

Home Care Case Management

**Invitational Roundtable
March 3 & 4, 2005**

Summary of the Proceedings



Canadian HomeCare
Association
canadienne des soins
et services à domicile

PREFACE AND ACKNOWLEDGEMENTS

The Canadian Home Care Association (CHCA) is a national, not-for-profit membership organization over 600 organizations and individuals from the publicly funded Home Care programs, not-for profit and proprietary service agencies, consumers, researchers, educators and others with an interest in Home Care. Through ongoing dialogue, publications, and position papers the CHCA acts as a united voice and access point for information and knowledge for Home Care across Canada.

In support of one of the CHCA's strategic initiatives this Roundtable was conducted to provide information and recommendations for health policy planners and administrators, government and health care leaders, and others who are interested in promoting the recommendations on Home Care contained in the 2004 10-year plan to strengthen health care.

The Canadian Home Care Association (CHCA) is enormously grateful to the Roundtable participants and presenters who contributed their time to provide ideas and direction on case management in home care.

The Canadian Home Care Association Board of Directors provided invaluable guidance and direction throughout the project and extends a special thank you to Marg McAlister, MMC Consulting for her facilitation of the Roundtable and writing of the final report.

It is our intention that this report will serve as a basis for discussion and further learning of home care case management in each province and territory.

Nadine Henningsen
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Canadian Home Care Association
March 2005

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The views expressed herein do not necessary represent the official policies or opinions of Health Canada.

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EXECUTIVE SUMMARY

Responding to the growing recognition of the importance of case management nationally, provincially and territorially, the Canadian Home Care Association (CHCA), with the support of Health Canada, hosted an *Invitational Roundtable on Case Management*. Participants to the discussion included home care leaders from every province and territory. The goal of the meeting was to define case management and in so doing develop a common understanding about case management within the federal /provincial /territorial home care programs.

Participants worked collaboratively to define the principles and elements of case management while recognizing the importance of maintaining a flexible framework which can be applied broadly depending upon each jurisdictional context. The Roundtable dialogue built upon the sharing of experiences and best practices across the country. While each provincial and territorial home and community care program differs in scope, access and content, the single unifying element of all programs is case management.

Throughout the Roundtable discussions there was general agreement that case management is not an independent function or designated to a specific discipline. Rather, it is a strategy or process¹ undertaken by all health care professionals; and indeed a strategy that clients themselves employ to varying degrees depending on their context and position within the health care continuum.

Case management is a strategy for maximizing client wellness and autonomy, within their context, through advocacy, communication, education, identification of service resources and service facilitation. Case management is built into all health professionals' scope of practice. The case manager, as part of a team, helps to identify appropriate services and options throughout the health care continuum, while balancing effective resource utilization in order to optimize value for the client and the system.

*Case Management is a **collaborative client-driven strategy** for the provision of **quality** health and support services through the effective and efficient use of **available resources** in order to support the client's **achievement of goals** related to **healthy life** and living in the context of the person and their **ability**.*

Roundtable participants identified the principles that guide case management to be:

- Centred around and driven by the client/caregivers of all ages, respecting their choices, culture and values.

¹ Participants agreed to use strategy and process interchangeably agreeing that the important distinction is that case management is not a service provided by a distinctly defined and trained group of professionals.

- Inclusive of strategies that enhance health promotion, illness prevention and risk mitigation through client education and emphasis on health promoting behaviours directed to the client's capacity for self management, self care.
- Purposeful incorporating evidence-based practice.
- Respectful and collaborative, engaging the family and community resources.
- Creative and innovative and requiring effective communication.
- Guided by an ethical framework.
- Advocating on behalf of clients, and promoting independence.
- Responsive to client characteristics and changes in needs.
- Incorporating of principles of population health and the broad determinants of health.

As a strategy to support health care and effective use of available resources, forum participants identified the following key elements of case management, regardless of the case management model.

- Intake, which includes screening, prioritizing and determining eligibility.
- Assessment in order to determine client needs, wants and goals.
- Care and service planning, and coordination of services which requires effective communication and liaising and considers cost-effectiveness.
- Care implementation.
- Monitoring and evaluating outcomes from a patient and population perspective.
- Reassessment/revision of care plan to reflect cycles of care.
- Disengagement, discharge, service completion.

