

Cúram 8.1.3

Outcome Management Guide

Note

Before using this information and the product it supports, read the information in [Notices on page 49](#)

Edition

This edition applies to Cúram 8.1, 8.1.1, 8.1.2, and 8.1.3.

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1 Outcome Management Guide

Outcome Management provides client-centric service delivery that focuses on the results a client is trying to achieve rather than focusing only on the services available. It allows agencies to use the expertise of individuals and organizations to best help clients.

Purpose

The following pages provide an overview of Outcome Management and outlines a basic understanding of how outcome management is used to identify and to address clients' needs to help achieve positive client outcomes.

Audience

The target audience is any reader that is interested in understanding the business concepts of Outcome Management. Knowledge of the application is not required.

Prerequisites

You must be familiar with the basic concepts of Cúram, particularly with how the agency plans and delivers services to clients. For more information, see the *Integrated Case Management Guide* and *Provider Management Guide*.

Key concepts

The following four points highlight the key concepts in the Outcome Management Guide:

- The goal of outcome management is to help clients and families achieve positive outcomes. To meet this goal, agencies must identify the root cause of clients needs and then address these needs through ongoing assessment and planning.
- Outcome Management supports this goal by providing assessment and planning tools that are used to identify client needs and to build plans of activities to address identified needs. These plans are built in collaboration with the client and with multidisciplinary teams who can provide expertise in a wide variety of disciplines.
- Activities must be monitored and managed to ensure that they are of high quality and that client expectations are being met.
- Positive outcomes are achieved through the constant monitoring of clients progress that uses reassessments, reviews, progress recording, and reports.

1.1 Understanding Outcome Management

Outcome management is a client-centric approach to service delivery that focuses on the results a client is trying to achieve rather than focusing only on the services available. A collaborative

approach is encouraged that allows agencies to utilize the expertise of individuals within the agency and outside of it.

What Is Outcome Management?

Traditional approaches in outcome management meant that clients did not receive the right help at the right time and, therefore, clients remain dependent on the agency for a longer time. Additionally, agencies work in silos and may not always have the necessary expertise to accurately identify clients' needs. For example, asking parents who don't have drivers' licenses and/or live in rural areas to attend parenting classes; not allowing adequate time for a parent to complete substance abuse treatment before re-entering the workplace; asking parents to attend parenting classes when lack of housing or transportation is the real problem.

Outcome management is most successful if planning is performed in a collaborative manner with an end result in mind. Planning begins with a clear understanding of a client's needs and the specific changes that are sought by clients. This will enable a planner to identify critical steps or objectives that clients need to take in order to achieve the specific change in behaviour, knowledge, skills, condition or status.

Outcome management focuses on and tracks a client's progress over time and looks at the effectiveness of service delivery through the achievement of client successes/changes as outcomes. It is a client-centric model, which puts the needs of the clients first.

Why Is Outcome Management Important?

The objective of outcome management is to enable an agency to achieve better outcomes for clients by identifying their real needs and addressing these needs with appropriate service delivery. This will in turn lead to cost reductions for the agency as the clients may no longer be dependent on the agency for support. Outcome Management also enables an agency to focus on the results the organization is trying to achieve, for example, the number of clients achieving Self Sufficiency is to increase by 15 percent in the following year. The ability of the agency to state clearly and simply the results of the clients enables the agency to potentially generate additional funds if necessary.

How Does Outcome Management Support This?

Outcome Management provides a structured approach to achieving positive outcomes for clients. It provides the tools necessary to identify clients' needs, to plan activities to address these needs and to monitor a client's progress over time to ensure these needs are being met. All aspects of outcome management can be managed within an outcome plan. This includes:

- The ability to configure and run different types of assessments to identify the root cause of a client's issues and needs. For example, caregiver strengths and needs assessments, self sufficiency assessments, and safety assessments.
- The assignment of a multidisciplinary team and provision of collaboration tools such as discussion boards and support for scheduling meetings and recording meeting minutes which enable persons to work collectively to help clients. A governance model is provided which

enables the sharing of certain information with a multidisciplinary team member via the MDT Portal.

- Based on needs identified, goals and objectives can be defined for a client which will help the client to focus on positive results during the planning process.
- Activities can be added to the outcome plan to address the needs identified. System recommendations based on assessment results are provided to help a case worker to identify the most appropriate activities for a client.
- Tools are provided which allow the client's progress to be regularly monitored over time to ensure their needs are being met by performing reassessments, reviews and recording progress.
- The ability to continuously improve the plan to assist clients in working toward their objectives and the ultimate goal of the outcome plan.

1.2 Configuring Outcome Management

Outcome Management can be used for the definition of assessments that are run to identify client needs. To address these needs, outcome plans can also be defined for the identification of clients' goals and objectives, and the scheduling and management of activities that help the client to achieve these goals and objectives.

Outcome Management is highly configurable. For more information about the configuration options for Outcome Management, see the *Outcome Management Configuration Guide*.

Configuring Assessments

Outcome Management allows agencies to define assessments. When assessments are defined, assessments can be run in order to identify and determine the severity of a client's needs.

There are five main aspects to configuring an assessment:

- configuring the assessment type
- configuring roles
- configuring sets of factors across which clients and their families are assessed
- categorizing and classifying factors according to their type
- configuring the possible results that can be achieved when a factor is assessed

The figure below shows an example of the structure of an assessment and the classifications of factors within that assessment. Each element of the assessment is described in more detail in this section.

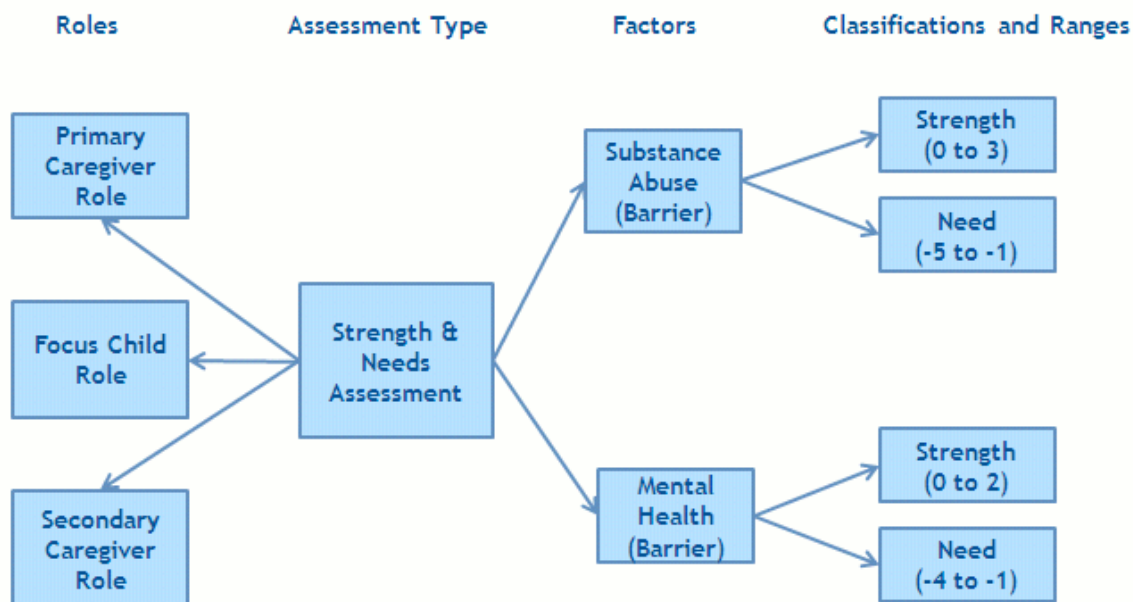


Figure 1: Assessment Structure

Configuring Assessment Types

Outcome Management provides the ability for agencies to configure and run multiple types of assessment to identify client needs. An assessment definition is a type of assessment which can be used by an agency to develop different assessments, for example, Caregiver Strength and Needs Assessment, Safety Assessment, Child Strength and Needs Assessment, and Self Sufficiency Assessments.

A configuration setting that shapes the way the assessment data is collected and the assessment results are determined is specified for each assessment definition. Intelligent Evidence Gathering (IEG) is used to collect data in the form of a question script and Cúram Decision Assist (CDA) or a Cúram Eligibility (CER) rule set can be used to determine the assessment results.

There are several other configuration settings such as whether the setting of priority factors is applicable to an assessment, whether reassessment is allowed and various settings that govern how the assessment results are displayed. The administrator can also specify whether the assessment is used to assess a group or household of clients or to assess clients individually. Assessing a group of clients means that questions are asked once and apply to the entire group

and a result is displayed for the group. Assessing clients individually means that questions are asked of each client (if there is more than one client being assessed) and a result is displayed for each client.

Configuring Assessment Roles

An assessment role identifies the part a client plays in an assessment, for example, a Caregiver Strength and Needs Assessment has roles of primary caregiver, secondary caregiver and focus child. Roles must be defined for an assessment definition and the client(s) satisfying those roles must be selected when running an assessment.

Configuring Assessment Factors

Agencies can define factors across which clients or groups of clients are assessed when a particular type of assessment is run. Client needs are assessed using factors. Typically a factor is considered either a need or a barrier. Needs are things that a client or family require to be self-sustaining but currently lack. Barriers are conditions that prevent or complicates a client's ability to obtain or achieve something. The administrator can specify whether the factor is involved in planning and not just used to record results so that objectives and activities can be associated to the factor. Examples of assessment factors include shelter, parenting skills, and substance abuse. Agencies typically assess clients and/or families to measure their current situation in relation to one or more factors.

Categorizing and Classifying Assessment Factors

Once the assessment factors that are applicable to an assessment are defined, they are categorized. At least one category must be specified for an assessment definition. Examples of assessment categories include need and barrier. Categorizing assessment factors effectively groups the factors that are applicable to the assessment by type. Each assessment category defines the type of factors that are applicable to an assessment. For example, housing, education, and shelter factors may be factors of type "need". Substance abuse and domestic violence may be considered factors of type "barrier". An assessment can consist of both need factors and barrier factors.

Factors are categorized in order to distinguish between the different types of factors that are included in each assessment and also to define the results that can be achieved by each client or group of clients when assessed for a particular factor. Each assessment has a set of factors which describe acceptable performance standards or range of results for that assessment. For example, a client assessed for the shelter factor may achieve one of the following results: In crisis, at risk, stable, or self sufficient. The range of results is used to measure a client or group's functioning in that factor. The range of results that can be achieved for each factor that is assessed are defined in application administration as classifications.

