its importance to the safety and quality of health care.[5]

2.3 Features of person-centred case management

At the core of a person-centred approach are the following features:[8]

- Client is at the centre of the plan
- Family and friends are involved as full partners
- Partnership between the person, their family and the service provider
- The person's whole of life is considered
- Continued listening, learning and action.

In general, most staff working in human services believe that they apply a person-centred approach to their interactions with clients as they genuinely care and want to provide the best support to their clients.[9] However, human services systems are often system- or service-centred rather person-centred. Table 1 shows some of the differences between person-centred and system-centred approaches.

Table 1. System-centred approach versus person-centred approach

System-centred	Person-centred
Talking about the person	Talking with the person
Planning for the person	Planning with the person
Focused on labels, diagnosis, deficits	Focused on the person's strengths, abilities and skills
Creating supports based on what works for the person with 'that diagnosis'	Finding solutions that could work for anyone, preferably community based
Things are done that way because they work for staff or the service	Things are done that way because they work for the person
Family and community members are seen as peripheral	Family and community members are seen as true partners

Source: National Diabetes Australia[10]

Person-centred case management is not a linear process. Clients may alternate between stages of care depending on their recovery, needs, and goals.[11] It is also important to note that there is a need to shift power and control from service providers to clients by supporting shared decision-making and engaging in respectful and mutual relationships.[4] Therefore, a person-centred approach typically involves more time upfront than a task-oriented culture.

When applied in the workers' compensation scheme, a person-centred approach involves the injured worker being at the centre of decision-making, where they have a say in the goals they want to achieve and the services they wish to receive. Injured workers are empowered and supported to meaningfully participate in decisions and to form partnerships with their case manager and service providers.[4] It is a process of continual listening and learning; focused on what is important to the injured worker, now and for the future; and acting upon this in collaboration with their employer, as well as their family and friends, as necessary.[8]

3. BEST PRACTICES FOR CONTEMPORARY CASE MANAGEMENT

3.1 Best practices

Person-centred planning requires a flexible and responsive approach to meeting a client's needs and changing circumstances, guided by the principles of good practice rather than a standard procedure.[12] While many best practices and models reviewed were developed with a focus on a specific cohort such as patients, homeless people, veterans and people with disabilities, many of the principles can be adapted and applied to the workers' compensation sector to improve claims management practices and prevent injured workers from developing a secondary psychological injury.

Guidelines, principles and best practices reviewed came from various Australian organisations and agencies such as Mission Australia, Life Without Barriers, and Safe Work Australia as well as overseas. Eight best practices that are consistent across the literature have been identified as a baseline for contemporary case management.

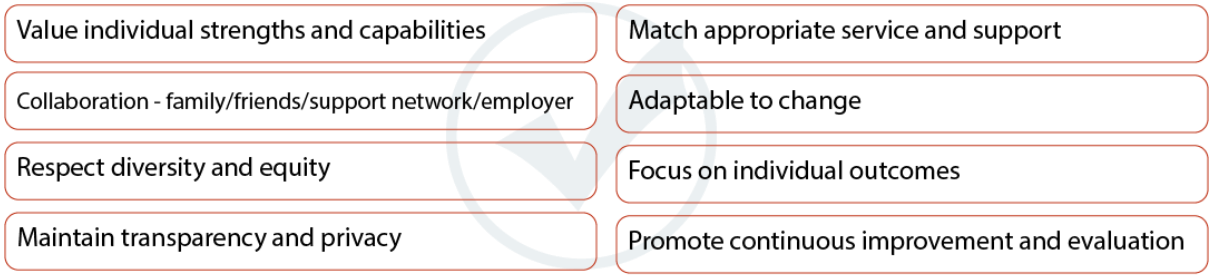


Figure 1. Best practices for contemporary case management

With all good intentions to achieve best practice, it is fundamental for person-centred approaches and practices not only be understood, but also to be implemented across all levels of an organisation, including:[4, 13]

- **Service system** – policy and procedures are available in all sectors and the service system, mechanisms and resources to facilitate, monitor and review person-centred practices are in place at all other levels
- **Organisational** – appropriate skills and resources are recruited to a create person-centred culture
- **Professional** – education and professional development focus on person-centred practices
- **Individual** – knowledge, attitudes and behaviours support person-centred approaches.

3.1.1 Value individual strengths and capabilities

Case managers should regard the individual as an 'expert' of their own experiences.[9] This involves working collaboratively with the client to identify their strengths, skills, needs and ability to overcome barriers; and to understand and respond to their views and choices. This is based on a strengths-based approach where barriers to successful recovery are perceived as challenges to be managed, rather than focusing narrowly on the client's problems.[11]

This will put the case manager in a more positive mindset to help the client build a person-centred care plan with goals for the future (e.g. RTW). One example is in the housing sector, where JHST Housing Program staff directed their efforts towards building on the client's positive attributes, looking to the future, and instilling a sense of optimism in the client.[14]

One-page profile

A simple tool that has been developed by Helen Sanderson Associates in the UK for the National Disability Practitioners aims to capture all the important information about a person on a single sheet of paper under three headings:[9]

- What people appreciate about me
- What's important to me
- How best to support me.

The outcome of this best practice is a care plan that is developed in consultation with the client and their supports; and follows these principles:[13]

- Reflects the client's capacities, what is important to the client and specifies the support they require to make a valued contribution to their community
- Builds a shared commitment to action that will uphold the client's rights
- Leads to continual listening, learning and action and helps the client to get what they want out of life.

3.1.2 Collaborate with families, friends, employer and social network

The importance of family, carers, providers, friends and social networks in planning and decision-making related to a client's care and recovery is recognised throughout the literature. In accordance with the client's wishes, case managers should actively include them and other service providers in all the processes that support ongoing involvement in the client's life and growth.[13]

In the worker's compensation context, this would also include the client's employer. Case managers need employers to be engaged and committed to support the injured worker to RTW. At the same time, case managers should also support employers with strategies to address any interpersonal issues and facilitate RTW, and discuss the benefits of doing so during this period of time.[15] Collaboration with employers, as well as with families and friends, can be achieved through case conferencing.

Employer support, particularly from an injured worker's direct manager, is one of the most important factors in ensuring a positive outcome for clients.[15] Findings from WSV Recovery Office Model also indicated that how employers engaged with case managers and support an injured worker can influence their recovery.[16]

3.1.3 Respect diversity and equity

Respecting diversity and equity involves engaging in respectful and equal relationships between clients and staff, including valuing clients' rights and acknowledging their range of lived experiences.[4] A holistic approach takes into account all the factors relating to a client's wellbeing (psychological, physical, cultural and social).

This involves listening attentively to clients' histories and backgrounds, and using cultural sensitivity skills to ensure clients have access to appropriate resources that are relevant to their self-identified goals and needs.[11] The Life Without Barriers service is one example of an organisation that aims to respect the culture, language, religious beliefs and priorities of all clients. Plans are developed with regard to social customs and traditions, and the individual's own culture and beliefs.[13]

Equity is important for people with disabilities and for Aboriginal and Torres Strait Islander populations, who often report experiences of stigma and discrimination by health workers. For

example, organisations could partner with local Aboriginal and Torres Strait Islander community representatives and ensure that the entire workforce receives adequate training and resources to provide culturally appropriate care and address barriers in access to services.

To achieve best practice, processes, communication methods, technologies and engagement, strategies should be tailored to recognise diversity, culture, class and power differences. Examples of supports and resources include:[4]

- Interpreter services and communication aids are used appropriately, and staff are supported to do so
- Communication, resources and environments are age appropriate
- Information is provided in different languages and in easy-read formats
- Staff at all levels demonstrate respect, awareness and empathy in every interaction with clients – they listen, believe and act
- Use plain-language resources and methods that don't intimidate or exclude people from participating
- Use communication aids to encourage an open dialogue of actively listening and learning from clients.

3.1.4 Maintain transparency and privacy

To maintain transparency and privacy, the client needs to be informed about what happens to their information, how their personal experiences will be used or shared, and whether their voice has been considered in any decisions.[4]

As part of quality governance, continuous improvement and good practice, the client's voice needs to be solicited, genuinely heard, and appropriately used to influence change. The Department of Health and Human Services (Victoria) has developed a 'Client voice framework for community services' with the goal of providing connected and person-centred services. The client voice underpins person-centred practice and guides behaviour to recognise that every client has unique insights that could add value and quality to the services and the relationship between the client and case manager.[4]

This does not mean that the client is always right, or that their lived experience is enough to meet all potential challenges. Similarly, the case manager or service providers may not always be able to act according to their client's wishes. The important factor is honest communication. Clients need a clear understanding of the processes and how their views have been used to inform decisions. Transparency regarding outcomes of their involvement is also essential and should be communicated in a timely manner.[4] Effective communication is discussed further in Section 5.1.2.2.

According to Mission Australia's policies, "Good practice case management adheres to privacy and consent legislation and funder and organisational requirements. The client's right to privacy and confidentiality is acknowledged and maintained at all stages of the case management process, and only information which is necessary for the delivery of the service is collected, used, shared and stored. Each client is advised of the purpose for which information is requested, the type of information kept and the person/s with whom the information will be shared".[17]

3.1.5 Match appropriate services and support

Real-time data and analytics, which are essential elements of predictive modelling, can be used to complement case manager capability to triage and segment claims (e.g. EML's PACE tool and WorkSafe Queensland's pilot of Recovery Blueprint). These tools can help case managers to deliver or allocate the most appropriate support for their clients. Additionally, having an established network of health and service providers may help clients access trusted and reliable services. The

case managers may also work with their clients to identify current support networks, agencies or professionals that can help them to achieve their goals. This requires the case manager to collaborate with relevant services or service providers and engage in regular case conferences as needed.[17] Appropriate client consent is needed if information is shared between agencies.

For people with a disability, Life Without Barriers encourage connections with people and their families, friends and informal support networks.[13] To maintain strong and sustainable partnerships to enable person-centred practices, the staff at Life Without Barriers have developed skills and expertise in negotiating with relevant organisations to help people with disabilities to access community activities or services.[13] Examples of these partnerships include:

- Professional and clinical groups
- The broader community
- Mainstream organisations
- Corporate enterprise and business
- Advocates (or groups).

3.1.6 Adaptable to change

Over time, a client's circumstances or goals may change and effective case management needs to be dynamic and flexible to respond to those changing circumstances as the client progresses. This involves regular monitoring and reviews of the care plan, which is a "living document", with the client, their support network and/or employer, as necessary.