Home care case management plays a role in some *transitions*; in gate keeping, resource utilization, and resource management. Case management varies in intensity according to client needs and is shared between the health practitioner (which includes the case manager) and the client/caregivers.

The case manager, as part of a team, helps to identify appropriate services and options throughout the health care continuum, while balancing effective resource utilization in order to optimize value for the client and the system. Typical outcomes of case management were reported by participants to include:

- Delivering the appropriate service at the right time.
- Decreased duplication of services.
- Reduction of hospital/emergency utilization.
- Improved client health status.
- Decreased caregiver burden.
- Improved connections across the system.
- Improved disease management.
- Avoidance of institutionalization.
- Increased client participation in care.
- Achievement of client goals.
- Client satisfaction.

However, these outcomes are difficult to quantify and/or prove that they are a result of case management intervention. Participants concurred that there is a risk to suggesting that case management can be accountable for outcomes that in fact are dependent on the rest of the health care team and on the system in which the health care service operates. Indicators specific to case management, need to be carefully selected and implemented in order to avoid wrongly attributing to case management results that are team or system dependent.

As the health care system continues to evolve and adapt to new challenges such as chronic disease management and systems integration, case management will become a vital factor in the effective and efficient functioning of our health care system. In the home care sector, the employment of the case management as a strategy for maximizing client wellness and autonomy will be enhanced through a common understanding of the definition, principles and outcomes of case management.

This report represents the integration and synthesis of the information and discussion shared at the Roundtable. CHCA hopes that it will provide federal, provincial and territorial home care stakeholders with a common definition and will also provide a guide to creating context specific models for case management; stimulate the development of case manager core competencies and influence human resources recruitment and retention strategies.

Building a greater understanding of the role of case management in systems integration will enable the capturing of best practices for the use of case management in home care programs in order to achieve improved delivery of health care services for acute, chronic and palliative clients.

The CHCA as a national voice for home care across Canada can play a key role in informing and influencing change by sharing a common understanding of case management to shape an overarching framework under which the provinces and territories can plan and develop their unique programs.

SITUATIONAL CONTEXT

The achievement of “health and wellness” requires many inter-related services including health prevention, promotion and protection, diagnosis, treatment/cure, rehabilitation, support and maintenance, and social adaptation and integration². **Home care** is uniquely positioned within our health care system to provide these components and services along the health care continuum and to function as a bridge between the various settings of care, whether they are the acute care hospital, the long term care facility, respite care or the physician’s office place.

The Canadian Home Care Association defines home care as an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal (family) caregiver. Home care programs often integrate the delivery of health care services in the home setting with the broad myriad of community services (i.e. meal delivery services, day programs, respite care facilities, visiting and other volunteer services, transportation services and personal support which in some provinces is considered a community service).

While each provincial and territorial home and community care program differs in scope, access and content, the single unifying element of all programs is case management. Case management addresses the challenge of matching client identified needs and choices with services often offered by multiple agencies, and within increasingly limited health care resources. This process is essential to ensuring the well being of the client while serving as the link between positive health outcomes, community resources and fiscal accountability.³

The November 2002 Romanow report, *Building on Values: the Future of Health Care in Canada* recognized the role and value of case management. The report notes that all provinces and territories offer some assessment and case management as part of home care services and recommends that “*coverage for post-acute home care should include case management, health professional services and medication management*”. Additionally, the report recommended that “*case management be included in the coverage as part of home care mental health services*”.

In 2004, the Federal/ Provincial/ Territorial *10 Year Plan to Strengthen Health Care*, identified case management as a core service in the home care baskets to which First Ministers agreed to provide first dollar coverage by 2006.

² Health Care in Canada 2001, Canadian Institute for Health Information

³ A Coordinated Home and Community Care Strategy. Essential Elements, November 2002, Canadian Home Care Association

Responding to the growing recognition of the importance of case management nationally, provincially and territorially, the CHCA with the support of Health Canada undertook a consultation with home care leaders from every province and territory to define case management and in so doing develop a common understanding about case management within the federal /provincial /territorial home care programs and with their respective health care and community partners. The results of the consultation are captured in this report to Health Canada. A description of the undertaking is available at Appendix 1.