Barrier factors may be classified differently to need factors. For example, a client who is assessed for the need factor of housing may be classified as safe, progressing, engaged and vulnerable, whereas a client assessed for a barrier factor of substance abuse may be classified as need and strength.

Classifications must be specified for each category. All factors must fall into a particular category and all classifications defined for that category are applicable to all factors belonging to it. So, at the factor level it is not possible to enter different classifications.

An administrator can however apply different ranges to each classification across different factors. For example, substance abuse (barrier) can be classified as need (-5 to -1) and strength (0 to 3). Mental health (barrier) can be classified as need (-4 to -1) and strength (0 to 2) i.e. different ranges can be applied to each classification of a factor.

The figure below shows an example of the structure of an assessment and the categorization and classifications of factors within that assessment.

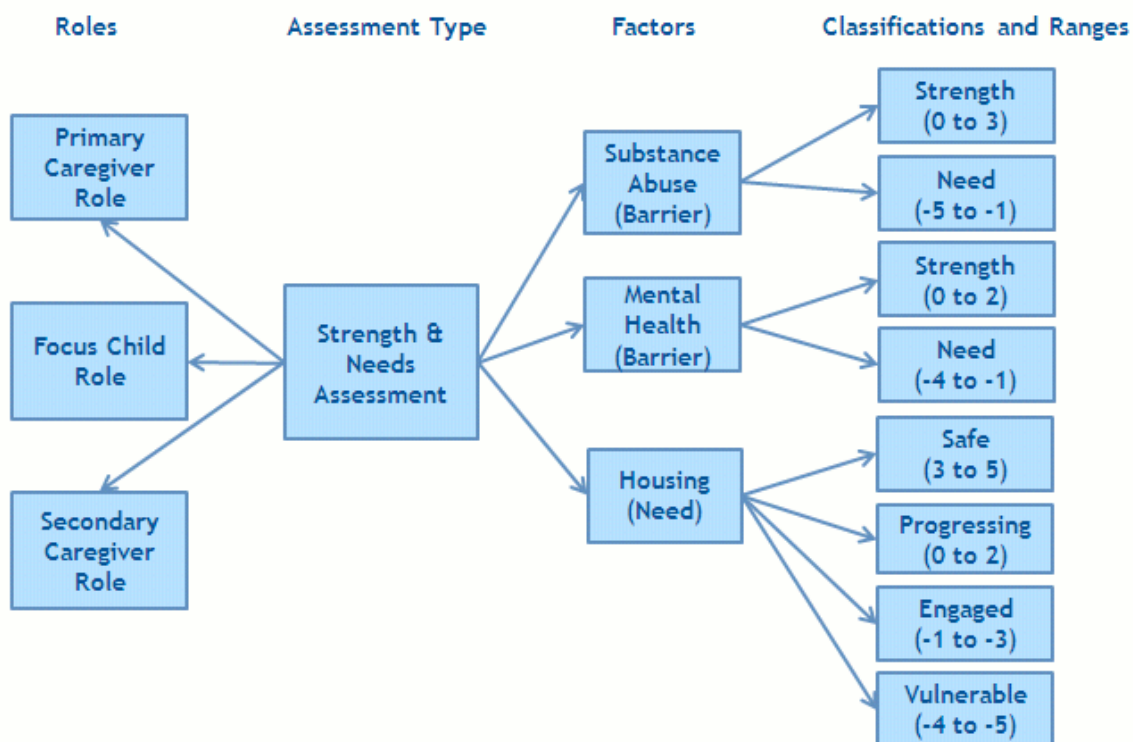


Figure 2: Assessment With Multiple Categories and Classifications

If some of the classifications associated with the category are not applicable for a factor, then the administrator should not specify ranges for that classification so that they are not displayed in any assessment results.

Configuring Outcome Plans

Outcome Management allows agencies to define different types of outcome plans. When outcome plans are defined, plans can be created to identify and address client needs.

There are a number of aspects to configuring an outcome plan:

- configuring outcome plan types
- configuring outcome plan goals
- configuring outcome plan objectives
- configuring outcome plan factors
- configuring multidisciplinary teams and members
- configuring visits
- configuring printable document content

The figure below shows an example of the structure of an outcome plan. Each of these elements are described in more detail in this section.

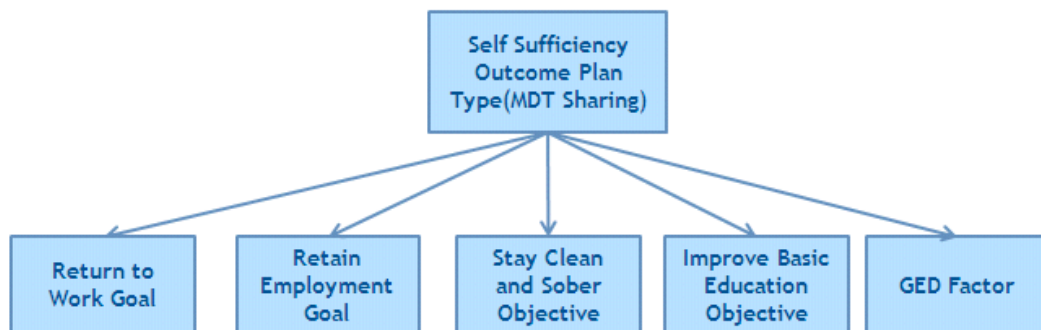


Figure 3: Outcome Plan Structure

Configuring Outcome Plan Types

Outcome Management provides the ability for agencies to configure multiple types of outcome plans which can be used to address a client(s) needs. For example, a Self Sufficiency plan can be defined to help a client return to work. A Reunification Plan can be defined to reunite a family who, for example, have been separated because of substance abuse issues in the home.

Each outcome plan type can define its own set of goals, objectives and factors such that only the appropriate goals, objectives and factors can be selected when that type of outcome plan is created for a client. For example, a goal of Return to Work could be associated with a Self Sufficiency outcome plan whereas a Return Home goal would be associated with a Reunification Plan.

Associating Evidence

One or more evidence types can be associated with a type of outcome plan. If an Evidence Type is added to the outcome plan, an Evidence tab is then present on that Outcome Plan when that outcome plan is created for a client. The configured Evidence Type can then be added to the client's outcome plan. If an Evidence Type is not added for a configured outcome plan, the Evidence tab is not present when the outcome plan is created for a client.

Configuring Outcome Plan Goals

Goals can be defined by an administrator and then shared across multiple types of outcome plans. Goals can then be added to an outcome plan by a case worker.

An overall goal can be specified for an outcome plan or a goal can be specified for each client on an outcome plan. Each outcome plan is created to assist a client in achieving a goal. For example, a Self Sufficiency plan is created to achieve the goal of returning to work. The goal is the primary objective that a client is working towards to become independent of the agency.

Configuring Outcome Plan Objectives

Objectives can be defined by an administrator and can be shared across multiple types of outcome plans. Objectives are smaller steps that can be undertaken by a client in order to achieve the outcome plan goal, for example, the objectives for a client on a Back to Work outcome plan may be to 'Improve Basic Education' or to 'Stay Clean and Sober'. Objectives can then be added to an outcome plan by a case worker.

Configuring Outcome Plan Factors

Clients are often assessed by running an assessment which contains multiple factors as described in [Configuring Assessment Factors on page 13](#). However, there are some instances where a client is assessed for a factor but this does not form part of an assessment with other factors. For example, General Education Diploma (GED) assessments are often out sourced to third party providers. The third party provider sends the result of the assessment back to the agency. The result can then be recorded by the case worker.

Unlike factors described earlier, a question script is not needed since the agency will not be asking the questions of the client. As a result of this, neither a CER rule set or CDA Matrix is required. Only categories and classifications must be defined for each factor which will allow the case worker to record the appropriate result for the assessment of the factor.

Outcome plan factors can be defined by an administrator and can be shared across multiple types of outcome plans. The administrator can specify whether the factor is involved in planning and not just used to record results so that objectives and activities can be associated to the factor.

Configuring Multidisciplinary Teams

Configuration settings exist that dictate if a multidisciplinary team can be assigned to a type of outcome plan. Configuration settings also exist to dictate the information that can be shared with a multidisciplinary team member, for example, an administrator can dictate that all individuals that fill a role of police officer can have access to notes if a case worker deems it necessary.

If an outcome plan is configured to allow for collaboration with a multidisciplinary team, this allows for the assignment of a multidisciplinary team to an outcome plan which will enable

collaboration between the case worker and individuals representing various disciplines within the team. Assigning a multidisciplinary team to an outcome plan will provide a multidisciplinary team access to a client's outcome plan via the Multidisciplinary Team Portal.

For more information on multidisciplinary teams, see the *Social Enterprise Collaboration Guide*.

Configuring Visits

Configuration settings exist that dictate if visitation plans are applicable to a particular type of outcome plan. Visitation plans allow a caseworker to specify and describe planned interactions that occur between individuals. For example, for Child Welfare, visitation plans describe the interactions between the child in out-of-home placement and family members (parents or relatives) or other participants. If visits are configured for an outcome plan, visitation plans and visitation logs can be created on the outcome plan. The caseworker can also evaluate visits as part of a review.

Configuring Printable Document Content

Outcome Management provides the ability to generate reports from an outcome plan. The caseworker can decide what content items should be included in the report, the list of content items which are available for selection by the caseworker are configurable for an outcome plan type. Examples of document content items include goals, objectives, assessments.

Associating Assessments with Outcome Plans and Cases

To enable an agency worker to create an assessment on a case or outcome plan, the case or outcome plan must be associated with the assessment.

For example, an administrator can define that a Caregiver Strength and Needs Assessment can only be run from a Reunification outcome plan. An administrator can also configure whether an assessment can be run from a review within an outcome plan, from the outcome plan itself or from both.

Configuring Outcome Management Activities

Activities are defined by an administrator and can then be added to an outcome plan by a caseworker.

Activities do not have to be associated with a type of outcome plan in administration before they can be added to a client's outcome plan. Activities are added to an outcome plan to address the issues or needs identified during assessment, for example, Alcohol Abuse Counseling can be added to a plan to address issues with substance abuse; Basic Job Skills Training can be added to a plan to address issues with finding employment.

There are *three* types of activities that can be defined and subsequently added to a plan - services, referrals and actions.