Regular assessments of clients' progress at appropriate intervals allows case managers to ensure their clients' needs and interests are being looked after at both individual and organisational levels. It also provides an opportunity to address challenges or barriers in a proactive manner. In line with person-centred principles, encouraging the celebration of achievements will enhance clients' resilience and motivation to reach their intended outcomes.[17]

Should a claim need to be de-escalated or escalated to more intensive case management, continuous triaging and early identification of additional risk factors will be able to bring that to the case manager's attention. While some organisations only triage at the early claims stage, others take a more dynamic approach, using real-time data analytics to identify changes in circumstances.[18] For example, CorVel (US) asserts that continuous triaging improves claims outcomes and reduces the likelihood of escalating claims severity.[18] At other times, alternative strategies may need to be developed to meet the changing needs and ensure continuity of care.

3.1.7 Focus on individual outcomes

Clients' support needs vary across a continuum from low resource-intense care (Guided) to high resource-intense care (Assisted, Long-tail) (See Figure 2). For those with higher support needs, good practice case management is based on supporting clients to create realistic and achievable goals, based on their preferences and aspirations; and empowering them to achieve self-sufficiency and independence. The **SMART** tool can be used to develop goals that are:[17]

- **S**pecific – is each goal well defined and focused?
- **M**easurable – what evidence will show the goal has been met?
- **A**ttainable – is it possible for this client to achieve this goal in their present situation?
- **R**elevant – will achieving this goal move the client towards achieving their longer-term goals?
- **T**ime Bound – will it be possible to achieve this goal in the timeframe available?

Given that a client's status and care needs may change over the course of their recovery, continuous triaging ensures that the service provision is still relevant and meets the clients' current needs.[19] This iterative process builds the knowledge base and supports continuous improvement.[4] Understanding the client's current situation at regular intervals also makes sure that their recovery plan is more targeted to their current needs and preferences, rather than what the service provider believes should be addressed.[9]

While the case managers may have day-to-day responsibility for directly applying person-centred practices to support the client's recovery, it is important for all person-centred practices to be embedded within the systems and procedures at all levels of an organisation.[9]

A set of questions, which were developed by Life Without Barriers,[13] may be used to check whether the organisation's policies and protocols focus on the client's needs and outcomes:

- Is this activity about the people we support at Life Without Barriers?
- Does this activity reflect the needs and aspirations of the people supported by Life Without Barriers?
- What can I do to remove the challenges and barriers to achieving the goals of the people we support at Life Without Barriers?
- How is the person being supported to participate, make choices and decisions?
- What does success look like for the person?
- Which outcomes domains are important to the person?

3.1.8 Enable continuous improvement and evaluation

Case managers should be encouraged to routinely collect data on the effectiveness of the systems and processes as part of a reflective exercise.[17, 20] A combination of quantitative (e.g. case manager workload) and qualitative (e.g. interactions in case notes) data can be used to inform improvements at different levels (e.g. workforce competencies, systems, protocols, leadership, partnerships).[17] An important consideration in the design of data collection is to ensure easy analysis and interpretation of the data. Complaints and compliments from stakeholders are also useful resources to inform improvements. Section 6 provides examples of tools are available to measure person-centred care.

3.2 Outcomes for clients and the case management workforce

Overall, there is a lack of robust evaluations to indicate the effectiveness of 'good practice' person-centred case management.[21, 22]

However, some aspects of the model have demonstrated benefits. There is evidence of significantly higher ratings of job satisfaction, reduced stress and emotional exhaustion, and higher morale amongst care providers using a person-centred approach.[19] The team-based culture was associated with less staff exhaustion, burnout and turnover amongst health care providers. Similarly, other studies showed significant improvements in client satisfaction, workforce attitudes, job satisfaction, emotional stress and overall workforce wellbeing.[5]

4. ROLES AND FUNCTIONS

4.1 Capabilities and personal attributes of case managers

> *"……we have no automatic right to participate in planning with people. It is something that we have to earn through our relationship with a commitment to the person whose plan it is."*[8]

The ability to deliver a person-centred approach requires the adoption of supportive philosophies, policies and practices across an entire organisation. The following section focuses on what has been identified in the literature as important or even essential capabilities and attributes of case managers to support their role in frontline delivery of person-centred practices to clients.

4.1.1 Formal professional qualifications

Case managers can come from a variety of employment backgrounds with differing skill levels and experience, ranging from those straight from year 12 who have been trained through their employment organisation to those with formal Allied Health qualifications and years of case management experience. Adopting a client-centred clinical approach was documented as early as the 1950s and has been applied across many disciplines.[23-25] Therefore, it is likely that case management staff with formal Allied Health qualifications will have already undertaken person centred training during their studies and possess an understanding of the key attributes and clinical skills required to support its delivery. However, case managers without formal training may require additional training when their organisation adopts a person-centred approach.

Where the challenge can arise is in the degree to which staff have been able to apply 'genuine' person-centred case management within their workplace. While case managers intend to, or even consider they are, delivering person-centred practice, in reality they may only be promoting some aspects of this approach that fit within the constraints of their current organisation and broader system. To support the organisational shift to genuine person-centred practices, case managers' roles and requirements will need to be reviewed both at an organisational and personal practice level to identify any changes required to embrace and support the delivery of fully person-centred case management.

A case manager's adherence to their respective professional practice code of ethics has also been identified for its role in supporting the delivery of person-centred practices. An alignment was found between social worker core values, as depicted in the Australian Association of Social Workers Code of Ethics, and the skills required in the delivery of person-centred practice.[26] These skills include: client advocacy; identifying barriers to outcome achievement; engaging with external support providers; and reviewing client progress and care plan effectiveness.

A code of ethics designed specifically for case managers has also been proposed by the European Centre for Social Welfare and Research.[27] It is worth noting that the components of this proposed code of ethics, which are listed below, closely align with the best practice case management principles outlined in Section 3.1.:

- Ensure privacy and confidentiality
- Ensure dignity and respect
- Maintain objectivity
- Inform clients adequately
- The welfare of participants must be given utmost priority and any harm to participants must be prevented or minimised
- Ensure that participants are able to make decisions freely
- Case managers should act with integrity and honesty in collecting, storing, analysing and interpreting data.[27]

In addition to their formal qualifications, case managers should be open to undertake further training when the need arises. Additional training may be required prior to and during the adoption of person-centred case management practices across their organisation, when working with specific needs client groups, and to gain skills outside their current expertise to support individual client goals.[8] A close working relationship with their supervisor will assist in identifying any skills deficits and training opportunities.

4.1.2 Philosophy

The basic premise of delivering person-centred case management is embracing the philosophical underpinnings of the model (see section 3.1). Individual staff members need to understand and adhere to the principles underpinning the person-centred case management model and this should be reflected across their workplace practices.

4.1.3 Reflective Practice

To implement this model successfully, staff should be cognizant of their underlying beliefs regarding the person-centred case management model and also toward the social inclusion of the clients they work with. Reflective practice provides case managers with an opportunity for introspection with the aim of gaining further insight into their personal attitudes and beliefs, strengths and biases that support or hinder their ability to practice at an optimal level.[28] Personal biases can include values and assumptions, cultural and religious beliefs, and in relation to WSV, the case manager's attitudes toward the inclusion of injured workers in the community.[13, 29]

Routine exposure to reflective practice is preferable to support staff with identifying and monitoring their personal influences in relation to new clients, and to enhance their ongoing delivery of a person-centred approach across existing clients' RTW journeys.[8]

With person-centred practice, a case manager's role is to support and guide a client with identifying their goals.[28] A well-developed level of self-awareness reduces the risk of practitioner influence into client goal definition.

4.1.4 Flexible and responsive to client direction

To be effective in a person-centred practice, case managers need to be adaptable. Initially, this means being adaptable to the changes in their workplace associated with their organisation's transition from a systems delivery model to a person-centred case management model. This flexibility is also important for assisting clients in adapting their plans to accommodate any changes in their rehabilitation path and/or goals.[30]

4.1.5 Equitable case manager / client relationships

To support the delivery of person-centred practice, case managers need to avoid reverting to a position of exhibiting power and control;[13] instead establishing a relationship that reflects shared commitment and responsibility.[8] Case managers should take the lead in navigating the establishment of an equitable client/case manager relationship. Clients who are used to a more hierarchical structure and adopt a more passive role in the relationship (e.g. long-tail clients) may require additional support to understand the benefits of adopting an active role in their recovery plan, and also support on how to achieve this.

The manner in which case managers frame questions to the client such as: How would you describe what you would like to achieve?, What are your most important goals?, How do you think I can support you in achieving your goals? can assist in developing a more equitable client-case manager relationship.[13] This will assist in establishing a relationship where the client is central, equal and empowered.

Motivated staff have been found to enhance client motivation and be more creative with options and opportunities they present to their clients. Interestingly, the adoption of person-centred practice has been shown to have reciprocal benefits for staff, with case managers reporting an increase in workplace satisfaction resulting from working closely with clients and their families and assisting clients to successfully attain their goals.[8]

4.1.6 Optimistic, strengths-based and future outcomes focus

When working with clients to devise case management plans, a focus on their current needs and capabilities is fundamental. However, it is also important that these plans are orientated toward future goals and aspirations in order to support clients in achieving their full potential.[8]

4.1.7 Support diversity

Case managers are employed across a broad array of client populations from a range of cultural backgrounds. To support the development of a strong connection with their clients, case managers need to present a communication style that is respectful to, and accommodating of, the various cultural backgrounds that individual clients identify with.[8] The employment of case management staff from a wide range of backgrounds (e.g. cultural, religious, indigenous, age, gender) will enhance the ability for organisations to match case managers to clients. Staff diversity will also enhance workplace acceptance and familiarity with diversity.[31] In-service training can assist in supporting staff to be more culturally aware and sensitive to reflecting this in their workplace practices. Life Without Barriers[13] highlights the importance for organisations to focus on "values-based recruitment".

4.1.8 Communication skills

To be able to establish sound working relationships with their clients in a person-centred model, case managers need to have well-developed communication skills. Active listening skills play a key role in gaining important background information about a client's psychosocial environment (e.g. current housing arrangement, family supports, carer commitments, financial situation);[13] helps to build trust; and sets the foundations for developing an appropriate case management plan.

A case manager needs to establish relationships in which clients feel empowered to speak up and contribute. Through gaining a more thorough understanding of a client's short- and long-term needs and goals, case managers can offer guidance and even novel suggestions that can broaden a client's focus on what they can achieve in their rehabilitation path.[8]

The language that the case manager uses should be client-appropriate, avoiding an overuse of formal jargon, remaining informative and avoiding being directive.[31]

Positive language and conversations, ideas and plans that have an optimistic future focus can enhance client outcomes.[31] This includes the ability to reframe a client's limitations through the identification of associated strengths and successes.

