Canadian Standards of Practice for Case Management

Connect, Collaborate, Communicate
The Power of Case Management

NCMN

National Case Management Network
Reseau National des gestionnaire de cas
du/of Canada

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Preface

Since the National Case Management Network of Canada (NCMN) was launched in November 2006, there has been intent to bring together a representative group of stakeholders to begin the development of national Case Management standards. In 2008 this intent became a reality. The purpose of the Canadian Standards of Practice for Case Management is to establish a level of excellence and point of reference against which individuals can be compared and evaluated. It is the hope of NCMN that these standards can be translated into improved health for Canadians and a strengthened Canadian healthcare system. The long-term objective of the NCMN awaits fulfillment – the dissemination and implementation of these National Standards throughout Canada for use by Case Management professionals and practitioners, by supervisory and quality assurance personnel, and by government and policy makers. The Standards represent a consensus document based on the collective wisdom of the NCMN Standards Roundtable, NCMN Standards Workgroup, NCMN membership, and Case Management communities of practice. With great pleasure, I present the Canadian National Standards of Practice for Case Management and on behalf of the Executive Committee of the NCMN, we look forward to the Standards taking flight.

Joan Park

President
NCMN 2009

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Standards Workgroup

Suzanne Amodeo	Bayshore Home Health Services
Barbara Baptiste	Rehabilitation Management Inc
Shannon Berg	Vancouver Coastal Health Authority
Barbara Copp-Engstrom	Veterans Affairs Canada
Kathy Craig	Craig Research
Kay Fitzgerald	Workplace Health and Safety Compensation Commission of New Brunswick
Jo-Ann Harris	Workplace Safety and Insurance Board
Sandy Jenkins	Hamilton Niagara Haldimand Brant Community Care Access Centre
Sarah Kravetz	Clarendon Foundation (Cheshire Homes) Inc. Ontario Community Support Association (OCSA)
Jill MacLean	Veterans Affairs Canada
Kathy Nakrayko	Saskatoon Health Region
Barbara Newport	Champlain Community Care Access Centre
Joan Park	St. Michael's Hospital
Raymond Rupert, MD	Rupert Case Management Services
Elaine Sandor	Rehabilitation Management, Inc.
Elaine Somers	Canadian Forces - Department of National Defence
Andre Wagner	Community Resource Connections of Toronto

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Background to Development of National Standards

National Case Management Network of Canada

The NCMN of Canada is established as a non-profit, membership-based, multi-disciplinary, professional organization dedicated to the support and advancement of Case Management professionals and practitioners. Through its leadership goal, NCMN seeks to identify Case Management best practices, to steward these discoveries into meaningful standards of knowledge, and to disseminate that knowledge nationwide.

In 2008, NCMN of Canada committed itself to producing National Standards of Practice that reflect the Canadian context. This has meant creating standards that are broad in scope while lending themselves to the ability to be met and measured.

The Standards are not intended to replace existing professional licensure requirements or College standards. Instead, NCMN Standards focus on the practice of Case Management for all to benefit from the existence of clear and concise practice standards.

Canadian Health Care System

Canada's national health insurance program, often referred to as "Medicare," is designed to ensure that all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis. Instead of having a single national plan, Canadians have a national program that is composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage. Framed by the Canada Health Act, the principles that govern our healthcare system are symbols of the underlying Canadian values of equity and solidarity. Provincial and territorial governments are responsible for the management, organization, and delivery of health services for their residents.

The Canada Health Act excludes members of the Canadian Forces (CF) from the list of persons who may receive health care under provincial health insurance plans. According to the Act, a person insured under the health care insurance plan of a province is a resident of the province, with the primary exception being when one is a member of the Canadian Forces. In that exception, the Department of National Defence (DND) is required by law to provide medical care to all members of the CF, both in Canada and abroad.