Configuring Services

Services must be defined in the Provider Management (CPM) services registry before they can be added to an outcome plan. A service is an activity which is provided directly to a client by

the agency or provided by a third party provider but paid for and tracked by the agency. For example, Alcohol/Drug Abuse Day Treatment may be provided by a third party provider; Mileage reimbursement may be provided directly by the agency.

A service can be configured to use product delivery processing to manage services delivered by the agency which will allow for eligibility checking and optional integration with CPM service authorization and invoice processing. Payments can be issued to the client or to the provider in respect of the service. Alternatively a service can be configured to use service delivery processing only which utilizes CPM service authorization and provider payment processing.

A number of other configuration options exist on the service offering which are used to define the information that can be specified when creating the service, such as whether a provider/provider type is mandatory or optional when creating a service, whether the service is appropriate for multiple clients, whether the case worker can specify the frequency of service, whether participation tracking is required, and whether the case worker can specify the rate to be paid to a provider for providing this service.

For more information about configuring services, see the *Provider Management Guide*.

Configuring Referrals

Referral services must be defined in the CPM services registry before they can be added to an outcome plan. A referral is a service which is provided to a client by a third party provider but not paid for by the agency, for example, Physiotherapy sessions.

Referrals allow for notifications to be sent to the client being referred and the provider who will be providing the service. A number of configuration options exist on the service offering which are used to define the information that can be specified when creating the service such as whether the referral service is appropriate for multiple clients and notification templates which can be used to produce the referral notifications sent to the client and the provider.

For more information about configuring referrals, see the *Provider Management Configuration Guide*.

Configuring Actions

Actions must be defined in outcome management administration before they can be added to an outcome plan. An action is an activity which can be added to an outcome plan which is not deemed a service or a referral, for example, Take Daily Exercise, Join a Basketball Team.

A number of configuration options exist on the action which dictate the information that can be specified when adding an action to an outcome plan such as whether the action is appropriate for multiple clients, whether there is a cost associated with the action, whether participation tracking is required and whether the client or the case worker should be responsible for the action.

A Rename Allowed Indicator allows a different action name to that defined in administration to be specified when a worker is adding an action to an outcome plan.

Evidence

Evidence can be added to an action on an outcome plan once an evidence type is associated with an action. An administrator can specify whether the evidence type is read only and also whether

the evidence is stored against the person or the outcome plan. A preview panel and home page can also be configured.

Configuring Recommended Objectives and Activities

Objectives and activities can be automatically recommended by the system. Recommended objectives and activities are displayed in the workspace in the outcome plan where they can then be added to the outcome plan by the caseworker.

Recommendations are defined such that an objective or activity is recommended when a particular type of outcome plan is created. For example, a Job Search activity can be recommended when a Self Sufficiency outcome plan is created. Recommendations can also be defined for factor classifications such that the activity is recommended when a client achieves a particular factor classification or score when assessed. For example, an Alcohol Abuse Counseling activity can be recommended when a client is assessed for Substance Abuse and is classified a Need.

Recommendations can be further broken down so that certain activities are recommended for a specific classification score, or a portion of the range for that score.

Conditions can also be defined which filter recommended objectives and activities. A condition can use a rule set, an assessment question and answer, client age and/or gender to filter recommendations. For example, a condition can be defined which will only recommend Adolescent Substance Abuse Treatment if the client is between the ages of 16 and 18.

Recommendations that are generated for an outcome plan when the plan is created are stored and displayed to the case worker each time the workspace is accessed. They are then regenerated at various points in the life cycle of an outcome plan, for example during assessment execution or the addition of a new client.

If changes are made to the configuration of recommendations that may have contributed to the creation of recommended objectives or activities within an outcome plan, the date and time of the update is captured and used by related outcome plans to determine when plan recommendations may have been invalidated by administrative changes.

If any previously generated recommendations have become invalidated by an administrative change, the recommendation is then no longer displayed in the outcome plan to the case worker.

1.3 Building an Outcome Plan to Achieve Positive Outcomes

Outcome Management plays an essential role in assisting a client to achieve their goal. You can use the features of Outcome Management to construct an outcome plan to identify and address client needs.

The first step in the process is to create a plan and to identify and prioritize the issues and needs of a client. Prioritization of needs allows the real problems to be addressed first. Based on the needs identified, the client or clients and the caseworker can work together to define a set of achievable goals and objectives. Appropriate activities can then be identified and scheduled in collaboration with a multidisciplinary team to achieve the goals and objectives and to ultimately

achieve a positive outcome for the client. For some outcome plans, visitation plans are an important aspect of the plan. The caseworker can create a visitation plan to specify the planned interactions that occur between clients and visitors.

The following seven steps is a summary of the process.

Note: The following steps are an example process flow. When a plan is created, the steps can be performed in any order.

1. Create a plan.
2. Identify and prioritize needs.
3. Assign MDT.
4. Identify goals and objectives.
5. Schedule activities.
6. Issue agreement.
7. Develop a visitation plan period.

Creating An Outcome Plan For Clients

An outcome plan can be created by a case worker in a number of ways. It can be created from an integrated case, it can be created outside of a case or it can be created automatically by the system.

When creating an outcome plan outside a case, the Citizen Context Viewer (CCV) is provided which allows a case worker to search for a client and to drag and drop the client, their cases and family members from the CCV into the outcome plan. For more information about the CCV, see the *Citizen Context Viewer Overview Guide*.

In certain circumstances an agency may choose to have the system automatically create an outcome plan. For example, when an income support case is created for a client, an agency may choose to automatically create a self sufficiency outcome plan which will be used to help the client return to work and become independent of the organization.

When creating an outcome plan from an integrated case, all members of that integrated case are available for addition to the outcome plan. The integrated case is then automatically related to the outcome plan.

Ownership of an outcome plan is assigned to the case worker creating the outcome plan. An agency can also specify their own default ownership strategy. An ownership assignment strategy can be defined in outcome plan administration which can be used instead of the default ownership strategy provided by Cúram. Standard Cúram supervisor assignment functionality is used to assign a supervisor to an outcome plan. Outcome Management provides the ability to view or maintain the plan owner and plan supervisor at any point in time.

Evidence can be added to an outcome plan to record more detailed information on the client. For more information about recording evidence, see the *Evidence Guide*.

Running An Assessment To Identify Client Needs

Cúram integrates assessments into the planning process. Assessments are crucial to identifying a client's strength and needs taking their health and social context into consideration so that workers can respond appropriately.

Workers can benefit from tools that can help to make accurate and reliable assessments of client circumstances. They can use the assessment infrastructure to run predefined assessments to help them in making effective decisions.

Creating An Assessment

In order to run an assessment, the assessment must first be created on the system. Assessments can be created from an outcome plan (and/or from a review within an outcome plan) or any type of case. Only members of the case or plan from which the assessment is created can be included in the assessment. For example, if James Smith and Linda Smith are members of a Self Sufficiency outcome plan, only James and Linda Smith are available when an assessment is created for that plan. When creating an assessment, an assessment can be selected from a list of predefined assessments for that outcome plan. The name of the assessment reflects the type of assessment that the case worker wishes to run. For example, Caregiver Strengths and Needs Assessment, Risk Assessment, Safety Assessment.

Once an assessment has been selected, the clients to be included in the assessment and the roles they fulfill on the assessment are specified. For example, in a Caregiver Strength and Needs Assessment, James Smith may play a role of primary caregiver. Linda Smith may play a role of secondary caregiver.

The roles that are available for selection when the assessment is created are defined as part of application administration. An administrator can specify whether one or more clients can fill a role on an assessment. For example, in the Caregiver Strength and Needs Assessment only one child can fill the role of focus child. If only one client is being assessed, and one role has been configured for that assessment, the client and role will be defaulted during assessment creation i.e. a case worker will not have to select a role.

Completing Assessment Questionnaires

Once the clients and roles have been selected for the assessment, the second step in running the assessment is to capture information about the client's situation. The information is captured using a predefined question script that are specific to the type of assessment being run. The question scripts are created using IEG. With IEG, information is gathered interactively by displaying a script of questions that a case worker can provide answers to.

Depending on how the assessment has been configured, questions can be asked of all clients being assessed or a subset of clients. For example, in the Caregiver Strength and Needs Assessment questions are asked of the primary caregiver and the secondary caregiver but not of the focus child. Additionally an assessment may be configured to assess a group of clients and as such one set of questions is asked of the entire group, for example, a Risk Assessment assesses a group of clients.

A Strength and Needs assessment may be used to determine a client's strengths and needs across one or more factors. Answers are recorded for the client across a number of factors such as

mental health, housing situation, social support system. Help text may be configured for the assessment questions and is then available from the IEG script for each question by expanding the Help icons.

The assessment is executed when all of the questions have been answered. When all of the answers have been completed, clicking the Next button executes the assessment.

The assessment answers are then applied to either a CDA decision matrix or a CER rule set to produce a set of assessment results. The decision to use either CDA or CER to determine the results depends on the complexity of the assessment.

For more information on choosing CDA or CER to determine the assessment results, .

Deriving Assessment Results

Assessment results are derived based on how the factors within the assessment have been defined in the administration application. For example, a client being assessed for substance abuse can be classified as either Need (-5 to -3) or Strength (0 to 3). To derive this, a score (-5,-3,0 and 3) is assigned to each possible answer for the substance abuse question within a CDA matrix. In this case there are four possible answers. If there were more than four possible answers additional scores could be assigned.

Based on the answer provided by the client, the system matches the score associated with the clients answer to the scores ranges associated with the classification of Need or Strength. So, if the score assigned to the answer 'Chronic Alcohol or Drug Abuse' is -3, then the client is classified as Need.

Viewing Assessment Results

The assessment results are automatically displayed when the assessment script is completed. Depending on how the assessment is configured in application administration, the assessment results are either displayed in a list or as a graph. For both graphed and listed assessment results, the following information is displayed for each client who answered questions in the assessment: the name of the client who was assessed, the factor across which the client was assessed, e.g., Cultural Identity, the classification achieved by the client, e.g., Need, Strength, and the score obtained by the client, e.g., -1.

If the results are displayed in a list format the result of each factor assessed is displayed in a list. If the results are displayed in a graphical format, a list of results is also displayed and this list can be displayed by classification i.e. all factors where the client has been classified as having a need are listed in one cluster and all factors where the client has been classified as having a strength are listed in another cluster.

Alternatively, one list which contains all factors can be displayed. If the results are displayed in graphical format, two types of graph are provided - a bar chart and a radar chart. The type of graph displayed by default is configured in assessment administration, however a case worker can also switch between the two types of graph if required.