Case managers should be skilled in setting up a communication style and manner that promotes a clients' notion of being central in the relationship,[24] and portraying a calm and relaxed environment to reduce client stress or anxiety. Many clients may not be familiar or comfortable with meeting case managers, especially those attending a first session. Clients who are used to being independent may be anxious due to their involuntary reliance on care, or they may have negative preconceptions about the relationship and outcomes. Not only will this assist in a more open and engaging relationship, but as creativity has been found to be more pronounced when people are in a relaxed environment, this will enhance discussion and identification of creative and innovative future goal options.[13]

Communication training for case managers should be based on approaches that focus on empowering clients to speak up and play an active role in identify solutions and actions. Example approaches include principles from motivational interviewing, behaviour change and health coaching methodologies.[32]

4.1.9 Inclusive of a range of relationships

In a person-centred model, case managers need to be skilled at navigating additional relationships associated with a client's plan. These include forming equitable relationships with family and peers and developing relationships with the client's broader community.

While case managers may be familiar with including family, friends and community into client management plans, they are not automatically included in the relationship, nor viewed as equals. Their roles are commonly just seen as providing some aspect of care for the client where and when directed by the case manager. Within a person-centred setting, family and friends are viewed as full partners in the relationship. It should be the client that decides who they want to include and to what extent.

Through gaining an understanding of the roles each family member and friend have, and continue to play, in a client's life, a case manager can strategically incorporate these relationships and associated contributions into the case management plan. Family and friends can also provide insights into the client's life before their injury, and into any relevant cultural and social circumstances. They are also typically the ones who provide additional and after hours support for clients and will continue to do so into the future, post case management.[5]

Family members of higher dependency and long-tail clients are also likely to have faced significant life changes as a result of the client's injury, including disruptions to their daily routines with support service staff coming into their family home to provide care. They are also the ones most likely to assist with problem solving when it comes to adjusting daily routines to accommodate a RTW (e.g. who picks up children from school). Alliance and collaboration with families that is respectful and inclusive has been found to enhance client recovery outcomes.[5]

With the increased inclusion of family, friends and community, it is important that case managers comply with privacy and confidentiality policies within their own organisation and with federal and State legislation.[13] The inclusion of family members is challenging and the aim should be to strike a balance between the principles of inclusivity, privacy and transparency. Case managers need clear guidance on how to establish boundaries with what can be shared and with whom. Family relationships are often non-traditional, so there needs to be clear processes to support case managers with navigating any privacy concerns to avoid the complexity and costs arising from the involvement of lawyers. Again, active listening skills play a key role in identifying the degree of information the client wishes to share and with whom.

It is also important for case managers to be mindful of potential negative consequences associated with these relationships and to have the skillsets to navigate them. Of utmost importance is the ability to identify abusive relationships. Other issues to avoid include clients developing an overreliance on relationships that are transient or unstable or result in clients reverting to a passive role in their recovery. Active listening skills play an important role in identifying who a client wants to include or exclude from their care management.

Community integration is an important component of a client's management plan in a person-centred model. This can include accessing local community health services, social activities, undertaking hobbies and interest groups. The breadth of community engagement is enhanced when case managers and clients are open to exploring novel and creativity opportunities. Community-based activities are often low cost or freely available and support clients in developing friendships and connections, and the overall health and wellbeing benefits associated with being part of a community are well documented.[5]

4.1.10 Case management models and expectations

The successful implementation of person-centred case management can be hindered by competing agendas of associated stakeholders, even within a single organisation/workplace (e.g. business models, organisational policies, resource allocation agendas). Front line case managers are no exception, often having to satisfy competing agendas such as their role within the organisation, their professional practice guidelines, and the needs of their client base. To address this, Treiger and Fink-Samnick[33] proposed that a collective paradigm shift was necessary within the case management field to successfully re-orientate from a focus on the care setting to that of prioritising a person-centred management approach. They developed a model to support this paradigm shift across all roles within organisations aiming to deliver person-centred case management. The COLLABORATE© model is designed to support the delivery of a consistent case management approach across various employment settings through the identification of a set of key performance expectations, and to enhance the cost effectiveness of delivery, client experience and outcomes. The term COLLABORATE© is used as an acronym identifying the eleven components of what the authors define as a "Universal Competency-based model for professional Case Management"[33] that can be applied across all health sectors.

The competencies associated with each of the letters of the COLLABORATE© acronym and the associated main attributes are listed in Table 2.

Table 2. COLLABORATE© model competencies and main attributes

Competencies	Main attributes
Critical thinking	Out of the box creativity; Analytical; Methodical approach
Outcome driven	Patient outcomes
Life-long learning	Valuing: Academia and advanced degrees; Professional development; Evaluation of knowledge requirements for new and emerging trends (e.g. technology, innovation, reimbursement); Practicing at top of licensure and or certification; Acknowledging that no one case manager can and does know all; Advanced communication skills
Leadership	Professional identity; Self-awareness; Professional communication; Team coordinator
Advocacy	Patient; Family; Professional
Big picture orientation	Biopsychosocial-spiritual assessment; Macro (policy) impact on micro (individual) intervention
Organised	Efficient; Effective
Resource awareness	Utilisation management; Condition/population-specific; Management of expectations per setting
Anticipatory	Forward thinking; Proactive vs reactive practice; Self-directed
Transdisciplinary	Transcending; Professional disciplines; Across teams; Across continuum
Ethical-legal	Licensure; Certification; Administrative standards; Organisational policies and procedures; Ethical codes of conduct

Source: adapted from Trieger and Fink-Samnick, 2014[33]

4.1.11 Accommodating specific client groups

Higher dependency clients (e.g. Assisted and/or Long-tail) may require more support and guidance in devising their plans, and also with identifying the full range of services they may require.[13]

A key component of person-centred case management is its client-driven design. However, this does not mean that case managers should adopt a passive role. Case managers play a key role in working alongside clients to assist them with exploring and defining the individualised components of their case management plan. While there may be several personal factors to take into account while devising a client's management plan, one common factor to identify is the level of support that a client will require. Typically, this is based on a client's current and predicted ongoing level of dependency (e.g. low, medium, high dependency). Within WSV, the management plan should be tailored according to the Future State Service Model Segments that an injured worker is categorised under (Figure 2). For example, Guided (low dependency) clients may need less resource-intense care and their RTW path may be more process-based, with minimal support required from a case manager.

Higher dependency clients (e.g. Assisted and/or Long-tail) may require resource-intense care due to more complex recovery issues. Long-tail clients are likely to be influenced by their past experiences with case management, including taking a more passive role in their care. This client group may require additional guidance or support when adapting to a person-centred management style, such as being able to identify broader or novel future goal possibilities, and how to speak up. High

dependency clients may require a greater level of staff expertise and formal qualifications. These qualification and expertise variations would need to be reflected in employment role classifications, salaries, and performance KPIs.[34]

Case managers should be open to undertake further training (formal and informal) where necessary.[5] For example, case managers who deal with psychological claims may require training in how to identify and respond appropriately to a client at risk of self-harm or suicide, or harming others.[34]

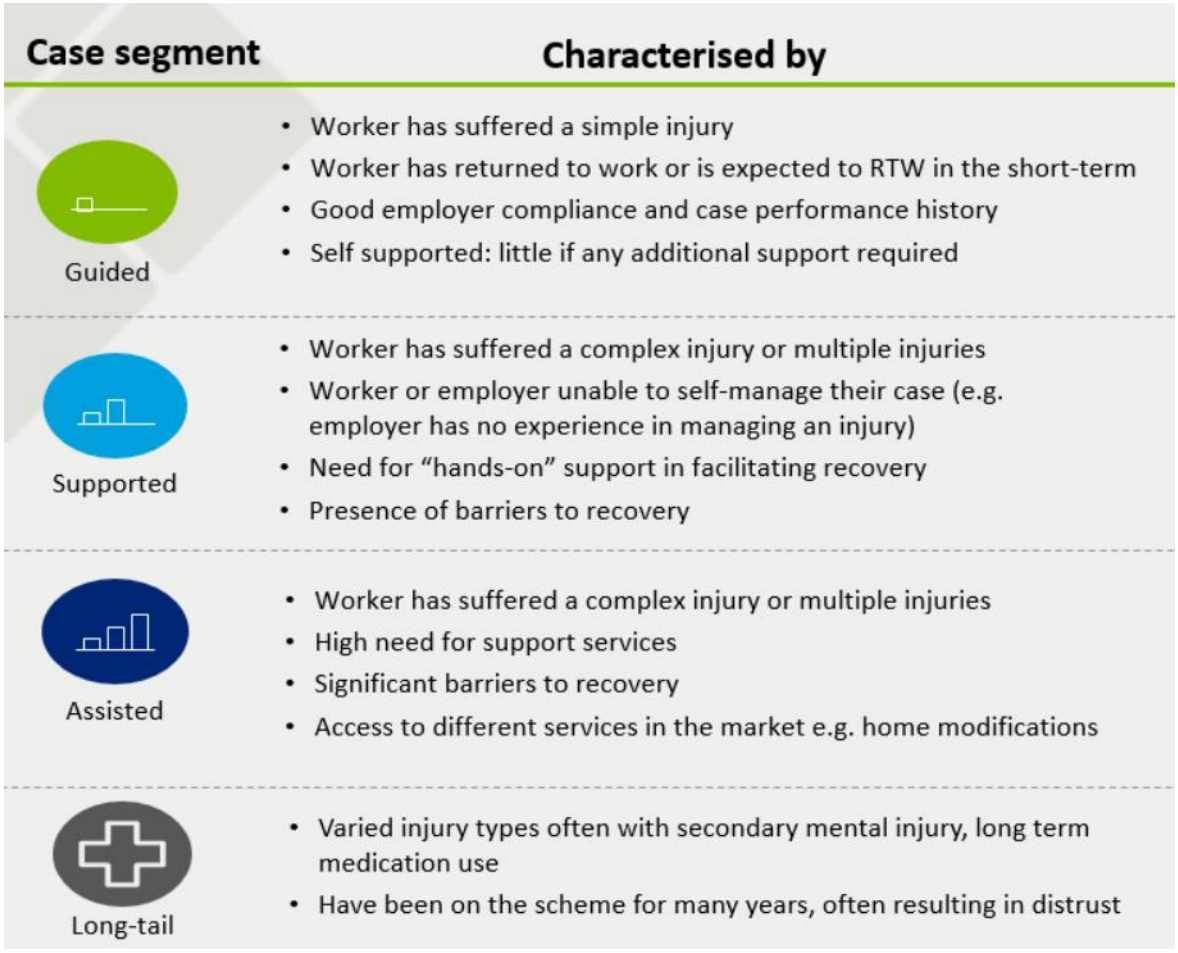


Figure 2. Future State Service Model Segments, WorkSafe Victoria

The attributes and skills required of a case manager working in a person-centred practice may change over the course of a client's recovery journey. Skills required during the initial or acute phase of injury may be superseded as the client moves toward the RTW phase of their recovery. Figure 3 produced by iCare NSW[35] identifies the key case management requirements associated across their three defined phases of client recovery. Although implementation and effectiveness of iCare's workers' compensation model has drawn criticism,[36] the key requirements for tailoring case management across the different phases of recovery, as shown in Figure 3, are consistent with the broader concepts of good case management identified in the literature.