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ROUNDTABLE DISCUSSIONS

Case Management: A Systems Approach

Sholom Globerman, Philosopher in Residence at the Baycrest Centre for Geriatric Care provided an overall commentary on health care systems and the role of case management in a systems structure. Key points from his presentation are described.

- Case management began in the 1970s. The approach was based on traditional health care dynamics which required case managers to define their work as a series of steps or processes and to function in a standardized manner, the assumption being that “cases” would fit into defined niches.
- The function of case management was as gatekeeper to prevent hospital or long-term care admissions and in so doing control costs. Case management has evolved differently across Canada, but generally toward having a stronger advocacy role in order to assist clients to navigate the system. Case management continues to have an emphasis on resource utilization. In many jurisdictions it also has responsibility to ensure service quality resulting in the development and application of service guidelines informed by utilization reports.
- Complex chronic conditions require an approach that is flexible, unique to each individual and to accept that the approach does not assure the same outcome each time. This, he argued, is distinct from acute and complicated diseases that are well served by surgery and hospitalization.
- Case management and indeed home care is about “expecting the unexpected”. Case management functions in an unstable system.
- Today health is a dynamic interaction between and individual and many environments. The goal is to keep people healthy at home.
- Case management functions within a complex system. Notwithstanding attempts to integrate our health system, some boundaries are useful and necessary. An important element of case management is the understanding of the boundaries and developing horizontal knowledge, watching the gaps, and understanding how to cross them.

Case Management: A Regional / District Approach

In order to move towards a common understanding of case management, the broad dialogue was enhanced with a series of presentations to showcase diverse approaches to the challenge of regional systems integration and case management. The presentations were from British Columbia⁴, Alberta⁵ and the United Kingdom⁶. As information was shared and impressions formed, subsequent questions and group discussions were pursued.

While intuitively understood to be important, there are a number of ways in which case management is understood and operationalized.

The **Health Regions of Interior Health and Vancouver Coastal Health**, in British Columbia shared their home care case management model impressing upon participants the importance of recognizing that case management operates within the client context and is “client-driven”. It uses a population health model framework to describe the health status and characteristics of the clients within the communities served. Case management is described as a process that operates within a continuum of health that spans wellness to complex acute episodes where clients experience an acute unstable health episode and require intensive care management. Along the continuum are an ever-increasing number of individuals with chronic conditions who benefit from case management directed at maximizing independence and preventing deterioration.

“All clients need their care managed.... Not all clients need a case manager.”

(Case Management in B.C. 2005)

Calgary Health Region, having released its *Framework for Case Management* in June 2004 challenged participants to accept that case management is a “client-centred strategy” that manages “the provision and coordination of care across the [health] continuum” and draws on experience and evidence to achieve client outcomes within available resources.

“Case management is a client-centred strategy that manages the provision and coordination of care across the continuum”.

(Framework for Case Management, Calgary Health Region, 2004)

Participants were reminded of the drivers influencing home care and case management – primary health care, chronic disease, primary care, and home care expectations. While case management strategies vary according to circumstances the framework’s key concepts include being “client-centred”, driven by “quality” and to achieving specific “outcomes”.

⁴ Alice Mah Wren, Director Health Services – Central Okanagan Interior Health; Debbie Weddell, Clinical Practice Consultant – Interior Health; Shannon Berg, Leader Regional Health Services Projects, Community Care Network -Vancouver Coastal Health

⁵ Barbara Korabek, Executive Director, Mental Health – Calgary Health Region

⁶ Ruth Hutt, Visiting Fellow in Health Policy, King’s Fund - England

From the **United Kingdom**, we learned about the evolution of case management and of the research that had been undertaken in order to inform their case management and policy development. Case management is aimed toward efficiently and effectively coordinating services in order to “improve quality of life and reduce service utilization”. Key to effective case management is participation on a team; and providing “pro-active”, “client-centred” care that crosses health and social service boundaries.

While cost containment has been a driver in Britain, Ruth Hutt’s research on the various models and approaches to case management around the world challenged Roundtable participants to question whether case management actually impacted health system utilization and cost.