Case Management and the Canadian Health Care System

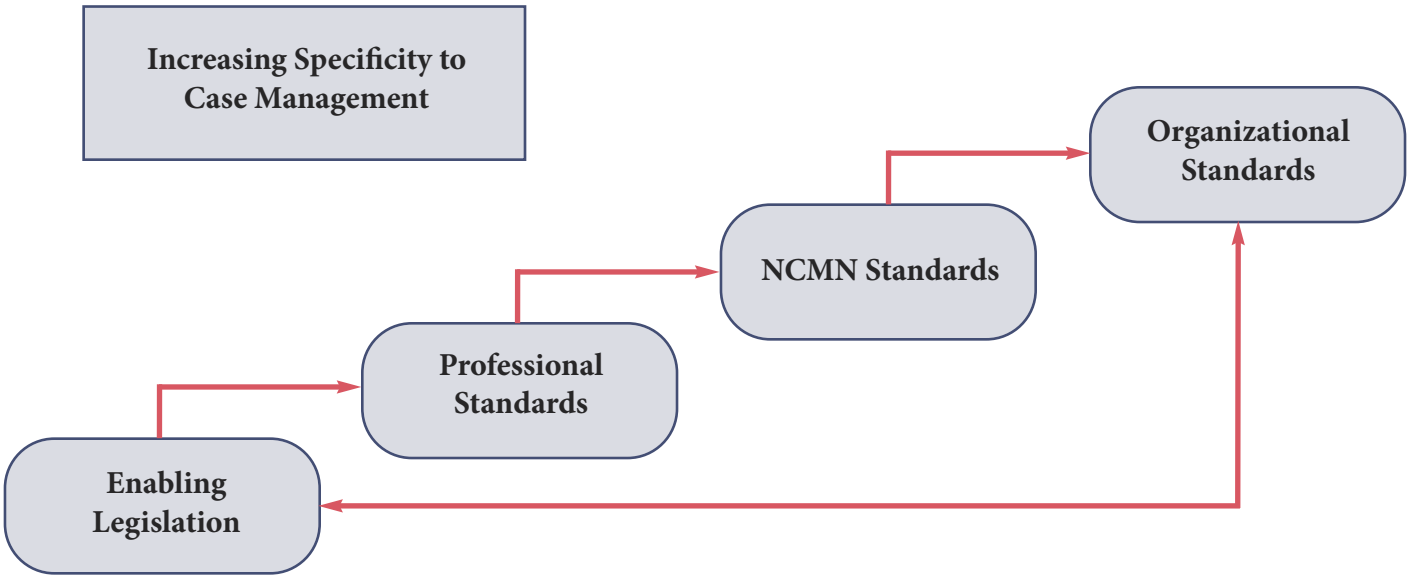
In the Romanow report (2002), Building on Values The Future of Health Care in Canada, a recommendation is made that the Canada Health Act be expanded to include coverage for three priority areas: home mental health case management and intervention services; post-acute home care and rehabilitation services including case management, health professional services, and medication management; and palliative home care services including pain and symptom relief, case management, professional services, medication management, and counseling when needed.

Moving forward, concrete actions to improve integration and continuity of care include establishing policies that foster the most cost-effective delivery of services through coordinated, ongoing, system-level case management – whatever the site of service – and that provide stability for clients, families and service providers. Such policies would also support the Canadian government's commitment to keep people in the community as long as possible and out of institutions.

Case Management Framework

To outline the context within which the Standards of Practice have been developed, Case Management is defined, and the guiding principles adopted by NCMN to support the Standards are explained.

The following structure depicts how the NCMN Standards provide a framework for Case Management practiced within various settings and sectors in Canada. Each step requires preserving and honouring the stipulations of the preceding legislation and standards step(s).



Case Management Definition

Case Management is a collaborative, client-driven process for the provision of quality health and support services through the effective and efficient use of resources. Case Management supports the clients' achievement of safe, realistic, and reasonable goals within a complex health, social, and fiscal environment.

Guiding Principles

The National Case Management Network of Canada presents the following principles to guide practice.

Case Management Supports Client Rights
Case Managers support the rights of clients within the funding and legislative frameworks that affect the relationship between the client, service providers, and payers. This is achieved through establishing effective relationships with the clients, ones in which the Case Managers assess and support the ability of individual clients to achieve their goals.