Using The Bar Chart View

The bar chart view is used to quickly identify a clients needs. Each factor is represented by a bar. Any bar below the x axis reflect areas in the clients life that need to be addressed. For example, substance abuse is a need that must be addressed. The Y axis reflects the possible scores that can

be achieved by a client when assessed. A configuration setting exists to dictate whether the Y-axis displays scores or classifications.

A tab is also provided which represents the result for each factor.

Using The Radar Chart View

Radar charts are used to depict data as a spider like diagram. Assessment administration provides the ability to display the assessment results as a radar chart. In the radar chart, each spoke is subdivided into a number of increments that make up the scoring range used to measure each clients functioning for each factor. Radar graphs are useful if a comparison is being made between one client's results and another's.

Any point close to the center on any axis represents a low score for a particular factor. A point near the edge represents a high score. The overall shape of the radar chart can be used to compare each client's scores across all factors.

Prioritizing High Priority Needs

Agencies do not always have the capacity to address all of the issues identified by an assessment and must concentrate on the most urgent needs. Outcome Management supports factor prioritization. Factor prioritization allows case workers to prioritize factors identified by the assessment as needing urgent or further attention. For example, if a client's assessment results indicates that Housing is an identified need, this factor can be prioritized such that the case worker will try to address this issue before any other issues are addressed.

Using Guidance Text

Guidance is help text and links to useful resources that is used to assist a case worker on how to proceed when a client achieves a particular score or classification when assessed. Guidance text is only displayed with the results if it has been defined for the factor as part of administration.

The guidance text that is displayed depends on the result achieved and the guidance text that is defined in administration. Guidance text can be defined for a particular classification, for example, guidance text can be defined for a classification of Need (0 to 5) such that a client scoring a value between 0 and 5 will result in guidance text defined for that range to be displayed.

Guidance text can also be defined at a more granular level for a particular value within a range. For example, it can be defined for a score of 1 within the classification of Need (0 to 5) such that a client scoring a value of 1 will result in the guidance defined for that score being displayed. Guidance defined at the more granular level takes precedence over any guidance defined at the classification level.

The system automatically keeps a record of the assessment guidance details for the assessment result for each assessment and subsequent reassessments. This ensures that the guidance displayed on assessment history records is the same as the guidance that was displayed when the assessment was originally run.

Identifying Additional Client Needs

Although assessments described above do lead to the identification of many of a client's needs, there are some instances where a client is assessed for a factor but this does not form part of an assessment with other factors. For example, General Education Diploma (GED) assessments. Outcome Management allows for the definition of these additional factors in application

administration, the addition of these factors to an outcome plan and for the subsequent recording of the result.

There may also be instances where only general interaction between the case worker and the client can lead to the identification of all of a client's issues. For example, through constant contact with a client the case worker may be able to identify that a client's health problems may be due to environmental issues if the client lives close to a toxic waste facility.

Standard assessments may not include questions on this area. Outcome Management provides a way for a case worker to record these user identified factors on an outcome plan and as such provide a more complete picture of a client's needs.

Approving or Rejecting an Assessment

In some cases it may be necessary for a supervisor to review and approve an assessment before it is deemed complete, for example, a supervisor may want to manually approve assessments performed by novice users. Outcome Management provides an assessment approval process whereby an administrator can define that a percentage of assessments submitted require approval by a supervisor. The assessment approval process can be configured as part of application administration. For more information, see the *Outcome Management Configuration Guide*.

The assessment is submitted for approval by the case worker when the results have been derived by the system and the case worker has specified priority factors (if prioritization of factors is appropriate for the assessment). Assessments which are submitted by users with approval privileges will be automatically approved; otherwise, the assessment will require manual approval by a user with the appropriate privileges. A task is assigned to a user with the required approval privileges. This task includes a link to the plan and links to either reject or approve the assessment.

When the assessment is submitted and subsequently approved or rejected, approval request information is automatically recorded by the system. The approval request details include the name of the user submitting the plan, the date of submission, the name of the user who approves or rejects the plan, and the date of approval or rejection.

Assessments submitted for approval have a status of submitted; approved assessments have a status of complete.

Rejected assessments have a status of in progress and must be resumed and resubmitted in order to progress. If priority factors apply to the rejected assessment, the case worker has the option to change the priority factors if necessary and resubmit the assessment.

Completing An Assessment

An assessment is completed once it has been approved. Assessments are either approved automatically by the system or manually by the case supervisor depending on whether manual approval is required or not.

Assigning A Multidisciplinary Team To An Outcome Plan

Two types of multidisciplinary teams that can be assigned to an outcome plan: predefined multidisciplinary teams consisting of persons who continue to work together to help multiple families, and multidisciplinary teams that are formed to assist a particular family's outcome plan.

The type of multidisciplinary team that can be added to an outcome plan is configured as part of outcome plan administration.

Fundamental to the success of achieving positive outcomes for a client is the ability to collaborate with multidisciplinary teams to leverage the experience of various disciplines and to effectively manage the needs of clients and their families.

Predefined teams and their team members are configured as part of social enterprise collaboration administration. All outcome plans that use a particular predefined team have the same team members. Predefined teams can be updated at the administration level so that all outcome plans relying on this team can automatically avail of these changes. For example, if a member of a predefined team is on holidays, a person can be assigned to fill their role.

Families with complex and ongoing needs require a multidisciplinary team who understands their personal circumstances. For example, a reunification plan that is aimed at assisting a child return to the family home requires team members who have established relationships with the child and the family.

Where predefined teams are designed to include team members filling specific roles, individual multidisciplinary teams are set up within an outcome plan to deal specifically with one family. For example, the teacher of a child on an outcome plan may be added as a multidisciplinary team member. To support the creation and maintenance of individual multidisciplinary teams, functionality is provided to add multidisciplinary team members who are in existing teams, register new members, and add existing agency users.

Collaborating With The Multidisciplinary Team

The ultimate goal of multidisciplinary teams is to use their range of skills to share information with agency workers in order to help clients and their families. Outcome Management enables information sharing and provides tools to enable multidisciplinary teams to achieve this goal.

In order to allow a multidisciplinary team to assist with addressing client needs it is sometimes necessary to share certain information with them. In order to do this, Outcome Management provides the agency worker with the capability to share information with selected members of the multidisciplinary team. The multidisciplinary team member can access this information from within the associated case in the Multidisciplinary Team Portal.

Configuration settings are provided which dictate the information that can be shared. These settings apply to the role a multidisciplinary team member plays on a team. For example, an administrator can configure that notes can be shared with all multidisciplinary team members who play a role of doctor on a team. The agency worker can then choose to share a particular note with the member who fulfills that role. Additional configurations exist at the individual multidisciplinary team member which override the configurations which apply to a role. For example, an administrator can configure that notes may be shared with all doctors on multidisciplinary teams, except for Dr. John Smith. The following functionality is provided on the outcome plan and can be shared with multidisciplinary team members:

Table 1: Multidisciplinary Team Information Sharing

Business Functionality	Summary
Notes	Standard case notes functionality is used to record notes for an outcome plan but it additionally allows for sharing of notes with multidisciplinary team members.
Attachments	Standard case attachments functionality is used to record attachments for an outcome plan but it additionally allows for sharing of attachments with multidisciplinary team members.
Activities (Service, Actions and Referrals)	See Planning Activities To Address Client Needs on page 28 below for details of activities functionality.

When a note, attachment or activity is added to an outcome plan by a case worker, an email is sent to the multidisciplinary team members with whom the note, attachment and activity has been shared to inform them that a particular record has been added. A configuration setting exists which dictates if any emails are sent to multidisciplinary team members.

When a note or attachment is added to an outcome plan by a multidisciplinary team member a task is assigned to the outcome plan owner to inform them of the addition of the note or attachment and to give them the opportunity to specify the multidisciplinary team members the note or attachment can be shared with (multidisciplinary team members cannot specify sharing).

Tools That Support Collaboration

The following table provides a summary of the business functionality that enables effective collaboration between case workers, multidisciplinary team members and clients. Caseworkers have access to these functions from an outcome plan, multidisciplinary team members have access to these functions from the Multidisciplinary Team Portal.

For more information, see the *Multidisciplinary Team Portal Guide*.

Table 2: Collaboration Functionality in an Outcome Plan

Business Functionality	Summary
Discussion boards	Multidisciplinary team members can use discussion boards to share advice and important information. These discussion boards can be configured to email multidisciplinary team members when discussions are posted and comments added making it as easy as possible for team members to be informed and have the opportunity to participate in a discussion. Note: Discussions are only available within an outcome plan when a multidisciplinary team is assigned to it. For more information on discussion boards, see the <i>Social Enterprise Collaboration Configuration Guide</i> .

Business Functionality	Summary
Scheduling meetings	Meetings can be scheduled by a multidisciplinary team member or agency worker. PIM integration allows meeting invites to be accepted in their personal calendars, for example in Microsoft® Outlook, making it easier to coordinate meetings. For more information about scheduling meetings, see the <i>Calendaring Guide</i> .
Recording meeting minutes	The record meeting minutes wizard provides functionality for recording general meeting details, adding meeting notes, listing meeting decisions, marking attendees, outlining actions, attaching files, and associating cases that were discussed. These meeting minutes can be automatically issued to meeting attendees, declining invitees, and other interested persons by email. For more information on meeting minutes, Integrated Case Management Guidesees the .

For more information about configuring multidisciplinary team members, see the *Social Enterprise Collaboration Configuration Guide*.

Establishing The Goals And Objectives Of The Outcome Plan

The goal is the primary objective or desired outcome of the outcome plan. It is the main objective that the outcome plan client or clients is working towards to become independent of the agency.

For example, an unemployed client may have a goal of self sufficiency. Objectives are smaller steps that can be undertaken by a client in order to achieve the outcome plan goal, for example, the objectives for a client on a Back to Work outcome plan may be to 'Improve Basic Education' or to 'Stay Clean and Sober'.

It is important to define goals and objectives in collaboration with the client to ensure that the case worker understands what the client is trying to achieve and also to ensure that the client remains focused and motivated in participating in the activities outlined in the plan. Objectives can be used to encourage a client(s) so that they are given a feeling of accomplishment throughout the process so that they are not overwhelmed by a seemingly impossible large outcome. Each time a client achieves an objective, they will feel that they are progressing.

Adding Goals To The Outcome Plan

A goal can be added to the outcome plan or a goal can be specified for each client on the outcome plan. The goals that can be selected are configured as part of outcome plan administration. A configuration setting exists in outcome plan administration to dictate if a goal can be specified for the outcome plan, the clients on the outcome plan or for both.