Themes & Trends in Case Management

In the Roundtable discussions a number of themes and trends impacting the thinking of case management emerged. These include:

- Agreement that case management is not an independent function or designated to a specific discipline. Rather, it is a *strategy* or *process*⁷ undertaken by all health care professionals; and indeed a strategy that clients themselves employ to varying degrees depending on their context and position on the health care continuum.
- Increasing interest to understand the *value* and contribution of case management with an emphasis on articulating *outcomes*. As health care activities are interdependent and it is important to clearly understand the role and contribution of all health care team members, isolating a team member and suggesting that they directly and solely influence specific health outcomes is too simplistic. Through algorithm /care pathway development the contributions of team members is best articulated and the health outcomes (clinical and system) are used to hold the team *accountable*.
- Increasing recognition of the importance of *collaboration* amongst the health care team and across traditional boundaries.
- Emphasis on the *ethical dilemmas* facing casing management is increasing as the tension between limited resources and increasing demands for service increases.
- Distinctions between *client centred* and *client driven* care reflect the increasing consumer awareness today. Respecting clients’ rights and choices in care can be achieved when cultural and linguistic needs are addressed and options are presented in a respectful and accurate manner.

⁷ Participants agreed to use strategy and process interchangeably agreeing that the important distinction is that case management is not a service provided by a distinctly defined and trained group of professionals.

- *Advocacy* is a key component of every professional's practice and accordingly integrated into an effective case management strategy arising from the commitment to client autonomy.
- The aging population and concomitant chronic diseases is straining the health care system, becoming a priority for governments and requires ever increasing emphasis on *resource utilization* (ensuring the right service for the right person at the right time) by the case manager.
- Home care case management has a role to play in some *transitions*; in gate keeping, resource utilization, and resource management; and that case management is built into all health professionals' scope of practice. Case management varies in intensity according to client needs and is shared between the health practitioner (which includes the case manager) and the client/caregivers.

WHAT IS CASE MANAGEMENT?

Achieving consensus as to the principles and elements of case management respects the jurisdictional flexibility of home care as a provincial program.

“Case management is not a profession in itself, but an area of practice within one's profession. Its underlying premise is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems and the various reimbursement sources.”⁸

Case management can be defined a number of ways based on different models of case management, various target populations, diverse home care organizational structures, and varied program goals.⁹ Definitions include:

- “a process that uses the integration of managerial and clinical knowledge and skills by a case manager who interacts within a service network to provide needed services in a supportive, effective, efficient, and cost effective manner.”¹⁰
- “a health care delivery process whose goals are to provide quality health care, decrease fragmentation, enhance clients' quality of life, and contain costs.”¹¹
- “a process of assisting a client to identify needs, set goals, develop a care plan and access resources, with the objective of facilitating the client's survival, personal growth, community participation and recovery from/adaptation to alterations in health status.”¹²

⁸ Case Management Society of America, <http://www.cmsa.org>

⁹ Ida M. Martinson, Ann G. Widmer, Carmen J. Portillo, *Home Health Care Nursing*, Second Edition (Philadelphia:W. B. Saunders Company, 2002), 15.

¹⁰ *Ibid.*, 14.

¹¹ *Ibid.*, 33

- “a client-centered strategy for the provision of quality health and social services. Case management is used to manage the provision and coordination of care across the continuum and to balance potential client outcomes with effective use of available resources.”¹³
- “a collaborative client-centred strategy for the provision of sustainable quality health and social services. Case management is used to manage coordination of care across the continuum, through the activities of intake, assessment, care planning, service delivery, monitoring, reassessment & disengagement to balance potential client outcomes with effective use of available resources.”¹⁴
- “the process of planning, co-ordinating, managing and reviewing the care of an individual. The broad aim is to develop cost-effective and efficient ways of co-ordinating services in order to improve quality of life.”¹⁵
- “a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.”¹⁶

The definition for home care case management has arisen from the consultations at the Invitational Roundtable on Case Management. The key words in the definition are highlighted.

