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Case Management in the Community

PRACTICE GUIDELINES

COMPETENCIES

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Communication

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Critical Thinking & Decision Making

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Accountability

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Teamwork & Collaboration

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Leadership

PURPOSE

This guideline is to assist:

- Providers to implement and manage the best practice approaches in case management.
- Support Case Managers to get the best out of the client/ case manager relationship.

DESIRED OUTCOME

- To maintain a quality and safe standard of service delivery support
- Improve the communication and engagement with clients and key stakeholders.
- Improve client outcomes in achieving their individual goals.

SCOPE

This guideline applies to the provision of paid support services in the community. They are relevant Australia-wide or when a participant is travelling overseas with their Australian team of support worker/s.

DISCLAIMER

This guideline is provided to help guide best practice in the disability, aged care and community support industry. This information does not in any way replace legislative, regulatory, or contractual requirements. Users of this document should seek appropriate expert advice in relation to their circumstances. ACIA does not accept any liability on the use of this guideline.

BACKGROUND

Case management is an integrative and collaborative process of coordinating individual care through assessment, planning, implementation and evaluation (Brooke, 2010). Case management has been reviewed and redefined for many decades, owing to the variety of applications and operational environments in which it occurs (Aliotta, 1996; Drennan & Goodman, 2004; Intagliata, 1982). Variations in definitions depend on the discipline in which evolved, the setting in which it was implemented and the intended application by different staff who engage with the framework In general, the aims of case management are to coordinate care, minimise costs, improve access to services and resources, sustain a cost effective service delivery model, and ensure inter-professional collaboration to achieve intended outcomes (Tyrer, 2000; White & Hall, 2006). Core functions of many case management models include needs assessment, service planning, implementation, and evaluation of the outcomes for clients (Huber et al., 2003).

DEFINITIONS & SUPPORTING INFORMATION

Community Supports and/or Services is defined as the provision of paid supports and services in a service user's home or community. It includes but is not limited to, the following activities of daily living:

- personal care or support
- housework or domestic assistance
- transport assistance
- community access
- social support
- nursing services
- clinical supports
- gardening and home maintenance
- palliative care
- respite care

Support Worker - A paid person who assists people to perform tasks of daily living so as to participate in social, family and community activities in the person's home and their community. Support Workers have been commonly known in the past as attendant care worker, disability worker, aged care worker, community worker, homecare worker, care worker or paid carer.

Service Provider - Organisation or person accountable for the delivery of supports to Clients.

Carer - a person that provides supports to the Client at no cost (generally family or friend).

Support Worker Competency - trained and assessed as competent by a Registered Nurse or a person deemed competent by the provider to safely and appropriately perform a specified task as a support worker.

Client means the service user, participant, user, care recipient, consumer or person receiving the nursing or support services.

Plan means a Service Plan, Support Plan or Individual Plan (however titled – the plan) is a document developed in response to a request for service. It is developed by a Registered Nurse or a person deemed competent by the provider from the service provider, prior to the commencement of service delivery. It outlines the expected outcomes of the requested care/services and the tasks, duties and interventions required to meet the care and service needs of the client (within the parameters of the funding program). The plan guides and directs the individual support worker or Registered Nurse in their day-to- day delivery of the services.

Registered Nurse means a person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered and licensed with the Australian Health Practitioner Regulation Agency (AHPRA) as a Registered Nurse.

Competent means having been trained and assessed by a registered nurse or enrolled nurse or approved assessor as competent to safely and appropriately perform a specified task.

Case Management – "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" (Case Management Society of Australia, 2004, p. 6).

Elements of Case Management

Each Case Management Model has elements applicable to the aged care and community sector, including: continuity of care, service accessibility, enhanced staff-client relationships and collaboration, Case Manager accountability, matching or aligning support to need, active intervention by the Case Manager, facilitating client independence, and client advocacy (Rapp & Goscha, 2004; Thornicroft, 1991).

