Alberta Health Services

EDMONTON SENIORS COORDINATING COUNCIL

Sage Seniors Association

This project was funded by:

Covenant Health
Network of Excellence in Seniors' Health and Wellness

Collaborative Case Management

SUMMARY REPORT

September 29, 2016

Executive Summary

Project Description

The objective of the Collaborative Case Management Project was to improve the referral and collaboration processes used by Alberta Health Services Home Living Case Managers (HLCM) and community-based Seniors Outreach/Support Workers (SOSW) to meet the needs of seniors (60+) living in the community.

The project was carried out in three phases:

- Phase 1: The project team reviewed current referral and collaborative practices to identify opportunities for enhancement.
- Phase 2: The team developed a simple practice support process and tools to facilitate referrals and collaboration.
- Phase 3: The proposed process was tested by nine HLCM and up to 13 SOSW and evaluated by the project team.

The Innovation

Collaborative Case Management, or CCM, is a practice support process in which HLCM and SOSW work together to meet the needs of vulnerable seniors who live in the community. CCM can be as simple as referring clients to one another to meet a specific identified need for service that the other can provide. Or it can be as complex as developing an ongoing relationship between a HLCM, SOSW and client to address a range of health care and social support needs by offering a wider continuum of services and supports.

CCM was designed to address the dual challenges of low awareness and reported time constraints on the part of HLCM, while avoiding the potential for overwhelming the limited number of SOSW in Edmonton. CCM is not an add-on to the work of HLCM or SOSW; rather, it can be easily integrated into the work they are already doing to maximize the supports available to vulnerable seniors living in the community.

Evaluation Results

Outputs: The CCM project produced a simple practice support process, five practice support tools and a commitment to ongoing training and support from the partners. The practice support tools include:

1) Home Living Case Manager Decision Tree
2) Quick Reference: Seniors Outreach/Support Workers
3) Quick Reference: Home Living Case Managers
4) Client Information Sheet
5) Collaborative Case Management Contact Sheet

Outcomes: As a direct result of the project, participating HLCM are aware of SOSW and both know when and how to refer to each other. By learning about the services that each other can provide, HLCM and SOSW are confident that they know when to refer and/or collaborate with each other to meet client needs. Both HLCM and SOSW recognize the potential of CCM to reduce gaps and duplication in services, while at the same time providing a more comprehensive continuum of services to their clients. In particular, participating HLCM found – or expect to find – that collaboration with SOSW allows them to spend less time on clients' non-health care needs.

Impact: Improved referral and collaboration between HLCM and SOSW increases seniors' access to a continuum of services, which contributes to greater confidence and comfort in their ability to live in the community.

Conclusion

The knowledge gained from this project could further inform the development of public policy in the health and human services systems. Given the skills, ability and flexibility of SOSW, collaboration between home care and community-based outreach services for seniors offers an innovative solution to providing an integrated and interconnected system of supports for seniors with complex health and social needs.

The CCM practice support process will be rolled-out to all HLCM and SOSW in Edmonton and area beginning in the fall of 2016.

Practice Support Tools

The CCM Project developed practice support tools to facilitate collaboration and referral among HLCM and SOSW. All tools were valued and accepted by participating HLCM and SOSW, as they filled an information gap and made it very easy to connect with each other. Practice Support Tools developed by the project included:

1. Home Living Case Manager Decision Tree

This is a training tool for HLCM. It outlines the basic decision-making process that a HLCM might use to refer a client to a SOSW, after eliminating other sources of support (to avoid overloading the limited number of SOSW in Edmonton). Over time, we expect HLCM to internalize this information and use the tool, when needed, as a quick reference.

See: Appendix B – HLCM Decision Tree

2. Quick Reference: Seniors Outreach/Support Workers

This tool provides a brief description of the role of SOSW and the services they provide. On the back of the sheet is a contact list of all senior-serving agencies that offer outreach/support services in each Edmonton Zone Home Living service area and city-wide.