*A **collaborative client-driven strategy** for the provision of **quality** health and support services through the effective and efficient use of **available resources** in order to support the client’s **achievement of goals** related to **healthy life** and living in the context of the person and their **ability**.*

¹² Case Management in B.C. – presentation at Roundtable

¹³ Framework for Case Management Calgary Health Region, p8

¹⁴ Roundtable Participant suggestion

¹⁵ Case-Managing Long-Term Conditions, p2

¹⁶ Case Management Society of America, <http://www.cmsa.org>

Core Principles of Case Management

Roundtable participants concurred that the following principles guide case management. These include:

1. Case management is centred around and driven by the client/caregivers of all ages. Case management strategies are based on clinical reasoning and a partnering relationship in which professionals work collaboratively with clients and their caregivers, respecting their choices, culture and values. This includes the participation of children and youth in their own health care.
2. Case management strategies enhance health promotion, illness prevention and risk mitigation through client education and emphasis on health promoting behaviours directed to the client's capacity for self management, self care.
3. Case management is purposeful incorporating evidence-based practice to ensure quality care and outcomes.
4. Case management is respectful and collaborative, engaging the family and community resources for needed support.
5. Case management is creative and innovative and requires effective communication.
6. Case management is guided by an ethical framework which is primarily embedded in the professional's practice guidelines and considers client rights, beneficence, equity, non-maleficence and autonomy and power imbalances.¹⁷
7. Case management advocates on behalf of clients, and promotes self advocacy and independence.
8. Intensity and type of care management and monitoring varies based on client characteristics and changes in the client's needs within the context of their world.
9. Case management incorporates principles of population health and the broad determinants of health into its approach.

¹⁷ Ethical Dilemmas in Home Care Case Management, p115

Key Elements of Case Management

As a strategy to support health care and effective use of available resources, forum participants identified the following key elements of case management, regardless of the case management model.

- Intake, which includes screening, prioritizing and determining eligibility.
- Assessment in order to determine client needs, wants and goals.
- Care and service planning, and coordination of services which requires effective communication and liaising and considers cost-effectiveness.
- Care implementation.
- Monitoring and evaluating outcomes from a patient and population perspective..
- Reassessment/revision of care plan to reflect cycles of care.
- Disengagement, discharge, service completion.

Competencies

While not specifically sought, discussion amongst Roundtable participants surfaced a preliminary list of specific competencies embodied by professionals employing effective case management strategies. These were generally thought to be achieved through experience within the health care system and include:

- Clinical knowledge.
- Critical thinking enabling evidence-based practice.
- Awareness of the organizational, legal and professional standards for documentation and reporting.
- Ability to operate flexibly within existing resources, protocols/policies/ legislation.
- Responsible and ethical advocacy involving cultural competence.
- Ability to be jointly accountable to the client and the system.
- Self-awareness.
- Communication skills that enable collaboration.

Outcomes of Case Management

Case management is a process or strategy directed toward achieving defined goals. Assessment of case management outcomes tends to focus on 'process-related' activities as to date there are no scientifically rigorous measurements of outcomes.

Case management is a strategy for maximizing client wellness and autonomy, within their context, through advocacy, communication, education, identification of service resources and service facilitation. The case manager, as part of a team, helps to identify appropriate services and options throughout the health care continuum, while balancing effective resource utilization in order to optimize value for the client and the system.

*Patient-centred
outcomes are often
improved upon but at
unknown cost”
(VATAP)*

Typical outcomes of case management were reported by participants to include:

- Delivering the appropriate service at the right time.
- Decreased duplication of services.
- Reduction of hospital/emergency utilization.
- Improved client health status.
- Decreased caregiver burden.
- Improved connections across the system.
- Improved disease management.
- Avoidance of institutionalization.
- Increased client participation in care.
- Achievement of client goals.
- Client satisfaction.

However, these outcomes are difficult to quantify and/or prove that they are a result of case management intervention. Participants concurred that there is a risk of suggesting that case management can be accountable for outcomes that in fact are dependent on the rest of the health care team and on the system in which the health care service operates. Indicators, specific to case management, need to be carefully selected and implemented in order to avoid wrongly attributing to case management results that are team or system dependent.