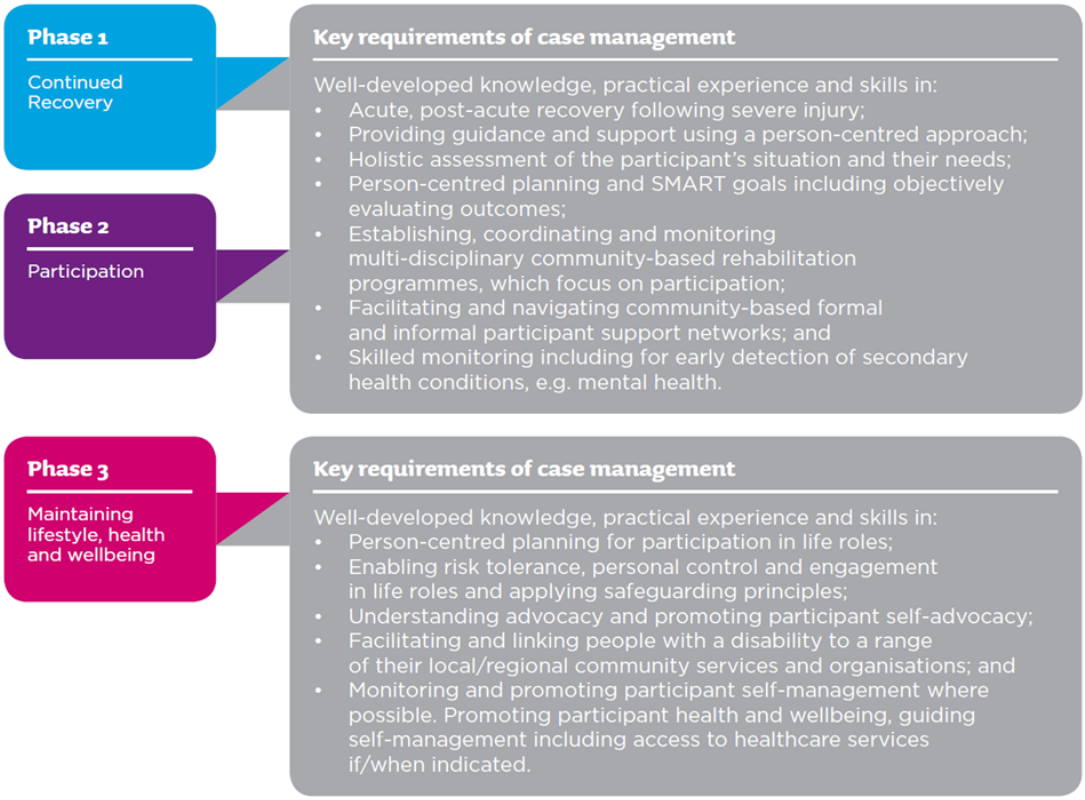


Figure 3. Case management requirements across client participation phases[35]

4.2 Supporting roles and functions

For case managers to practice person-centred case management effectively, several roles and functions need to work together to create a supportive working environment. Figure 4 illustrates the roles and functions identified from the literature:

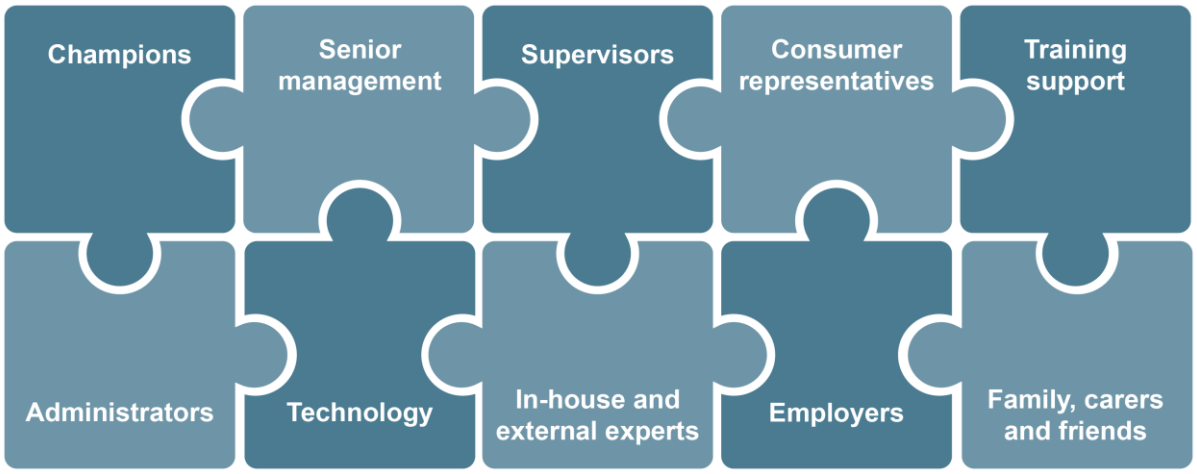


Figure 4. Supporting roles and functions in case management

4.2.1 Champions

Champions are a catalyst for change

Champions not only support the delivery of person-centred care in concept, but also practise person-centred care delivery. Their role as a catalyst for change is important to building buy-in, especially when an organisation is undertaking ongoing cultural change.[5, 37]

For this role to be successful, a champion should be embedded at every level of the organisation if possible. Any staff member with a good understanding of the merits and practices of person-centredness can become a champion, although support and buy-in from senior management, can have a more powerful effect.[5, 37]

4.2.2 Senior management

Senior management key to sustainability of person-centred culture

Committed senior management are in the best position to articulate and implement a person-centred strategy across the organisation as they have the authority to make key decisions that impact on the operation and culture of an organisation, such as the organisational structure, systems in place, capability and capacity and budget.[38] It was evident at John Fawkner Private Hospital that when management decisions and resources prioritised patient needs, staff were more inspired to provide person-centred care.[5]

The more involved senior management are, the more first-hand experience they would have on the transformation that takes place once a person-centred culture begins to take shape. This in turn will lead them to support operational decisions to further embed person-centred practices in the organisational culture, such as putting management structures in place that provide regular supervision and feedback where relevant.[38]

Without their commitment and active involvement, a person-centred culture cannot be sustained over the long term.[5, 38]

4.2.3 Supervisors

Supervisors empower case managers

Case managers need supervisors, senior staff and managers who are able to entrust them to address and make decisions that relate to their work responsibilities. Staff who are valued and empowered to make decisions, take risks, and be creative are more likely to provide care and support from a person-centred approach.[19]

In an organisation with a person-centred culture, staff empowerment extends to all staff positions. Opportunities for deeper understanding at a practical level such as having conversation planning and debriefing with supervisors should happen regularly, rather than limited to performance management.[8, 15]

Evidence shows that training alone will not achieve sustained skills acquisition and behavioural change. For best practice claims management, staff should receive supervision and regular feedback to reinforce expectations, build skills and achieve performance.[15]

4.2.4 Consumer representatives

Consumer representatives engaged for their shared experiences with clients

Consumer representatives are valued for their perspectives and insights. For consumer representatives to be engaged in a meaningful way, organisations could offer professional orientation, training and ongoing support. It is a formally recognised role that can influence an organisation's governance and decision making, training, co-design and evaluation processes.[5]

By incorporating consumer perspectives into workforce training, case managers may be able to provide better culturally appropriate care. For example, organisations could partner with local Aboriginal and Torres Strait Islander community representatives to provide training and resources to case managers provide culturally appropriate care.[5]

Consumer representatives also offer mutual understanding based on shared experiences with clients. Sometimes it is difficult for case managers and other professionals involved in the client's care to completely understand what they are going through and therefore consumer representatives can play a valuable part in contributing to person-centredness.[7]

They could be a family member, community member, a service provider or a consultant. The important thing is that they should be a good listener, willing to work diligently and creatively to help the client.[39] Consumer representatives are sometimes known as peer workers or facilitators.

This approach is common in healthcare. For example, John Fawkner Private Hospital had a consumer representative with an armed forces background to talk to veterans if required. They also recruited staff who were multilingual to assist patients with simple daily tasks such as translating meal selections. Patients were appreciative and the staff member were recognised for their contribution to person-centred care.[5]

4.2.5 Training support

Access to continual learning and opportunities

A person-centred work culture fosters continual learning and opportunities, both informally and formally. While supervisors can provide day-to day coaching, case managers may need to undertake training and intentional education programs for professional growth. For example, case managers dealing with more complex cases, such as psychological claims, may require training in identifying and responding to a client at risk of harming them self or others, mental health first aid, and suicide prevention.[15] An organisation may need to expend monies to implement strong staff training and mentoring programs, but the net cost savings from reduced staff turnover is usually justifiable.[38]

4.2.6 Administrator/Coordinator

Administrator supports process-oriented tasks

More process-oriented tasks, such as eligibility determinations and benefit payments, can be redistributed or transferred to a dedicated unit or third party so that case managers could focus on client needs.[15] For example, in iCare's claims management decision framework, their triage specialists apply a standard clinical practice model to determine the right level of support for each claim, according to the complexity of injuries. All claims with forecast time loss beyond two weeks are then assigned to a dedicated case manager.[40]

4.2.7 Technology

Technology must enhance, not substitute, person-centred experience

There are many technology platforms and decision support tools on the market to help case managers make appropriate and timely decisions. It is important to remember that case management technology should not only support case managers, but also improve the client experience.

Case managers at the Cleveland Clinic South Pointe Hospital managed to achieve both by using a collaborative case management tool that improved care coordination and patient satisfaction. Apart from collecting information about patients' medical needs and social determinants of health, the tool also assisted case managers in understanding patients' post-discharge needs. In addition, the tool encouraged patients and their families to be involved in the discharge plan. Not only did it reduce unnecessary readmissions, the hospital scored 100% on patient satisfaction survey metrics related to information provided to patients and addressing patients' needs at discharge ever since the tool was implemented.[41]

4.2.8 In-house and external experts

A comprehensive network of experts for referrals

Being the single point of contact for the client and by extension their families and carers, case managers need the support from a range of in-house and external specialists such as a medical panel, injury management advisors and rehabilitation providers, so that they can make appropriate referrals to clients.[15] For example, iCare has a Medical Support Panel as a permanent feature of the insurer's person-centred claims services model. With a target of no more than five days to review claims once a completed referral is received, the panel provides case managers with medical case support to fast-track decision-making.