Figure 1: Collaborative Care Case Management Model (CCCMM) (Brooke, 2010)

Collaboration

Case management requires a concerted commitment to open and effective communication and collaboration between all key stakeholders (Day, 1996; Rosen & Teesson, 2001). Clients need contact with 'familiar' Case Managers at all times, including times when crisis intervention is needed and when emergency situations arise (Rapp & Goscha, 2004). Where therapeutic relationships are developed, there is evidence of improved client outcomes (Howgego et al., 2003). Case management literature identifies case conferences as one strategy that facilitates collaboration. Case conferences are an important collaborative strategy in case management, involving as many key stakeholders, including the client where possible (Biala, 2002; Gagnon et al., 1999; Kuklierus et al., 2000; Mitchell et al., 2005; Peterson, 2004; Stanton et al., 2000; Whywialowski, 2004). Regular case conferences and open communication channels (Cudney & VanTuyle, 2001; Halcomb et al., 2006).

Client Engagement

The focus of all case management models is the client and client-centred care is considered a principal overarching philosophy for many management models aimed at better outcomes for older people (Chenoweth et al., 2009; Fricke, 2006; Glasson et al., 2006; Ponte et al., 2003; Wolf et al., 2008). The centrality of the client is present in all case management models, as is client empowerment through active engagement in decision-making processes (Clemens et al., 1994; Coleman et al., 2004; Cox & Albisu, 2001; Fricke, 2006). Key stakeholders in this process include the client, carer, staff, allied health professionals (including the Medical Practitioner), external support services and where relevant, religious/spiritual personnel. All staff involved in the care of the client must be considered

stakeholders along with family members and need to be actively involved in decision-making, while being up-skilled for the role (Mullen & Kelley, 2006; Stanton et al., 2000).

Key Stakeholder Engagement

Regular and effective communication among the health team is critical in every case management model (Anderson & Tredway, 1999; Bourdeaux et al., 2005; Case Management Society of Australia, 2006; Day, 1996; Halcomb et al., 2006; Taylor, 1999). Ineffective verbal and written communication regarding client requirements is of concern in healthcare and is frequently a contributing factor in negative client outcomes (Haig et al., 2006). Inter-professional collaboration is essential for effective case management, since no one discipline has been found to successfully provide this care service in isolation (Huber, 2000; Tyrer, 2000; White & Hall, 2006). Effective inter-professional collaboration contributes to holistic client assessment, goal planning and care delivery (Hyland et al., 2003; Tucker et al., 2008), which is particularly important for clients with complex health needs and therefore, well suited to the community care sector context (Flicker, 2000; Hickman et al., 2007).

Preparation

Planning to ensure adequate preparation is pivotal (Callaway, 1997; Sinnen & Schifalacqua, 1991). Issues such as developing an organisational vision around case management that is both supported and cohesive is required initially, followed by gathering baseline data (for example; client satisfaction, skin tears, funding classification) and supporting an efficient evaluation. Ensuring processes are based on evidenced based practices, using pathways and capturing variance assists development of quality case management systems.

Organisational Vision

Organisational vision needs to be well articulated and planned prior to implementation (Aliotta, 1996; Cox & Albisu, 2001; Cudney & VanTuyle, 2001; Daniels, 2003; Henson & Daniels, 2002; Intagliata, 1982; Johnson & Proffitt, 1995; Kesby, 2002; Summers, 2009; Taylor, 1999; Thomas, 2008). Henson and Stefani (2002) identified that a lack of vision led to less direction or focus in areas such as financial management, resource allocation and relationship building. Importantly, "lack of vision was often the single most significant impediment to the design of a fully successful case management program" (Daniels, 2003, p. 84). A shared vision and mission "eliminates redundancy, improves health, quality and efficiency, increases access and control costs" (Qudah et al., 1998, p. 11).

Community care sector Pathways

Within community care sector, care plans are routinely developed for all clients, with clinical interventions and funding considerations well integrated, as compared with case management literature that suggests using clinical or care pathways for care planning. Clinical and care pathways are a sequential set of documentation of predicted events and milestones that are expected for the client, using an inter-professional approach (Beilman et al., 1998; Bradley, 1995; Ireson, 1997; Rotter et al., 2008). The value of clinical pathways and care plans includes: cost containment (Johnson & Proffitt, 1995; Rotter et al., 2008); reduced length of stay (Johnson & Proffitt, 1995; Rotter et al., 2008); improved delivery of care (Singh, 2005); assurance of quality care and improvement in client outcomes (Rotter et al., 2008; Sesperez et al., 2001); increased inter-professional collaboration; and improved staff performance (Schriefer & Botter, 2001).