The reason for adding a goal to the outcome plan and the date that the client is expected to achieve the goal must also be specified. This date can be subsequently modified and if modified, a history of date changes is automatically recorded. Multiple goals can be specified for the plan and clients over time but only one goal can be in progress at any given time.

Adding Objectives To The Outcome Plan

An objective can be optionally specified for one or more clients on an outcome plan. The objectives that can be selected are configured as part of outcome plan administration.

There are two ways to add an objective to an outcome plan. An objective can be added by dragging the objective from the recommendations panel in the plan workspace. Alternatively, a case worker can add a new objective from the objectives listing within the outcome plan by searching for and selecting the objective.

A configuration setting exists in outcome plan administration to dictate if a worker can rename the objective when adding it to the outcome plan. The reason for adding the objective to the outcome plan and the date that the client is expected to achieve the objective must be specified. This date can be subsequently modified and a history of date changes is recorded.

Associating Factors To These Objectives

Factors involving the clients selected for the objective can also be associated with the objective. This enables a case worker to identify the activities that are helping toward a particular objective. See [Adding Activities To The Outcome Plan on page 30](#) for more information on associating factors with activities.

Planning Activities To Address Client Needs

The most important part of achieving positive outcomes for a client is the identification and scheduling of activities to address their needs.

Activities may be paid for by the agency, for example a Counseling service, or clients may be referred to external providers for a service which can help them but are not paid for by the agency, for example a referral for Alcoholics Anonymous sessions. Activities can also be scheduled which may help a client improve their health or integrate better with society, for example a case worker may create actions to take daily exercise or to join a basket ball team.

The following pages outline how the different types of activities can be scheduled and the information that is recorded when scheduling them.

The Workspace

The workspace in an outcome plan provides a case worker with the capability to access recommended and recently added objectives and activities.

The Objective workspace

The objective workspace provides a caseworker with the capability to easily access recommended and recently added objectives and activities, to quickly schedule new objectives and activities. It provides a central view on all objectives and activities that are currently scheduled for clients within an outcome plan.

The objective workspace allows the caseworker to work on both objectives and activities, maintain associations between them, and understand the hierarchy of objectives and activities in the plan. An activity can be associated with an objective or can be added as a stand-alone activity within the workspace.

There are two main areas within the workspace:

- The workspace view on the left shows all the objective and activities that are scheduled for the client. The activities associated to an objective are shown under the objective. The stand-alone activities are shown separately at the same level as the objective. Objectives and activities can be marked as favorites. A timeline view is also provided whereby the caseworker can obtain a daily, monthly, and quarterly view of the objectives and activities.
- The recommendations pane on the right displays the recommended objectives and activities. The Objectives tab displays the recommended objectives based on the type of plan. The caseworker can also search for objectives based on keywords or use the objectives that are marked as favorites. The Activities tab displays the recommended activities based on the type of plan and objectives that were added to the plan. The caseworker can also search for activities based on keywords or use the activities that are marked as favorites.

The recommended objectives and activities are added to the workspace view by dragging and dropping them from the recommendations pane to the workspace view. An activity is added and associated to an objective by dragging and dropping them over an objective in the workspace. An activity is added as a stand-alone activity by dragging and dropping them over a plain area in the workspace. When an objective or activity is selected and expanded in the workspace, the name of the caseworker who added it, the date it was added, and the reason it was added are displayed.

(deprecated) The Activity Workspace

The activity workspace provides a case worker with the capability to easily access recommended and recently added activities, to quickly schedule new activities, and to have a central view on all activities currently scheduled for clients within an outcome plan.

There are three main areas within the workspace. On the left hand side is the time line panel. A time line shows all activities which are current and have been scheduled for the client. This time line can be filtered such that case workers can choose to see activities for selected clients, expected outcomes, priority factors and factors. A daily, weekly and monthly view of activities is also provided. An analysis view is also provided which provides a visual representation of all components of an outcome plan. See [Outcome Plan Analysis View on page 35](#) for more information.

On the right hand side, a recommendations panel displays recommended and recently added activities. A Plan tab shows recommended activities based on the type of plan. A Factor tab displays recommended and recently added activities for each client assessed based on the score or classification achieved by the client(s) when assessed. An accessible listing of the recommended activities is also available which displays all plan and factor recommendations and recently added activities.

On the bottom is the activity workspace panel which works in conjunction with the recommendations panel and the time line. When an item is selected in the recommendation panel or time line, associated information is displayed at the bottom of the workspace.

When a client is selected in the recommendations panel, his or her planned activities and expected outcomes are displayed. When a factor is selected, details of when the factor was last assessed are displayed as well as guidance, a graphical representation of progress, a graphical representation of the clients historical results for the selected factor and the latest note added to that factor.

When a recommended activity is selected, the reason, which has been configured as part of recommendation administration, is displayed as well as a description of the activity. Lastly, when a recently added activity is selected, the name of the case worker who added the activity

as well as the date it was added, the reason why it was added and a description of the activity is displayed. When an activity is selected in the time line, details about the activity are displayed.

Tools For Matching Activities To Client Needs

An important part of trying to achieve positive outcomes for clients is to identify the best course of action to meet their needs and to ultimately achieve their goals. Outcome Management provides guidance and recommendations to case workers to assist them with proceeding in the right direction to address client needs.

Recommending Activities For Assessment Results And Outcome Plan Types

Recommendations are used to ensure that case workers are consistent in their approach to client needs and allows them to spend more time assisting clients rather than having to search for new activities. For more information configuring recommendation see [Configuring Recommended Objectives and Activities on page 19](#).

Activities Added By Other Case Workers

Activities which have been added by other case workers to address the needs of clients in similar circumstances are also displayed to the case worker as recommendations in the activity workspace.

The recently added activities to be displayed can be configured to return the most frequently added activities in the past number of days. For example, an administrator can configure to return the 5 most frequently added activities in the last 7 days i.e. The number of recently added activities to display and the number of days are configurable in system administration.

Activity Recommendations In Guidance Text

Guidance text, as described earlier, can be configured for factors within assessments and factors outside assessments, and can be used to assist a worker on how to proceed when a client achieves a particular classification or score when assessed.

For example, the following guidance can be displayed if a client is assessed for Substance Abuse and is classified as 'Need': 'The client may use alcohol or prescribed drugs; however, use does not negatively affect his ability to look after himself. Minimum support is required; perhaps ensure that the client has support from family and friends and/or the community.'

Adding Activities To The Outcome Plan

There are two ways to add an activity to an outcome plan. An activity can be added by dragging the activity from the recommendations panel in the plan workspace or from the recommendations listing within the outcome plan which opens the appropriate activity creation wizard. The activity is preselected in this case based on the recommended activity selected. Alternatively, a case worker can add a new activity from the activities listing within the outcome plan. In this case, the case worker must search for and select the activity.

There are a number of common pieces of information that are specified when creating an action, service or referral activity. The table below outlines this information.

Table 3: Common Activity Information

Information	Description
Client(s)	At least one client must be selected when creating an action, service or referral. Services, referrals and actions can be configured such that they are only appropriate for one client or for multiple clients. If an action, service or referral is configured to be appropriate for one client, the worker is prevented from selecting multiple clients for the selected action, service or referral.
Reason	The reason for adding an activity to an outcome plan must be specified.
Sensitivity	Activities can be secured using sensitivity security. All users are assigned a sensitivity level. By assigning a sensitivity level to activities, only those users whose sensitivity level is equal to or greater than the sensitivity level can access the activity.
Schedule and Check Availability	The period during which an activity should take place can be specified for actions and services. A start date must be specified but an end date is optional. A referral date can be specified for referrals and represents the date that the client should meet with the specified provider of the referral service. Once a start date or referral date are specified, functionality is provided to allow a worker to check a clients availability for the dates specified. Any services, actions, referrals or meetings already scheduled for the dates specified will be displayed to the worker. This will ensure that the worker does not schedule activities during periods when the client is involved in other activities. A configuration setting is provided for services and referrals which dictate if they should be returned when checking availability, for example it would not be necessary to include a Mileage Reimbursement as this is not a service that a client attends.
Factors	The factors that the selected activity is helping towards can be selected during creation. For example, a case worker can specify that an Alcohol Abuse Day Treatment service is helping towards a clients issues with substance abuse. . All factors involving the clients selected for the activity are displayed for selection.
Collaboration	To enable collaboration with multidisciplinary team members, a worker can choose to share activities with the multidisciplinary team members assigned to the outcome plan the activity is being added to. Workers only have the option to share activities if the associated outcome plan has been configured to allow for sharing. If sharing is allowed, the multidisciplinary team members with whom activities can be shared are displayed for selection. Multidisciplinary members can be preselected if collaboration configuration dictates it.

Scheduling A Service For A Client

Scheduling a service begins with the selection of the service. A case worker can search for and select a service using a taxonomy search or a name search which returns services from the CPM services registry or the service can be recommended by the system and subsequently selected by a case worker. The service selected will then dictate the information to be specified. Depending on how the service is configured the following information can be specified when scheduling a service: Number of units, authorized rate, frequency, required participation, nominee payment, owner and provider. For more information about scheduling a service, see the *Integrated Case Management Guide*.

Referring A Client For A Service

The process begins with the selection of the service. A case worker can select from a list of referral services stored in the CPM services registry or the referral service can be recommended by the system and subsequently selected by a case worker. The service selected dictates the information to be specified. The following information can be specified when scheduling a referral: Referral date, whether to follow up with the client, provider and whether to send notifications to the client(s) and provider. For more information about referring a client for a service, see the *Integrated Case Management Guide*.

Scheduling An Action For A Client

This section outlines the process of creating an action for a client. Evidence can be added to an action to record more detailed information on the client. For more information about recording evidence, see the *Evidence Guide*.

The process begins with the selection of an action. A case worker can select from a list of actions defined in Outcome Management administration or the action can be recommended by the system and subsequently selected by a case worker. The action selected will then dictate whether the information outlined in this section can be specified. When first created the action has a status of Not Started if the start date is in the future. The action has a status of In Progress if the start date is today or in the past.

Note: A configuration setting exists in action administration to dictate if a worker can rename the action when adding it to the outcome plan.

Cost

Actions may have a fixed cost associated with them, for example, providing a client with a bus pass may have an associated cost of \$50. Certain actions may have a cost associated with them but it cannot be identified until the action has been completed. In this case, the case worker can only estimate the cost of the action on creation. Other actions may have no cost associated with them, for example, the case worker may create an action for a client to take daily exercise.