Effective evaluation of health care services assesses the outcome of the collective health care team. One does not measure system impact by the contribution of the nurse on the hospital ward; but rather recognizes that to reduce length of stay, for example, one assesses the work of the entire health team. Accordingly attempts to assign system wide cost savings to case management are not valid. “The best case-management arrangements may fail to reduce hospitalization if they are not developed in conjunction with social care and other services needed to maintain people in the community.”¹⁸

The *outcomes of a case management strategy* embedded within the effort of the health care team are:

- the ability of the client/caregiver to make progress toward their goal within limits of available resources; and
- the improvement of the overall effectiveness of health care services through collaboration with the health care team to increase appropriate utilization of services and reduce duplication, gaps and barriers to service.

There is mixed evidence as to the cost-effectiveness and impact on system utilization of early intervention to provide clients with case management of their chronic disease in order to prevent co-morbidities and delay deterioration. Notwithstanding, there is a great deal of interest in providing case management to patients ‘upstream’ in order to avoid costs later. Intuitively, it makes sense, but more research is needed.

However, the reality of increasing demand is that health costs will remain unchanged as the next neediest patients who are not case managed access care.¹⁹

Requirements to Support Effective Case Management

Forum participants articulated a series of environmental, system and human resource requirements that must be in place to support the effective implementation of case management as a strategy for maximizing client wellness and autonomy.

Limited resources

- Financial – insufficient funds; prescriptive funding (units of specific service).
- Little or poor technology and tools to support data collection and information sharing.
- Shortage of human resources and insufficient supply of skilled and available personnel.
- Absence of formalized knowledge base upon which to build educational programs to help professionals develop case management competencies.

¹⁸ Managing Long-Term Care, p20

¹⁹ Case -Managing Long-Term Conditions, p 19

Absence of integration incentives within the health care system

- Health care funding and delivery “stove pipes” area a disincentive to collaborative care and health promotion case management.
- Lack of trust and understanding of scope of practice among different service providers, often resulting in duplication.
- Compromised knowledge of services available.
- Restrictive eligibility requirements especially evident in the preventative elements of health care.
- Lack of understanding and optimization of case management across the health care continuum.

Absence of Evidence to support decision making

- Lack of national practice standards and consistent education for case management.
- Absence of formalized processes to share knowledge and access experts on case management (i.e. standards, accepted ethics, best practices).
- Knowledge of population based needs.
- Lack of concrete evidence at the systems level of cost benefits /cost avoidance to case management.

Policy Implications

The expectations from First Ministers; escalating chronic disease in Canada and a commitment by health care stakeholders to undertake continuous quality improvement initiatives are driving greater emphasis within the Canadian health care system. As a constant in home care, the principles of case management need to be understood and commonly defined in order to ensure equity across the country.

The CHCA as a national voice for home care across Canada can play a key role in informing and influencing change by sharing a common understanding of the definition, principles and outcomes of case management to shape an overarching framework under which the provinces and territories can plan and develop their unique programs. In so doing the common principles can be relied upon to develop local community responsive programs.

Roundtable participants proposed a number of recommendations to advance a common and consistent understanding and approach to home care case management in Canada.

They felt that their recommendations would address the key challenges articulated. They suggest that the CHCA:

- Maintain a leadership role in case management dialogue to shape the future direction of this key health care strategy.
- Share case management models and best practices by publishing a 'Portraits of Case Management' that describes the models and related policies for each of the federal / provincial and territorial jurisdictions.
- Develop a Case Management Position Paper to engage the health team beyond home care in understanding and valuing case management (engage representatives from physician groups, public health, consumers, mental health, etc).
- Facilitate and promote Case Management discussions and planning through the National Home Care Conference.
- Support a dissemination strategy to communicate the outcomes of this roundtable in gain further consensus on a definition, functional components and principles of case management.
- Participate in the development of outcome measures – e.g. client satisfaction; clinical outcomes.

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APPENDIX 1

PROJECT DESCRIPTION

The CHCA hosted a stakeholder roundtable to develop consensus on the definition, principles and outcomes of case management in the home care sector in Canada and advise the federal government on the challenges, gaps and policy implications to achieving these outcomes. The roundtable included a broad representation of home care programs and service providers across Canada (see Appendix 2).