4.2.9 Employers

Employer support crucial to injured workers' recovery

As mentioned in best practice (see section 3), employers or direct managers of the injured worker play an important role in working with case managers to provide suitable duties for the injured worker in worker's compensation claims. According to the feedback the Recovery Model Office had received from supported workers, a lack of support from employers attributed to the lack of progress in injured workers' recovery.[16] Therefore, case managers should establish protocols to ensure the active involvement of the employer in RTW planning and interventions to achieve person-centred outcomes for their clients.[15]

4.2.10 Family, carers and friends

Social support regarded as true partners

For the process to be meaningful and beneficial for the client, there needs to be buy-in from the client's circle of support.[39] As mentioned in best practice (see Section 3), the importance of family, carers, friends and social network is recognised throughout the literature. Case managers should regard them as true partners in the client's recovery. Long spells of illness lead to social isolation[42] and this can be prevented by maintaining social networks.[43] Therefore, case managers need to be aware of social isolation and encourage clients' social connectedness. In disability care, families are encouraged to consider what they feel is appropriate for their family member with a disability and what that family member may want.

5. ORGANISATIONAL SHIFT TO PERSON-CENTRED CASE MANAGEMENT

This section discusses the roles and responsibilities of the organisation in transitioning to a person-centred case management model. This includes the resources and tools needed to support the workforce throughout a change in approach; and to measure the impact of the new model on all the stakeholders (e.g. case managers, clients, service providers, employers, insurance agents and WorkSafe or compensation scheme).

5.1 How do organisations delivering best practice case management meet the needs of their customers?

5.1.1 Identifying the appropriate level of support

In order to appropriately align recovery services with injured workers' needs, compensation claims are classified according to a range of different risk criteria related to:[18]

- **Individual characteristics**: worker's age, occupation, psychosocial factors, recovery expectations
- **Injury characteristics**: nature of injury/injuries, location and mechanism of injury
- **Job/workplace characteristics**: type of work, support for RTW.

Injured workers' needs vary substantially along a continuum of management and services. While the majority of claims can be managed with the 'light touch' approach, other claimants with greater needs require a person-centred approach to manage their cases. A 'light touch' approach may be sufficient for those with minor injuries, no time off work or an expected early RTW, and a role and workplace that can accommodate modified tasks when the worker returns, if required. In contrast, workers with complex or multiple injuries (including psychological injury), or limited workplace accommodations, are likely to require tailored services and more intensive claims management over a longer period. However, initial predicted recovery expectations may change over time. For example, workers with minor injuries may develop complications that require more intensive case management; and workers with more complex injuries may improve faster than predicted. Therefore, some adjustment of claims across levels of case management may be required.

A systematic review of case management among patients with chronic conditions who frequently use primary health care services reported the importance of identifying patients who were most likely to benefit from a case management approach.[44] The authors suggested that accurate case-finding processes increased the effectiveness of case management. While this relies heavily on the skills and experience of case managers, case-finding decisions are often made in consultation with RTW specialists.[18] Accurate case-finding is also facilitated by having small caseloads, regular follow-up with clients, and working with a multidisciplinary team, which provides opportunities to learn from others and address clients' needs more holistically.[44]

In the workers' compensation sector, one approach is to apply a predictive risk algorithm to the available data to identify injured workers with a high probability of a long recovery. Various predictive risk models have been developed to assist the case-finding process; and the task may be to identify the best fit for the organisation. For example, the Wallis Occupational Rehabilitation Risk (WORRK) model was developed to identify injured workers with orthopaedic trauma who were at risk of non-RTW.[45] The model was moderately effective at identifying workers with persistent impairments, irrespective of their literacy or language fluency. The authors also understand WSV has done some work in this area.

5.1.2 Clients' needs and priorities

In general terms, clients expect that their unique circumstances, views and preferences will be considered in any decisions that impact on them.[6] An examination of patients' priorities regarding their health care identified several key characteristics of patient-centred care, including:[6]

- Respect
- Courtesy
- Competence
- Efficiency
- Patient involvement in decisions
- Time for care
- Availability and accessibility
- Information
- Communication.

Similarly, in the primary care setting, communication and partnership were identified as important in a survey of patient preferences.[6]

5.1.2.1 The right to choose

The importance of patient choice has been recognised internationally in several health policies. In the UK, the National Health Service Constitution (2010) established three rights related to patients' choice:[6]

- The right to choose their General Practice
- The right to express a preference for a particular doctor within their General Practice
- The right to make choices about their health care, including information about their choices and available options.

However, despite these rights, evidence suggested that almost half of patients surveyed did not recall being offered choices; and 10 per cent of patients were not as involved in decisions about their care as they would like.(The King's Fund, 2010, 2016 in [6])

In Italy, a similar recognition of patients' rights led to establishing a set of indicators to systematically measure the quality of health services from the patient's perspective.[6] However, the implementation of this framework has been inconsistent across different regions.

In contrast, the Dutch health care system has embedded patients' freedom to choose health care providers and insurers in legislation; and this has led to very high levels of satisfaction with the health system.[6]

In the workers' compensation setting, injured workers may also have the right to select their own case manager. Changing claim managers during the course of a claim, which led to a loss of case history, was identified as challenging for injured workers.[46] iCare has a 'Finder Tool' that allows the injured worker to find a case manager that fits their needs.[47]

5.1.2.2 Effective communication

From the point of first contact, the relationship with a client is dependent upon clear and consistent communication. A functional client–case manager relationship is built on a foundation of mutual trust, respect, honesty, compassion, empathy, transparency, and ongoing communication.[48]

Good communication includes using plain language and avoiding jargon, acronyms, and ambiguous terms that may be common in the workers' compensation field, but tend to mystify clients, particularly in cases of poor literacy or culturally and linguistically diverse communities.

Injured workers identified a perceived lack of communication as an important barrier to care and recovery.[49] The injured workers reported high levels of stress due to navigating the systems related to workers' compensation claims; and this has been associated with poor longer term outcomes.[49] Workers also described difficulties with the complex language and jargon related to claims and a feeling of disempowerment. In contrast, effective communication with clients was identified as essential to improving quality of life and satisfaction with care among injured workers involved in workers' compensation case management.[49] Workers who perceived that their interactions were fair, and communication with the system was effective, reported improved quality of life and satisfaction with care. Thus, the perception of procedural justice is a strong indicator of good outcomes.

In situations where a face-to-face intervention is impractical, alternative methods of communication that are tailored to the individual's preferences may need to be considered. For example, SMS texts may enhance the personalised care by increasing compliance with requirements as well as providing opportunities for case managers to deliver targeted information.[49]

In addition, informational needs may change over the course of an injured worker's recovery pathway and workers stressed the importance of timing, frequency and quality of interactions with a case manager. While case managers may not have the power to influence organisational decisions related to a particular case, they may be able to improve the quality of information and communication with the client.[49]

5.1.2.3 Shared decision-making

The definitions of shared decision-making are numerous and varied. However, the SHARE model, which was developed for the health care setting, incorporates several elements that are common to the process and relevant to case managers across a variety of sectors:[48]

- **S**eek your patient's participation: Define/explain problem
- **H**elp your patient explore and compare treatment options: Present options; discuss pros/cons (benefits/risks/costs)
- **A**ssess your patient's values and preferences: Discuss patient ability/self-efficacy; Doctor knowledge/recommendations; Check/clarify understanding
- **R**each a decision with your patient: Make or explicitly defer decision
- **E**valuate your patient's decision: Arrange follow-up.

A contractual model of shared decision-making is based on a strong trusted relationship between stakeholders that takes time to develop. Effective shared decision-making incorporates elements of:[48]

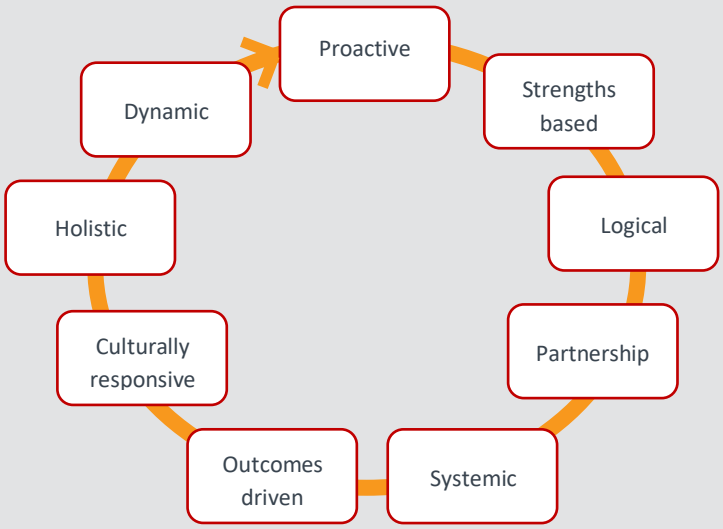
- Justice
- Freedom
- Dignity
- Truth-telling
- Promise-keeping.

In the case manager's code of professional conduct, it is expected that case managers will provide the "necessary information to educate and empower a client in making informed decisions".[48] While good communication and strong relationships underpin all interactions between a case manager and client, these are skills that evolve over time as the case manager's experience and expertise develops; and organisations need to provide ongoing opportunities to develop knowledge and skills (See the COLLABORATE© model in Section 4.1.7).

On the next page is a case study that illustrates a framework for case management developed by the Homelessness Strategy Division.[20]

A case management framework - Homelessness

The case management framework to address homelessness prioritises the needs of clients to obtain safe, secure long-term housing in South Australia.[20] To do this, the framework places the client at the centre of the service response and engages the client in developing a plan to identify the relevant services required. Although the framework is designed to address homelessness, the nine principles and six steps could readily be applied in the claims management sector.



1. Intake:
    a. Client engaged and needs identified
    b. Risk and safety issues assessed; and eligibility determined
    c. Provide client or service referral; and identify agencies involved with client
2. Assessment of needs
    a. Assess all life domains; need for external/specialist support and gather information
    b. Collate information and observations
    c. Provide immediate support/action where warranted
3. Case planning
    a. Determine specific goals and strategies to achieve outcomes
    b. Clarify all roles and timeframes
    c. Identify and respond to risk and safety issues
4. Implementation of the plan
    a. Deliver on case plan tasks
    b. Provide referrals and advocacy
    c. Facilitate sound collaboration and coordination of services
    d. Provide regular communication and information sharing
5. Monitoring
    a. Reviewing progress and re-strategising
    b. Identifying and responding to change
    c. Celebrating milestones
    d. Planning for transition or exit stage
6. Evaluation, transition or exit
    a. Provide recognition of achievements
    b. Plan next steps; and evaluate progress and outcomes
    c. Identify continuous improvement opportunities; and recognise contributors

While it is acknowledged that organisational level supports, such as technologies, structures and systems, are required to enable person-centred case management, additional literature searches with a more specific focus on these aspects is needed to adequately discuss their role.

5.2 How do you successfully transition your organisation to deliver best practice case management (current state to future)?

No specific examples of successful transition from a traditional to a person-centred case management model were identified in the literature. However, there are generic models that may be applied to a variety of settings.