To cater for these various cost models, a configuration setting is provided which allow an administrator to dictate they type of cost associated with an action i.e. No cost, fixed cost or user specified cost. On creation of an action, estimated cost can be specified if the action has been configured to allow a user to specify a cost. If a fixed cost has been configured, the actual cost is displayed to the case worker during creation of the action. If there is no cost is associated with an action, cost is not displayed to a case worker during action creation.

Required Participation

In certain circumstances, it may be necessary for a client to participate in an action for a defined frequency and duration. For example a client receiving cash assistance may have a sanction placed on their benefit if they do not meet the required participation. To cater for this, an action can be configured such that a case worker must specify a frequency and duration during action creation.

Assigning an Owner

The owner of an action is the person who is responsible for ensuring that the action is completed. The owner assigned to an action can be the case worker creating the action, a member of an MDT (multidisciplinary team), the client, or any other user on the system. A configuration settings exists which dictates how the owner is assigned to an action. The action can be automatically defaulted to the worker creating the action in which case the worker does not have to select an owner. If the action is configured such that the owner can be any user, the worker creating the action can specify themselves as the owner or they can search for and select another user as the owner.

Assigning Responsibility

Responsibility for an action indicates who is responsible for carrying out the action. Responsibility can be assigned to either a client, to a user or to a member of a MDT (multidisciplinary team). For example, responsibility for providing a bus pass to a client would be assigned to a case worker. Alternatively, responsibility for an action to take daily exercise would be assigned to a client.

Certain actions are always the responsibility of the client, and certain actions are always the responsibility of a user or MDT member. To prevent a worker from having to always specify responsibility, a configuration setting exists to dictate the assignment of responsibility and in some cases automatically default responsibility for an action. For example, responsibility can be automatically assigned to the worker creating the action in which case the worker does not have to specify responsibility.

Managing Client Agreements

When the caseworker and the client have agreed all elements of a plan, the caseworker and client agree in writing to adhere to the activities outlined within it.

Outcome Management provide case workers with the ability to create agreements which can subsequently be signed by both parties. One or more agreements can be created on an outcome plan. For example, if there are five clients on the outcome plan a separate agreement could be created for each client. This section outlines the process for creating an outcome plan agreement.

Creating Client Agreements

Creation of an agreement begins with the selection of one or more clients and one or more signatories. A signatory is a person who can sign the agreement on behalf of the client. All clients on the outcome plan are displayed for selection. Subsequently, the case worker selects the activities which will be covered by the agreement. The agreement can then be completed so that it can be issued to a client.

Approving Client Agreements

In some cases it may be necessary for a supervisor to review and approve an agreement before it can be issued to a client, for example, a supervisor may wish to manually approve agreements which have been created by novice users. Outcome Management provides an agreement approval process whereby an administrator can define that a percentage of agreements submitted require approval by a supervisor.

Once a case worker is satisfied that the agreement is ready to be signed, the case worker indicates that the agreement is completed and ready to be issued to a client. If approval criteria have been specified for agreements, then the agreement may need to be manually approved by a supervisor before it can be completed and issued. Agreements which are completed by users with approval privileges will be automatically approved; otherwise, agreements will be submitted for manual approval by a user with the appropriate privileges. A task is assigned to a user with the required approval privileges. This task includes a link to the outcome plan on which the agreement has been created and links to either reject or approve the agreement.

When the agreement is submitted and subsequently approved or rejected, approval request information is recorded. The approval request details include the name of the user submitting the agreement, the date of submission, the name of the user who approves or rejects the agreement, and the date of approval or rejection.

Agreements which are completed and require approval have a status of submitted; approved agreement have a status of Completed.

Rejected agreements have a status of Open and a case worker must complete them again in order to progress.

Issuing Client Agreements

On completion of the agreement i.e. when the case worker is satisfied with the contents of the agreement and it has been approved, a generated agreement can be issued to any one of the signatories or clients on the agreement. The agreement can be either issued by email or post. The means by which the agreement is issued is dependent on a configuration setting which dictates if the agreement can be sent by email only, by post only, or by email or post.

An agreement can be reissued to a client, if, for example, the initial agreement is lost in the post. A history of each time the agreement is issued is recorded on the system and indicates when it was reissued, who issued the agreement and who it was issued to.

Signing Client Agreements

When a case worker receives a signed agreement from a client, a date signed can be recorded on the system. The agreement can then be scanned and stored as an attachment.

Developing Visitation Plans

Visitation plans are developed to specify and describe planned interactions that occur between clients and visitors.

For Child Welfare outcome plans where children are in out-of-home placements, visitation plans are important to maintain relationships between the child in out-of-home placement and family

members (parents or relatives) or other participants. Visitation plans, which can be court ordered, or mutually agreed upon by the agency and the family, typically specify when, how and where a visitation occurs as well as the frequency and the duration of the planned interactions. When creating a visitation plan, the caseworker must identify the participants involved.

Configurations exist which allow an administrator to specify the lower and upper age limit of the clients to visit which filters the list of clients to visit on the visitation plan. For example, for a Child Welfare outcome plans, the upper age limit for clients to visit might be 21 whereas for Adult Protection outcome plans, the lower age limit might be 21.

Tracking Actual Visits

Visitation logs enable the user to capture the details of actual visits/interactions that occur for a visitation plan. The caseworker must specify the clients visited and visitors on the visitation log along with the visit date, quality of the interaction, the contact method, whether the visit was scheduled, unscheduled or rescheduled. If the visit is a rescheduled visit, the rescheduled reason must be provided. The caseworker is required to provide a narrative or description of the visit.

1.4 Monitoring Client Progress

To successfully complete an outcome plan and achieve positive outcomes for clients, it is important to regularly monitor and evaluate a client's progress. By regularly communicating with the client, a caseworker can identify progress and also identify if the activities outlined in the current plan are sufficiently addressing client needs.

The following Outcome Management features are provided to assist a caseworker in monitoring progress:

- An analysis view provides a visual representation of the outcome plan.
- Reassessments to identify if the clients' circumstances improved since first assessed.
- Results of outcome plan reviews can be recorded and tracked.
- Client progress can be recorded against activities, goals, objectives, and factors.
- Reports can be generated which contain the details of assessments and outcome plans that can be used as a reference in client meetings or in court proceedings.

Some additional tools are also provided to support the process of monitoring client progress.

Outcome Plan Analysis View

The outcome plan analysis view provides a visual representation of an outcome plan. It displays the outcome plan clients, objectives, factors, activities and the relationships between these elements making it easy to obtain a holistic view of all of the elements of an outcome plan. The analysis view contains nodes representing the objects (outcome plan, clients, objectives, factors and activities) within the outcome plan and lines connecting these nodes which represent the relationships between the objects. The client, objective and factor node can be collapsed and expanded to show/hide additional relationships for that node.

Reassessing Clients Needs Over Time

Client assessment is a formal, continuous and iterative process of determining current, and potentially future, client needs. Outcome Management supports this by allowing agencies to reassess clients over time in order to identify current needs and also to identify a clients progress over time.

Running A Reassessment

Reassessment allows the agency to re-run an assessment on a client or group of clients in order to identify current needs and monitor their progress over time.

For example, the agency may reassess a client in order to measure his progress in achieving self sufficiency across factors that have previously been marked as a priority in the initial assessment.

If the reassessment is assessing a group of clients, i.e. Questions are asked of the entire group, only clients that are part of the original assessment group can be reassessed. For example, if three clients were assessed as part of the original assessment, only these three clients can be reassessed. If the reassessment is assessing clients individually, clients who were not assessed in the initial assessment can be assessed in the reassessment.

During reassessment, a caseworker has the option to reassess the client or client group across all of the factors that were assessed during the original assessment or across a subset of factors only. For example, if the original assessment was run across factors of substance abuse, social support, and domestic violence factors, the case worker may decide to only reassess the client across the substance abuse and domestic violence factors because the client achieved a sufficient score for the social support factor when the initial assessment was first run.

If priority factors are applicable to the assessment, on running a reassessment, new priority factors can be selected from the reassessment results. For example, if the reassessment results show that a client has achieved sufficiency in a factor that was previously marked as a priority when the original assessment was run, the caseworker may decide to concentrate on new priority factors on reassessment, i.e., factors for which the client achieved the lowest scores on reassessment.

If the assessment has been configured to allow role changes during reassessment, on initiating the reassessment, a case worker can update the roles played by the clients on the assessment if necessary. For example, if James Smith is assigned the role of primary caregiver and Linda Smith is assigned the role of the secondary caregiver when a CSN assessment is first run and after the assessment, Linda Smith becomes the Primary Caregiver, the case worker can change the client who satisfies the role of the primary caregiver for reassessment purposes.

Comparing Assessment Results

Assessment result comparison is used to compare the results of an initial assessment with any reassessment or to compare the results of any two reassessments which have been run on a particular client or group of clients. By comparing assessment results, a worker can easily identify what has caused a change in a client's progress from one assessment and another i.e. the factors which have different results can be identified as well as the questions/answers which have lead to these differences.

In order to compare the results of two assessments, the assessments to compare must be specified. The initial assessment and all subsequent reassessments which have been run are available for selection.

When the results of two assessments are compared, the system displays the classification, e.g., Strength, Need, and the score achieved for both assessments per factor and client assessed. For example, for Assessment A, James Smith may have achieved a score of -1 for the Substance Abuse factor which is classified as a Need. For Assessment B, James Smith may have achieved a score of 2, which is classified as a Strength.

The assessment answers captured by the worker for each client included in the assessment are also displayed for each assessment that is compared. This allows the worker to compare the assessment answers.

To easily identify the differences between each set of assessment results, the differences between the assessment results and the answers are highlighted. Differences can be hidden or displayed using the Highlight Differences and Clear Differences options on the Compare Assessment page. The comparison can also be reset if the case worker wishes to perform a new comparison.

Viewing Assessment Results History

The purpose of the assessment history is to provide a case worker with access to the results achieved by client(s) each time the clients were assessed. The following information is available for each assessment: the client(s) that was assessed, the role(s) that the client played on the assessment, when the assessment was started and completed as well as a list or graphical representation of the results.

If the assessment is configured such that the assessment results are displayed graphically, either a bar graph or a radar graph is displayed. An administrator can specify the type of graph that will be displayed by default but a case worker has the option of switching between the two graphs. Tabs for each factor assessed are also provided which will display a line graph representing a clients progress over time for each factor.