Case Outcomes and Measures (COMs)

Case management is closely aligned with 'outcome management', since "Case Managers are accountable for case management outcomes and case management interventions" (Powell, 2000, p. 55). To demonstrate success, documented case management outcomes must be objective and aligned to organisational goals (Aliotta, 1996; Huber et al., 2001; Powell, 2000; Taylor, 1999), similar in process to quality improvement strategies. As with every planned intervention, case management requires robust data gathering procedures, including baseline client data to measure against achievement of planned goals (Cesta & Falter, 1999; Dewing, 1997).

Implementation

Implementation of case management requires a resource-intensive planning phase, where a model is identified and adapted as required (Callaway, 1997; Sinnen & Schifalacqua, 1991), and key stakeholders are suitably informed and up-skilled. Case management "cannot

work in a vacuum and needs to be a part of a larger activity focused on system-wide improvement in care delivery" (Nash, 1998, p. 144). Implementation of case management is dependent on strategic, well communicated initiatives (Gibbs, 1999). Adequate infrastructure is required, including administrative support and up-to-date information technology (Aliotta, 1996; Carr, 2000; Phelan, 1996; Rosen & Teesson, 2001; Stanton et al., 2000). Challenges implementing case management include confusion due to: overlapping responsibilities; resistance to asking for help (Dzyacky, 1998); fragmented care following from impaired communication (Coile & Matthews, 1999; Day, 1996; McKendry, 2004; Stanton et al., 2000); limited evidence of cooperative practices; and perceived power struggles in care service (Cudney & VanTuyle, 2001). Comprehensive documentation, including client care plans, pathways and variances, is crucial to the success, or failure, of case management (Birmingham, 2004; Devine, 2004; Strassner, 1996; White, 2004). Common barriers to effective documentation centre on handwriting legibility, insufficient information documented, time deficiencies and communication difficulties (Devine, 2004). System, policy and procedure manuals need to remain up to date, accurate, easy to follow and accessible (Aliotta, 1996; Cox & Albisu, 2001; Dzyacky, 1998; Muller, 2004) to assist with clearer communication of client needs and service evaluation.

Comprehensive Assessment and Evaluation

Within almost every case management model are the functions of assessment, planning, monitoring and evaluation within the continuum of care, regardless of context (Calhoun & Casey, 2002; Case Management Society of America, 2002; Case Management Society of Australia, 2004; Chan et al., 2000; Evans et al., 2005; Feldman et al., 1993; Ginther et al., 1993; Intagliata, 1982; McCollom, 2004; Moneyham & Scott, 1997; Mullahy, 1988; Roberts et al., 2007; Schaefer & Davis, 2004; Strassner, 1996; Taylor, 1999; Yau et al., 2005). A plan of care should reflect this care continuum and present specific individual needs and priorities, yet assessment of total client needs is frequently not undertaken in a comprehensive way (Challis et al., 2004). To achieve comprehensive assessment, client and carer interviews should be conducted during the initial assessment stage, suitably informed by key stakeholders, to enable the development of an effective outcome-based care plan (Challis et al., 2004; Marek & Rantz, 2000; Zink, 2005).

Case Management is most effective when client (and family) assessment goes beyond an episodic plan of care to consider long-term needs of the client and carer (Grachek, 2000; Strassner, 1996; Zink, 2005), through an ongoing process which includes at least weekly visits to each client (Intagliata, 1982). It has been identified that the more comprehensive an assessment undertaken is, the more effective the case management process (Vasquez, 2009). Monitoring the dynamic situation for the client requires rigorous and critical thinking approaches (Tullett & Neno, 2008) and evaluation of client outcomes (Evans et al., 2005; Rothman, 1991). Increased rigor in this assessment, planning and evaluation processes will actively support improved client outcomes (Elwyn et al., 2008).