There are three models that have become the cornerstones in organisational change and are still used widely across many types of organisations and settings:[50]

5.2.1 Lewin's change management model: A 3-stage process of change developed in 1940s

1. **Unfreeze**:
    a. Determine what needs to change
    b. Ensure strong support from senior management
    c. Create the need for change with a compelling argument
    d. Manage and understand the doubts and concerns.
2. **Change**:
    a. Communicate often
    b. Dispel rumours
    c. Empower action
    d. Involve people in the process.
3. **Refreeze**:
    a. Anchor the changes into the culture
    b. Develop ways to sustain the change
    c. Provide support and training
    d. Celebrate success to bring closure.

5.2.2 Bridges' transition model: a 3-stage model developed in 1991

1. **Ending, losing and letting go**: people may experience a range of emotions when change is proposed, including: fear, denial, anger, sadness, disorientation, frustration, uncertainty, or a sense of loss. At this stage, Bridges suggests that it is important to accept resistance and to understand people's emotions.
    a. Listen empathetically
    b. Communicate openly
    c. Describe how people can apply their skills, experience and knowledge in the new environment
    d. Explain the resources and training that are available.
2. **The neutral zone**: people may experience a higher workload as changes are implemented. They may also experience scepticism or resentment towards the new initiative, low morale, low productivity, or anxiety about their role or status.
    a. Meet frequently and give feedback on performance related to change
    b. Set short-term, achievable goals
    c. Boost morale.

3. **The new beginning**: people begin to embrace the initiative and build their required skills. They may experience high energy, openness to learning and renewed commitment to their job/role.
    a. Link personal goals to organisational goals
    b. Reward team for their efforts.

This transition model is designed to be used alongside change models, such as Lewin or Kotter's change management models.

5.2.3 Kotter's change management model: 8-step model developed in 1995

1. **Create urgency**: develop a sense of urgency around the need to change; buy-in from senior management is essential
2. **Form a powerful coalition**: find effective change leaders within the organisation to lead and establish a team of key stakeholders
3. **Create a vision for change**: develop a clear vision that articulates the values, goals and a strategy to achieve them
4. **Communicate the vision**: communicate the vision frequently and embed it in decisions, problem-solving and all operations
5. **Remove obstacles**: establish a structure for change; monitor and address barriers
6. **Create short-term wins**: short-term targets that are achievable will sustain motivation; reward those who help to achieve targets
7. **Build on the change**: analyse changes as they are achieved to see what needs improving
8. **Anchor the changes in corporate culture**: ensure the changes become part of the core of the organisation and its culture by communicating successes.

The key common elements in these generic change models involve preparation, communication, leadership and empowerment. Further information is available on how change management was addressed by WorkCover Queensland when introducing a new risk-based model of case management (Recovery Blueprint) (personal communication, Dr Ross Iles).

5.2.4 The role of the workforce and workplace culture in transition

The COLLABORATE© model of case management has been developed to be fluid enough to suit a variety of care settings and to adapt as changes occur over time and across different sectors (e.g. health care, insurance).[33] (see Table 2) A key challenge to transitioning to a new organisational model is changing the organisational culture that often has been based on a set of factors, including: goals, roles, processes, values, communication practices, attitudes and assumptions. Trieger et al.[33] suggest understanding and assessing the current organisational culture is needed before implementing changes. The Organizational Culture Assessment Instrument (OCAI) is one of several tools designed for this purpose.

The workforce culture, which incorporates core values and practices that guide both personal interactions and specific tasks, is fundamental to establishing a person-centred culture of care for vulnerable individuals.[38] Moreover, it is the strength of the relationships between staff and clients that facilitates all the steps needed to achieve good outcomes for clients, whether that is in the area of workers' compensation, health care, disability or housing.[14]

For example, in the long-term care of the elderly, the more traditional care culture was hierarchical, task-oriented and focused on organisational needs; whereas a person-centred care culture is more adaptive and flexible, employing self-directed multidisciplinary teams that focus on the needs of the elderly residents. Developing a workforce culture that embraces the subtle shift from a task-driven

to a person-centred culture needs to precede any changes in the processes or services. The key elements of a person-centred care work culture are:[38]

- Staff stability
- An appropriate number of staff (all shifts, every day)
- Consistent staffing assignments
- Leaders, managers and supervisors who are trained specifically to lead and manage
- Staff who are effectively oriented, trained and mentored to build person-centred care skills and competencies
- Staff empowerment and delegated decision-making authority models
- Self-managed, multidisciplinary work teams.

High staff turnover is costly, but can also lead to a cascade of negative implications that limit the capacity of an organisation to provide person-centred care. This includes: higher workloads for remaining staff while new staff are recruited and trained; reduced service quality, lower staff morale and low satisfaction among staff and the people in their care.[38]

One of the key attributes of an effective case manager is being agile and adaptable to change. Given their prime position in managing core business, their collaboration and commitment to organisational initiatives is essential. There is a growing argument that a culture of professional development among case managers is essential to effectively implementing best practice[51] and that the case manager role requires a professional status.[33]

Trieger et al.[33] argue that case management has evolved from task-oriented roles within large organisations, rather than a professional career path *per se.* This has led to substantial diversity in the roles and functions of case managers in different sectors and settings. While there are benefits and efficiencies in focusing on tasks and use of checklists, vital information may be overlooked and the nuances of a person-centred approach may be lost in the routine of day-to-day activities. Critical thinking, which is the first competency described in the COLLABORATE© model, demonstrates the shift away from the task-oriented case management approach.

> *Case management will continue in neutral unless stakeholders across academia, professional organizations, and certification/accreditation bodies agree to work together in taking on the real challenges of transforming case management practitioners from mid-level functional technicians to warriors on a mission to transform health care delivery.*[33]

5.2.5 Human-centred design

A human-centred design approach aims to align services with the needs and desires of the service users.[1] This approach, which begins with a client perspective on a particular issue ("outside-in approach"), provides a wider context around the issue and is thought to reduce the risks of failed implementation of change initiatives. While this design focused on the Victorian Government public sector, the principles and challenges are relevant to organisations in other sectors.

For the purposes of this review, the principles of the human-centred design approach are applied to developing a best practice case management framework:

- **Address the right problem**: Employ an iterative, non-linear process to develop a clear understanding of the problems and the contexts, based on the real-life experiences of those who will be impacted by any proposed changes (e.g. focus groups or interviews with case managers, injured workers and other stakeholders)
- **Test ideas quickly and cheaply**: Ideas can be piloted in discrete phases, without a large investment of time or cost, thereby reducing financial or reputational risks
- **Minimise support costs**: Ensuring the system and processes are user-friendly also minimises the need for training and increases adoption (e.g. piloting on-line materials with relevant stakeholders before rolling out system-wide)
- **Build capacity and work across silos**: Given the wide set of stakeholders, working in multidisciplinary teams helps to build capacity and social capital that can project forward to other business
- **Understand the worker's perspective**: Understanding the case manager's challenges and strengths will inform the design of a system that the worker is more likely to engage with.

5.2.6 The business case for person-centred case management

While the economic value of person-centred case management is not the focus of this review, successful transition towards this model may be facilitated by presenting a strong business case. One example of this was demonstrated in the health care sector. Tabbush et al.[19] reported that the highest amount of US health care expenditure occurred in a small population of chronically ill beneficiaries in their last year of life. The authors highlighted improved quality of care as well as positive financial value of "a person-centered approach that elicits, respects, and is congruent with an individual's goals, values, and beliefs". Although person-centred case management entailed a higher investment in some areas of care, the return on investment demonstrated substantial savings in high-cost care, such as reduced hospital length of stay, readmissions and emergency department visits; and reductions in unnecessary service utilisation. Other benefits of this approach included higher levels of staff and provider satisfaction and better patient experience. These cost savings provide incentive for providers to better meet the needs of their clients as well as policy and budgetary considerations.

The principles are similar in the workers' compensation setting. Higher resources are needed to manage injured workers with more complex claims; therefore, only a small impact is needed to realise potential cost savings for this group.

6. EVALUATION

There is a wide range of tools available to measure person-centred care. These include assessing overarching concepts or specific components, such as shared decision-making or effective communication. Some have been validated in specific settings and others not.

There are three main approaches used to assess person-centred care:[52]

- Surveys or interviews with those experiencing the care services
- Surveys or interviews with those delivering the services
- Observations of encounters between the case manager and client.

The most commonly reported tools for measuring person-centred care are listed in Table 3.

Table 3. Examples of approaches and tools used to measure person-centred care

Concept	Common measurement approaches	Common measurement tools
Holistic person-centred care	• Surveys (professionals, patients) • Interviews (professionals, patients, family) • Focus groups • Observations • Review of records	• Individualised Care Scale • Measure of Processes of Care • Person-centred Assessment Tool • Person-centred Climate Questionnaire
Sub-components of person-centred care		
Patient satisfaction / experience of care	• Surveys (patients, family) • Interviews (patients, family) • Focus groups	• Consumer Assessment of Healthcare Providers and Systems Hospital Survey • Patient Assessment of Chronic Illness Care
Patient engagement / activation	• Surveys (patients, professionals)	• Patient Activation Measure
Empathy / compassion / dignity	• Surveys (patients, professionals) • Interviews • Observations, simulations	• Jefferson Scale of Physician Empathy • Consultation and Relational Empathy Scale
Behaviours supporting person-centred care		
Person-centred communication	• Surveys (patients, family) • Observations	• Wide range of tools (no single common tool) • e.g. Doctor's Interpersonal Communication Survey
Extent to which professionals support self-management	• Surveys (patients, family) • Observations	• Wide range of tools (no single common tool) • e.g. Resources and Support for Chronic Illness Self-management Scale
Shared decision-making	• Surveys (patients, professionals) • Observations	• Decisional Conflict Scale • OPTION Scale

Source: Adapted from de Silva, 2014[52]

6.1 Benchmarking and key performance indicators

No specific benchmarks for best practice person-centred case management in the workers' compensation sector were identified in the literature. However, there are several health care organisations that are recognised as leaders in delivering high-quality, effective person-centred care.[43]

Kaiser Permanente (US)

Kaiser Permanente (KP) is a highly regarded health care managed organisation that has invested not only in the structure of the organisation, but also in the processes that deliver person-centred, integrated care. In particular, KP recognised the importance of creating an organisational culture that recognised the health and wellbeing of the nursing staff responsible for delivering patient-centred care. For example, evidence showed that both nurse and patient outcomes were significantly better in KP hospitals compared with others.[53] Therefore, appropriate investment in the personal and professional wellbeing of those who have direct contact with clients may be advantageous for staff, clients and the organisation itself.

Southcentral Foundation Nuka system of care (Alaska)

The Nuka system of care is an innovative health care system that recognises the unique needs of the First Nations population in Alaska, who are "customer-owners" of the system and control all aspects of the system.[54] The Nuka system has been internationally recognised for its high standards of person-centred care and community engagement in a challenging environment. With a strong focus on shared responsibility and commitment to quality, the key lessons from this approach lie in the development of strong relationships and the overarching principle of wellness.

