Collaborative Case Management

Interview with Beth Whalley, Acting Manager, Practice Development Team, South West Home Care, Alberta Health Services, Edmonton Zone

Reflection: "*We all had ideas about gaps in other's practice but not our own. It was a good ego check to realize we all had to work together differently to make things work better for seniors.*"

What Changed?

Three things changed in how the participants in the Collaborative Care Management project approached seniors' care:

- The use of the project's decision tree by Alberta Health Services Home Living Care Managers and community-based Seniors Outreach/Support Workers helped them know when and how to refer to each other.
- Time spent by Home Living Care Managers on non-health care needs of clients was reduced.
- Gaps and duplication in services were reduced and integrated care for seniors was increased.

The project had three phases: review of current referral and collaborative practice; development of simple, standardized practice support process with tools; use and evaluation of support process.

How did seniors' voices or experiences inform your project?

In Phase 1 of the project, a sample of four seniors who were receiving, or had received, services from both Home Living and outreach support workers were interviewed to understand their experience and identify any gaps or duplications in service. In Phase 3, seniors benefited directly from the project through referrals made by Home Living and outreach support workers, which provided access to a wider range of services and supports.

The team relates an example of how the collaborative approach worked. An isolated senior had suffered nerve damage in both wrists that limited her movements. During home visits by the SOSW, the senior said her inability to maintain good hygiene affected her self-esteem and contributed to her isolation and depression.

The outreach support worker told the senior about the bath assist service offered by Home Living and the senior agreed to a referral. Working together, the outreach worker and Home Living ensured the senior was assessed and supported through a bath assist and equipment.

The result was the senior reported increased confidence and willingness to engage in the community. The outreach worker saw the senior become more positive and recover her sense of

humour. Both agencies continue to work together with this senior and will be there to help as her health care needs change.

How did your thinking and/or that of your colleagues change?

"We realized that managers needed to be involved to address structural support that was needed," says Whalley. "The other important learning was that Comprehensive Care Management needs to be part of the overall education and training in care, so case management practice leads, clinical nurse educators and others who teach and lead have an important part in making it a successful approach for improving seniors' care."

What do we need to ensure all seniors who need it can benefit from this change?

The Comprehensive Care Management process and tools can be easily adapted to local agencies/services. The learnings would also be valuable to municipalities that do not currently offer outreach/support services to seniors but are exploring better ways to support seniors living in their communities.

The knowledge gained from this project could further inform the development of public policy in the health and human services systems.