Goals

- To develop a document including the definition, principles and outcomes of case management within the home care sector and provide policy advice on the challenges and gaps to achieving these outcomes.
- To support the development of the case management role in provincial, territorial and federal home care programs by jointly articulating the definition, core principles and outcomes of case management in home care.
- Build on the achievements of current CHCA projects (*Augmentation of the role of Case Management in Primary Health Care, The Canadian Home Care Human Resource Sector Study* and the *Case Management & System Integration Roundtable* proceedings at the 2004 CHCA conference) to promote further dialogue on the evolution of the case management in the home and community care sector nationally.

Objectives

- To hold a two day invitational roundtable of provincial, territorial and federal stakeholders in February or early March 2005. Provincial and territorial participants will be identified by the CHCA Board of Directors who represents CHCA membership across Canada. The CHCA will work collaboratively with Health Canada representatives to identify federal participants for the roundtable.
- The roundtable will include updates and presentations on current home care case management strategies (including the role of the informal / family caregiver in case management) to set the context of the discussion. The group will be tasked to develop common principles and outcomes of case management. Additionally, challenges, gaps and policy implications to achieving these outcomes will be identified and discussed during the second day of the round table.
- To reach an understanding and consensus on the definition, principles and outcomes of case management as they relate to home care in Canada.

The final report will help inform the Provincial / Territorial and Federal activities supporting the 2004 Health Accord and future development of home care programs. The CHCA will disseminate the report to the roundtable participants, CHCA members and home care stakeholders across Canada.

APPENDIX 2

GLOSSARY OF TERMS

Advocacy - act of recommending, to plead the cause of another; to speak or write in favor of. (*Ref: Case Managements Society of America*)

Assessment - a systematic process of data collection and analysis involving multiple elements and sources. (*Ref: Case Managements Society of America*)

Autonomy – freedom of self-determination (*Ref: Webster's Canadian Dictionary*)

Beneficence – the principle dictate the need to inflict no harm on clients, to try to inflict benefits, or to ensure that the benefits outweigh the harm. (*Ref: Ethical Dilemmas p117*)

Canadian Home Care Association - (CHCA) is a national not-for-profit membership Association dedicated to ensuring the availability of accessible, responsive home care and community supports which enable people to stay in their homes with safety, dignity and quality of life. The CHCA represents over 600 organizations involved in home and community care across Canada. Through ongoing dialogue, publications, and position papers we act as a national voice and promote excellence in home care through leadership, awareness and knowledge to shape strategic directions.

Home Care - CHCA defines home care as an array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal (family) caregiver. Home care services are for infants, children, adults and seniors. Home care programs often integrate the delivery of health care services in the home setting with community services (e.g. meals on wheels, day programs, respite care facilities, volunteer services, and transportation services).

Client Centred care – planning, treatment and management involves patient, caregivers and advocates at all levels and goals are related to patient outcomes. (*Ref: What is the evidence for the effectiveness of managing the hospital/community interface for older people?*)

Client Directed service delivery - the need for client choice in making decisions about their requirements, client abilities, and the need to ensure that the service fits the context in which the client lives. (*Ref: Client Centered Practice: What Does it Mean and Does It Make a Difference?*)

Competency - the skill, ability, knowledge, behaviour and attitude that is instrumental in the delivery of desired results and, consequently, of job performance. (*Ref: Pan American Health Organization, 2002.*)

Equity – distributive justice (*Ref: Ethical Dilemmas p118*)

Non-maleficence – doing no harm (*Ref: Ethical Dilemmas p118*)

Process – intervention taken to achieve the outcome (*Ref: Advanced Case Management p 55*)

Outcomes: Measurable results of case management interventions, such as client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle. (*Ref: Case Management Society of America*)

Strategy – a unified comprehensive and integrated plan...designed to ensure that the basic objective of the enterprise are achieved. (*Ref: Framework for Case Management, p34*)

Transitional care - coordinated and continuous planning for health care during transfer of patients between locations or levels of care – e.g., hospitals, acute, post acute and long-term nursing facilities, home, and specialist referral. (*Ref: What is the evidence for the effectiveness of managing the hospital/community interface for older people?*)

Transition planning - the management of a complex two-way interface between institutions and community-based service providers. The two-way nature of this information exchange implies an on-going and continuous relationship between providers of care, permeable boundaries and the need for enhanced accountability between care providers in different sectors. (*Ref: OHCC*)