See: Appendix C – Quick Reference: Seniors Outreach Support Workers

3. Quick Reference: Home Living Case Managers

This tool provides a brief description of the role of HLCM and the services they provide. On the back of the sheet are specific instructions for contacting an HLCM, depending on whether or not the client is already receiving Home Living services

See: Appendix D - Quick Reference: Home Living Case Managers

4. Client Information Sheet

This one-page information sheet can be given to a client by either a HLCM or SOSW, when working in collaboration. The purpose is to explain the role of the SOSW, and to indicate when the client can call the SOSW and when the client can call the HLCM. The sheet also provides clear contact information for both the HLCM and SOSW.

See: Appendix E – Client Information Sheet

5. Collaborative Case Management Contact Sheet

Developed as data collection tool for Phase 3, some project participants said they would continue to use the data tracking sheet (now renamed CCM Contact Sheet) as it provides an easy to use tool for SOSW and HLCM who want to maintain a simple record of contacts and ongoing collaboration.

See: Appendix A – Data Tracking Sheet

Practice Support Process

1. CCM is an enhancement, rather than an add-on, to the work of HLCM and SOSW. The process and tools are used, as needed, in day-to-day practice.
2. The process begins when a client – new or existing – presents as someone who would benefit from collaboration between a HLCM and SOSW.
3. The initiating HLCM or SOSW uses the practice support tools to determine if referral/collaboration is appropriate.
4. The initiating HLCM or SOSW contacts a collaborator and engages in a case conference. This case conference can be as simple as an initial phone call, or more complex, such as a face-to-face meeting with the client and caregiver(s). The collaborators decide what is necessary.
5. Contacts and other relevant information are tracked in case notes or on the CCM Contact Sheet.
6. Ideally, a collaborator will update the initiator when a service is provided, a client moves out of the service area and/or a client file is closed. The type and amount of information shared is negotiated between the collaborators.

Appendices

Appendix A

Collaborative Case Management Project – Data Tracking Sheet

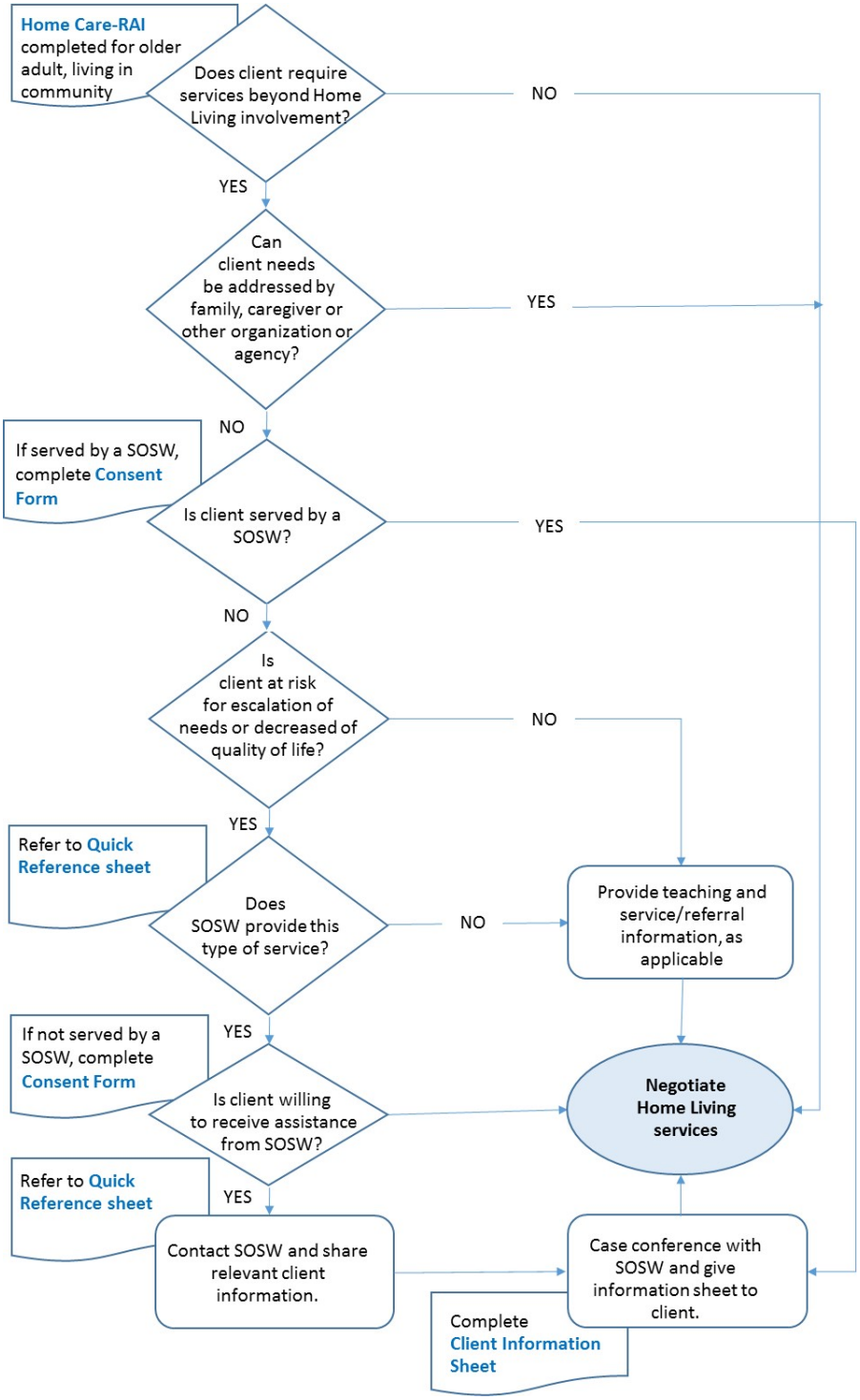
Name	Page _____ of _____
AHS Home Living Office	Seniors Agency/Organization

