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CASE MANAGEMENT IN FIRST NATION COMMUNITIES

A STEP BY STEP GUIDE TO GETTING STARTED

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Case Management

The Basics:

"*Case Management is about providing the best possible support to individuals and families in the most cost, time and resource-efficient manner possible. It is really all about "placing the client at the centre of the process*". *- Gloria Nelson, Kanesatake Clinical Case Manager*

After visiting a health facility, how many times have you heard a community member say, "I have been asked those same questions over and over again and they all seem to be giving me different answers – don't they know what they are doing?"

This type of remark is not unique to First Nation people[1] or communities; but it is a definite symptom of a disorganized health and social support system. Our health and social systems in First Nations communities across Canada are plagued by inefficiencies, duplications and a general lack of working together and/or not having clear communication between service providers and various government departments.

This guide and accompanying video is therefore meant to assist you in planning an alternate way of delivering care in a more organized manner; which is often referred to as *Case Management*. Maybe you have already taken steps toward improving collaboration and communication in your community, or perhaps you don't know where to get started. This guide can either help validate and support what you are already doing, or it can help you to get started and begin to chart new directions for your community. With the financial support of Health Canada, we have gathered information from several sources such as community and regional workshops, interviews with key informants, academic and grey literature, and information available on the web. We have synthesized this information and developed this simple guide, which suggests a process for organizing care and services that may be relevant for First Nation communities across Canada.

When we consider the consequences for the disorganization that exists within the health care system, the effects can be devastating. There are multiple programs, departments and organizations offering support and services to individuals and families in your community and each entity may be collecting different and/or the same information. Individuals and families are getting requests for information from these various health systems and there are difficulties sharing this information between programs; each program is doing their best to offer services to their clients, but each program does not know what their neighbors are doing. Furthermore, there

[1] Although we refer to First Nation(s) throughout this document, the subject matter is also applicable and relevant to Metis communities. We primarily utilize the one term for brevity.

are other concerns that the services and programs are fragmented in First Nation communities, as funding and reporting relationships vary across programs.

We have heard from communities that have implemented a case management approach, that services were not sufficiently family-centered before adopting the case management model in their community. There may have been duplication of services, overlap of services, no continuity of care, competing priorities, or no client autonomy. There were often assumptions and guesswork about what services and support the family may be getting and, even worse, some were not getting any service at all due to these erroneous assumptions. We want this to change. We want efficiency and the delivery of health services to be less problematic and effective in meeting the needs of people. The National Case Management Network of Canada (NCMN) believes that the practice of Case Management is a vital and dynamic strategy that results in the delivery of care that is more efficient, more effective, and holistic. It is an approach that addresses most of the issues identified above.

What is Case Management?

The National Case Management Network defines Case Management as: *"**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 client's achievement of safe, realistic and reasonable goals within a complex health, social, and fiscal environment**"*[1]

The First Nation community of Kanasetake in southern Quebec defines Case Management as: ***The process of assessment, planning, implementation, monitoring, and review of care that aims to strengthen outcomes for families, children and young people through integrated and coordinated service delivery that applies equally across the early intervention, child protection and out-of-home care streams***.[2]

Regardless of the definition you choose, Case Management is about coming together, collaborating and communicating across programs or disciplines, making decisions and record keeping with the objective of providing the best possible care for your community members that ultimately leads to improved health outcomes and puts the client at the centre of the process.

[1] Resource material obtained from a visit to the Kanasetake Health Centre, Kanasetake, Quebec; May 2010.

Why do we need Case Management?

In short, we need Case Management to prevent all of the inefficiencies and issues that result in disorganization and poor delivery of health and social services. First Nation communities who *have* taken a Case Management approach indicated there are some very good benefits in doing so; these include:

- Enhanced Coordination and Communication between supports and services in the community;
- Puts the client back at the centre of supports and services and facilitates the return of the individual or family to a maximum state of balance in the shortest possible time frame. This allows the individual or family member to return or regain his or her status as a contributing member of the community and encourages them to reach for their maximum potential;
- Greater autonomy and awareness for individuals and families in the services they receive and referrals that are made for them;
- Centralized documentation of supports and services that facilitates better access to information;
- Promotes better continuity of care across disciplines and throughout the lifespan of the individual;
- Reduced duplication of supports and services;
- Better collection of data, through the use of common assessment and organized data collection tools;
- Improves accountability across programs and to the leadership in the community.