Ongoing Assessment Management

Once an assessment is complete case workers are provided with additional functionality to analyze the assessment results allowing them to accurately understand and address client needs.

Viewing Assessment Summary Information

The assessment results summary provides a case worker with easy access to the latest results for all factors assessed. The case worker can easily identify who was assessed, the roles each client played on the assessment, when the assessment was started and completed as well as a list or graphical representation of the results achieved by each client assessed.

If the assessment is configured such that the assessment results are displayed graphically, either a bar graph or a radar graph is displayed. An administrator can specify the type of graph that will be displayed by default but a case worker has the option of switching between the two graphs.

Reviewing Answers To Assessment Questions

Assessments allow case workers to view the answers recorded for the client(s) during the assessment.

Viewing Assessment Approval Requests

As part of the approval of assessments, a list of assessment approval requests which have been sent to the case supervisor for approval are recorded. Case workers can use this list to see all of the assessment approval requests that have been submitted to their supervisor for approval.

The approval request details displayed include the name of the user who requested the approval, the date the approval request was submitted, the user who approved or rejected the approval request, the decision date, and the decision, i.e., Approved or Rejected. Note that if no decision has been recorded for the approval request, the decision is Submitted.

Assessment Report

To assist a case worker with conducting reviews and meetings about client's assessments, Outcome Management provides the facility to generate reports. This section describes the Assessment report.

The generated assessment report contains the following sections:

- An overview section which shows all clients who were assessed and a tabular representation of the results for all factors assessed. Notes recorded on the assessment are included.
- A section for each client assessed which includes a tabular representation of their latest assessment result. The latest assessment questions and answers and all questions and answers recorded for all reassessments are included.
- A section for each factor is displayed which displays the results in tabular format for each client assessed.

Closing An Assessment

An assessment can be closed at any time. For example, a CSN assessment may be closed if the assessment results show that the client(s) no longer have any needs that need to be addressed by the agency.

Once an assessment has been closed, it cannot be reopened.

Assessment Statuses

Each assessment has a status which describes it's progress. There are five assessment statuses: in-progress, submitted, complete, canceled, and closed. Each status changes during assessment processing.

The following table describes each assessment status:

Table 4: Assessment Processing Statuses

Status	Description
In-progress	An assessment status is "in-progress" when an assessment is created and has not yet been submitted. An assessment status can also be "in progress" when an approval request has been rejected.
Submitted	An assessment status is "submitted" when the assessment is submitted for approval. Only assessments with a status of "in-progress" can be submitted for approval.
Complete	An assessment status is "complete" when the assessment has been approved by the case supervisor. An assessment status can also be "complete" when approval is not required and it is completed by a user.
Canceled	An assessment status is "canceled" when the assessment is deleted from the system. Only assessments with a status of "in-progress" can be canceled.
Closed	An assessment status is "closed" if the assessment is closed by a case worker. Assessments with a status of "complete" can be closed and "in-progress" initial assessments can be closed.

Reprioritizing Factors

Factor reprioritization allows case workers to prioritize factors within an outcome plan. For example, if a client's results indicate a low score for a factor of 'Parenting', these results can be prioritized and dealt with by the case worker before other factors. Factor prioritization assists case workers in ensuring that the most pressing client needs are dealt with first. Outcome Management allows a case worker to reprioritize factors over time and the system automatically maintains a history of the reprioritization.

Lapsing Factors

A factor may not be reassessed for a long period of time and consequently the results are considered lapsed. Lapsing factors means that recommendations will not be produced for that factor on the activity workspace. Factors are lapsed if the next assessment due date has passed and the factor has not been reassessed. Note: If a next assessment due cannot be calculated (this occurs when an assessment interval has not been defined for the factor in administration or on the assessment definition for factors which are part of an assessment) then no lapsing occurs.

Managing Outcome Plan Reviews

Reviews are often undertaken to ensure that the activities on an outcome plan are correctly addressing the needs of clients, to assess the clients progress towards achieving the plan goals and objectives, and to make appropriate changes to the plan depending on the clients current circumstances. For example, in Child Welfare, permanency plans are created to implement the most permanent long-term living situation possible for a child, consistent with the child's best interest. A Return Home permanency plan can be created which has a goal of returning a child to their parents. This plan is then reviewed regularly to ensure that all clients on the plan are participating as required in order to achieve the overall goal.

Reviews may result in many changes to a plan and in order to record and track these changes, Outcome Management allows a case worker to create a review for an outcome plan that will store changes made to the plan during the time the review was open. A case worker can use the review to easily identify the changes made as a result of a particular review. This section outlines the process for creating a review and reviewing activities in a plan.

Creating A Review

Reviews are normally undertaken on a regular basis, for example, a review can take place every 90 days. The first review however can be undertaken shortly after plan creation to ensure that any issues a client is experiencing can be dealt with early in the planning process. To cater for this, each type of outcome plan can be configured to define the number of days after which the plan is created that the first review should occur. In addition, a review frequency can then be specified that defines when subsequent reviews need to be undertaken. Based on this configuration, a next review date is displayed for each outcome plan to inform the case worker when a review should be undertaken.

The process begins with the case worker creating a review on the system and specifying a period which is being reviewed and an expected completion date. The case worker can also specify the type of review. Once the review is open any action to add, complete or review a goal, expected outcome or activity is associated with the review. This association means the case worker will always be able to identify the changes made to an outcome plan as a result of a particular review as there can only be one review open at any given time.

The expected completion date can subsequently be updated by a case worker and a history of changes to the expected completion date is recorded. A textual narrative of the review can be recorded as well as review notes.

Reviewing Activities, Goals And Objectives

A review of an outcome plan may lead to new activities, goals or objectives being added or existing activities, goals or objectives being reviewed and completed depending on the client's circumstances. To identify that these changes were made as a result of a review, the addition, review, and completion of these elements of an outcome plan are automatically associated with the review that is open at the time that the action was performed by a case worker.

For example, if a review created on an outcome plan on 1 January 2022 and a service was added by a case worker to this outcome plan on 2 January 2022, the addition of this service is automatically associated with this review. Case workers can then identify that the service was added as a result of this review. To allow a case worker to easily identify added, completed, and reviewed activities, goals and objectives, a list of added, completed, and reviewed elements are shown in the review. To allow a case worker to easily identify elements that have not yet been reviewed, activities, goals, and objectives that have not yet been reviewed are listed.

The case worker is also provided with a list of actions that have been performed on activities, goals, and objectives to allow them to identify the actions performed on each element as a result of a particular review.

Note: This is not provided for referrals as it is envisaged that referrals are not reviewed or completed as they are not paid for or tracked by the agency. The addition of referrals is visible from within a review if they were added while a review was open.

The review can be completed when the case worker has reviewed all necessary aspects of the plan.

Review Assessments

Assessments are integrated into the review process to allow caseworkers to execute an assessment as part of a review. The output of the assessment may provide information to the caseworker to review other items such as goals or objectives. Configurations exist which allow an administrator to specify whether an assessment can be executed from a review.

Evaluating Visits

Outcome management provides the caseworker with the ability to review/evaluate the effectiveness and appropriateness of visits (or interactions) between visited clients and visitors where a visitation plan has been scheduled during the outcome plan review period. A visit review is created for each visited client and visitor where a visitation plan for the participants exists for the review period. To assist the caseworker performing visit evaluations, a list of visits that occurred during the review period along with the compliance is displayed for the visit reviews.

Compliance measures whether or not the visitor was compliant with his or her expectations with regards to the frequency of visits with the visited client in question. A visit is considered compliant if the following criteria are satisfied:

- it must have a contact method that corresponds to a contact method specified on the visitation plan
- it must be either a scheduled visit or rescheduled visit with an acceptable reschedule reason
- it must meet the minimum duration criteria if duration is specified. The acceptable duration percentage is configured for an outcome plan type

Unscheduled visits are not considered compliant. The compliance percentage is derived by comparing the compliant visits to the number of planned visits in the visitation plan, that is $(\text{Actual Visits} / \text{Planned Visits}) * 100$. The compliance value is determined by comparing the calculated compliance percentage against compliance ranges defined in the administration application for an outcome plan type.

Review Statuses

Each review that is created has a status which describes its progress. There are three review statuses: Open, Completed and Cancelled. Each status changes during review processing. The following table describes each status:

Table 5: Review Status

Information	Description
Open	A review status is 'Open' when first created on the system.

Information	Description
Completed	A review status is 'Completed' when completed by a case worker.
Cancelled	A review status is 'Cancelled' when deleted by a case worker.

Recording Client Participation

To ensure that a client is participating in the services and actions assigned to them, a case worker or provider can record client participation information. If a client is not participating as required, sanctions may be applied to their benefits. A provider can record daily attendance for services using rosters in CPM.

A case worker can also record daily attendance for actions and services from within an outcome plan. This section outlines the processes provided to record participation within an outcome plan. For more information about recording daily attendance using rosters, see the *Provider Management Guide*.

Recording Daily Participation

Recording daily participation allows a case worker to record the number of hours that a client attended, or was absent from, an action or a service on a particular day. If the participation information specified by a case worker is different to the scheduled participation recorded during the creation of the service or action, the case worker is informed.

Additionally if the participation dates specified are outside of the period specified for the action or service, the start date or end date of the associated actions or services is automatically updated with the participation date. For example, if a service is scheduled from 1 January 2010 to 31 January 2010, and participation is recorded for the 1 February 2010, the end date of the service is updated to 1 February 2010.

Recording Scheduled Attendance

Recording scheduled attendance allows a case worker to record participation for a period of time in the past or for a period of time in the future (projected attendance) where the case worker knows that the client will attend. When scheduled attendance is recorded, the system automatically creates participation records based on the participation defined when creating the action or service. For example, participation is specified such that a client is required to participate in a service once a week on a Monday for 4 hours. If a case worker records scheduled attendance from 1 January to the 31 January, the system automatically records attendance for 4 hours for every Monday that falls on or between the 1 January to the 31 January.

If a case worker subsequently identifies that the client was absent for some of the days that were projected or that the actual attendance is different from the projected attendance, the individual attendance records created can be updated to reflect the correct attendance information.