Jönkoping County (Sweden)

The Jönkoping County Council has a holistic vision that focuses on the overall quality of life of its population, not just on the delivery of care.[55] Jönkoping County is an international leader, with the highest ranking in Sweden for quality indicators related to efficiency, timeliness, safety, patient-centredness, equity and effectiveness.

Although these models are internationally renowned, they operate in systems that differ markedly from the Australian health systems. Therefore, any application of best practice or benchmarking will need to be modified to accommodate the differences.

In addition, one literature review examined ten articles specifically related to benchmarking in person-centred care.[56] The key factors identified as potential benchmarks for assessing person-centred care were:

- Assessment of need
- Provision of person-centred support
- Monitoring of outcomes and progress
- Review of person-centred care
- Involvement of carers (based on care of people with dementia)
- Organisational strategy.

Various key performance indicators were described in the literature and may be used to develop appropriate benchmarks relevant to the workers' compensation sector.

In the health care sector, the Institute of Medicine has prioritised six dimensions of good quality patient-centred care:[52]

- Being respectful to patients' values, preferences and expressed needs
- Being coordinated and integrated
- Providing information, communication and education

- Ensuring physical comfort
- Providing emotional support and relieving fear and anxiety
- Involving family and friends.

The quality of person-centred care is typically measured by determining:

1. **Preferences**: the type of care that patients wanted; the attitudes of values of health care professionals
2. **Experiences**: the extent to which patients perceived that they received patient-centred care
3. **Outcomes**: the impact of patient-centred care (e.g. effective communication and effect on patient experience).

The International Alliance of Patients' Organizations[57] identified and assessed eleven sets of indicators that measure the patient-centredness of organisations. The quality indicators were spread across five principles of patient-centred health care (respect, choice and empowerment, patient involvement in health policy, access and support, information), with most related to access and support areas. Examples of indicators within the five domains are shown in Table 4.

Table 4. Examples of indicators related to five domains of person-centred care

Domain	Examples of indicators of person-centred care
Respect: care approach that respects individual's unique needs, preferences, values, autonomy and independence	• Clients had opportunities to discuss their concerns and preferences • Clients perceived their needs and preferences were considered in care decisions • Clients were treated with dignity, kindness, courtesy, respect • Staff were courteous and respectful
Choice and empowerment: individual has the right to participate to their level of ability and preference; treatment options should fit with patients' needs	• Clients' care was tailored to their needs and preferences • Clients were actively engaged • Clients perceived that treatment options met their needs
Patient involvement in health policy: meaningful and supported engagement with patient and patients' organisations at all levels of decision-making	• Clients actively participated in decisions • Clients were involved in changes to care • Client representatives were included in organisational policies
Access and support: access to safe, quality and appropriate services, treatments; including non-health supports	• Clients experienced coordinated care and interactions between health and social care professionals • Clients experienced appropriate levels of access and support • Staff were accessible when needed
Information: accurate, relevant and comprehensive information is essential to make informed decisions about treatment; presented in appropriate format according to health literacy principles	• Clients understood the information and options related to treatment • Staff were fully trained and knowledgeable

Source: extracted from IAPO, 2012[57]

The Australian Commission on Safety and Quality in Health Care[5] developed seven key attributes of high-performing person-centred health care organisations, which they described as "holistic, interrelated and connected" (Figure 5). For each of these attributes, a number of strategies were outlined to help organisations achieve success in implementing person-centred care.

Figure 5. Seven key attributes of high-performing person-centred health care organisations

The seven attributes are:

1. **Comprehensive care delivery**

   Person-centred values are applied in every interaction with patients, carers and family. Effective communication underpins care and compassion; patients are actively involved in decisions about their care. Care is coordinated across a team, guided by patients' goals and preferences, and with respect and support for diversity and equity.

   - Ensure effective, respectful communication tailored to each patient
   - Ask "What matters to you?"
   - Explain care options and support choices
   - Encourage and support communication about patient's care
   - Enable transparency of care for both compliments and complaints

2. **A clear purpose, strategy and strong leadership**

Leaders at every level champion the importance of person-centred care as an organisational goal, with a clearly stated commitment to both the workforce and the community.

- Lead by example at all organisational levels and set cultural tone
- Recognise and encourage champions of person-centred care to lead and advocate among their peers
- Explicit statements about person-centred care in organisational documents, processes, plans, guidelines and public communication materials
- Measure and communicate outcomes of person-centred care, such as workforce satisfaction, cost reduction, better alignment of care with patient goals

3. **People, capability and a person-centred culture**

A systematic commitment to developing a person-centred culture is supported by comprehensive training and capability development. Workforce wellbeing is prioritised to enable high quality care.

- Recruit individuals with person-centred attributes, including teamwork, empathy, courtesy, communication
- Provide training in communication, shared decision-making, leadership, cultural competency, customer service
- Provide coaching, mentoring and supervision to develop skills
- Monitor workforce satisfaction and wellbeing

4. **Person-centred governance systems**

Consumer involvement is enabled through training and support. Co-design and co-production enable consumer involvement. Management decisions, such as resource allocation, prioritise person-centredness.

- Develop partnerships with patient organisations, patient representatives and families to address quality and safety processes
- Include patient representatives on interview panels, development of patient information, planning and design of services, workforce training
- Pilot test patient information and processes to identify barriers and facilitators to care delivery
- Mentor and support patient representatives with appropriate orientation to their role in the organisation
- Consider the patient experience in financial and resource decisions to ensure patient-centredness is prioritised over technical cost-efficiency

5. **Strong external partnerships**

Strong partnerships are integral to coordinating services according to the needs and preferences of patients, including transitions between care settings.

- Develop connections with organisations that address the social determinants of health and wellbeing (e.g. housing, social services)
- Focus on coordinating appropriate services to improve the patient's care and recovery pathway
- Recognise the role that volunteers may play in enhancing the patient's experience (e.g. transport services, cultural activities)

6. **Person-centred technology and built environments**

Good physical design principles and innovative technology are used to enable a person-centred approach, complementing people, culture and capability.

- Consider aspects of environment design that impact on health and wellbeing (e.g. natural light, outdoor spaces, quiet areas)
- Provide clear access and directions
- Use technology only where it enhances the patient experience or improves care and collaboration

7. **Measurement for improvement**

An organisation-wide culture of continuous improvement focuses on measuring patient outcomes and experiences. 'Measure what matters' to get outcomes that patients value.

- Report on activities and successes; show examples of good outcomes as well as areas that need improvement
- Use data from complaints and compliments to inform improvements
- Celebrate and share successes
- Use evidence of improvement to drive and support change.

From a scoping review of the literature, Santana et al.[58] developed a set of patient-centred quality indicators to measure system performance. Although the indicators were developed for the health care setting, none had been implemented in care settings. The patient-centred framework classified measures into three areas: structure, process and outcome (Table 5).

Table 5. Patient-centred quality indicators for measuring system performance

Type of indicator	Domain	Examples of patient-centred care indicators
Structure	Creating a patient-centred care culture	• An induction program promotes philosophy of care • Clear policies describe how services are offered to patients
	Supporting a workforce committed to patient-centred care	• % staff attending education sessions about patient-centred care (clinical and non-clinical)
Process	Cultivating communication	• % patients with access to digital communication technology • % patients reporting that they received information about their condition • % patients reporting that they were involved in care decisions
	Respectful and compassionate care	• % patients reporting that they were treated with respect and dignity
	Engaging patients in managing their care	• % patients who actively participated in developing their treatment plan • % staff reporting adequate assessment of patients' perceived needs, goals, concerns, choices
	Access to care	• % patients seen by clinician within specified timeframe • % patients who reported that they had sufficient time to address all health-related concerns
Outcome	Patient-reported experiences	• % patients who reported that their provider had all the necessary information about them and their needs • % patients who reported that the provider had all the equipment and resources needed • % patients who reported that the provider was knowledgeable and competent • % patients who rated the provider as very good or excellent

Source: Modified from Santana et al., 2019[58]

7. CHALLENGES AND CONSIDERATIONS

7.1 Challenges

There was no consensus in the literature on the terminology or definitions of person-centred case management related to practice, roles or functions. Given the wide variability in case management across different sectors, the roles and functions are likely to reflect how different organisations perceive case management and how it fits their own culture and purpose.

There was a lack of robust evidence that focused on person-centred case management. While there was an abundance of literature related to the components of person-centred case management, there was a scarcity of evaluations of its effectiveness or impact on outcomes. Hundreds of quality assessment tools have been developed, but few evaluations were identified.

In terms of implementing person-centred case management, several challenges were also identified in the literature. When organisations in different sectors need to come together to provide a coordinated, integrated plan that is in the best interests of the client, there are often competing interests. This may be due to differences in funding structures, size of organisations, focus or availability of resources; or even confusion in the language and understanding of roles and functions.[29] At the injured worker level, their employer plays an important role in RTW decisions. However, greater engagement with the employer throughout the recovery process may not only increase their understanding of the worker's challenges, but also give the employer opportunities to prepare appropriate accommodations and ensure the RTW is fully supported in the workplace.

Identifying organisational priorities may help to guide how the competing interests of others are managed. In addition, implementing a person-centred approach may also be challenging due to the time, effort, training and system reform costs.

For example, Tabbush et al.[19] identified several challenges related to scaling up person-centred case management across organisations in the health care sector, including:

- Traditional paternalistic approach to patient-physician communication and decision-making
- Heavy physician workload
- Lack of appropriate indicators i.e. few health metrics to guide care compared with traditional quality of life measures
- Provider concerns for risk and safety when the patient and physician disagree on the course of care
- Inconsistent terminology regarding key aspects of person-centred approach (e.g. person- versus patient-centred, case management versus care coordination)
- Lack of payment structures compatible across health care and community-based organisations
- Lack of comprehensive electronic health records across multiple providers
- Lack of strong, prevailing leadership to champion person-centred care efforts
- Misaligned incentives regarding cost assumption and receipt of savings.

The Picker Institute[6] identified the need to recruit and train adequate staff to implement a person-centred approach as an important challenge for organisations. Despite some evidence of better outcomes and improved cost-effectiveness associated with the person-centred approach, existing economic restraints in the organisation may be a barrier to shifting to a different model.

More broadly, the Australian Commission on Safety and Quality in Health Care[5] identified aspects of the Australian health care system that may be potential barriers for organisations aiming to achieve person-centred care, including:

- **System fragmentation**: Funding and regulatory separation of elements in the health care system, including primary health care (Commonwealth government) and hospital systems (State/Territory governments). This fragmentation may make it more difficult for case managers to coordinate services and establish continuity of care for their clients.
- **Focus on hospital care**: Higher investment in hospital funding compared with other parts of health care (e.g. primary health care, preventive health). This may limit access to various non-acute services, which are the mainstay of rehabilitation for injured workers.
- **Public-private health care systems**: Australia's mixed model of care adds complexity to negotiating health care systems. Case managers need a comprehensive understanding of the differences in the public and private health care systems due to the overall lack of integrated care and limited compatible communication systems between them.
- **Output-based funding models**: The current transactional model is organised around specific items related to diseases or procedures (i.e. Medicare), rather than the needs of the patient. Case managers need a good understanding of how costs of health care services are reimbursed through Medicare so that clients are aware of potential out-of-pocket costs.