A Success Story with Case Management

"Case Management" is not a new concept or idea in First Nation communities. It is a modern and fancy phrase that describes the way First Nations and communities have always conducted tribal or community business by providing support to those families and clan members in need.

In the past, we utilized the strengths and knowledge of those within or closely connected to our communities to provide care or to assist individuals and families in achieving wellness. We had traditional healers, spiritual leaders, medicine lodges, rites of passage, customs, ceremonies, Elders, wise women, wise men, midwives, those who nursed, teachers, leaders and "helpers" of many kinds. Because we were diverse across cultures, our "professionals" (experts and helpers) - varied from village to village or from tribe to tribe.

If there was one thing common across cultural lines that was perhaps lost but can be relearned it is this: *the gift of caring for each other is founded on building positive and healthy relationships and rooted in our spirituality.*

One such community that rediscovered this strength is Kanesatake, located 30 minutes outside of Montreal, Quebec.

The Kanesatake community is the story subject of this video. We would encourage you to listen to their story in addition to reading this guide to see and hear what they have to share. They recognized their community is not idealistic by any means as they endure many of the health and social illnesses that affect many First Nations across Canada. But what they hope to share with you is a *process* that has been tried in their community, which is demonstrating greater efficiencies in providing health care for their families. It is really about looking for and utilizing the *strengths* and *resources* in the community, about making the proper connections, about bringing these strengths and resources together to address issues and concerns in a better way as First Nations have done so in historic times. It is the hope of the community of Kanesatake that the lessons they learned along the way and the documenting of progress they have made will serve to assist your community in making its first or further steps to improving health services. They, and we, wish to congratulate you and celebrate with you if your community is one that has already begun to take some of these important steps in your journey.

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The following guidelines are a synthesis of information we have gathered from the First Nation community of Kanesatake, Quebec. They have been successful in implementing a Case Management process in their community. It is based on their experience only and is meant to assist you in a Step-by-Step manner to help you get started. The authors recognize there are many resources and other approaches that you may consult. The community of Kanesatake was open and willing to share their experiences in successfully incorporating Case Management; this process can be summed up in two phases:

1. Preparation Phase
2. Implementation Phase

The preparatory phase involves getting your community ready for case management and the second phase provides some practical steps to consider for successful case management planning and implementation.

Please feel free to modify, add, or adjust this process to suit your community's needs or aspirations.

Phase 1:
Preparation - Community Mobilization

Change takes time. This is particularly true when one considers shifting the way business is conducted in First Nation communities. Change needs to involve everyone from community level workers to those in leadership to individual community members. Here are a few key practical steps:

1. **Educate yourself First.** Read through this Guide and watch the video. You, or others, may have already attended a Case Management workshop. That is great. If you have an opportunity to attend a workshop, then do participate in one. If you decide that you are the best individual to promote Case Management, then you have already accomplished the second point below which is identifying a community "champion" or lead person. If you do not feel that you have the right strengths to educate the community, then you may want to look for the individual with the right strengths or a group within the community that can get things moving in positive directions.

2. **Identify a community "Champion".** Remember it is not about who does what at this point, it simply means looking for that individual who can organize presentations to your health and social support staff and to your leadership. Qualifications for this champion or leader are simple: a) desire to improve the organization of services in your community, and b) ability to stand up and talk to people publically.

3. **Educate the Community (Community Awareness Workshop).** Organize a Case Management workshop to the health, social and wellness teams in your community. Provide them with a "*Case Management Basics"* presentation or show them this video. You may want to have a facilitated discussion after the presentation and video, or break out in smaller groups if your groups are large enough. You may begin with a discussion on how programs and services currently interact with each other in your community to learn where the strengths and inefficiencies are; then to decide how to get started. The following are suggested ideas, steps or questions for the workshop:

   - List or map all the resources that are available in your community. Organize these resources into themes (health, social, spiritual, recreational, etc. Resources may be individuals as well: public speaker, facilitator, teacher, crafters, etc.

   - How are referrals made and does communication occur between these resources (letter, phone-calls, chat in the hall, form)? Are there referral forms in use?

   - How can the coordination of these services be improved?

- How can the community get started in organizing resources and services you already have in your community?