Recording Scheduled Absence

Recording scheduled absence allows a case worker to record absence for a period of time in the past or for a period of time in the future (projected absence) where the case worker knows

that the client will be absent. When scheduled absence is recorded, the system automatically creates absence records based on the participation defined when creating the action or service. For example, participation is specified such that a client is required to participate in the service once a week on a Monday for 4 hours. If a case worker records scheduled absence from 1 January to the 31 January, the system automatically records absence for 4 hours for every Monday that falls on or between the 1 January to the 31 January. Any attendance information, that has been recorded previously for the specified period, will be deleted and replaced by the appropriate absence.

If a case worker subsequently identifies that the client actually attended or that the absence information is different from the projected absence, the individual absence records created can be updated to reflect the correct information.

Evaluating Client Progress

While qualitative assessments are a good indicator of client progress, these assessments may not be run frequently. For example, a CSN assessment may be run every 90 days. In order to record a client's progress during these interim periods Outcome Management allows a case worker to record client progress by selecting a progress value such as Good, Bad, Excellent and also allows a case worker to record a progress note. A graphical representation of a client's progress is also provided based on the progress recorded. The progress values that can be selected by a case worker are configurable in Outcome Management administration.

Progress can be recorded against many of the elements within an outcome plan i.e. Goals, objectives, factors, services and actions. Progress may not always be appropriate for all services, for example, recording progress against a Mileage Reimbursement service would not be appropriate. To cater for this, a configuration setting is provided in service administration to dictate whether a case worker can record progress for a particular service.

Tracking Activity Cost

With ever decreasing agency budgets, tracking the costs of plans and their associated activities has become an essential part of Outcome Management. Tracking cost not only allows a case worker to easily identify spiralling costs and to take appropriate action but it also allows comparisons to be made between the cost of a service provided by one provider over another. For example, a case worker may identify that outcomes are the same regardless of whether a higher cost provider is used or not.

To support the tracking of cost, Outcome Management provides a cost statement which displays all estimated and actual costs to date involved in the delivery of actions and services on a plan.

The estimated cost of an action is derived based on the estimated cost specified by a case worker (if any) at the time of creation or it is derived from a fixed cost specified for the action in action administration. The estimated cost of a service is derived based on the estimated cost calculated on creation of the service. For more information on how this cost is calculated, see the *Integrated Case Management Guide*.

The actual cost of an action is derived from the actual cost specified by a case worker when completing an action, if any, or it is derived based on the fixed cost configured for the action in action administration. The actual cost of a service is derived based on payments made to

a provider as outlined in the *Integrated Case Management Guide*. Actions which have no associated cost are not displayed in the cost statement.

The progress of each action and service is also displayed. The status of the action or service will highlight to the case worker that the actual cost shown may not be the final cost of the activity. The total estimated cost and total actual cost is also displayed.

Additional Tools For Assisting Caseworkers

The following additional tools are also be available within Outcome Management. Many of these features are modeled on core Cúram functionality.

Case Worker Summary Views

Because of the high case load of case workers it is often difficult to be constantly aware of activities that need immediate attention. To assist them with their daily work activities, Outcome Management provides a number of summarized views and productivity pages which are used to highlight areas of work that may need urgent attention. For example, a plan review may need to be performed in the next few days or it is already overdue. This section outlines functionality that helps case workers to easily identify work activities that need to be addressed. The summaries and productivity pages described below are specific to Outcome Management and are in addition to those available in other areas of the application.

The following summaries are available: a summary view to identify reviews which are due and over due and a summary view to identify reviews that are currently in progress.

The following productivity pages are available: items due to complete, activities due to start and items past expected end date. The productivity pages consist of two sections: a filter and a results list. The filter allows the case worker to specify the criteria for displaying the results, for example, the type of items to display or the number of days that an item is overdue by. The first time the case worker opens the page, the filters must be set. The filters are persisted so that every time the caseworker accesses the page, the filters are automatically set with the previous settings and the search results are returned.

Next Reviews

The Next Reviews summary displays a list of the outcome plans, owned by the currently logged in case worker, for which a review is either due in the next number of days or is already overdue. This can be used by a case worker to identify reviews that need to be performed immediately. The summary can be configured such that reviews returned are those that fall due within a user specified number of days. For example, a case worker can specify that all reviews which fall due in the next 5 days are displayed. A configuration setting is also provided which dictates if overdue reviews are returned. A default configuration is provided if one has not been saved by the case worker. In this case, reviews due in one day are returned and overdue reviews are included. Overdue reviews are highlighted by displaying the number of days that they are over due.

Ongoing Reviews

The Ongoing Reviews summary displays a list of reviews that are currently in progress on outcome plans owned by the currently logged in user.

Items Due To Complete

The Items Due To Complete productivity page displays a list of the items (plans, goals, objectives, services, actions, referrals and reviews) that are due to complete within the specified number of days. Only items associated with a plan where the case worker is the plan owner or an MDT member on the plan on which the item exists, are returned. The case worker can set filters for the type of items that are displayed, and set the number of days within which the items are due to complete. The number of days is inclusive of today. For example, If the user enters 2 for the number of days within which items that are due to complete are returned, items due to complete today and tomorrow are returned in the results.

Activities Due To Start

The Activities Due To Start productivity page displays a list of the activities that are due to start within the specified number of days. Only activities associated with a plan where the case worker is the plan owner or an MDT member on the plan on which the item exists, are returned. The case worker can set a filter for the number of days within which the activities are due to start. The number of days is inclusive of today. For example, If the user enters 2 for the number of days within which activities that are due to start are returned, activities due to start today and tomorrow are returned in the results.

Items Past Expected End Date

The Items Past Expected End Date productivity page displays a list of the items (plans, goals, objectives, services, actions and reviews) that are past their end date by a specified number of days and have not yet been updated as completed. Only items associated with a plan where the case worker is the plan owner or an MDT member on the plan on which the item exists, are returned. The case worker can set the type of items and the least number of days past the expected end date to filter the items that are returned. For example, if the user enters the number of days as 3, then items that are past their expected end date by 3 days or more are displayed.

My Outcome Plans View

A case worker may be the owner and/or an MDT member on a number of outcome plans at any one time. To assist the case worker in managing their outcome plans, Outcome Management provides a My Outcome Plans view which displays a list of the open outcome plans that the case worker is currently participating in, either as the owner or as an MDT member.

Attaching Files

Attachments in Outcome Management are the same as case attachments. Supplemental files can be attached to the outcome plan and accessed by other system users who have the appropriate security privileges. Within outcome plans, it is also possible to attach supplemental files to services, referrals, actions and agreements.

Outcome Plan Report

To assist a case worker with conducting reviews and meetings about a clients progress towards achieving positive outcomes, an outcome plan report can be generated. There are two versions of the report available to a case worker: an overall outcome plan report and a short version for individual items associated with the plan.

When selecting to generate the overall outcome plan report, the case worker has the option to select the items to include in the report. For example goals, objectives, activities, factors. The items available to the case worker to select are based on the content items configured in the Administration Application. If the caseworker does not select any items to print, the generated document will contain a table of contents and an overview section, which shows outcome plan details and the clients on the outcome plan. Based on the items that are selected by the case worker, the document may also contain details for the goals, objectives, factors, assessments etc, that are associated with the plan.

The case worker also has the option to generate a report for an individual item associated with the plan, for example a goal. The report contains relevant details for the selected item, for example, progress, reviews, notes etc. This print option is available for goals, objectives, factors, assessments, reviews, services, actions, referrals, cost statements, contact logs and visits associated with a plan.

Managing Correspondence

Correspondence can be sent to or from the agency by using standard Cúram Communications. Communications can be paper, telephone, or email based. Communication functionality can be integrated with Microsoft® Word templates, XSL templates, or email servers.

As mentioned in [Referring A Client For A Service on page 32](#), a case worker can also send referral letters to the client and provider associated with the referral or they can send them at a later date. Once the referral has been created the case worker can print the letters and post them to the client or provider.

Recording and Updating Notes

Notes are used to provide additional information about an element of an outcome plan. Users can add a note to an assessment, a service, an action, a referral, a factor, an objective and a goal. A note is entered as free text and can be prioritized and given a sensitivity rating so that it can only be accessed by certain users.

Users can modify a note that is added to outcome plans and assessments to update its priority, sensitivity, and append additional note text. If configured, they can also edit their original note text for a specific time period. For more information about appending to notes and editing notes, see the *Integrated Case Management Guide*.

Notes that are added in outcome plans to services, actions, factors, objectives, and goals cannot be modified.

When a note is added or appended, the system maintains a note history which includes each version of a note, the time and date the note was entered on the system, and the user who made the modifications.

For more information about configuring notes, see the *System Administration Guide*.

Related Cases

A case relationship is a link between an outcome plan and an integrated case. Case relationships can be created manually by a worker or automatically during case processing. A relationship can be manually created between two cases for a number of reasons. Certain relationships are created

automatically during case processing, for example when an outcome plan is created from an integrated case, a case relationship record is created between the outcome plan and the integrated case.

Completing The Outcome Plan

Completing an outcome plan involves reviewing each element in the outcome plan and identifying whether a positive outcome was achieved on completion. Actions, services, goals and objectives can be completed at any time while the plan is open but should be completed before closing the outcome plan.

Completing Actions And Services

Completion of an action or service indicates that the client will no longer be participating in that action or service i.e. the service or action has ended. When completing an action or service the following outcomes can be recorded - successful, not successful i.e. whether the service or action was successful in meeting the needs of the client. If the service or action was not successful, a reason must be specified to indicate why it was unsuccessful. Specifying the outcome of a service or action helps to identify a client's progress on a plan and helps to identify if the service or action should be used in future to try to meet client needs.

When completing an action the case worker may also specify the actual cost of the action. Actual cost of the action can be specified if the action has been configured such that estimated and actual costs can be specified by a user.

Completing And Recording Outcomes For Goals And Objectives

As with actions and services, goals and objectives can be completed. Completing goals and objectives indicate whether the client achieved a positive outcome for the goals and objectives defined for them. If the goal or objective was not attained, a reason must be specified to indicate why it was unsuccessful. Specifying outcomes for objectives can be used as an indicator of a clients progress towards achieving their overall goal. For example, if a client has an objective to 'Remain Clean And Sober', it is not likely that the client will attain their goal of Self Sufficiency if they do not attain this objective. Specifying the outcome of a goal identifies the clients over all success having been involved in the planning process.

Closing The Outcome Plan

An outcome plan can be closed at any time. However, it is advised that it is only closed when all goals and objectives within the outcome plan have an outcome specified i.e. whether the outcome was attained or not attained. Once closed the outcome plan status goes from 'Open' to a status of 'Closed'.

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