7.2 Considerations

While there are many published best practices on person-centred care across a variety of disciplines (especially disability and healthcare), there is a lack of publicly-available literature in person-centred case management for worker's compensation. Based on the available literature, several issues may need to be considered in the design and implementation of a person-centred case management model in the workers' compensation setting:

- **Leadership and champions**: Systematic integration of the principles of person-centred case management at the organisational level increases adoption. Champions who are committed to the model, and work at different organisational levels, are needed to drive the transition and to embed the model into systems and practices.
- **Variability in 'best practice' models**: A bespoke framework that is tailored to the workers' compensation setting may be needed to achieve best practice. Borrowing from existing frameworks that have been developed in other settings is useful, but it is important to consider the unique characteristics of the workers' compensation context In Victoria.
- **Targeted performance indicators**: An appropriate set of performance indicators that target the compensation sector may be needed. Like the model, these can be borrowed from other areas, but modified so that they 'measure what matters'. This includes monitoring the processes as well as the impact of changes on both the workforce and the clients' outcomes and experiences.
- **Change management**: Transitioning to a new model needs to consider the stages of change that impact on the workforce, ensuring all staff are engaged and that their concerns about changes that impact on them are addressed.
- **Standardised competencies**: To get consistency across organisations, case managers may benefit from a standardised training program that targets core competencies and also provides an appropriate career path that recognises the higher level of knowledge and skills needed.

8. REFERENCES

1. Victoria State Government. Human-centred design playbook. Melbourne: Victoria State Government, 2020 Contract No.: version 1.4.
2. Starfield B. Is patient-centered care the same as person-focused care? Permanente J. 2011;15(2):63.
3. CMSA. Case management definitions Queensland: Case Management Society of Australia & New Zealand; 2021 [cited 2021 June]. Available from: https://www.cmsa.org.au/about-us/definitions-of-case-management.
4. Department of Health and Human Services. Client voice framework for community services. Melbourne: 2019.
5. ACSQHC. Review of the key attributes of high-performing person-centred healthcare organisations. Sydney: Australian Commission on Safety and Quality in Health Care, 2018.
6. Paparella G. Person-centred care in Europe: A cross-country comparison of health system performance, strategies and structures. England: Picker Institute Europe, 2015.
7. National Mental Health Consumer & Carer Forum. Person centred approaches to care and support. 2016.
8. NSW Department of Ageing Disability and Home Care. Exploring and implementing person centred approaches: A guide for NSW community participation program service providers. 2009.
9. National Disability Practitioners. Factsheet: What is a person centred approach? 2016.
10. NDSS Diabetes Australia. Person centred care for people with diabetes. 2015.
11. John Howard Society of Ontario. Client-centered case management: Benefits and outcomes of individualized care. 2012.
12. NDA. Guidelines on person-centred planning Ireland: National Disability Authority; 2014 [cited 2021 June]. Available from: http://nda.ie/good-practice/guidelines/guidelines-on-person-centered-planning/.
13. Life Without Barriers. Person-centred practice approach. Newcastle: Life Without Barriers, 2015 Contract No.: Submission 148.
14. The Centre of Research Policy & Program Development. Effective, Just and Humane: A case for client-centered collaboration. John Howard Society of Ontario, 2012.
15. Safe Work Australia. Taking action: A best practice framework for the management of psychological claims in the Austrlalian workers' compensation sector. Canberra: Safe Work Australia and Superfriend, 2018.
16. WSV. Recovery Model Office (RMO) Quarter three update. Melbourne: WorkSafe Victoria; 2021.
17. Mission Australia. National case management approach. Mission Australia, 2020.
18. Bywood P, Arora R, McMillan J. Triage project. Data elements for triaging workers' compensation claims. Melbourne: Institute for Saftey, Compensation and Recovery Research, 2019 June. Report No.: Environmental Scan 238.
19. Tabbush V, Kogan A, Mosqueda L, Kominski G. Person-centered care: The business case. SCAN Foundation, 2016.
20. Homelessness Strategy Division. Case management framework: Specialist homelessness and domestic and Aboriginal family violence services. SA: Housing SA, Department for Communities and Social Inclusion, 2013.
21. Gridley K, Brooks J, Glendinning C. Good practice in social care for disabled adults and older people with severe and complex needs: evidence from a scoping review. Health Soc Care Community. 2014;22(3):234-48.
22. Lion KC, Mangione-Smith R, Britto MT. Individualized plans of care to improve outcomes among children and adults with chronic illness: A systematic review. Care Manag J. 2014;15(1):11-25.
23. Reeves A. An introduction to counselling psychotherapy. From theory to practice. 2nd ed. Oaks CA: Sage; 2018.

24. Josefowitz N, Myran D. Towards a person-centred cognitive behaviour therapy. Couns Psychol Q. 2005;18(4):329-36.
25. Waters RA, Buchanan A. An exploration of person-centred concepts in human services: A thematic analysis of the literature. Health Policy. 2017;121(10):1031-9.
26. Australian Association of Social Workers. Scope of Social Work Practice: Case management and care coordination. Melbourne: 2015.
27. European Centre for Social Welfare Policy and Research. Integrated case management of employment and social welfare users in the Western Balkans - Guidelines and Good Practices. 2018.
28. Ferguson H. How social workers reflect in action and when and why they don't: The possibilities and limits to reflective practice in social work. Soc Work Educ. 2018;37(4):415-27.
29. Department for Communities and Social Inclusion (SA). Case Management Framework: Specialist homelessness and domestic and Aboriginal family violence services. 2013.
30. McCormack B, Dewing J, McCance T. Developing person-centred care: Addressing contextual challenges through practice development Wollongong: University of Wollongong; 2011 [cited 2021 June]. Available from: https://ro.uow.edu.au/smhpapers/2471/.
31. Manley K, Hills V, Marriot S. Person-centred care: principle of nursing practice D. Nurs Stand. 2011;25(31):35-8.
32. O'Halloran PD, Blackstock F, Shields N, Holland A, Iles R, Kingsley M, et al. Motivational interviewing to increase physical activity in people with chronic health conditions: A systematic review and meta-analysis. Cliln Rehabil. 2014;28(12):1159-71.
33. Treiger T, Fink-Samnick E. COLLABORATE(C): A universal competency-based paradigm for professional case management, Part III: Key considerations for making the paradigm shift. Prof Case Manag. 2014;19(1):4-15.
34. Iles R, Collie A. Psychological injury claims project, Synthesis report. Melbourne: Monash Insurance Work and Health Group, Monash University, 2021.
35. iCare NSW. Case management expectations Sydney: iCare; 2020 [cited 2021 June]. Available from: https://www.icare.nsw.gov.au/practitioners-and-providers/forms-and-resources/lifetime-care.
36. Dore J. Independent reviewer report on the Nominal Insurer of the NSW workers compensation scheme. NSW: State Insurance Regulatory Authority, 2019 December. Report No.
37. The Health Foundation. Person-centred care made simple: What everyone should know about person-centred care. 2016.
38. Center for Excellence in Assisted Living. Perseon-centered care in assisted living: An informational guide. 2010.
39. Farkas J. Person-centered planning: Pathways to your future – a toolkit for anyone interested in person-centered planning. Tucson: University of Arizona, Sonoran UCEDD, 2015.
40. iCare. Claims management decision framework NSW: iCare; 2020 [cited 2021 June]. Available from: https://www.icare.nsw.gov.au/employers/make-a-claim/claims-management-decision-framework#gref.
41. Young M. Person-centred case management tool improves discharge. Hosp Case Manag. 2020;April 1.
42. Leiva R, Rochaix L, Kiefer N, Dupont J-CK. Evaluating the impact of intensive case management for severe vocational injuries on work incapacity and costs. J Occup Rehabil. 2021:1-15.
43. Farmanova E, Baker GR, Cohen D. Combining integration of care and a population health approach: A scoping review of redesign strategies and interventions, and their impact. Int J Integr Care. 2019;19(2).
44. Hudon C, Chouinard M-C, Pluye P, El Sherif R, Bush PL, Rihoux B, et al. Characteristics of case management in primary care associated with positive outcomes for frequent users of health care: A systematic review. Ann Fam Med. 2019;17(5):448.
45. Luthi F, Deriaz O, Vuistiner P, Burrus C, Hilfiker R. Predicting non return to work after orthopaedic trauma: The Wallis Occupational Rehabilitation RisK (WORRK) model. PloS one. 2014;9(4):e94268.

46. Leembruggen M, Pejic D. Victorian Injured Worker Outcomes Study (VIWOS). Phases 1-3 summary report. Melbourne: Institute for Safety, Compensation and Recovery Research, 2018.
47. iCare NSW. Working with a lifetime care case manager NSW: iCare; 2020 [cited 2021 June]. Available from: https://www.icare.nsw.gov.au/injured-or-ill-people/motor-accident-injuries/case-managers/working-with-a-case-manager.
48. Treiger TM. Shared decision-making: A new frontier for case management leadership. Prof Case Manag. 2020;25(2):56-76.
49. Hutson M, Dunning T. Using new methods of communication to improve outcomes in workers' compensation case management. Prof Case Manag. 2020;25(3):179-83.
50. MindTools. Bridges' transition model. Guiding people through change. Available from: https://www.mindtools.com/pages/article/bridges-transition-model.htm.
51. Casey P, Cameron I. Principles of best practice in occupational rehabilitation for AIA Australia. Sydney: AIA Australia, 2014.
52. de Silva D. Helping measure person-centred care. A review of evidence about commonly used approaches and tools used to help measure person-centred care. London: The Health Foundation, 2014.
53. McHugh MD, Aiken LH, Eckenhoff ME, Burns LR. Achieving Kaiser Permanente quality. Health Care Manag Rev. 2016;41(3):178.
54. Gottlieb K. The Nuka System of Care: Improving health through ownership and relationships. Int J Circumpolar Health. 2013;72(1):21118.
55. Baker G. The roles of leaders in high-performing health care systems. London: The King's Fund, 2011.
56. Dow B, Haralambous B, Bremnerand F, Fearn M. What is person-centred health care? A literature review. Melbourne: Victorian Government Department of Human Services. Melbourne: Victorian Government Department of Human Services; 2006.
57. IAPO. Patient-centred healthcre indicators review. UK: International Alliance of Patients' Organizations, 2012.
58. Santana M-J, Ahmed S, Lorenzetti D, Jolley RJ, Manalili K, Zelinsky S, et al. Measuring patient-centred system performance: A scoping review of patient-centred care quality indicators. BMJ Open. 2019;9(1):e023596.