You may need to have a number of these sessions to have all the questions answered or seek the assistance of a skilled facilitator (or someone you may have identified as a resource within your community).

4. **Obtain the necessary "Buy In" from community leadership.** This may come in the way of a *Band Council or Community Council Resolution*, issue of community policy directive or a statement if you are presently at the Health Director level in your community. Follow your community protocols for implementing any policy change or resolution to improve care in your community. Posting of any policy directive, resolution or statement complete with rationale, for staff and the public, is part of the community education as well. If the statement were clear on the reasons why such change is necessary, then it would likely be more understood and accepted. Keep in mind that information and communication is key!

5. **Pool together key individuals to form a "Core CM Planning Team".** From the initial workshop, a few individuals may have emerged as natural members of your core planning team, or some may have indicated that they are interested in joining your CM planning team. This core team will be important to prepare the community for the implementation of CM. This group might consider beginning the work on the following tasks:

- Developing guidelines for eligibility criteria;
- Draft job descriptions/roles & responsibilities for Case Managers;
- Draft CM community policies & procedures: intake, assessment, frequency of meetings, referrals, follow-up, etc.;
- Developing guidelines for discharging cases.

6. **Identify Potential Community Case Manager(s).** It is possible to work within the existing human resources structures in your community with a little creative planning. Depending on your community size, you may identify one, two or three Managers. You may have a clinical Case Manager's approach or a mental health or social approach. Once those have been identified, review carefully the roles and responsibilities of being a Case Manager. For more information on core competencies you may visit the National Case Management Network of Canada (NCMN), a federally incorporated, membership-based, multidisciplinary non-profit professional organization dedicated to the support and advancement of Case Management available at: http://www.ncmn.ca.

7. **Create your own specific CM Steps or protocols.** Now that you have chosen the Case Manager(s), the next step involves creating a CM framework or protocol that works for your community. This will involve organizing a series of meeting to set all the groundwork. Suggested topics for the initial meeting are: What will be our purpose of CM in our community (this can be framed to become your purpose statement)? Will there be sub-teams (for example: mental health, addictions, children's programs, maternal health, wellness and physical activity, chronic illness prevention, etc.). What referral mechanism will be used? What documentation will be required and what forms are needed? How often will the teams meet? What will the accountability structure be, and who will Case Manager's report to? What will be your eligibility criteria and how will you determine who is eligible? And so on.

8. **Research or create standardized Tools/Forms to Aid in Your Work:** Identifying, creating and agreeing upon common tools and forms prior to implantation of CM will avoid unnecessary delays. Unfortunately, no ideal fully comprehensive set of tools/forms exists. The quickest solution would be to do a scan and collect samples of forms that are already in use and customize to suit your community. One of the most important tools is the Assessment Tool. You and your planning team may be the best resource to identify a common assessment tool. This is one of the first important tools that must be chosen prior to implementing Case Management. The assessment tool may be used to determine eligibility, or gather pertinent information on potential "cases". There are many examples of assessment tools – some are intended for mental health, social and behavioral assessment, social needs, health and medical based, or on the need for home based care. This tool is the mechanism that, once chosen, can avoid the common issue talked about at the beginning of this document i.e., people who feel they are being asked the same questions over and over by different people.

   It may be necessary to develop your own assessment tool. However, in judging an assessment tool, it is important that it looks at your community's strengths and that it is culturally relevant. It should also contain some criteria about whether the individual or family meets the "eligibility" for case management. The tool should be comprehensive enough that it captures demographic data and information that is important to your community.

   In addition to the *Assessment Tool*, the following is a list of other forms that may be useful:

   - Intake Form
   - Case Notes
   - Care Plan (optional)
   - A Family-Centered Goal Plan
   - Referral Form for Case Management Services
   - Referral Form for Supportive Services

- Referral Tracking Form
- Consent to Release or Share information

An Additional Step to Consider: Draft criteria for discharge. This should ideally be developed prior to implementation of Case Management, but can be reviewed and evaluated as more experience is gained. There are no clear guidelines as to *when* discharge and closure is required, but the Case Manager/Team at the community level can develop a number of elements and criteria. Decision to discharge and close a case may involve the integration of tools such as a Family-Centred Goal Plan[3], case discussions and opinions from trained professionals, including the direct input from the individual or family. This could be as simple as creating a checklist, discharge plan or similar means of assessing the readiness of the case to either be moved to another service, or discharged from the case management program.