APPENDIX 3

Roundtable Participants

Mary Lou Ackerman	Vice President of Information Management Saint Elizabeth Health Care CHCA Silver Patron
Shannon Berg	Leader, Regional Health Services Projects, Community Care Network Vancouver Coastal Health British Columbia
Lucy Barylak	Coordinator of the Caregiver Support Center, Elder Abuse Consultation Center and Mental Health for the Elderly CLSC Rene Cassin, Institute of Social Gerontology of Québec Quebec
Joanne Besner	Social Service Clinical Supervisor Homecare CLSC Rene-Cassin Quebec
Nancy Blades	Supervisor Case Management COTA Health CHCA Gold Patron
Cec Charlebois	Home Care Manager Saskatoon Health Region Saskatchewan
Gail Chester	Home Care Social Worker Yukon Home Care Program Yukon
Donna Davis	National Nursing Officer Veterans Affairs Canada
Linda Doody	Manager, Seniors Program Department of Health and Community Services Newfoundland
Susan Donaldson	Facilitator Susan Donaldson & Associates

Rheta Fanizza	Chief of Staff CCAC Procurement Review Ontario
Arlene Gallant-Bernard	Director Patient Services & Community Health West Prince Health Price Edward Island
Gogi Greeley	A/Director Health & Social Services Government of Nunavut Nunavut
Jennifer Greene	A/Manager Home and Continuing Care Policy Unit, Health Canada National
Kathy Greenwood	Director of Continuing Care Nova Scotia Department of Health Nova Scotia
Cheryl Hansen	Director of Extra-Mural Program and Rehabilitation Services N.B. Department of Health & Wellness New Brunswick
Nadine Henningsen	Executive Director Canadian Home Care Association National
Ruth Hutt	Visiting Fellow in Health Policy King's Fund England
Pauline Jackson	Territory Manager Calea Ltd. CHCA Gold Patron
Ialeen Jones	Senior Nursing Consultant, Home Care Department of Health & Social Services, Government of the Northwest Territories NWT

Sue Kelly	National Health & Wellness Manager We Care Health Services CHCA Silver Patron
Judy Knight	Director Policy and Planning Branch, Manitoba Health Manitoba
Barbara Korabek	Executive Director of Mental Health Calgary Health Region Alberta
Georgia Livadiotakis	Policy Analyst Primary Health Care Policy Unit Health Canada National (Health Canada)
Joanne Lucarz-Simpson	National Coordinator, Home and Community Care, First Nations Home and Community Care Program Health Canada National (FNIB)
Alice Mah Wren	Director Health Services – Central Okanagan Interior Health British Columbia
Wendy Marlow	VP Homecare Mktg & Business Development VitalAire CHCA Gold Patron
Sharon Marsden	Program Manager, Community Care Access Centres Branch Ministry of Health and Long-Term Care Ontario
Marg McAlister	Facilitator MMC Consulting

Kay Morrison	Director Client Services Community Care Access Centre Simcoe County Ontario
Bob Morton	Executive Director Community Care Access Centre of Peel Ontario
Carol Nafziger	National Clinical Director, Nursing and Home Support Comcare Health Services Service Provider
Kathy Nakrayko	Manager Client Patient Access Services, Saskatoon Health Saskatchewan
Judy O'Keefe	Assistant CEO Health and Community Services Eastern Newfoundland Newfoundland
Major Joanne Plemel	Specialist Services Coordinator Deputy Chief of Staff Health Services Delivery Canadian Forces Medical Group Headquarters National (DND)
Sharon Robson	Manager, Peel SDC Saint Elizabeth Health Care CHCA Silver Patron
Corrine Rowswell	Home Care and Palliative Care Policy Analyst Department of Health and Social Services Prince Edward Island
Janet Simm	Director, System Planning & Liaison NS Department of Health, Continuing Care Branch Nova Scotia
Sandra Sims	Program Consultant Dept. of Family & Community Services N.B. Department of Health & Wellness New Brunswick

Marilyn Soper

Home Care Nurse
Government of Nunavut
Nunavut

**Lieutenant Francine
Tremblay**

Case Management Program/Programme de Gestion des cas
Canadian Forces Health Services Group HQ
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Ava Turner

Manager
Comcare Health Services
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Sue VanderBent

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Debbie Weddell

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