Date	Agency(ies) Contacted (enter # - see below)	Referral Made (✓)		Reason(s) for Referral (enter # - see below)	Case Conference (✓)		Follow-up Contact (✓)	Comments
		Yes	No		Yes	No		

Agencies	
1. Home Living (all)	8. North Edmonton Seniors Association (NESA)
2. Edmonton Aboriginal Senior Centre (EASC)	9. North West Edmonton Seniors Society (NWESS)
2. Edmonton Seniors Centre (ESC)	10. Operation Friendship Seniors Society (OFSS)
3. FCS Strathcona County	11. Sage
4. Jewish Family Services (JFS)	12. SCONA
5. Mill Woods Seniors Association (MWSA)	13. South East Edmonton Seniors Association (SEESA)
6. Multicultural Seniors Outreach via Sage	14. Strathcona Place 55+ Centre
7. Multicultural Women & Seniors Services Association (MWSSA)	15. Westend Seniors Activity Centre (WSAC)

Reason for Referral	
1. Health care needs	8. Food security, nutrition
2. Income supports	9. Language/cultural
3. Taxes	10. Social isolation
4. Housing	11. Elder abuse, safety
5. Transportation/mobility	12. Hoarding
6. House/yard care	13. Guardianship/trusteeship
7. Grief, mental health, addictions	14. Other

Appendix B



Collaborative Case Management

HLCM Decision Tree: Referral to a Seniors Outreach/Support Worker

This project is funded by:

Covenant Health Network of Excellence in Seniors' Health and Wellness

Alberta Health Services

Partners:

Edmonton Seniors Coordinating Council

Sage Seniors Association

Appendix C

Quick Reference: **Seniors Outreach/Support Workers (SOSW)**

What is a Seniors Outreach/Support Worker?

Seniors Outreach/Support Workers are employed by non-profit, community based agencies that serve older adults. Many SOSW are social workers or related professionals. SOSW provide one-time and ongoing services to seniors and their families in their own homes, seniors centres or elsewhere in the community.

Who do SOSWs serve?