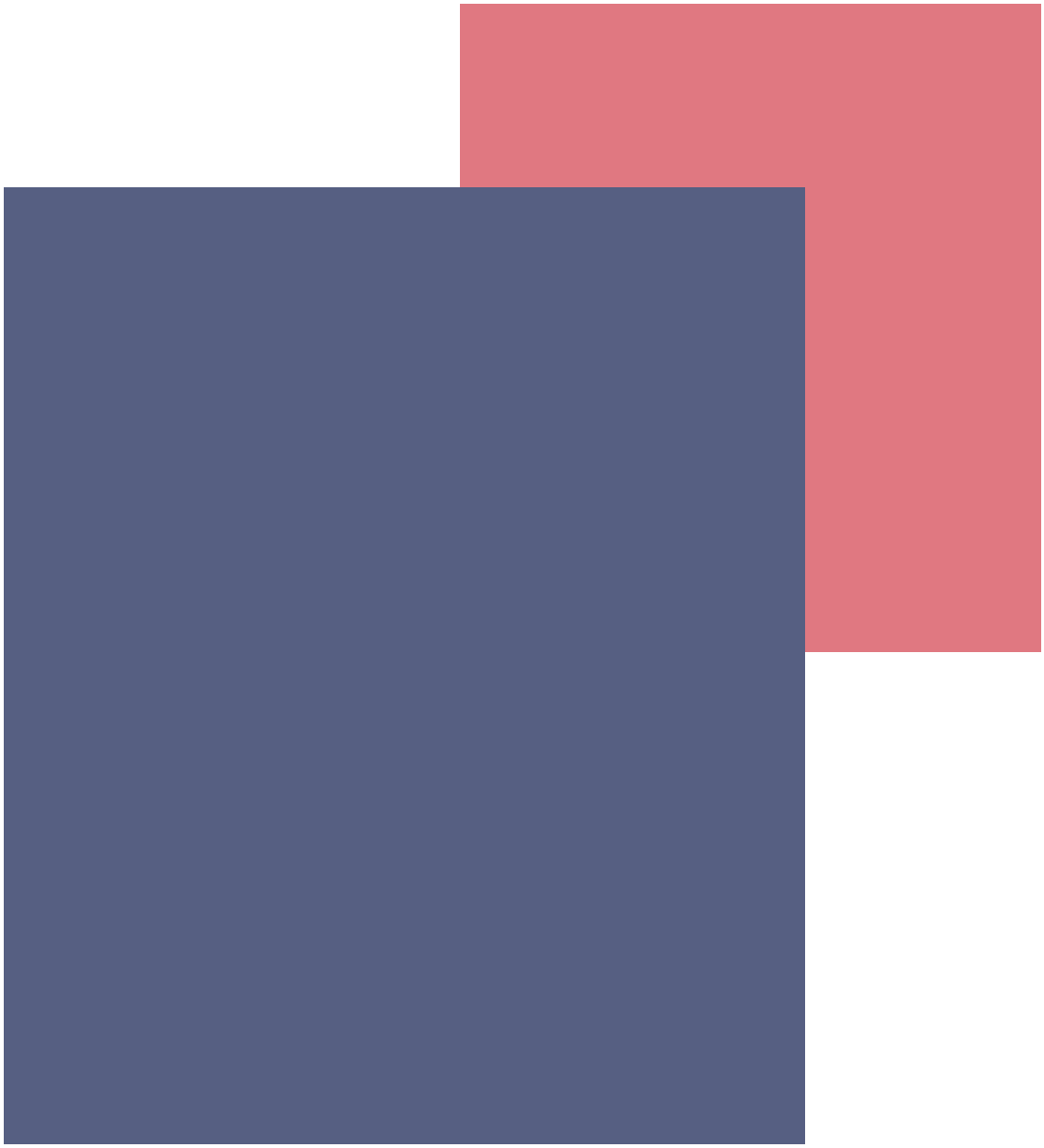
Case Management Is Purposeful
The actions of Case Managers must address the specific needs of clients as documented in each client's goals. Therapeutic interventions should best meet the client's needs. Case Managers assist clients in the selection of services and resources that are of the highest possible quality within the accessible range of services.

Case Management Is Collaborative
Case Managers work within a larger community system. Many individuals and groups come together to support clients, with their consent, to achieve health and independence. Success requires collaborative and proactive relationships to facilitate the client's goals. Whenever necessary, Case Managers refer clients to other practitioners who have skills and knowledge to best meet the client's needs.

Case Management Supports Accountability
Case Managers facilitate and organize service delivery that is coordinated, timely, and appropriate for each client's optimal health care benefit, goal achievement, and maximal selfcare and independence. The role of the Case Manager is dynamic because it is both proactive in assessing and planning and responsive to the changing abilities and needs of the client. Case Managers work to ensure equitable access to healthcare services and use of healthcare resources that is ethically responsible and fiscally reasonable.