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Phase 2: Implementation

Step 1: Set a Target Date to Launch CM in Your Community

Set a target date to launch Case Management. You may want to be near completion of all the necessary forms and tools and have the draft policies and procedures in place prior to setting this date.

Step 2: Initiate the First Case Management Implementation Meeting

At this time you may want to bring the planning team back together to meet the Case Managers, clarify roles, responsibilities, accountability and reporting structures and review al the forms. If there are more than one case manager, and sub teams bring them all together to review all the draft tools and process. Review the Assessment tools and criteria, review expectations for how often teams will meet. A good question to discuss at this meeting is how to organize the actual case conferences to involve the clients or families in the portion of the meeting where their case is being discussed.

[3] A Family-Centred Goal Plan is about settings directions (goals) with a family or individual and then evaluating progress in meeting those specific goals. Once goals are attained, this builds confidence and inspires families or individuals to then set new targets.

Step 3: Train staff on the Assessment and other Tools

Screening and Assessment is an essential element of successful case management. The Assessment process should be ongoing, capturing and analyzing available information from the individual or credible sources, leading to professional judgment of risks, strengths and needs. The synthesis of this information is important for determining the needs of the individual or family, and what support they could benefit from, (and from whom) and developing a plan of care. Identify the best resource to provide training to the Case Managers or professional who may be assigned to do the assessments. Suggested training should include basic or motivational interviewing techniques, cultural sensitivity in asking sensitive questions, and legal requirements for documentation.

Step 4: Finalize Documentation Requirements & Create Case Files

There are legal requirement for record keeping. Each case file should contain a signed *Consent or Release of Information* that clearly defines whether information is shared within and outside the community. Other points to consider are:

- Creating a formal charting system for documenting case management.
- Create local community policies in regard and who will have access to the files and their level of access to files.
- Ensure record keeping is consistent for each case.
- Protect all records as you would any confidential file in a locked cupboard in a secure location away from general public.
- The Consent or Release of Information forms should be signed by the individual prior to Assessment process. Case Management should be thoroughly explained to the individual or family, prior to documentation and recording of any findings. This includes explaining in detail the purpose of case management, and intent and use of any information that is shared with the interviewee. The Consent to release or share information form should contain the section identifying whom the information will be shared, be signed and dated by the individual or legal guardian.
- A Referral Form for Case Management may have come from another program or service provider involved with the family and has provided a lot of information of the individual or family to the case manager prior to the assessment. In this case, the information may be collected in the form of a Referral for Case Management and the Case Manager is still obligated to initiate contact with the family, get informed consent and complete the assessment process.

Step 5: Completing the Assessment and Assigning a Case Manager

This is the first and critical step in effective case management of individuals or families in your community. Much valuable information may have been obtained during the Assessment process. In many cases, the person completing the assessment may be the Case Manager so this step would be unnecessary. This task may be assigned to a professional working in the community, who is not a case manager, but who may decide who the best fit would be as a Case Manager. If you are the Case Manager, and through the process of assessing the family, you may find that the "case" may be better suited to another manager, so you may want to refer them on to another Case Manager.

Step 6: Creating Goals & Case Plan

This is another critical step in Case Management that includes setting goals and objectives for each case that addresses the physical, emotional, educational, social, spiritual, and cultural needs of the individual or family. Each initial case should begin by involving the individual or family in setting some measurable goals and objectives. It is entirely within each individual or family's right to participate in their individual meetings where their specific case is discussed. They can be brought in at the scheduled time, at the team meetings or they may take place in the home or alternate location. After the initial meeting, they may consent to having the conferences occur in their absence, providing they are updated when there are any changes that are considered in their Case Management plan.

- The first critical step is working with the client to create some goal and objectives. Goals should be SMART – Specific, Measurable, Attainable, Realistic and with clear Timelines (See Templates and Tools). Goals should be short term; a good guideline is less than 6 months.

- Ensure that that the individual or family understands each of the goals. Provide them with a copy for their own records.

- Create a plan with short, intermediate and longer-term activities associated to each goal.

- Add a copy of the Goal Plan to the main record or chart.