Older adults*, living in the community, who have some or all of the following characteristics:

- Complex needs or circumstances
- Not able to address needs on own
- Unaware of what help is available
- Limited or no contact with family/friends
- Socially isolated (even if living with or supported by family)
- Needs help with transportation
- Does not have sufficient finances to meet needs

** Referral age may vary by agency.*

A SOSW <u>might</u> be able to help if your client needs support in any of these areas:

- Help finding a place to live
- Help finding house or yard care
- Help filling out forms (Financial Benefits or other)
- Help filing taxes/connecting to a tax clinic
- Help finding transportation for getting to appointments, shopping, banking
- Help getting meal services or food from the food bank
- Help connecting to social opportunities and supports
- Help with private guardianship and trusteeship processes
- Help with language/cultural barriers
- Help dealing with grief and loss, mental health problems or addictions
- Help when elder abuse is suspected
- Help addressing hoarding issues (Sage "This Full House" program)

What information will a SOSW need to know about my client?

- Name
- Gender
- Date of Birth or Age
- Phone number
- Home address
- Marital status (married, divorced, widowed, common law, single)
- What language the client speaks and if interpreting services will be required
- What services the client is receiving from Home Living, including if client is in a day program or CHOICE
- If there are any issues that might impact the safety of the SOSW (e.g. suspected elder abuse, extreme hoarding, large animals in home, someone in the home who smokes, etc.)

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How can I contact a SOSW?

Call 211 and ask for Seniors Outreach/Support Services OR call one of these offices directly:

Seniors Outreach/Support Program	Postal Code Area	Phone
All Postal Codes and/or Specialized Services		
Bent Arrow Traditional Healing Society (Aboriginal seniors)	All	780-474-2400
Jewish Family Services	All	780-454-1194
Multicultural Seniors Outreach via Sage Outreach (languages/communities served: former Yugoslavian, Spanish speaking, Kurdish, Eritrean, Korean and the Africa Centre)	All	780-701-9019
Multicultural Women & Seniors Services Association	All	780-465-2992
Sage (city-wide outreach services, specializing in guardianship/trusteeship, elder abuse, hoarding)	All	780-701-9019
Strathcona Place 55+ Centre	All	780-433-5807
North Home Care Office (191 Boudreau Rd, St. Albert)		
North West Edmonton Seniors Society	T5X-T6V	780-451-1925
Northeast Home Care Office (10611 Kingsway Ave.)		
Edmonton Seniors Centre	T5B-T5G-T5H-T5J-T5K-T5W	780-342-8124
North Edmonton Seniors Association	T5A-T5C-T5Y-T5Z	780-414-8790
North West Edmonton Seniors Society	T5E-T5L	780-451-1925
Operation Friendship Seniors Society	T5B-T5G-T5H	780-429-2626
Westend Seniors Activity Centre	T5M-T5N	780-483-1209
Southeast Home Care Office (1090 Youville Drive)		
Mill Woods Seniors Association	T6K-T6L-T6N-T6T-T6X	780-508-9253
SCONA (Seniors Citizens Opportunity Neighbourhood Association)	T6C-T6E-T6G	780-433-5377
South East Edmonton Seniors Association (SEESA)	T6A-T6B-T6C-T6P	780-468-1985
Southwest Home Care Office (16930-87 Ave)		
North West Edmonton Seniors Society	T5V	780-451-1925
South East Edmonton Seniors Association (SEESA)	T6E	780-468-1985
Westend Seniors Activity Centre	T5P-T5R-T5S-T5T-T6M-T6R	780-483-1209
Strathcona Home Care Office (Bower Dr, Sherwood Park)		
Family and Community Services Strathcona County		780-464-8076

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Appendix D

Quick Reference: **Home Living Case Managers (HLCM)**

What is a Home Living Case Manager?

A Home Living Case Manager is a health professional employed by Alberta Health Services to provide case management services in the AHS Home Living program. HLCM are typically registered nurses, occupational therapists or social workers. Their purpose is to promote client independence and to supplement care and supports provided by families and community services.

Who do HLCM serve?

HLCM provide support to Albertans of all ages with a valid health care card. Every HLCM manages an assigned caseload of clients that live in the community. These include clients that live in their own homes or in seniors' buildings, lodges or private supportive living sites. Most clients have long term health care and social support needs.

What services do HLCMs offer?