Case Management Strives For Cultural Competency.

Cultural awareness is the demeanor through which the Case Manager displays respect, appreciation, and sensitivity to the values, beliefs, lifeways, practices, and problem-solving strategies of a client's culture and heritage. Cultural competence is the conscious application of a protocol of congruent behaviours, attitudes, and policies within a system or agency or among individual professionals that enables the system, agency, or professionals to work effectively in cross-cultural interactions. To provide culturally competent service, a Case Manager remains aware to replace one's own biases by collecting relevant cultural data, seeking knowledge about cultural distinctions, and partnering with others who are fluent in diverse cultures (as appropriate).



Structure of Standards

The Case Management Standards of Practice are structured to reflect core competencies and practice expectations.

Each Standard is presented in the same format:

Standard: A statement defining expected performance

Rationale: The reason(s) why the Standard is important

Interpretation: The intended meaning of the Standard

Guidelines: The descriptive statements outline the desirable actions that can be performed to uphold the Standards. These statements help to ensure consistency and applicability across practice environments and roles.

Throughout the Standards, health and social services are inclusive of all aspects of health, including mental and behavioral well-being, end-of-life comfort measures, health insurances, and community supports. The term client encompasses all health and social service consumers however they are defined. For infants, youth, and dependent adults, the concept of client includes the primary caregiver and essential caregiver network, including substitute decision makers.

The plan refers to the collaboratively developed client-centred goals, schedule of services, providers, sources, timelines, and objectives which should be adjusted as needed. The concept of quality is affected by the constraints of time, cost, and scope. The term holistic is meant to refer to one's body, mind, and spirit including physical, mental, social and spiritual aspects.

Standards of Case Management

I. Client Identification And Eligibility For Case Management Services

Standard
Clients who meet the eligibility criteria for Case Management services are identified.

Rationale
An element of assessment occurs to determine the initial needs of the client. These needs are matched against the eligibility criteria of the program under which Case Management is provided.

Interpretation
Assessing and explaining eligibility is the first step in establishing an appropriate Case Management service relationship.

Guidelines
Case Managers are expected to:

- Ensure that individual clients understand their rights and responsibilities
- Obtain client consent for participation in the Case Management program
- Gather required information about clients while respecting their confidentiality and privacy
- Identify and prioritize each client's initial needs
- Explain the Case Management process to each client, including eligibility, assessment, planning, implementation, evaluating, and transitioning
- Ensure the client understands the complaints and appeal processes for Case Management services as appropriate
- Communicate with the client regarding the criteria that indicate end of a Case Management service relationship
- Provide sufficient information about applicable options in the event of ineligibility

II. Assessment

Standard

In conjunction with the client, the Case Manager conducts and documents an individualized assessment using a structured process.

Rationale

Information generated by the assessment process serves as the foundation for planning.

Interpretation

Assessment is a dynamic and ongoing collaborative process that actively involves the client and others to secure information in a timely manner and to identify the client's values, goals, functional and cognitive capacity, strengths, abilities, preferences, resources, supports, and needs.

Guidelines

The Case Manager engages in a collaborative process in which the Case Manager seeks to:

- Guide the early identification of client's goals
- Respect the client's right to self-determination
- Facilitate an exploration of client's needs, concerns, values and choices
- Demonstrate sensitivity to the client's language and cultural needs
- Interact with the client actively to engage him or her as a primary source of information
- Discuss informed consent with the client and secure that such informed consent is obtained for future interactions
- Apply knowledge that reflects the general needs of the client population while capturing the individuality of the specific client's needs
- Collaborate with others in a multi-disciplinary and multi-dimensional manner to avoid duplicating other assessments
- Include relevant subjective and objective information from a variety of sources, including providers.

- Identify clients at risk of harming themselves or others and clients at risk of health status and safety deterioration if left alone or with insufficient supportive services

The Case Manager engages in an interaction that:

- Is respectful and courteous
- Takes place in a reasonable time frame
- Occurs in a manner and mode that is sensitive to the client's situation (such as an interaction conducted in person face to face or through an exchange by telephone, conferencing, or written format, as appropriate)

The Case Manager ensures that results are:

- Discussed with the individual clients in relationship to achievement of their goals
- Documented in a confidential manner
- Shared with other practitioners with the consent of the client (or representative)

III. Planning

Standard

Client goals and priorities are documented and are reflected in the strategy for action agreed upon between the client and the case manager.