Step 7: Identifying Resources and Making Referrals

This process is similar to the mapping exercise you may have already done. Arranging services with resources internal and external to the community is one of the most important components of Case Management. There may already be a number of activities and supports that were identified through the assessment and goal setting process. Point to consider:

- Each family or case is unique, so the resources that are needed may be for each case as well. Compile a list of those resources and supports that may be required for each case. Prepare to consult with other team members if it is unclear which support or service may be necessary. It may help to be aware of specific teams that have common issues and themes. For example, children with complex needs or disabilities team, mental health and addictions teams, supportive healthy family teams, etc. Keep in mind each case may be unique;

- Discuss with the individual or family that this referral is being made on their behalf;

- Make a legal record of the referral by utilizing the referral form you had already created, regardless if you make the referral by telephone or in person;

- Make a note on the case notes and/or referral tracking form. Be sure that the tracking form includes a date i.e., 3 months - to follow up on the referral;

Step 8: Begin Case Planning And Meet Regularly;

- There are several approaches to organizing team meetings, but the key message here is that meetings and case discussions occur on a regular and consistent basis. There are group case discussions and more complex cases may require individual case discussions;

- Each Case Manager should create a schedule of conferences or meetings that team members have access to;

- Keep in mind that individuals and families have the right to participate in their own case conferences.

Step 9: Track all Follow-ups on Referrals

It is a good practice to create and implement a regular schedule to follow up on all referrals. Some communities may chose to keep track on their day planner or calendar that is separate from the case files, as it sometimes easy to lose track. You may want to bring these calendars to the case conferences, but regardless of the system good follow-up on the referrals that have been made is key to quality case management.

Step 10: Maintaining Quality of Service & Documentation:

It is a good practice to maintain quality of all documentation, and not just the referrals being made. Create a quality assurance checklist and a mechanism to audit all charts periodically. This could include a quality check to ensure that all referrals are followed up on by Case Managers as discussed in the previous step, regardless if they are within or external to your community. Ensure that this process highlights all the strengths and things that are going well, but also a process to make improvements to the Case Management process.

Step 11: On-going Care and thorough Evaluation of Services

Once the initial assessment, goals and case planning has begun and services and supportive services are in place, you will need to have regular review of the progress of each case, or on an Ad Hoc basis. Meetings and case discussions should occur on a regular basis and each Case Manager should create a schedule of meetings that team members have access to:

- Each Case Manager could begin by creating a regular schedule to evaluate each case. This evaluation is more in-depth than the regular follow-up of the case and can be done on a bi-annual basis. Obtaining regular feedback from the individual or family, worker or service provider is necessary and goes hand in hand with continuation of services, but with an emphasis on evaluating the support or service that the client receives;

- The evaluation meeting should include a review of goal plans for each case being reviewed. All goal plans should be reviewed with the client to ensure that the goals are still valid. This review may include an assessment of whether the goals have been met; or whether modification or change in timelines may be necessary. Provide an opportunity for the client to provide their perspective on how the support or service is going;

- Initiate telephone call, drop in or schedule regular contact with service provider/supportive service to obtain their opinion on how things are going with how the family is progressing. Follow-up on all referrals and evaluation of support or service put in place, should go hand in hand with continuation of services until such time the family and case manager feel that goals have been achieved and it is time to move on to new goals, continue on the present course, or close the case.

Step 12: Discharge and Closure

Develop criteria for discharge. A number of elements could be considered, when considering discharging or closing the case:

- Has there been consistent progress and achievement of goals and objectives?
- Has the individual and family been requiring less and less intervention, services or support?
- Has the family moved from the service area? And if so, do they require a transition plan?
- Refer to your criteria for discharge. Ideally, these could be based on the questions above, and section to explain the reasons if professional judgment.
- Document closure of the case, discharge or transition plan. If the case is moved to another community or jurisdiction, ensure that the plan is transferred to the service or agency that is assuming the case and the Consent or Release of Information includes this option.

References:

1. The National Case Management Network of Canada (NCMN), http://www.ncmn.ca.
2. For link to NCMN Canadian Standards of Practice for Case Management: http://www.ncmn.ca/resources/documents/english%20standards%20for%20web.pdf.
3. Kanesatake Health Services; http://www.kanesatakehealthcenter.ca; g.nelson@kanesatakehealthcenter.ca (Gloria Nelson, Clinical Supervision / Program Manager).