Caseload

The time allocated for case management will vary according to the services and resources required to effectively coordinate and manage an individual clients' needs (Balstad & Springer, 2006; Huber & Craig, 2007). Caseloads can range from between five and 250, depending on the model (see Table 3.14). Factors to consider when allocating caseloads include: contact frequency, client need and acuity, Case Manager competence, caseload maturity, and consideration for shared workload, and administrative roles (Craig & Huber, 2007; King et al., 2004; Simpson et al., 2003; Strassner, 1996; Waite et al., 1997). While a small caseload alone does not predict the success of case management goal achievement, smaller caseloads afford greater flexibility to devote time to developing therapeutic relationships with clients and family members and increases the opportunity to implement individualised plans of care (Rapp & Goscha, 2004). A smaller caseload increases the amount of time to advocate, coordinate, liaise, plan and educate the client (McGettigan, 2003; Rapp & Goscha, 2004; Simpson et al., 2003), increases response-time to clients' needs, provides more opportunity for client contact during hospital admissions and enables client advocacy (Aliotta, 1996; Hellwig et al., 2003; King et al., 2004; McGettigan, 2003; Simpson et al., 2003).

Skilled Case Manager

The Case Manager is "the most critical component" and is an important link between the client and health system (Intagliata, 1982, p. 659). This role is central to assuring clients receive optimal care. Core functions of a Case Manager include: assessment, provision of coordinated services (Carr, 2000; Kuklierus et al., 2000; Schaefer & Davis, 2004); education (Chu et al., 2000; Kuklierus et al., 2000); client care (Berger, 1988; Carr, 2000; Schaefer & Davis, 2004; Taylor, 1999); crisis intervention (Cox & Albisu, 2001); counselling (Chu et al., 2000); leadership; monitoring activities of daily living (Novak, 1998); developing therapeutic relationships (Sherrod & Richardson, 2003) and referral (Carr, 2000; Chu et al., 2000; Schaefer & Davis, 2004). Health promotion activities are also considered an important

component of the role (Rieve, 1999), although this is under-represented in the literature. The Case Manager needs to be committed to quality assurance and evaluation (Blass & Reed, 2003; Intagliata, 1982; Zhan & Miller, 2003) and is therefore accountable for client interventions and outcomes (Rapp & Goscha, 2004). The Case Manager is accountable for care and service delivery at every stage of the clients' time with the service provider (Rosen & Teesson, 2001). A Case Manager must be highly skilled and experienced as a health advocate (Allred et al., 1995; Case Management Society of Australia, 2004; Daniels, 2009; Tahan, 2005).

The ethics of case management, as with any health professional involves "doing the right thing, at the right time, for the right reason" (McCollom, 2004, p. 203). The centrality of the advocacy role is based on the development of a transparent and trusting therapeutic relationship (Beeforth et al., 1994; Burns & Santos, 1995; Coombs & Byrne, 2003; Kanter, 1991; Shendell-Falik, 2002; Simpson et al., 2003; Tahan, 2005; Thornicroft, 1991; White, 2004). An international debate continues as to which professional roles and staff levels are well positioned and most suited to the case management role. Zink (2001) argued that the discipline providing the majority of services should undertake case management. Each profession brings to the role a unique set of strengths and each remains underpinned by the principles of case management (Rapp & Goscha, 2004; Robbins & Birmingham, 2005; Schuetze, 2006).

Competent Staff

Being professionally competent and demonstrating currency of practice for the case management role has engaged many discussion papers and enriched contemporary dialogue. Professional competence is:

> "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2002, p. 226).

Competency in leadership is not only required by the Case Manager, but by the entire healthcare team (Case Management Society of Australia, 2004; Leung et al., 2004; Rosen & Teesson, 2001; Tahan et al., 2006; Thomas, 2008). When implemented, the right style of leadership can motivate organisational vision and drive the agenda to achieve quality care and positive client outcomes. Effective leadership also works to engage participants in positive change processes (Hocker & Trofino, 2003). Leadership is linked to quality care in some studies, since "good leaders tend to produce good care and poor leaders tend to produce poor care" (Cunningham & Whitby, 1997, p. 14). nCompetency attributes and skills for case management are, therefore, specific and comprehensive. The above studies reporting these attributes and skills and subsequently aligning these to case management outcomes, reveal the importance of good planning, education for staff involved in Case Management and ongoing monitoring of case management outcomes.

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