Rationale

Documented goals reflect the outcome of the process of assessing client needs. Planning includes the identification of available resources and addresses pertinent obstacles.

Interpretation

The planning is designed to document the actions to achieve client's short-term and long-term goals and optimal outcomes. The plan of care outlines the purposeful use of formal and informal services and resources.

Guidelines

Case Managers are expected to:

- Respond to the client's own assessment of his or her needs
- Provide the client with comprehensive explanations of options for the current circumstances, which are refreshed as circumstances change
- Identify, in a proactive manner, barriers that restrict and strategies that facilitate the client's ability to meet the identified goals
- Ascertain the clear understanding of the services and choices available so that the client is, and continues to be, an informed decision-making participant
- Consider, among others, these specific decision issues:
    - Safety
    - Risk to client and others
    - Financial and human resources
    - Timeliness of access and implementation
    - Requirements for sharing client information with others
- Support and optimize each client's independence to access resources to meet care needs
- Document client goals and plans of care including measurable criteria such as clinical stability, adherence factors, and effectiveness of care strategies
- Ensure the client and others who require this documented information have unhindered access to it

IV. Implementation

Standard
Planned services, resources, and supports are initiated, coordinated, and adjusted as necessary.

Rationale
The Case Manager works to ensure that all parties involved work together constructively and efficiently so that each client receives the services, resources, and supports that have been planned.

Interpretation
Implementation reflects the Case Manager's accountability to ensure the client's individualized plan of care is being fulfilled. Implementation is the process in which all parties involved in the service and resource plan collaborate to carry out the mutually agreed-upon activities, interventions, and interactions contained in the client's plan.

Guidelines
Case Managers are expected to:

- Initiate and build relationships to ensure a client-centred approach to service implementation
- Outline and facilitate agreement upon roles and responsibilities of all parties involved
- Facilitate and develop the client's self management skills
- Foster client independence
- Maintain regular communication with both the client and the informal and formal providers
- Arrange group discussions and decision-making sessions when appropriate
- Monitor the client's needs and preferences
- Identify and act upon opportunities for improvement
- Address and facilitate the resolution of discordant issues
- Identify and facilitate the management of conflict promptly
- Explain and reiterate the likely or potential transition alternatives, roles, and responsibilities to the client at appropriate junctures that allow ample time for consideration, questions, and adjustments

V. Evaluation

Standard

A periodic reassessment is conducted to identify the client's current needs and to monitor progress within the client's individualized plan.

Rationale

Evaluation activities measure and document the effectiveness and efficiency of the Case Management interventions designed to meet specific client needs. The results of the evaluation will inform the next steps recognizing that the client's needs can change over time, as can the health and social service environment in which the client receives care and support.

Interpretation

Evaluation is a monitoring process and includes information from clients and others to determine the progress made by clients towards the identified goals within the plan.

Guidelines

Case Managers are expected to:

- Determine intensity and frequency of reassessments on an individual client basis
- Evaluate conditions such as:
    - The client's identified goals are current
    - Effective and efficient movement towards those goals exists and is occurring within a reasonable timeframe
    - The client and providers are satisfied with the process and outcomes of the plan
    - The stability of the client and the client's family environment is maintained
- Document quantifiable impact on and specific movement towards the client's goals
- Identify gaps in services or support structures
- Attempt to remove or resolve service and support gaps to the client's benefit to the best extent possible

VI. Transition

Standard
A process that supports disengagement or shift in the mechanisms for achieving client goals.

Rationale
The dynamic nature of the client's state or journey often necessitates movement to alternate settings, care, and roles.

Interpretation
A redefinition occurs regarding the professional relationship between the client and Case Manager in the evolution of the client's journey. The relationship may be completed with achievement of agreed upon goals, or concluded with goals unfulfilled.

Guidelines
Case Managers are expected to:

- Discuss disengagement and the criteria for disengaging Case Management services early in the relationship
- Determine if disengagement criteria are understood by the client
- Provide clients with information or links to alternative community resources
- Support the client in his or her efforts to secure other appropriate or alternate resources, if the client so desires
- Maximize client independence by supporting the development of self-advocacy skills
- Ensure the transfer of timely and accurate information across settings when it is needed for the execution of transition
- Provide contact information about re-accessing services or support
- Address concerns about disengagement before the finalizing the disengagement

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Notes