Home Living provides help with activities of daily living that clients cannot do themselves or cannot get help with from another source. Services are provided in clients' homes or in Home Living Clinics. Based on an assessment of unmet needs, a HLCM works directly with the client and is responsible for:

1. Supporting Self-Care
   - Assessing client/family's ability to develop or maintain independence
   - Identifying client/family's support networks and resources
   - Identifying factors that impact client's independence and functioning
2. Negotiating Service Options
   - Working with the client to maximize strengths and utilize existing support networks and resources
   - Educating or coaching the client/caregiver
   - Exploring the use of aids/equipment
   - Identifying barriers to independence
   - Planning to prevent crisis
3. Delivering Service
   - Providing ongoing case management
   - Facilitating access to professional health care services
   - Authorizing the delivery of hands on, personal care, e.g. bath assistance, medication assistance

Home Living <u>might</u> be able to help if your client needs professional support and/or **support for activities of daily living**. A HLCM will explore all available options within the Home Living Portfolio. Services might be provided by a geriatric consult team, nurse practitioner, physical therapist, pharmacist, respiratory therapist, rec therapist, social worker, placement services, or other professional(s).

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How do I refer to a HLCM?

If your client is <u>not</u> connected to Home Living and does <u>not</u> have a HLCM, call Central Intake at 780-496-1300.

- Before calling Central Intake, ensure you have completed a client consent form.
- Ideally, your client should be with you when you contact Central Intake.
- Once connected to an intake worker, the telephone intake process will take approximately one hour.
- Have the following client information ready when you call:
  - Name
  - Gender
  - Date of Birth
  - Alberta Health Care card number
  - What language the client speaks and if interpreting services will be required
  - Reason(s) for referral
  - Current living arrangements (e.g. with spouse/partner, with child, with relatives, etc.)
  - If there are any issues that might impact the safety of the HLCM (e.g. suspected elder abuse, extreme hoarding, person in the home who smokes, large animals in home, etc.).

If your client is <u>already receiving Home Living services</u> (or you think s/he might be) and has a HLCM, you can contact the HLCM directly.

- Ask your client for the name and contact information for his or her HLCM. Every Home Living client receives a sheet of *Important Phone Numbers for Home Living Services* from the HLCM.
- If your client is unable to provide this information, or if your client doesn't know if s/he has a HLCM, call the Home Living office below that aligns with your client's postal code.
- Before calling the HLCM, make sure you have completed a client consent form.

Home Living Office	Phone	Postal Code Area Served
Northeast 10611 Kingsway Ave.	780-342-4400	T5A -T5B -T5C -T5E-T5G -T5H -T5J-T5K -T5L-T5M -T5N -T5W -T5X -T5Y-T5Z -T6S
Southeast 1090 Youville Drive	780-735-9559	T6A -T6B -T6C -T6E -T6G -T6J -T6K-T6L -T6N -T6P -T6T -T6W -T6X
North 191 Boudreau Rd, St. Albert	780-418-8400	T5E –T5L –T5X –T6V –T8N
Strathcona Bower Dr, Sherwood Park	780-342-4500	T8A –T8B –T8C –T8E –T8G –T8H –T8L
Southwest, 16930-87 Ave	780-735-2442	T5N -T5P -T5R -T5S -T5T -T5V T6E -T6G -T6H -T6M -T6N -T6R -T6W

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Appendix E

Client Information Sheet

Your Home Living Case Manager is working with a Seniors Outreach/Support Worker in your community to help you stay independent for as long as possible.

There is no cost to get help from a support worker. Your worker can meet with you in your home, at a seniors centre or in your neighbourhood. You decide what services you need and when you don't need help anymore.

Your Support Worker's Name is:

_____

Agency/Seniors Centre: _____

Phone number:_____ ext. _____

Call your support worker if you need:

- Help finding a place to live
- Help finding house or yard care to stay in your own home
- Help with filling out forms (Financial Benefits or other)
- Help with filing your taxes
- Help getting meal services or food from the food bank
- Help getting out of the house to meet people and have fun
- Help finding transportation (for getting to appointments, shopping, banking)
- Help dealing with grief and loss, mental health problems or addictions

Call your Home Living Case Manager for all questions or concerns about your Home Living (home care) services.

Your Home Living Case Manager's Name is:

_____

Phone number:_____ ext. _____

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